

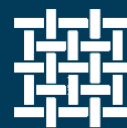
ISSUE BRIEF

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**ADVANCING VALUE AND EQUITY
IN THE HEALTH SYSTEM**

THE CASE FOR ACCOUNTABLE COMMUNITIES FOR HEALTH

CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE



FUNDERS FORUM
on Accountable Health

ADVANCING VALUE AND EQUITY IN THE HEALTH SYSTEM

THE CASE FOR ACCOUNTABLE COMMUNITIES FOR HEALTH

ABSTRACT

Accountable Communities for Health (ACHs) are an increasingly prominent model for addressing health and health equity using multi-sector, community-based partnerships, data and analytics, and an integrated portfolio of community interventions in service to a shared collective vision. The “value case” for an ACH often lies in the long-term, however, and many ACHs face a challenge demonstrating the early value of their work to key stakeholders. In this paper, we examine an alternate framework for defining and assessing value that moves beyond “ROI” to capture the transformational nature of an ACH’s work through the lens of three brief case studies. By defining what value looks like along the full spectrum of an ACH’s model and not just its outputs, we hope to give ACHs the tools to sustain momentum in their work while they build toward the ultimate goal of improving outcomes in key measures of community health and health equity.

INTRODUCTION

Reflecting the nation’s growing attention to systemic racism and the disparate effects of the COVID-19 pandemic, policymakers are increasingly working to address health inequities and the social determinants of health that contribute to them.

Work to improve health outcomes has often focused on value-based care and purchasing, which provide greater flexibility to providers and incentivizes health systems to improve care. These strategies may help address equity-related concerns: a recent announcement by the Centers for Medicare and Medicaid Services encourages states to promote more value-based purchasing in the Medicaid program,¹ which serves a population most affected by inequity and with many health-related social needs. If equity is to move to the center of the health policy and transformation

agenda, however, we must move beyond a focus on purchasing and financing arrangements—and short-term changes in health outcomes—and build the capacity to collectively address the widespread and systemic root causes of inequity.

Achieving the twin goals of advancing both health and health equity is now the central challenge of health reform, and it is not a challenge the health care systems can address alone. Health inequities are intersectional, the product of what happens in the health care system but also in many other sectors of the community. No single partner or system holds all the levers necessary to mount an effective response. Rather, multi-sector partnerships are needed to support this broader vision of health reform, and such partnerships require an infrastructure to support and sustain them.

With more than 125 examples in communities across the United States, Accountable Communities for Health (ACHs) are designed from the ground up to support multi-sector, community-based partnerships that work collaboratively to address health and health equity. Although ACHs vary widely, nearly all share a few core components:²

- **Shared Vision:** ACHs hold a common vision for community partners who want to work together through collective action to address shared challenges.
- **Equity:** ACHs form around a common commitment to advancing equity in the community through direct work on health and in addressing upstream determinants or root causes.
- **Governance:** ACHs support a shared decision-making structure partners can use to decide on and act together around challenges.
- **Community Voice:** ACHs are strongly and authentically connected to community voice and wisdom, often “bridging” systems and residents to ensure their work genuinely reflects community priorities and is sensitive to community context.
- **Backbone:** Every ACH has a trusted backbone organization responsible for facilitating alignment between all ACH members and the community. More than administrative, these well-trained and connected conductors bring essential skills and resources to the table.
- **Data & Analytics:** Most ACHs recognize that shared data across sectors is as important as connecting the work. They support collective, data-informed action.
- **Portfolios of Interventions:** ACHs focus less on specific interventions or programs, and more on ensuring the community’s various programs are coordinated, aligned and

designed to mutually reinforce one another for optimal impact.

- **Sustainability:** ACHs are designed to address ongoing collective work, so most include a mechanism for sustaining the work through establishing community wellness funds, driving value-based payment transformation and supporting related strategies.

ACHs have emerged through a variety of investments by philanthropy and government. The federal government has supported several versions of the model, directly through its Accountable Health Communities at CMS and SIM, and indirectly through Medicaid waivers—approving demonstrations at the state level. Similarly, in places like California, coalitions of philanthropic funders have pooled resources to provide support for emerging ACHs working to address shared community health challenges. But regardless of how they emerge, all versions of the ACH model are designed to seek long-term financial sustainability that goes beyond their initial catalytic investments.

