

The Power of Multisector Partnerships to Improve Population Health: What We Are Learning About Accountable Communities for Health

March 2021

The Funders Forum on Accountable Health

The [Funders Forum on Accountable Health](#) is a project of the Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health.

The Forum is a common table for the growing number of public and philanthropic funders supporting accountable communities for health initiatives to share ideas, experiences, and expertise. It is a shared venue for funders to explore potential collaborations and consider how to assess the impact of these investments over time.

The following foundations support the Forum's work: Blue Cross and Blue Shield of North Carolina Foundation, Blue Shield of California Foundation, California Endowment, Commonwealth Fund, Episcopal Health Foundation, Kresge Foundation, RCHN Community Health Foundation, Robert Wood Johnson Foundation, W. K. Kellogg Foundation.

This report was prepared by Jeffrey Levi, PhD, Janet Heinrich, DrPH, RN, Dora Hughes, MD, MPH, and Helen Mittmann, MAA.

Overview

Over the past year, the nation has witnessed tremendous health inequities from COVID-19 across populations defined by race, ethnicity, geography and disability. As part of the pandemic response and recovery, communities have leveraged multisector partnerships to address individual and community-level health and social needs. Indeed, in the recently released [National Strategy for the COVID-19 Response and Pandemic Preparedness](#), the Biden Administration commits to:

Facilitate linkages between clinical and social services. Given the increased need for social services during this pandemic, HHS will identify opportunities and mechanisms to support screening, referral and linkage to social services during COVID-19 testing and vaccination programs, with *particular focus on expanding community-based, multisector partnerships that can align health and social interventions.*

As foundations that have invested in and continue to support expansion of community-based, multisector partnerships, we applaud this commitment. Comprehensive, integrated and collaborative efforts will be essential to support the most at-risk communities. We hope that the Administration will support these partnerships as not just a response to the COVID-19 pandemic, but as part of rebuilding and transforming our health system to address health and social inequities that have exacerbated the impact of the pandemic in Black, Indigenous, and people of color (BIPOC) communities across the United States. Indeed, this approach has critical elements that can also address the Administration’s commitment to a government-wide approach to racial justice.

For four years now, the [Funders Forum on Accountable Health](#) – a collaborative that brings together philanthropic and public sector funders of multisector partnerships that address equity and social determinants of health – has been following the development of Accountable Communities for Health (ACH) across the country.

Accountable Communities for Health (ACHs) are multi-sector partnerships that bring together health care, public health, social services, and other local partners to address the unmet health and social needs of the individuals and communities they serve. The Funders Forum on Accountable Health has [identified](#) more than 125 ACHs across the country in different stages of development. They are diverse in their titles (e.g., accountable care communities, coordinated care organizations, and accountable health communities), funding sources, organization and structure. As one example, the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS) has invested \$157 million to establish the [Accountable Health Communities model](#) in 29 sites across 22 states, to support bridge organizations that address the health-related social needs of Medicare and Medicaid beneficiaries by linking clinical and community service providers. A second example is the [California Accountable Communities for Health Initiative \(CACHI\)](#), a privately funded demonstration that currently supports 13 unique ACHs in communities across the state. The [Build Health Challenge](#)

is another national initiative that is seeing considerable success, with funding from 11 national and local foundations that supports 37 projects in 21 states. This initiative has [documented significant systems change in communities](#) as well as progress in addressing health and health equity. ACHs have launched in states that have expanded Medicaid and those that have not, such as the Episcopal Health Foundation’s Texas Accountable Communities for Health Initiative and North Carolina’s Lead Pilot Entities, which is supported by a Medicaid 1115 waiver. By definition, ACHs working with the Medicaid population serve some of our highest risk groups, but even those ACHs that are separate from the health care financing system focus on the needs of underserved populations.

While implementation of the ACH model is varied, the differing approaches share a number of essential elements (**Figure 1**) and several key features have emerged – most notably, the importance and value of the structure in and of itself in bringing people and organizations to a common table to solve complex problems in their communities. ACHs use evidence about health inequities to advance change and are, above all, about changing how a community creates health and how it shares power—particularly among low-income individuals, BIPOC, and other underserved populations—which are both central to improving outcomes and advancing equity. The core value of the ACH experiment has been demonstrated throughout the pandemic response, as ACHs across the country have been able to pivot quickly to provide crucial health and social services to populations most in need.

This paper summarizes key observations about the ACH model as it has developed over the last four years and concludes with policy implications for sustaining and scaling the ACH model and similar collaborative efforts.

