

CACHI: BUILDING, DIVERSIFYING, TRANSFORMING

Three-Year Interim Evaluation Brief (2017-2019)

SUMMARY

The following brief presents interim evaluation findings of the California Accountable Communities for Health Initiative (CACHI), covering approximately three years of implementation (2017-2019).

CACHI is a six-and-a-half-year, \$17 million initiative jointly funded by The California Endowment, Blue Shield of California Foundation, Kaiser Foundation, Sierra Health Foundation, California Wellness Foundation, Social Impact Exchange and Wellbeing Trust.

In Phase One (2016-19), two cohorts—6 Catalyst sites and 7 Accelerator sites—were established with significant differences in the level of funding and program support. In Phase Two (2019-21), both groups were combined into one cohort. The 13 grantees receive up to five years of support in total.

This evaluation brief covers Phase One for the six original Catalyst communities. The purpose of this brief is to summarize the status, primary accomplishments and challenges of the initial six Catalyst sites in their implementation of the seven key elements of the CACHI model. It will also provide an assessment of progress toward systems change in each of the communities.



The California Accountable Communities for Health Initiative (CACHI) is leading efforts to [modernize our health system](#), advance statewide health equity and improve the health of entire communities, not just individual patients.

To realize this vision, CACHI utilizes a new model known as **Accountable Community for Health (ACH)**, a groundbreaking vehicle for bringing community leaders, residents and key stakeholders across multiple sectors together to collectively address our most pressing health priorities.

Learn more at www.CACHI.org.

BACKGROUND



The Initiative

CACHI aims to create a “more expansive, connected and prevention-oriented health system” in which multiple sectors and the community come together to address high-priority health issues facing communities.

The CACHI model incorporates seven key elements:

1. **Shared vision and goals**, based on a common understanding of the health issues facing the community.
2. **Governance, partnerships and leadership** to create meaningful collaboration and distributed leadership among partners across multiple sectors.
3. **Community and resident engagement** in shaping the direction and work of the accountable community for health (ACH).
4. **A backbone entity** that serves as the collaborative facilitator and convener.
5. **A portfolio of interventions (POI)**, defined as a set of coherent, mutually supportive interventions that address common goals across five domains: clinical care, community programs and social services, community-clinical linkages, environment, and policy and systems change.
6. **A Wellness Fund, along with a sustainability plan**, that attracts resources from a variety of sources to support the infrastructure, priorities and—as needed—the activities of the ACH.
7. **Data analytics and sharing capacity** using data to set direction, and monitor and communicate progress toward the ACH’s goals.

In addition to these elements, CACHI communities also embed **equity, diversity and inclusion as core principles** throughout their policies and practices.

BACKGROUND



The Communities

The [six original sites](#) that launched in the fall of 2016 represent a range of geographic locations and collaborative models. Each site has chosen a focus area or target condition and is approaching its work from a different community and historical context. The profiles below provide an orientation to each site.

1. **The East San José Peace Partnership** aims to decrease community violence, family violence and associated trauma, and to increase resiliency, social and cultural capital, and community assets. It serves a portion of Santa Clara County, and the County Health Department acts as the backbone.
2. **The Imperial County ACH** had primarily focused on asthma, a significant health and health equity concern in the community, and a priority of the county's Community Health Improvement Plan. It soon took on mental health and Adverse Childhood Experiences. (ACEs). The Local Health Authority Commission acts as the governing body of the ACH, and the Imperial County Public Health Department serves as the backbone.
3. **The Merced County ACH** had the goals of reducing diabetes, heart disease and associated depression, but eventually began tackling health equity, trauma and resilience. The ACH targets its work to three of the five supervisorial districts in the county, and the Merced County Department of Public Health acts as the backbone.
4. **The Reinvent South Stockton Coalition** focuses its efforts on the defined geographic area of South Stockton, where a public-private collaborative of health, housing, education, social services, law enforcement and community organizations formed a Promise Zone to focus resources to address decades of divestment, poverty and limited economic opportunities. As part of CACHI, the RSSC, which serves as the backbone organization, has prioritized access to behavioral health and trauma-informed care for its health-related work.
5. **The San Diego Accountable Community for Health (SDACH)** is committed to achieving health, wellness and equity for the entire county. SDACH began with the aim of achieving ideal cardiovascular health across the lifespan, but soon expanded its scope to embrace trauma-informed approaches to nutrition and create Neighborhood Networks that connect community health workers with CBOs. To date, they have focused efforts in southeastern San Diego and the north inland region of the county. Be There San Diego, a coalition of patients, communities and health care systems, serves as the ACH backbone.
6. **The Sonoma County ACH**, in its initial years, has focused on addressing cardiovascular disease primarily in southwest Santa Rosa. They are now working to enable Sonoma County Health Action, a long-standing county-wide partnership group with the mission of improving health, educational attainment and economic well-being to function as an ACH. The Sonoma County Health Department currently provides backbone support.