ACHs are community entities, organized to address population health and health equity in a way that recognizes the interdependent forces and factors at work while holding and executing a shared vision around health and health equity. ACHs may focus on distinct priorities, but all start with the simple idea that the community’s most critical challenges are complex, and no single partner controls enough levers to address them alone.

In this paper, we define and advance the value proposition of ACHs as a promising approach to addressing structural fragmentation across the health-producing continuum. Without a different way of measuring value, our long-term efforts to address inequity will be condemned prematurely as failing.

“*Achieving the twin goals of advancing both health and health equity is now the central challenge of health reform, and it is not a challenge the health care system can address alone.*”

WHY AN ACH APPROACH?

Health is a multi-dimensional challenge, shaped by opportunities and experiences across multiple systems, but our approaches to building and maintaining health are often fragmented and exacerbate inequities. We use distinct and separate systems to manage physical, mental, dental and social health. We also manage the upstream, preventive aspects of health, such as food and housing, through different systems.

Clinical and community outcomes are profoundly interconnected with bidirectional impacts—health outcomes influencing outcomes in other systems and vice versa. Yet they are rarely considered together when developing and funding programs, services and interventions.

Despite overwhelming evidence of this connectedness, we have built a non-system

that yields a disconnected and chaotic approach, producing suboptimal outcomes that can be overwhelming, dehumanizing and unapproachable, especially for historically excluded communities.

Ultimately, compartmentalized approaches are unlikely to ever solve multi-dimensional problems.

“ Health is a multi-dimensional challenge, shaped by opportunities and experiences across multiple systems; but our approaches to building and maintaining health are often fragmented and exacerbate inequities. **”**

EVIDENCE OF IMPACT

The evidence base for the longer-term impacts of ACHs is still developing, as are the tools and methodologies available to assess an ACH's value. A meta-analysis of 25 collective impact efforts (ACHs are a form of collective impact) found clear evidence of contribution to population change in at least 8 sites, including impacts on diverse goals such as teen birth rates and youth justice involvement.³

Other work has demonstrated an association between multi-sector population health work and community mortality rates.⁴ Cottage Grove ACH in Greensboro, N.C. was able to decrease childhood asthma hospital admissions by improving substandard housing, saving millions in Medicaid dollars.⁵ And when Staten Island Performing Provider System (PPS) integrated data and launched an integrated multi-sector set of

interventions to address substance use, opioid overdoses fell by 45% relative to baseline.⁶

Still, to date there are few studies that adequately assess the full spectrum of an ACH's efforts and impact, largely because ACHs themselves are complex and often place-informed initiatives operate at multiple levels, from policy to programmatic, in ways that are intentionally designed to build upon, align and integrate existing local energy and efforts. Capturing the unique or additive impact of the ACH can be challenging in the near term, and not easily differentiated from these related activities and initiatives. As researchers continue to refine methods for assessing the impacts of such multi-faceted work, ACHs and their proponents are left with a relative dearth of tools that can be used to definitively assess the model's value.

THE VALUE CHALLENGE

A key challenge ACHs face is how to demonstrate the value of their work, especially in the early stages of implementation. By design, ACHs seek to shift policy and fundamentally change how systems work together. Their work, and the value it creates in the community, is not strictly transactional. While every ACH ultimately hopes to demonstrate a strong financial return on investment (ROI) for health care and other systems, assessing ROI is difficult—particularly without discrete programmatic interventions. It is even harder when multiple interventions are in play and, more broadly, when systems change work has long time horizons and numerous confounding factors.

New ways of working can create value for a community even in the absence of an immediate ROI. Indeed, much of the value of an ACH may be submerged like an iceberg, with a small portion of the value visible while most of the benefits exist beneath the waterline and thus out of sight. As one group of evaluators noted, value can be “difficult to measure, to monetize and sometimes even to see... Calculations of value can risk focusing only on the part that is visible, generating misleading information and encouraging poor decision-making.”⁷

An ACH creates value in its community long before the long-term financial impacts of its work are apparent:

- When an ACH works to align the visions of disparate partners, it creates value by paving the way for integrating resources in the community to increase the total impact of collective work.
- When an ACH helps amplify community voice, it creates value by helping ensure shared work is done with rather than to or for communities, and that equity remains at the center of that work.
- When an ACH creates a structure for shared decision-making, it creates value by ensuring that systems working to address multi-dimensional problems have access to multi-dimensional solutions.

ACHs make things happen in communities that would not otherwise have been possible, creating enduring infrastructure that can be used to activate change or improvements on a wide array of community priorities. The value proposition of an ACH exists along the entire spectrum of the model, not just its outputs.



