



Accountable Communities for Health

Strategies for Financial Sustainability

MAY 2015

JSI Research & Training Institute, Inc.

Jeremy Cantor, MPH
Rachel Tobey, MPA
Kiely Houston, MSPH
Eliana Greenberg, BA

This report was produced with generous support from The California Endowment.

Acknowledgements

We are grateful to Marion Standish at The California Endowment and Barbara Masters at Masters Policy Consulting for initiating this work and providing wisdom and guidance throughout. The key informants below were generous with their time, ideas, and experience; we deeply appreciate their commitment to innovation and improved health in communities across the country.

Key Informants

- » Kevin Barnett, DrPH, MCP, Senior Investigator, Public Health Institute
- » Peter Barth, MPP, Director, Third Sector Capital Partners
- » Jennifer Blanchard, MPP, MSW, Care Integration Planning Coordinator, Minnesota Department of Human Services
- » Ernest Cawvey, MPA, Program Associate, ReThink Health
- » Anne De Biasi, MHA, Director of Policy Development, Trust for America's Health
- » Suzanne Delbanco, PhD, Executive Director, Catalyst for Payment Reform
- » Alison Fleury, BS, Senior Vice President, Sharp HealthCare
- » Elizabeth Gibboney, MA, Deputy Executive Director/COO, Partnership HealthPlan of California
- » Chris Girod, FSA, MAAA, Principal, Consulting Actuary, Milliman
- » Elinor Hall, MPH, Consultant, Health Policy and Management Consulting
- » Maria Hernandez, PhD, President and COO, Impact4Health
- » Jim Hester, PhD, Principal, Population Health Systems; Former Director, Population Health Models Group, Center for Medicare and Medicaid Innovation
- » Dale Jarvis, BA, CPA, Dale Jarvis and Associates
- » Jessica LaBarbera, MPA, Director, Strategic Innovation, Nonprofit Finance Fund
- » Jeff Levi, PhD, Executive Director, Trust for America's Health
- » Bobby Milstein, PhD, MPH, Director, ReThink Health
- » Heather Petermann, MS, Care Delivery and Payment Reform Lead, Minnesota Department of Human Services
- » William Pinakiewicz, MBA, MA, Vice President, Eastern Region, Nonprofit Finance Fund
- » Lisa Santora, MD, MPH, Chief Medical Officer, Beach Cities Health District
- » Loel Solomon, PhD, MPP, Vice President of Community Health, Kaiser Permanente
- » Mark Thomas, BCC, Community Health Development Coordinator, PacificSource Community Solutions, Inc., Columbia Gorge Coordinated Care Organization
- » Tom Williams, DrPH, Former President & CEO, Integrated Healthcare Association
- » Bobbie Wunsch, MBA, Partner, Pacific Health Consulting Group
- » Coco Yackley, BS, Operations Manager, Columbia Gorge Health Council; PacificSource Community Solutions, Inc., Columbia Gorge Coordinated Care Organization

Contents

Introduction	2
Background.....	3
Methodology.....	4
Findings	5
Key Principles.....	5
Strategies by Phase.....	8
Appendix I. Economic Modeling Approaches	23
References	24

JSI is a public health research and consulting firm dedicated to promoting and improving public health in California, the United States, and across the globe. Our mission is to improve the health and well-being of underserved and vulnerable people and communities. JSI works across a full range of public and community health areas, strengthening health systems to improve services—and ultimately, people’s health.

JSI San Francisco
260 California Street, Suite 500
San Francisco, CA 94111
415-400-0020

www.jsi.com

Introduction

What is an Accountable Community for Health?

California's Accountable Community for Health workgroup developed the following definition:

An Accountable Community for Health is a multi-payer, multi-sector alliance of the major healthcare systems, providers, and health plans, along with public health, key community and social services organizations, schools, and other partners serving a particular geographic area. An ACH is responsible for improving the health of the entire community, with particular attention to achieving greater health equity among its residents.