Evaluation Approach & Methods

As a learning evaluation, the focus of the assessment is to document successes, progress and challenges for CACHI sites and the initiative as a whole, and to understand the role that ACHs play in systems change and improved community outcomes. The evaluation draws on several methods of inquiry and types of data, including site visits, stakeholder interviews, annual written partner surveys, bimonthly site check-in calls, document review and observations at annual backbone meetings and convenings.

PROGRESS ON THE SEVEN KEY ELEMENTS



The sites continue to make steady progress on establishing the seven key CACHI elements to create the conditions necessary for achieving their longer-term systems change goals. In the first three years, sites made significant progress in the areas of partnership building by establishing a common vision for change across partners, and refining and implementing aspects of the POI. There was more variability across the sites in their progress toward assessing and tracking outcomes by authentically engaging the community and residents, and implementing the wellness fund. Success factors and challenges are described below.

CACHI'S SEVEN KEY ELEMENTS

Shared Vision & Goals

Governance, Partnerships & Leadership

Community and Resident Engagement

Backbone Entity

Portfolio of Interventions

Wellness Fund

Data Analytics and Sharing

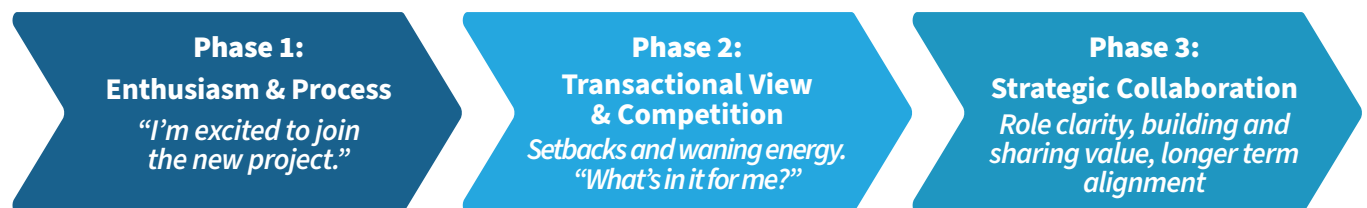
Success Factors and Challenges

Vision, Governance & Partnership, and Backbone

Building the right infrastructure. CACHI sites devoted significant energy during their initial years to building the right infrastructure and partnerships that were grounded in the mutually reinforcing elements of vision, governance and backbone. Progress was demonstrated through consistent meeting attendance by partners, as well as partner commitment to the shared vision and goals of the ACH. Equity as a principle was incorporated into governance and decision-making, using guidance from resident work groups.

Transitioning from centralized governance to distributed leadership. A key strategy implemented by most sites was to gradually shift from a centralized governance structure, driven primarily by the backbone entity, to a more distributed leadership model, where partners lead and are accountable for aspects of the work and are key contributors to decisions.

Establishing meaningful and high functioning partnerships takes time. Building committed ACH partnerships takes time and progresses through three phases (see diagram below). While enthusiasm may be high for a new, exciting project, partners may then begin to look more closely at what they have to gain by participating. Longer term success requires more strategic collaboration, clearly defining roles and shared values. Some sites experienced setbacks in partner involvement and momentum, and most experienced turnover in key backbone staff and leadership.



PROGRESS ON THE SEVEN KEY ELEMENTS



Community and Resident Engagement

Investing in resident engagement and commitment to a community-driven effort sets ACHs apart from other initiatives. ACHs increasingly are driven by the community, with diverse voices in leadership present at decision-making tables. Some sites have made investments in resident leadership training and capacity building. Partnerships expanded beyond health and social service sectors into other areas, such as business and faith communities.

Authentic community and resident engagement requires intention and time.

Whether it is finding a convenient meeting time and location for residents, developing a common language free of professional jargon or addressing long-standing issues of systemic racism, ACHs are learning how to build and foster necessary trust among system and organizational partners, and the community, for authentic involvement. Strategies include establishing resident- and community-led work groups, assessing and holding conversations around equity and inclusion practices, establishing clear representation and roles for community members in the governance structure, and engaging the community to shape and mobilize policy agendas.