New ways of working can create value for a community even in the absence of an immediate ROI.”

HOW ACHs GENERATE VALUE

These “below the waterline” components of ACH value arise from the very components or activities needed to build the ACH as a forum to engage people around a common purpose and vision: cross-sector and organizational relationships, meaningful engagement of residents, trust between partners and with the community, and distributed leadership at multiple levels.

These core tenets enable the ACH to play at least **three key roles** that shift ACHs from coordinating and carrying out strictly transactional activities to becoming engines of transformational change:

- **Catalyzing alignment, innovation and new ways of working together** to eliminate ineffective, siloed, program-by-program interventions. ACHs collectively problem solve, align interests and incubate new ideas. Moreover, with this infrastructure, ACHs can rapidly pivot to address emerging issues and crises, such as COVID.
- **Establishing collective accountability among stakeholders and the community to drive sustainable systems changes and, ultimately, outcomes** by facilitating data sharing and using common measures to support a common understanding of the problem, develop solutions and demonstrate outcomes. Through such collective accountability, collaboration shifts from an add-on activity to becoming part of the “culture” and way of doing business.
- **Leveling the playing field so community voice has a real say in defining the problem and advancing solutions that prioritize equity.** Organizations, sectors and residents come to the table with unequal power. By centering equity and community voice through intentional and meaningful resident engagement, ACHs shift power and resources to produce more equitable outcomes and facilitate greater community cohesiveness.

CATALYZING ALIGNMENT

ACHs are often seen as “neutral conveners” in communities, bringing together partners with disparate goals and interests to help facilitate collaborative action. ACHs are a natural fit for this role because they do not have the same narrow financial or programmatic interests as other players. They represent diverse and multiple interests, have strong community engagement strategies and can help represent community voices as part of important decisions. They also serve as a critical nexus of the community’s equity work.

As a result, ACHs are often in the position to create value in a community by engaging partners to work together toward mutually beneficial goals.

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CASE STUDY | CATALYZING ALIGNMENT

Maximizing the Total Community Impact of Housing Vouchers

The Healthy Living Collaborative (HLC) was a collective impact initiative in Vancouver, Washington, that has since merged with Southwest Washington ACH (SWACH). HLC/SWACH boasts a robust array of over 40 cross-sector partners, a shared governance model and strong community engagement mechanisms facilitated by a strong network of neighborhood-based community health workers and peer health specialists. Like many communities, Vancouver faced an acute shortage of affordable housing and a years-long waitlist for housing vouchers, which the community identified as a key determinant of the kind of health inequities HLC was designed to help address.

At the same time, the HLC’s educational partners signaled that schools were facing significant challenges with chronic absenteeism, and their health care partners were challenged managing high cost patients with significant medical and social complexity.

The HLC recognized the potential interconnections of these systems’ distinct challenges: some of the families whose children were missing school might have unstable housing situations, just as housing instability might be an important complication for medically fragile patients in the health care system. But the available resources were relatively fixed—no massive infusion of new funding was coming to solve any of these big community challenges. As the convener, the HLC pulled these partners together to explore the possibility of changing how the system was currently deploying available resources to align partners’ interests and maximize the total amount of positive impact the community could realize.

The idea was simple: the community didn’t have enough vouchers to go around, so some kind of waitlist was necessary. Given that, could some portion of the existing vouchers be prioritized for families with school-aged children or for

CASE STUDY | CATALYZING ALIGNMENT

Maximizing the Total Community Impact of Housing Vouchers (*Continued*)

those who were facing complex health care challenges? This was truly a “health in all policies” approach—reshaping housing policy in a way that might maximize the impact of available resources on important community health and vitality outcomes for other sectors. A limited resource in one sector (housing) would be deployed in a manner intended to optimize outcomes in two others (education and health care). This was systems change in action.

But changing how systems work is never risk free. Would the community accept such a shift in resources? Was this approach consistent with the community’s shared goals around improving equity across its systems? Would the data sharing necessary to make such an approach work pass muster? Might there be unanticipated consequences, especially for historically underserved or marginalized communities? With real reputational risks for all involved, there was understandable reluctance about proceeding without some reassurances in place.