Figure 1. Essential Elements of Accountable Communities for Health



Key Observations

1. ACHs have developed new relationships across sectors and can be the driver for addressing equity in a community

With the growing recognition that addressing social determinants of health is the long-term key to advancing the health of communities comes the recognition that health cannot be improved by the health sector alone. This is a major attribute of the ACH model. All of the ACHs of which we are aware have developed new relationships across sectors, aligning resources to better address priorities in the communities they serve. Work on developing and maintaining these relationships is constant and time consuming, as well as critical to the success of the ACH. Almost all ACHs bring together health care systems and providers, public health, social service providers, community-based organizations, and residents. Many have developed non-traditional partnerships with businesses, schools, local police and financial institutions. For example, NEK Prosper!, the Caledonia + Southern Essex ACH in northeast Vermont, [has brought together many member organizations](#), including financial institutions and economic development organizations, which have provided technical expertise and resulted in new thinking regarding investment vehicles that can support community well-being. The relationships among the sectors evolve as people become stewards of their communities, potentially resulting in new approaches to decision making, a deeper understanding of community needs, and the ability to better leverage new and existing resources in a community.

2. ACHs have developed new approaches to building accountability to communities by establishing shared priorities, transparency and decision making about how resources are deployed

If a community is to successfully address the social determinants of health – or at least the health-related social needs of their community members – then multiple sectors must be part of prioritization, transparency and decision making and those decisions must reflect the unique needs of individual communities. While conducting community health needs assessments is now commonplace for non-profit hospitals and health departments, conducting joint needs assessments and developing coordinated plans across sectors is not. It is the engagement of people in the community in decision making and joint planning that is key. Effectively engaging multiple sectors in communities requires new approaches for establishing priorities and decision making about how resources are deployed, which are being developed, tested and built by ACHs. The Yamhill Community Care Organization (YCCO) in Oregon is an example of shared community health assessments resulting in a community health improvement plan that cuts across the hospital, health department, social services and education sectors. Funds from the Oregon Health Authority and federal Medicaid funds are [distributed to YCCO and reinvested according to community priorities](#) to address social determinants such as food insecurity or in prevention programs in schools, like the PAX Good Behavior Game. The result is accountability to the total community, the county of Yamhill.

3. ACHs define community needs by analyzing a broader set of data on health outcomes

Because they bring together multiple sectors, ACHs define community needs by analyzing a broad set of data related to health outcomes, often looking at both health and social data and across racial and ethnic groups for the purpose of addressing inequities in a community. Sharing data across sectors helps to increase understanding of differences in needs and wellbeing, and which populations in a community should be a priority for interventions. While data collection, sharing and analysis capacity vary across ACHs, and remain one of the biggest challenges ACHs face, there are exemplars of how this can be done. For example, the CMMI-funded [Camden Coalition in NJ](#) worked with community-based organizations to develop SDOH screening protocols and referral systems, and is able to link screening information with COVID-19 testing to better address the needs of high-risk populations. The [Health Net of Western Michigan](#) ACH developed an electronic system linking resources across sectors that was easily adapted during the pandemic to identify populations most in need of food, shelter and transportation services.¹

4. ACHs have been successful by traditional outcome measures

While ACHs are still in their early stages of development, there is already evidence that ACHs have been successful by traditional health outcome measures such as reducing ER visits, rehospitalizations or decreasing opioid overdose and deaths. In some instances, policy changes have been implemented that impact the entire community and population health. The [Imperial Health ACH in southern California](#) reduced ER visits for children with asthma and improved school attendance by coordinating services to families across schools, primary care settings, emergency medicine departments and in the home through home visiting services. The Staten Island Performing Provider System (PPS) in NY [reduced opioid overdose and deaths](#) by 35% by developing treatment protocols and data sharing across police, EMS first responders, homeless shelter providers and hospital officials. The Communities that Care Coalition in Western MA [reduced alcohol use in youth](#) by 25% by conducting community education programs for students, parents, police and health care providers. The Collaborative Cottage Grove ACH in Greensboro, NC [increased local housing investments](#) resulting in revitalization of substandard housing in Black and other minority neighborhoods. This also reduced emergency medicine department visits for children with asthma, resulting in hospital savings and better school attendance.