Portfolios of Intervention

Understanding the POI as both a catalyst for change and a network of solutions.

Some ACH sites have described their POI as a “vehicle for change”—a mechanism by which to engage and align partners, understand community needs and develop new ways of working together. In such cases, the collection action process or journey in developing rather than finalizing the POI is what matters and creates the conditions for transformation among the partners and the community. Some sites also characterize their POIs as a “network of solutions” for an identified problem or disparity. By partners agreeing to align and work together differently, the POI serves in both roles.

Leveraging the clinical-community linkage for the POI. The clinical-community linkage domain of the POI is central to systems change within the ACH model. This domain, more than others, creates new opportunities for community-based organizations (CBOs) and traditional health system stakeholders to partner on interventions that impact the community. As one ACH partner stated, “The community-clinical linkages domain holds the whole portfolio together.” Backbone entities are well positioned to bridge clinical services and community programs, and they have leveraged this role to support greater collaboration between partners in a way that did not exist prior to CACHI.

Using community health workers to bridge communities and health delivery system/ health plan partners. Community health workers (CHWs) create stronger access points between clinical and community programs for addressing the social determinants of health, while providing greater community outreach and engagement capacity for health care entities that lack field-based capacity. Four ACHs are using this model to bridge services in their communities (Imperial, Merced, San Diego and Sonoma).

PROGRESS ON THE SEVEN KEY ELEMENTS



Establishing a clear vision of change for POI development. Having a clear set of outcomes and understanding of “root causes” of the problem being addressed through the ACH helps partners to develop a coherent, mutually reinforcing POI. It is important to identify longer-term outcomes (e.g., reduce cardiovascular mortality), as well as shorter-term outcomes (e.g., increasing the percentage of individuals with controlled blood pressure).

Approaching and developing POIs happens iteratively. POI development and implementation is iterative and goes through three distinct phases: creation, implementation and refinement. By design, POIs continue to evolve over time, reflecting the reality of collective approaches to addressing complex health and social issues.

Wellness Fund and Sustainability Plan

Taking incremental steps to develop a wellness fund. Developing a wellness fund is a longer-term process that involves a series of steps. Different CACHI sites made progress by creating value propositions, drafting sustainability plans, establishing fund administrators, selecting fiscal agents to house the wellness fund, and identifying potential investors, contributors or contractors. These proved to be the steps required before moving on to an established fund or sustainability plan.

Developing a Wellness Fund is the most political and technically difficult of all ACH activities. Many ACHs experienced delays developing Wellness Funds and sustainability plans as they needed first to focus on building and establishing other ACH components. Additionally, Wellness Fund and sustainability plan development requires a certain expertise and capacity that might not be available in all ACHs. The wellness fund conversation requires ACH backbone organizations to build the value proposition for the ACH as a whole and to clarify the ACH’s infrastructure as an integrator and builder, rather than as an administrative support organization. ACHs faced difficulties in establishing equitable processes for distributing wellness fund monies.

Data Analytics and Sharing

Devoted time for data and measurement conversations. Some ACHs designate a work group focused solely on data and metrics, while others incorporate the function into an existing work group. Conversations focus on defining and adjusting medium- and long-term outcomes, assessing the data capacities of ACH partners and incorporating data into storytelling.

A lack of data or concerns about sharing it makes it difficult to track success. Publicly available data are limited, and most sites did not allocate sufficient funding to support data collection, analysis and visualization, which made it difficult to identify metrics and data to present in dashboards or share with partners. In some cases, partners also raised concerns about sharing data that might “make my organization look bad,” requiring attention to trust building and education to better understand the role of data in the ACH and the need for adopting shared measures to demonstrate greater impact by all partners involved.

IN THE WORDS OF ACH PARTNERS:

ACH VALUE AND ACCOMPLISHMENTS



Across the six CACHI sites, there is strong agreement among partners that the ACH is effective and adds value to advancing work related to the target issues being addressed. The following section documents the various ways partners are currently ascribing value to CACHI in their communities, in terms of effectiveness, equity and inclusion, convening and promoting collaboration among cross-sector partners, and impact on partner organizations.