Just as it had been positioned to initiate the talks, the HLC was poised to help mediate these concerns and move the deal forward. Through its robust multi-sector partnership council, which included scores of organizations and agencies from across the community, the HLC was able to vet the idea with other players whose clients or stakeholders might be impacted by the change. And with its strong community engagement infrastructure, including a network of neighborhood-based community health workers rooted in the region’s highest risk communities and with lived experience navigating

the systems in question as clients, the HLC was able to gather feedback directly from the communities most likely to be impacted by the changes. And because of its connections across the community and years of hard-earned trust as a neutral convener, the HLC was able to represent the opportunities and challenges transparently and honestly in order to advance the community conversation and ensure everyone involved was comfortable with the proposal.

The housing voucher prioritization system that emerged in Vancouver was the result of vision and hard work from many people in multiple community systems, but its path to fruition was made possible because of the essential elements of an ACH—in this case, a trusted neutral convener with strong community engagement that could facilitate the difficult conversations, seed trust, and ultimately seal the deal, as well as a shared governance structure that supported collective decision making, and data and analytics capacity that could help the distinct systems involved in the deal navigate the regulatory challenges of data sharing necessary for their collaborative action to succeed. These elements were strengthened by the HLC’s eventual merger with SWACH, allowing the full benefits of the ACH model to be realized.

“The HLC pulled these partners together to explore the possibility of changing how the system was currently deploying available resources to align partners’ interests and maximize the total amount of positive impact the community could realize.”


The “value” offered by the ACH in this case wasn’t in staffing some new program or launching some new intervention. Rather, value was generated by facilitating a deal that changed the way systems work together to maximize their collective impact on shared outcomes, thus **catalyzing alignment** and helping systems in the community work together to find multi-sector solutions to complex problems and cement those innovations into practice.

ESTABLISHING COLLECTIVE ACCOUNTABILITY

The ACH structure creates the conditions for participating stakeholders—individuals, organizations and sectors—to transcend their respective internal interests by collectively maximizing financial and non-financial resources to support a common goal or address a shared need.

Data is shared and common measures are used to facilitate a shared understanding of the problem and solutions, and to demonstrate outcomes.

Collaboration becomes part of the “culture” and way of doing business.



Collaboration becomes part of the ‘culture’ and way of doing business.”

CASE STUDY | COLLECTIVE ACCOUNTABILITY

The Regional Supportive Housing Impact Fund

When an ad-hoc coalition of health care systems, regional philanthropic foundations, housing providers and advocates came together to discuss homelessness in Portland, Oregon, they were prompted to action by one inescapable fact: the housing crisis represented a multi-dimensional challenge whose effects rippled across multiple systems throughout the community. The group had already pooled resources in an unprecedented cross-sector investment, with health systems and foundations pitching in over \$23 million to support the construction of a major new housing and services center on the city’s hard-hit outer eastside, but they knew addressing the crisis would require more than a one-time donation. They wanted to build on that initial success to create an enduring mechanism for collective investment and action to address housing and homelessness in the city.

The group spent several years working on a new plan: RSHIF—the Regional Supportive Housing Impact Fund—a flexible, data-driven resource pool designed to work in tandem

with other regional housing efforts, focusing particularly on connecting very low-income persons with complex health challenges to deeply affordable supportive housing options that include the services they need to remain stable and housed. To create maximum flexibility for aligning with other regional efforts, RSHIF would braid and blend funding from across sectors and partners, then nimbly deploy those funds in ways that maximize their total community impact.

An interconnected community data system, including health care, public safety and housing data, would be used to identify high-leverage investment opportunities, to empirically assess the impact of those investments on community outcomes, and to identify shared savings that could be reinvested in the fund. A shared governance structure would be developed to oversee the fund’s strategy, ensuring broad representation and community-informed decision-making would always be at the center of RSHIF’s work.

The Regional Supportive Housing Impact Fund (*Continued*)

After several years of collaborative work and the development of a strategic framework, however, the coalition found itself facing a pair of seemingly intractable challenges regarding how to operationalize the framework. First, the fund was designed to integrate and deploy funding from many different players with diverse interests, some of whom were competitors in the community. Who could be trusted to house such a shared effort and make strategic decisions about major community investments without favoring one interest over another? And even if the interests of major supporters and funders could be balanced, who could also ensure that the interests of community members—especially those in historically excluded or marginalized communities who would not be major RSHIF funders but for whom the fund’s investment decisions would have real and tangible consequences—would be adequately and authentically represented in the fund’s governance and decision-making?