5. ACHs can be engines for advancing health system reforms

In some states, ACHs are the engines for advancing health system reforms. For example, in Washington state, the [nine regional ACHs](#) are transforming Medicaid under a Section 1115 Delivery System Reform Incentive Payment (DSRIP) Program waiver. The goals of the program are to promote health equity; create, support and collaborate on local health improvement plans; support providers' movement to value-based payment systems; and align resources that improve whole-person health and wellness. All of the ACHs in the state have [achieved tangible](#)

¹ Source: personal communication

[improvements in health outcomes and policy changes](#). For example, the Pierce County ACH has been successful in lowering the number of low-birth-weight babies born to high-risk mothers, while Southwest Washington ACH has been successful in changing policies for affordable housing. Oregon has [incorporated their Coordinated Care Organizations \(CCOs\) into their health system reforms](#) and is moving to embrace greater health equity policies moving forward.

Having an ACH-like infrastructure in place also can offer providers a partner in addressing social needs and increase the likelihood that value-based purchasing (VBP) can succeed. [Health Net of West Michigan](#) is working with clinicians using a variety of VBP approaches to provide a systematic process to bridge clinical and community services, resulting in lower utilization of emergency services and total cost of care. It is also clear that to fully support the interventions that can address the health-related needs of community members, ACHs need to tap a variety of [healthcare, insurance and social programs](#). For example, the [Regional Health Hub of Trenton, NJ](#), which is an ACH model, is contracting with the state Medicaid program, the local health department, and health and hospital systems to assure sustainable funding as they work with residents to address health-related social needs and the pandemic. Other states that are including ACHs in their health system reforms include Idaho, Minnesota, North Carolina, Rhode Island and Vermont.

6. The federal government has embraced key elements of the ACH model

It is particularly worth noting that through a series of investments, the federal government has embraced key elements of the ACH model through CMMI. The initial investment was \$157 million in the [Accountable Health Communities \(AHC\) model](#), which is based on systematically screening high users of health care services for health-related social needs and linking individuals with the needed services. The premise being tested is that meeting social needs of high-risk individuals will result in less utilization of high-cost health care services. Another model being tested by CMMI is the [Integrated Care 4 Kids model](#), a nearly \$126 million, 7-year child-centered local service delivery and state payment model aimed at reducing expenditures and improving the quality of care for children covered by Medicaid and CHIP, especially those with or at-risk for developing significant health needs or out of home placements. A new model, the [Community Health Access and Rural Transformation \(CHART\)](#), is about to be launched, and its Community Transformation Track builds on what is being learned in prior models to address social determinants of health, as well as financing mechanisms. Each of these models focuses on strong partnerships across sectors and data sharing.

7. Several ACHs are exploring and implementing Wellness Funds as a sustainability strategy

All ACHs have been started with some kind of special funding, whether public or private grants or as part of waivers under the Medicaid program. Sustaining the ACH's capacity beyond the grant period is a continuing challenge. [In prior work](#), the Funders Forum has identified various ways that ACHs can sustain their infrastructure within the current health care financing and programmatic system. Interestingly, several ACHs are exploring and implementing Wellness

Funds as a sustainability strategy. Often called other names, such as Community Health Funds or Community Resiliency Funds, they are established to better align health improvement investments in a community toward a shared set of goals. Wellness Funds explicitly build the capacity to braid, blend, and align resources with sustainability in mind. These funds often start with aligning or pooling resources that may already be available in the community. Such sources of funding may be from local philanthropy, health insurance plans, state and local health departments, local businesses, banks, community development funds and industry. [For example](#), Elevate Health of Pierce County, WA plans to use the following sources to capitalize their community resiliency fund: direct state contracts, contracts with payers/MCOs, incentive-based funding from the state’s Medicaid Transformation Project, community development financing, hospital community benefit dollars, dedicated taxes and fees, private and philanthropic funding and reinvested shared savings from alternative payment models.

8. ACHs continue to face a number of challenges

As ACHs continue to evolve, there are also many challenges. Keeping residents and essential organizations engaged and at the table solving problems together takes considerable effort, a conscious openness to resident engagement, and “leveling” the decision-making table. There is invariably turnover of people in leadership positions that can be a setback for ACHs, creating the need for rebuilding trusting relationships. Data collection, data exchange among organizations, and data analysis are a constant challenge for ACHs, even when the backbone organization has considerable expertise in data management. Data sharing is especially challenging for community-based and social services organizations. HIPPA certification of organizations, both ACHs and social service partners, helps with data exchange but is not the complete answer. Additionally, ACHs are constantly concerned about sustainability, always looking for new grants or a steady stream of funding that will allow them to continue to grow and build the cross-sector networks critical to meeting the needs of their communities.

9. ACHs are committed to equity but there is no consensus on how to measure equity impact

For many if not most ACHs, addressing and promoting health equity throughout the communities that they serve is a core concern. Yet, a consensus has not been reached regarding which health equity frameworks and metrics are the most important for the ACH model.