ACHs “get things done.” Between 2018 and 2019, partners agreed more strongly that ACHs “get things done.” They view ACHs as offering a platform to align partners and interventions, and to facilitate the collective work of cross-sector collaborators. As one partner noted, *“In my opinion, the ACH has created a catalytic space for partners to do more than they ordinarily would do due to competing priorities and other demands.”*

ACHs are promoting principles of equity, diversity and inclusion. Between 2018 and 2019, all of the Catalyst sites invested significantly in strategies to address health equity and authentically engage community residents. For example, Merced engaged an equity and accountability person to participate in meetings. San Diego’s Community and Resident Engagement Workgroup (CREW) developed equity guidelines for all of the other work groups to use. A majority of partners across the sites agree that the ACHs are promoting and using principles of equity, diversity and inclusion in their work. One survey respondent noted that *“the ACH uplifts community voice, promotes community empowerment, listens and incorporates community assets identified by residents.”*

ACHs convene and promote collaboration among cross-sector partners and the community. Nearly one-third (31%) of respondents to surveys sent to members of all ACHs noted the value of the backbone and the ACH in convening cross-sector partners for networking, collaboration and communication. Nearly a quarter noted the ACH’s value in promoting partnership and collaboration, and aligning the vision and activities among cross-sector partners. One respondent noted, *“The ACH brings together diverse stakeholders to work collectively toward shared goals related to community health improvement. These partners would likely not meet and work collaboratively to the extent that they do if the ACH did not exist.”*

As a result of their involvement in ACHs, partners make improvements in their own organizations. When asked to describe the impact of ACH participation on their organizations, partners reported re-examining their organizational missions due to growing awareness of health equity issues; changing practices to better align with partners; learning to value and include community-resident engagement as a priority; and valuing the power of working collectively and collaboratively with partners rather than in isolation. One partner commented, *“Our organization has increased its focus on equity and diversity because of its partnership in the ACH. It has allowed us to better communicate the challenges we face and look at our work with a greater eye for the individual.”*