The goals of an ACH are to: 1) improve community-wide health outcomes and reduce disparities with regard to particular chronic diseases; 2) reduce costs associated with healthcare and, potentially, non-health sectors; and, 3) through a Wellness Fund, develop financing mechanisms to sustain the ACH and provide ongoing investments in prevention and other system-wide efforts to improve population health.³

The concept of Accountable Communities for Health (ACH)—and similarly named and intentioned initiatives such as Accountable Care Communities and Accountable Health Communities—has been gaining momentum nationally as a leading-edge approach to achieving ambitious community-level health improvements. The time is right for such innovation due to increasing recognition of the efficiency and cost-effectiveness of community prevention approaches, particularly for addressing chronic disease and health disparities and inequities.^{1,2} Support for ACH initiatives is also bolstered by Affordable Care Act implementation and increased attention to the Triple Aim (higher quality care, reduced cost, improved health). In some states, ACH initiatives have received designated funding, such as the Center for Medicare and Medicaid Innovation (CMMI) grants to Minnesota and Washington.

In 2013, California received a CMMI State Innovation Model (SIM) Design Grant. With this funding, the state issued the California Health Care Innovation Plan in March 2014, which included an initiative to develop ACH pilots. To prepare for potential implementation, the state formed an ACH Work Group, composed of representatives from community clinics, health plans, hospitals, public health, prevention, academia, philanthropy, and the California Department of Public Health. The Work Group was charged with developing recommendations for the design and implementation of the ACH pilot program. In December 2014, California was not awarded a Testing Grant in this round but instead received an additional \$3 million Design Grant. Despite this news, stakeholders in California have continued to advance the ACH concept³ including research on strategies related to portfolio, governance,⁴ and sustainability.

Rooted in our primary research, the purpose of this brief is to provide policymakers, decision-makers, and practitioners on the ground in California and nationally with guidance regarding the question: *“What are the facilitators of sustainable, multi-payer investment in a geographic, multi-sector, portfolio approach to population health?”*

As an emerging concept, examples of successful multi-payer support for ACHs and guidance for achieving such support are not yet available. Nevertheless, national thought leaders and early innovators in ACH-like efforts can provide insights on the key question of how to financially support an ACH at its conception and over time. The host of strategies detailed in this brief is intended to provide guidance for communities seeking to secure the necessary funds to systematically shift an ACH from a compelling concept toward a standard operating procedure for improving community health.

Background

In order to establish a shared vision, parties interested in forming an ACH need a common definition and understanding of an ACH’s core operational components. Figure 1 depicts the basic components of an ACH:

1. A focal geography and target condition(s) or risk factor(s)
2. Initial resources from multiple sources
3. A strong set of partners from health care, public health and other public agencies, and community organizations
4. A governance structure and lead organization or organizations (backbone/integrator) to convene and oversee the process, facilitate collaboration, and coordinate existing programs and funds
5. A mechanism for managing pooled resources (Wellness Fund)⁵
6. A mutually reinforcing portfolio of evidence-based and practice-informed strategies for addressing the target condition(s) or risk factor(s) spanning the following dimensions:⁶

- **Clinical:** Health systems interventions to more effectively deliver quality services and treatment with a focus on prevention.



Figure 1: Components of an ACH

- **Social Services and Community Resources:** Programs that provide support to patients and community members. These can be based in governmental agencies, schools, worksites, or community-based organizations, such as the YMCA. Community-based interventions frequently target lifestyle and behavioral factors, such as exercise and nutrition habits, and also include peer support groups and social networks.
- **Clinical-Community Linkage:** Mechanisms to connect the clinical care setting to social services, community resources, and policy, systems, and environment change efforts.
- **Policy, Systems, and Environment (PSE):**⁷ Improvements in social and physical environments through policy and system change to make healthy behaviors easier for individuals in the community. Strategies could include legal and regulatory changes ranging from modifying healthcare delivery system incentives to urban planning decisions related to the built environment.

7. A set of agreed upon financial and health indicators that can be measured over time.
8. Reinvestment of resources in order to continue and/or expand ACH activity.

Methodology

To explore the topic of financing for an ACH, between November 2014 and January 2015, John Snow Research and Training Institute, Inc. (JSI), a public health research and consulting organization, reviewed national peer-reviewed and gray literature and conducted in-depth discussions with over 20 key informants. Key informants were selected based on their innovative work in healthcare payment reform, funding for community health, multi-payer initiatives, philanthropy, hospital community benefits, and social impact bonds and pay-for-success initiatives. JSI qualitatively analyzed the literature and interviews to identify key themes and opportunities to structure and implement a sustainable ACH.