In the end, the coalition needed a place to hold *collective accountability* for the work—someone who could step forward to balance the many interests involved and anchor the community’s commitment to being accountable to those interests. The coalition approached *Health Share of Oregon*—one of the state’s Coordinated Care Organizations (CCOs) that hold many of the key functions of an ACH and acts as the state’s closest equivalent—and asked it to inherit the RSHIF strategic framework, operationalize it and be accountable for its shared community vision and outcomes.

Because of its ACH-like structure, Health Share was well positioned to address the specific concerns that had impeded RSHIF’s launch by deploying several critical elements of an ACH: a backbone structure with mature fiscal and operational elements that could help launch and sustain RSHIF, a shared governance model for collaborative decision-making, a strong community engagement system via its community advisory council and other established avenues for enhanced community engagement, and a data and analytics infrastructure that could be expanded to support the RSHIF vision and provide transparency around key accountability metrics and reporting.

The work of developing RSHIF happened outside of Health Share, with a group of concerned partners coming together with a vision to build something genuinely innovative and enduring in their community. Years of work went into a framework for collective impact in the supportive housing space, but when it came time to turn that framework into reality, the challenges of real-world implementation in an environment

of diverse interests and agendas were daunting, and there was real risk that the progress made would simply dissipate.

In this case, the value of the ACH was less about generating the initial innovation, which arose organically out of existing community efforts, and more about providing a cohesive, trusted platform supporting **collective accountability** among the initiative’s stakeholders and community members for sustainable systems change.



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LEVELING THE PLAYING FIELD

ACHs are multi-dimensional, interdependent, interconnected efforts that connect and integrate efforts across the health continuum. An ACH may simultaneously work to address the “upstream” structural conditions that shape health experiences and outcomes across the life course, mitigate the “midstream” effects of individual exposure to health risk factors and improve the “downstream”

efforts to care for people who are already facing health challenges. And all of this important work across the health continuum needs to occur within the context of community voice and power, recognizing that there are historical power gaps between the systems that control many of these important health levers and the communities most impacted by them.

CASE STUDY | LEVELING THE PLAYING FIELD

Neighborhood Networks in San Diego

The San Diego Accountable Community for Health (San Diego ACH) was formed to create a “wellness system” to create health and wellness for all San Diego communities with an initial focus on lifelong cardiovascular health. The work has focused on connecting and integrating health systems and community-based efforts designed to address the key social and structural determinants of poor cardiovascular health. Launched as part of the California Accountable Communities for Health initiative (CACHI), the San Diego ACH’s (SDACH) comprehensive and integrated portfolio of strategies has yielded a comprehensive approach to tracking progress using population-level health data, a focused effort on nutrition in the North Inland Region of San Diego mixing program level and population health data, a robust learning community that provides an opportunity for community organizations and healthcare organizations to learn together, and the development of a Community Health Worker initiative.

As the SDACH worked to assemble its multi-sector coalition of partners, it included an extensive community engagement process to ensure strong roots in the communities themselves. This process revealed that for many communities in the region, a long history of historical racism, underinvestment in community-driven efforts,

and a tendency for institutions to arrive with the answers had profoundly damaged trust in some of the very systems SDACH intended to integrate and activate. To be successful, the ACH needed first to earn the community’s trust back.

A key factor for building and maintaining trust was developing a viable post-CACHI funding sustainability plan for the ACH that would disrupt the typical pattern of fragmented, grant-to-grant programing that left the community feeling exploited and without a viable strategy for improvement. Efforts to establish a Wellness Fund were met with skepticism from the larger health systems and institutions in the region whose investment priorities differed from the ACH and the community.

Faced with this circumstance, SDACH leadership worked to develop a program that would both generate revenue and fulfill the core mission of the ACH. Establishing a network of community health workers (CHWs) was identified as a viable strategy to align these two goals. A community-based workforce—comprised of people with deep expertise in and knowledge of their own communities—could anchor the entire experience in a trusted human connection, thereby increasing engagement and helping people navigate and access the resources that best match their needs and context wherever

CASE STUDY | LEVELING THE PLAYING FIELD

Neighborhood Networks in San Diego (Continued)

they may lie on the health continuum. A network of CHWs with shared lived experience could both help draw people back into the new, more connected system San Diego ACH was building and create a richly textured, multi-dimensional approach for supporting and building community health that leverages the ACH's position as a multi-sector convener of major systems. As such, SDACH would be working with—rather than on behalf of—the community members most impacted by historical inequities.