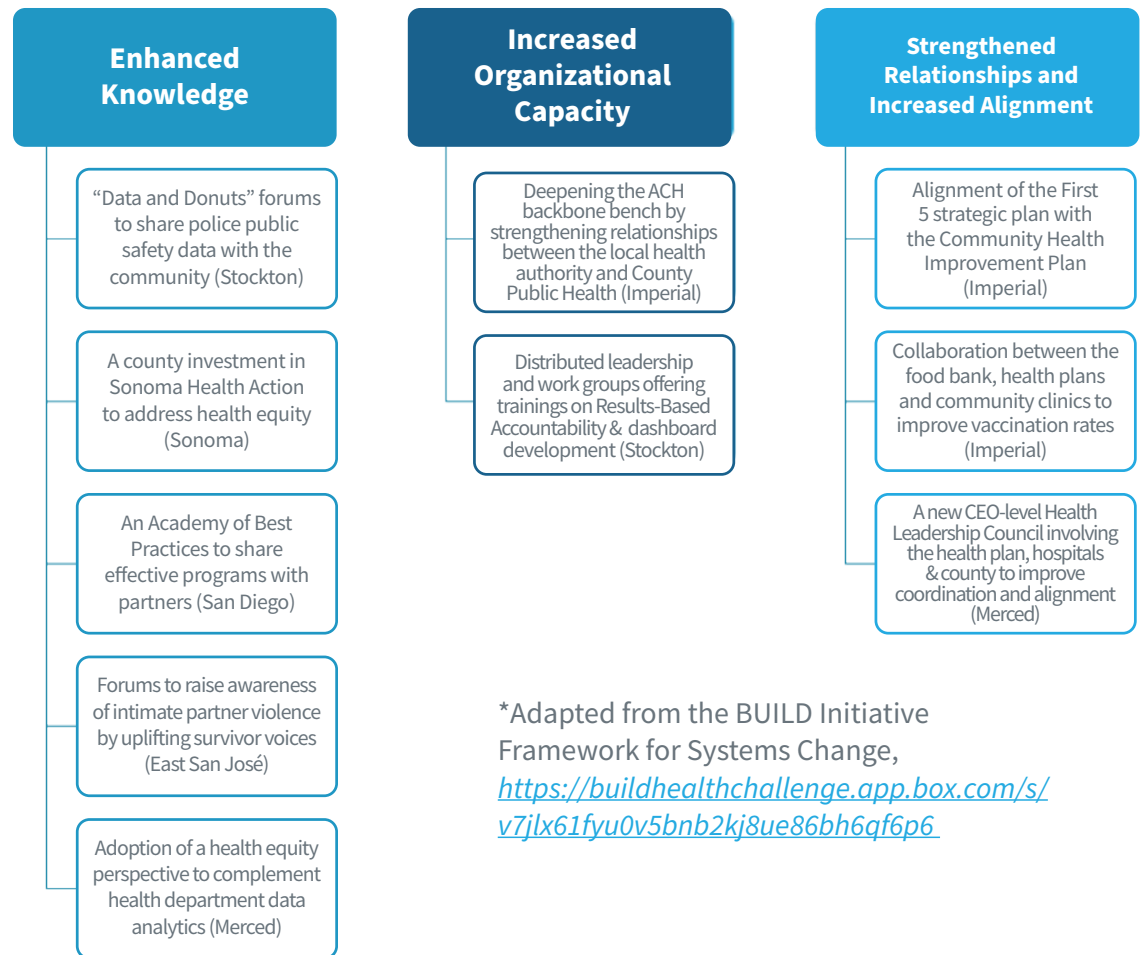
SYSTEMS CHANGE ACCOMPLISHMENTS



At its core, CACHI is a systems change initiative aiming to realign and transform policies, practices, power and capacities in communities to improve health equity and long-term population health outcomes. Overall, the six sites have made demonstrable progress in establishing the foundational elements of a functioning ACH governance structure and common vision necessary for creating the conditions for longer term systems changes. Sites also have achieved systems changes that are necessary for reaching their end goals related to improved population health and health equity. (These concepts are adapted from the BUILD Initiative Framework for Systems Change).

Examples of progress on preconditions for systems changes are shown in **Figure 1**.

Figure 1: Examples of Progress on Preconditions for Systems Changes*



In addition, as described below, four organizations achieved system changes by “transforming norms and ways of working” (Imperial, Sonoma and San Diego) and reallocating program funding (East San José) that are being applied to new issues and challenges in their communities.

East San José — The County of San José allocated re-entry program funding to the Wellness Fund. \$250,000 of re-entry funding was allocated to the Wellness Fund to support the work of the ACH, including addressing displacement efforts due to gentrification.

SYSTEMS CHANGE ACCOMPLISHMENTS



Imperial — The ACH backbone served as a neutral convener to transform practices and service delivery related to psychiatric crisis management. Leveraging its recognized role in the community as an effective convener, the backbone facilitated and oversaw a process to understand root causes and develop a strategic action plan to improve the capacity and workflows for addressing psychiatric crisis management (5150s) in the community. This was the first cross-sector (hospital emergency departments, law enforcement, County Behavioral Health) effort to address this significant community issue and will lead to improved treatment access and better care experiences for patients and families; better use of resources by law enforcement on public safety, not psychiatric crisis management; improved ED provider experience and satisfaction; and improved financials for hospitals.

San Diego — Neighborhood Networks of CHWs solve capacity needs and performance requirements of CBOs and health plans. As a sustainability and capacity-building strategy, the ACH backbone developed “Neighborhood Networks” to create a sustainable CHW workforce to fulfill the outreach, engagement and care coordination needs of health plans serving populations with complex chronic conditions. The ACH is contracting with CBOs and serving in an administrative services organization capacity to broker a connection between health systems and CBOs. This value-added ACH function is enabling CBOs for the first time to secure reimbursement for services.

Sonoma — Cross-sector alignment and collaboration solves new problems. Although not its primary focus, the collaborative was able to drop the opioid overdose rate quickly by building a shared lens about what it takes to make a difference. This lens recognizes that the health of the community depends on other types of organizations and services being at the table, in alignment with health care, to improve community health.

LESSONS LEARNED & CONCLUSION



Over the first three CACHI project years, the six original sites diligently built their multi-sector collaboratives by: 1) developing and refining their collective vision, and roles and responsibilities within the governance structure among backbone organizations and partners; 2) amplifying the community voice by establishing clear roles and engagement opportunities for residents and community members; and 3) creating and refining the POIs to ensure relevance and responsiveness to community needs and priorities. To a lesser extent, the ACHs established Wellness Funds and sustainability strategies, as well as data and measurement strategies, to demonstrate their impact.

What became clear through these implementation experiences is that ACH establishment is an iterative and interdependent process that manifests differently depending on the starting capacities, history and priorities of each community. From an evaluation standpoint, it is helpful to understand progress on each of the seven key elements. Yet to really understand the ACH as a holistic approach, it is essential to recognize that the key elements intersect, interact and reinforce in ways that differ from the early framing of the CACHI model. Moving forward, the evaluation will focus more on the inter-relationship of the key elements, particularly in terms of their value and impact in establishing the ACH as a unique and enduring transformation platform to address and advance population health and equity in communities.

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