The Wellness Fund

A Wellness Fund is a mechanism for pooling resources from multiple sources to support community health initiatives. A Wellness Fund would essentially function as an ACH's bank account and clear rules and procedures would need to be put in place to govern its administration and decision making about allocation of resources.

The “Dose Effect” of a Portfolio of Interventions

Public health experience with tobacco, lead, car seats, etc., demonstrates the power of adopting a mutually reinforcing-portfolio approach: combining clinical, community resource, linkage, and PSE strategies where individual and educational approaches have not succeeded. Using multiple strategies targeting the entire population (with specific attention to those who are at highest risk) has been shown to create a “dose effect,”⁸ where the strength and reach of the collective, aligned strategies is greater than the predicted effect of individual strategies and is sufficient to change behaviors that shape chronic disease outcomes at a population level. This notion is also supported by research showing the influence of social relationships and norms on health behaviors and chronic disease outcomes.⁶

Findings

The findings below are divided into two sections: key principles and a set of sustainability strategies. The key principles should be viewed as core components of sustainability and apply throughout ACH implementation while the sustainability strategies are organized into phases. Multiple interviewees emphasized that sustainability must be woven into the fabric of an ACH and considered in all decisions. As an emerging initiative, it is unlikely for an ACH to “kick off” with long-term investment and reinvestment mechanisms firmly in place. As a result, the initial question on facilitators for sustainable ACH financing became three sub-questions for three phases of ACH development:

1. **Formation:** What existing assets or initial actions make ACH sustainability more likely?
2. **Implementation:** What strategies should an initiative put in place during implementation in order to encourage investment?
3. **Reinvestment:** How can multiple payers be engaged as long-term re-investors in an ACH?

In practice, these three phases will be more a continuum than discrete periods and the sustainability strategies will often stretch over phases. Our research indicated that intentionally phasing strategies, even if reality is more fluid, could best facilitate moving toward sustainable, multi-payer investment.

Key Principles

Through our research, we identified four key principles for ACH financial sustainability that should be considered in all three phases of implementation (Figure 2). Unsurprisingly, these four principles align closely with the “Six Key Elements of an ACH” identified by the California ACH Work Group (shared vision, leadership, collaboration and partnerships, trusted backbone or integrator organization, data and analytics capacity, wellness fund). The four principles are discussed here from a sustainable investment perspective.

Figure 2. Key principles and phases



1. Leadership—Create a Center of Gravity: Incipient ACH efforts nationally reveal that strong leadership is essential to attract investment in an ACH, particularly in prevention-focused efforts with long-term returns on investment that many health payers do not invest in today. The key from a sustainability perspective is that leadership has both the influence and motivation to make the ACH a priority over an extended period of time. As a number of our interviewees remarked, an ACH should look to “create a center of gravity” that bends spending, decisionmaking, and messaging of public and private entities in a community toward health goals for the population (Figure 3). There are numerous models for engaging the necessary leadership, ranging from a single influential champion to a group of organizations.⁴

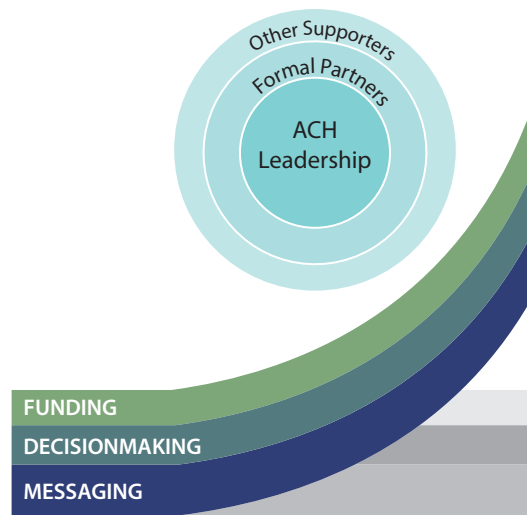


Figure 3. Center of gravity: An influential ACH can bend existing funding, decisionmaking, and messaging to align with its goals and activities

2. Collaboration—Trust Built on Transparency: Ensuring that financial decisions and contributions are transparent is particularly critical for building trust among partners that may be collaborating for the first time. An ACH likely represents a culture shift and ACH partners will need to spend the time and effort to build relationships and to create systems for mutual accountability. Transparency can promote fairness in contributions among peer organizations; ensure understanding of the ACH financial model; highlight the resources that are expressly going toward “backbone” administrative functions; and build a sense of collective momentum toward ACH activities and outcomes both among organizational partners and community stakeholders.