This vision became Neighborhood Networks, which is a service designed to address the health and social needs of community residents with complex challenges that complicate their ability to achieve and maintain good health. A network of CHWs (called Neighborhood Navigators) taps into the ACH's cross-sector network of partners to provide community-based solutions for care management and health promotion. Acting as the hub, SDACH links patients or clients referred from some partners, such as health plans, to community care organizations that host trained Neighborhood Navigators positioned to assess each client's health-related social needs, explore their context and preferences, and connect them with the array of services best suited to their needs and circumstances. SDACH also provides necessary infrastructure, such as contracting and reimbursement for the community organizations doing the field work, data sharing, training and quality improvement support for its partners to better foster connection and coordination of care and services across the health continuum.

This innovative service provides a clear value for everyone. For partners like health plans, it provides access to a community-based network of services that can comprehensively address the complex, multifaceted drivers of poor health and high cost of care outcomes. For participating community-based organizations, it provides a way to be reimbursed

for services that generate tangible value by improving health and reducing the costs of care.

For members of the community, it provides a “one-stop” entry point into a comprehensive set of health supports anchored in a human connection and guided by a trusted community member with shared cultural and lived experiences. And for the community-at-large, it provides a concrete mechanism to lift up the most crucial health related social needs being identified by the neighborhood navigators for further action by the ACH.

An ACH is the perfect place to hold this community value. Indeed, these essential elements of an ACH are exactly what it takes to create it: a mutually reinforcing portfolio of interventions that can address both the upstream drivers of health and their downstream consequences; a backbone structure that is trusted by diverse partners with distinct interests to hold essential functions; a data sharing infrastructure that can connect work across sectors; a strong community engagement structure that can assure solutions are grounded in community wisdom and participatory principles; and a sustainability mechanism predicated on the value produced by the ACH's work for downstream stakeholders, such as health plans and hospital systems.

By leveraging these components to create something new, San Diego ACH brought value to the community effort by **leveling the playing field**, giving community-based organizations access to more resources and a critical role to play in the success of

the region's health plans. Through authentic resident engagement and efforts to align the goals of larger systems with those of organizations representing the communities, the ACH positioned itself to re-engineer how health is created and supported for some of the region's most vulnerable populations.

“SDACH would be working with—rather than on behalf of—the community members most impacted by historical inequities.”

CONCLUSION: TRANSFORMATIONAL CAPACITY AS VALUE

ACHs are inherently transformational enterprises endeavoring to change the way people interact with systems, and the way systems interact with each other to generate improved health and health equity for their communities. This kind of systems change is no small task. Even modest changes to how systems interoperate can take years to achieve. The value to any change effort is typically assessed by comparing the costs or effort required to produce it to its relative impact on outcomes we care about. Return on investment (ROI) is the operative framework—we want to see if an ACH’s work can ultimately improve health, lower the total costs of health care, reduce recidivism in the jail system or some other collectively defined outcome. And until those outcomes are produced, we are tempted to withhold judgement about whether it was “worth it” or merits continued investment and effort.

The ROI framework is also transactional in nature. Yet increasingly, evidence suggests a need to move beyond transactional relationships and transform the way people, organizations, systems and sectors interrelate and interact to change the trajectory of population health.

To be clear, health and financial outcomes *are* important. But the value equation of an ACH includes more than its outputs. The very act of building an ACH brings value to the community by creating transformational capacity that can be used to activate meaningful change in the service of shared goals.

The essential elements of an ACH are inherently valuable to communities because they allow things to happen that otherwise might not, and they represent a tangible capacity for change.

In this paper, we presented three mini case studies—from Washington, Oregon and California, respectively—that represent three different ways an ACH can create value *even before the effects of its work are apparent*. These are by no means isolated examples. Many of the 125+ ACHs currently operating around the United States are hard at work creating comparable value in their communities. The true value of examples like these lies in the *architecture for change* that is created and persists in each community after the building is done.

The next time a group of community partners in SW Washington, Portland or San Diego want to do something innovative together, the essential elements of collaborative action will have already been built. The engine doesn’t go away once an ACH completes its first journey. It remains, poised and ready for the community to select a new shared goal, line up the wheel and step on the gas. Indeed, this kind of architecture will be essential in communities across the country as policymakers promote stronger emphasis on value-based approaches that advance equity.

“The essential elements of an ACH are inherently valuable to communities because they allow things to happen that otherwise might not, and they represent a tangible capacity for change.”

END NOTES

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