The Forum supported development of [a new framework](#) for measuring the health equity impact of ACHs, allowing assessment of four components: (1) internal initiatives to promote equity throughout ACH leadership, governance, and operational functions; (2) targeted portfolios of interventions to address disadvantaged individual and/or community needs; (3) community-level efforts to tackle systems and structural drivers of health inequities; and (4) longer-term health outcomes for disadvantaged individuals and communities. The framework acknowledges important synergies between the different “buckets” of activities, which would help to amplify impact. The next step is to identify and test metrics that could be used for each component of this equity framework.

Numerous resources outline a range of health equity metrics, with convergence around key domains (such as education, housing, and income). However, most of these resources are within the “gray literature” and not peer reviewed. Further, many of the metrics identified as “health equity metrics” could be more appropriately described as measures of social determinants which allow assessment of differences, but such differences may not be “avoidable, unfair, or remediable differences.” Metrics relating to systemic and structural drivers of racism are not readily identifiable, nor are measures relating to racial equity and social justice. As such, new metrics may be needed, especially to measure ACH impact on systems and structural change.

Moving from “what” to measure to “how” to measure will similarly require study. In particular, with competing initiatives underway in many communities, an important methodological concern is attribution and contribution. However, in light of ACHs’ multi-system, dynamic nature and their orientation to health equity, measurement must continue to evolve from traditional, linear processes to ones that allow identification of patterns of wellbeing, justice, and thriving. Finally, many ACHs will need technical assistance and adequate resources to support assessments of health equity impact, which should be integrated into other assessments to maximize efficiency.

The COVID-19 pandemic has provided the impetus for ACHs and other institutions to take on the measurement challenge as it has highlighted the critical importance of integrating health care, public health, and social services in a manner that equitably benefits all populations, both in terms of implementation as well as outcomes.

ACHs and COVID-19 Response

In response to the Covid-19 pandemic, ACHs provide a flexible platform to coordinate needed care and services to people in greatest need. They are seen as critical to understanding the needs of the most vulnerable populations and available resources in their local communities.

- ACHs are playing a pivotal role in providing information about the pandemic and available community resources. [HealthierHere](#), the ACH for Seattle/King County in Washington state, provides information about testing sites, hospitals, behavioral health, food pantries and other needed resources.
- The Rhode Island Health Equity Zones have been training CHWs in contact tracing and “hot spotting” to better direct services to neighborhoods most in need during the pandemic. They have been able to link the needs of people in quarantine with services such as SNAP.²
- Building on its data exchange and screening for SDOH platform, the [Camden Coalition in NJ](#) is assisting hospitals, providers and local public health agencies in identifying people who are positive for Covid-19. Additionally, this ACH is working with homeless shelters and hotels providing quarantine services to provide medical care and other needed services.
- The [Parkland Center for Clinical Innovation \(PCCI\)](#) in Dallas, TX has been able to identify hotspot neighborhood locations where the COVID-19 virus is disproportionately impacting poor and underserved residents. PCCI is connecting local community-based organizations and faith-based organizations with public health workers and clinicians to enhance contact tracing and care planning for high-risk residents.
- Many ACHs are ensuring an equitable distribution of pandemic resources including testing. [East San Jose PEACE Partnership](#) used disaggregated race and ethnicity data to inform where their emergency operations center should deploy a mobile Covid-19 testing unit. They were able to use Wellness Fund dollars to support families without access to other funding.

² Source: personal communication

Conclusion

ACHs are a way of engaging diverse sectors of the community and residents in joint problem solving. New norms are being established that allow for power sharing within communities and joint decision making about how to invest existing and new resources and funding streams. There are many exciting examples of how ACHs are working to address community and population health needs across the country, coordinating and aligning sectors. The challenge is how best to scale these demonstrations to additional states and communities.

We recognize that one size does not fit all in supporting and sustaining these partnerships. But we have also learned that a firm commitment to focusing on equity and aligning sectors through shared decision making is critical to addressing the root causes of our nation's health challenges, regardless of the particular variations in health systems and community needs across the country.

The private foundations engaged in supporting ACHs and other multisector partnerships are committed to continuing down this path because this model – and the importance of the health system being accountable to communities – is one of the most promising approaches to advance population health. The ACH model, if scaled, will help the nation rebuild in the post-pandemic period with an equity-focused response to the underlying challenges that exacerbated the pandemic. We need the federal government to join in this effort – because only the federal government has the resources and authorities to scale this model to ensure that all communities across the nation are able to benefit from this approach.