3. Measures—What Gets Counted Counts: Having stakeholders conceptually agree on the goals of the ACH and measuring progress toward those goals is essential for building partnerships, designing effective portfolios of activities, and securing financial commitments. In an ideal world, ACH success and corresponding investment decisions would be measured through comprehensive and integrated cost and health data. However, many data efforts, such as health information exchange (HIE) and all-payer claims databases (APCD), are still too early in their development to be the foundation of an ACH measurement approach in the short run. Nevertheless, ACHs can use a small number of

agreed upon measures drawn from existing data sources to act now while preparing and advocating for a data future that allows for more rapid and cost-effective analysis of all health-related data in a community.

- 4. Investment—“All in” for Mutual Benefit:** Securing investment, even in-kind contributions, from a wide range of stakeholders across sectors will establish a strong base of support for the ACH and provide justification for funding strategies at the PSE end of the portfolio that target the entire geographic population—the constituents of multiple stakeholders. It is particularly important to get the “all in” commitment from health payers who hold financial risk for the majority of the population and thus will benefit from improvements in health status. The “churn” in patient populations (e.g., individuals switching insurance) is a barrier to investment in geographic community prevention approaches: no one wants to pay if they won’t benefit. Identifying strategies to encourage “all in” investment would offset the risk of churn and potentially lead to mutual benefits if the ACH is successful in meeting outcome targets.

“The key factor here is that we are talking about a unit of investment that is above, or sheer influence that is beyond, what any one organization can do themselves. We define regional health systems strategy as requiring actions that no single actor can do alone—otherwise you are just talking about organizational improvement.”

- Key Informant

As an initiative develops, it is critical to review progress toward sustainability at regular intervals. These key principles can serve to organize and guide that review.

Strategies by Phase

Our research uncovered a wealth of ideas about facilitators of investment in an ACH. These ideas are synthesized into the strategies described below. The strategies are organized according to the phase (formation, implementation, or reinvestment) in which, based on what we heard in our research, they would most likely be initiated. This should not be considered a set of prescriptive instructions but rather a flexible menu to develop an approach in a given context.

I. Formation Phase Strategies

- **Identify champion(s):** To lay a foundation for ongoing financing, an ACH will need to maintain the attention of disparate players and encourage prioritization of collective goals over individual interests. An influential champion, or champions, can help focus and quickly legitimize the ACH effort. For example, in San Diego, Health Care Services leadership acted as a champion by using the LiveWell San Diego initiative to focus on “3/4/50”—3 behaviors that lead to 4 conditions that are related to 50% of healthcare costs. That focus helped to define the scope of the project, and county health leaders were able to make LiveWell an organizing objective for multiple players. One result of the County being a champion was that San Diego was able to attract external funding, including a Centers for Disease Control and Prevention (CDC) Community Transformation Grant and Beacon funding, for LiveWell activities.

It is important to be cautious when identifying and engaging champions. For example, elected or appointed officials are natural targets as champions given their influence and high profile, but an official who is likely to leave office within the first few years of ACH implementation could be detrimental. An individual with strong ties to a specific organization or sector may not be an optimal champion as he or she may be viewed as partial. In environments where there is a history of fierce competition, it may be necessary for the public sector to play a more robust, facilitating role. A group of champions may also serve to offset tensions among a group or the weaknesses of any individual.

- **Create an ACH “brand” and opportunities for public endorsement:** Building a brand for an ACH can be critical for “bending” existing resources toward ACH goals and for attracting new funding streams. An ACH should take advantage of its novelty, community-wide focus, and partnerships to draw attention and prime community members for action on the target health condition. A recognizable “brand” conveys the aspirations of the ACH simply and makes it easy for partners to express affiliation. For example, the Shape Up Somerville initiative in Massachusetts, which reduced overweight and obesity among children within two years,⁹ is very clear in its mission and communications that the goal is

“community-wide health” through multiple physical activity and healthy eating strategies and structured partner engagement.¹⁰ Materials such as decals for restaurants were created to make affiliation readily apparent. Branding should focus on the ACH being an engine of innovation—an initiative in which new, creative ideas will be considered and implemented.

