CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

CACHI

...The Next Generation of Health System Transformation

Demonstrating Success With Accountable Communities for Health

The ACH model is a groundbreaking approach to transforming community health with a more connected, prevention-oriented health system. Early ACH experiments have already delivered evidence of success.

A Tested Model

The ACH model has been put into the field in communities across the United States.

126+
Active ACHs in the U.S.

33+
States

The ACH model has led to incredible results in communities with strong multi-sector collaborations:

20%
Decline in Deaths
Communities with Strong Partnerships

19%
Improvement in Blood Pressure
Sonoma's ACH

45%
Reduction in Drug Overdoses
Staten Island's ACH

Millions
of Health Care Dollars Potentially Saved

Backed by Data

A study published by world-renowned public health researcher Glen Mays in *Health Affairs* revealed a statistically significant **20 percent reduction in mortality** in communities with multi-sector population health activities, such as those supported by ACHs.

The study also concluded that these collaborations help close geographic and socioeconomic disparities in population health, especially when backed by incentives and supporting infrastructure.

Impact of Multi-Sector Population Health Collaboration on Community Mortality Rate

> *"**Deaths** due to cardiovascular disease, diabetes, and influenza **declined** significantly over time among communities that expanded multi-sector networks."*
>
> **— Glen Mays, et al., Health Affairs (2016)**

What's an ACH?

Accountable Communities for Health are multi-sector, community-based partnerships that bring together health care institutions, public health, safety and social service agencies, community-based organizations, the justice system, and businesses to address population health.

Working in tandem, these organizations focus on a shared vision and joint responsibility to improve the health of the community. An aligned portfolio of interventions, linking health care and communities, coordinates action, collects data, and executes plans that lead to more prevention and less treatment.

To date, ACHs have tackled dozens of complicated problems through cross-sector collaborations that better align and coordinate interventions.

Issues addressed nationally have included:

- Diabetes
- Obesity
- Asthma
- Substance Use Disorders (SUDs)
- Violence/Trauma
- Food Insecurity
- Health Equity
- Transportation

Learn More & View Sources at www.CACHI.org/Resources

California ACH Successes

Humboldt County

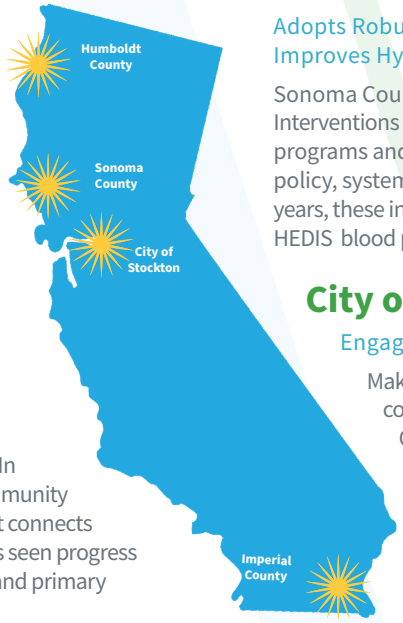
Cross-Sector Collaboration Likely to Reduce Costs Significantly

Faced with a perinatal substance use disorder (SUD) rate 3.7 times the state average, the Community Perinatal SUD Project, partnering with Humboldt's ACH, recruited 17 diverse partners to pool resources and improve health outcomes for pregnant women and newborns with SUDs. An initial economic analysis estimates its cross-system interventions will lead to improved health, and significant medical and social service cost savings.

Imperial County

Successfully Navigates Asthma Patients From Emergency Department (ED) to Primary Care

Imperial's ACH employed a system-wide approach to fundamentally change how asthma is treated in their county. In partnership with hospitals, providers, school nurses, and community organizations, the ACH's Asthma Community Linkages Project connects asthma patients in the ED to appropriate follow-up care. It has seen progress on many milestones bridging the gap between ED discharge and primary care, creating an effective interdisciplinary asthma care team.



Sonoma County

Adopts Robust Portfolio of Interventions, Improves Hypertension HEDIS Score by 19%

Sonoma County's ACH developed a robust Portfolio of Interventions (POI) that included clinical services, community programs and services; clinical-community linkages; and policy, systems, and environmental changes. Within three years, these interventions led to a 19 percent improvement in HEDIS blood pressure control among patients.

City of Stockton

Engages Community to Improve Health

Making inroads in low-income communities of color isn't as easy as simply providing services. Often the challenge is gaining community trust. Stockton's ACH used a unique community engagement model employing resident trust builders to successfully reach over 1,300 residents, opening the door to greater use of critical services. Essential feedback on problem areas was provided to partner organizations.

What's Happening in Other States?

ACH	Process Changes	Policy Changes	Outcomes
Communities That Care Coalition, MA	A multisector coalition established to reduce alcohol, tobacco, and illicit drug use among youth. In 2011, it expanded its focus to include physical activity and nutrition among youth.	Schools optimize their policies and practices to support substance use prevention, nutrition, and physical activity promotion, and share best practices. Now CTCC is integrating a cross-sector racial justice focus.	Since 2003, CTCC has reduced youth rates of: • Alcohol use by 25% • Marijuana use by 21% • Binge drinking by 13% • Smoking by 6%
Trenton Health Team, NJ	Built a Regional Health Information Exchange to include social services. Trenton soon became a Health Hub for coordinating health care, public health, and social services under an accountable, responsive infrastructure.	Build an accountable, responsive system to address population health and social service needs of the population.	• Aligned services and support, improved outcomes and efficiencies, and significantly reduced costs • Reduced pre-term births by 9.4% • Reduced age-adjusted deaths due to stroke to 31 per 100,000 • Reduced age-adjusted deaths due to suicide to 7.7 per 100,000 • Boosted school attendance and transformed the built environment
Staten Island Performing Provider System, NY	Staten Island has developed partnerships across sectors and incorporated the Care Transitions model process and workflow as part of New York State's 1115 waiver.	Staten Island uses a data warehouse that integrates hospital, BH, FQHCs, EMS, police, fire, and homeless population data. There is also data exchange with CBOs. Social determinants of health services are paid for with value-based purchasing agreements.	Reduced: • ER Visits • Asthma • Childhood obesity • Transfers to nursing homes • Opioid overdoses by 45% • Overdose deaths by 35%
Yamhill CCO, OR	Yamhill Coordinated Care Organization serves Oregon Health Plan members in Yamhill County, and parts of Clackamas, Washington, Polk, Marion, and Tillamook counties.	Increase number of primary care providers using screening, brief intervention, and referral to treatment. Partnered with behavioral health clinicians to be included in primary care teams. Reimbursed medical providers for oral health care when providers complete early childhood cavity education.	• Adolescent Well Care visits increased from 24.8% to 60.5% • Developmental screenings increased from 16.8% to 75.5% • Colon cancer screening rates increased from 15.7% to 55.5% • $1 million allocated for a Wellness Fund

Citations

Mays, Glen P., Cezar B. Mamaril, and Lava R. Timsina. "Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks." *Health Affairs* 35, no. 11 (2016): 2005–13. https://doi.org/10.1377/hlthaff.2016.0848.

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Additional information self-reported by individual ACHs.