- **Use teaming, partnership, and membership agreements:** In order to make financial and other commitments, shared goals, and decision-making processes transparent, many ACH-type initiatives are using teaming, partnership, and/or membership agreements or memoranda of understanding (MOU). The level of specificity and formality of these agreements depends on the legal and financial extent of the partnership in question.⁴ For example, the three founding institutions of the Atlanta Regional Collaborative for Health Improvement (ARCHI) used a highly formal teaming agreement to define their respective financial, staffing, and infrastructure roles and responsibilities. ARCHI also used a simple “membership agreement” to confirm the support of at-will members.¹¹ In between formal, legally binding teaming agreements and pledges of membership or participation, a range of partnership agreements could be developed. A 2014 study of hospital-public health collaborations found that most efforts start as “loose affiliations or coalitions” with informal agreements and commitments regarding activity and contributions.¹²

While securing fiscal commitments would be of great value, in-kind contributions such as staff time should not be discounted. For example, in the Upper Connecticut River Valley region of New Hampshire and Vermont, a group of health leaders committed to an extended planning process that required significant investment of time as well as sharing of data and other resources. The explicit commitments of those health leaders drew others to participate in initiative planning including a workgroup focused on global payments and capturing savings from change efforts to reinvest in upstream, health promoting activities.¹³ Alignment with existing, community-driven efforts could also be valuable for an ACH. For example, in Bakersfield, CA, a group of mothers formed the Greenfield Walking Group to support daily exercise. They found their routes in and around their local park to be so hazardous that they ended up leading a walking assessment and successfully advocating for significant infrastructure changes¹⁴ including securing funds from local businesses for a new walking trail. An ACH concerned with increasing physical activity might coordinate with and support such an effort by creating a mechanism for clinicians to refer patients to join the walking group and enlisting ACH partners to support the walking group’s recommended policy and environment changes.

“It’s like we have a lot of bricks but no mortar - we are the mortar in many cases.”
- Key Informant

■ **Identify a small number of consensus metrics:** Measuring success is critically important for ACH sustainability because funders and potential investors want to understand what they are “buying.” Selecting metrics upfront (and then revising as the initiative and data systems evolve) also provides an opportunity to focus ACH activity and encourage partner engagement. Considerations for metric selection include:

- Use existing data when possible to reduce costs and increase comparison with other geographies
- Align metrics with overarching ACH goals
- Include indicators across the portfolio of strategies
- Measure process and capacity as well as health-related outcomes
- Take into account the interests of key partners

Table 1. Example measures with diabetes as focal condition

Categories	Example Measures
Clinical	<ul style="list-style-type: none"> » Emergency department and hospitalization rates » Diabetes and pre-diabetes prevalence rates
Linkage	<ul style="list-style-type: none"> » Percent of pre-diabetics and diabetics who have regular contact with a care coordinator » Number of community health workers employed in community
Social Services and Community Resources	<ul style="list-style-type: none"> » Percent of pre-diabetic population referred to and participating in Diabetes Prevention Program » Number of community members receiving food assistance
Policy, Systems, and Environment	<ul style="list-style-type: none"> » Retail Food Environment Index score » Local policies or organizational practices changed due to collective advocacy
Process/Capacity	<ul style="list-style-type: none"> » Number of partnership agreements established » Specific cost-savings/efficiency opportunity identified

A successful ACH will need to balance specific interests of partners with an emphasis on community-level change. An overemphasis on achieving goals for specific stakeholders can make it easier for those stakeholders to withdraw support once their initial goals are achieved, thus stunting the momentum and sustainability of the ACH. A set of metrics that includes a robust focus on community-level change makes community-wide impact a visible ACH goal. These metrics can also provide a hedge against becoming a fiscal sponsor for independent programs as community-level change will require collective action. An ACH can save time and money by drawing metrics from existing data sources. Sources might include Behavioral Risk Factor Surveillance System, External Accountability Set data, HEDIS measures already collected by health plans, and Community Health Needs Assessment and Public Health accreditation data. During the formation phase in particular, early ACH-type efforts have tried to leverage existing measurement systems.

- **Compose a case statement/business plan:** In order to engage new partners, build consensus among existing partners, and appeal to potential investors, ACH leadership should put together a brief overview of the initiative that highlights:
 - ACH goals, principles, purpose, and measures of success (include health status and cost)
 - Strategies to be employed (both process and portfolio strategies)
 - Financial resources and partnership commitments that are in place
 - Potential benefits of ACH activity for a range of stakeholders

The case statement/business plan is an opportunity for ACH leadership to lay out the “value proposition” for potential investors in general terms. As the initiative develops, that proposition can be articulated with more fiscal specificity (see economic modeling discussion below).

- **Secure seed/match funding:** Before moving into the “implementation” phase, the ACH will need to secure adequate funding for both programmatic and administrative/backbone functions. Many interviewees cited that “start-up” resources are necessary in order to engage in the types of collaboration-building activities detailed in this brief. Philanthropic, hospital community benefit, and government grants will often be the most likely sources of seed funding given the innovative and unproven nature of an ACH. For example, federal SIM funds are being used to support ACHs in Minnesota and Washington, and Community Transformation Grant and Partnership to Improve Community Health funds from the Centers for Disease Control and Prevention support community-wide health initiatives. The California Endowment has invested in the Building Healthy Communities initiative in 14 California communities, and the Kresge Foundation recently launched the BUILD initiative with additional support from the Robert Wood Johnson Foundation, de Beaumont Foundation, and the Advisory Board Company.

ACH leadership should explore multiple options for securing seed funding including the engagement of health payers. For example, after working with the ReThink Health team to analyze their current health system and potential change strategies, the Pueblo Triple Aim Coalition was successful in engaging health payers to invest 1% of all healthcare spending (\$50 million over five years) in an effort to improve the health of the community.¹⁵ Three other possible strategies for expanding seed funding are to: 1) require a local match for any

“There is a very important and catalytic role for government dollars and philanthropic dollars to play in demonstrating that there are in fact health interventions that can generate positive outcomes.”

—Key Informant

ACH grants (this is particularly feasible if there is some level of competition for selection as ACH sites); 2) seek investment (“founding investors”) among statewide or national entities, such as health plans, that have an interest in being seen as “part of the solution;” and 3) pursue Social Impact Bond (SIB) or Pay-for-Success (P4S) funds. The latter are emerging approaches to bringing significant capital from a range of sources (venture capital, investment banks, philanthropic impact investment funds, local community banks) to support community health initiatives where there is a high probability of return on investment. This could be an appealing option for an ACH that is seeking funding for a specific strategy in their portfolio such as a diabetes prevention program. However, given the level of fiscal sophistication necessary and potential concerns about savings accruing to entities outside the community, it may take more time to establish these agreements.

- **Engage healthcare partners:** Thought leaders we interviewed repeatedly emphasized the importance of engaging healthcare payers and providers that cover/serve a high percentage of the population, and that global capitation creates collective incentive to invest in ACH-type activities. Healthcare payers and providers control the majority of health resources. They are also visible (and often trusted) stewards of health and possess skills and data necessary for ACH success. Participation from healthcare entities early in the process will validate the ACH enterprise, providing a critical foundation for future financial commitments both from the healthcare sector and from other potential investors. A recent analysis of 17 multi-payer medical home initiatives concluded that when payers are aligned from the start, they are much more likely to collaborate and exert a positive influence on program design.¹⁶

Understanding which parties hold the financial risk for the population is critical for targeting investment appeals. Interviewees in other states noted that globally capitated hospitals are more motivated to address upstream social determinants of health as a strategy for reducing avoidable hospital utilization. For example, Maryland’s recent move toward a universal Global Budget Revenue program for hospitals is being credited with significant programmatic innovations targeting population health and social factors.^{17, 18} In Minnesota, regional Integrated Health Partnerships, which have established shared-risk contracts, are a required entity in all SIM-funded ACH initiatives. Vermont is developing an ACH-type initiative that builds on payment reforms, including a shared savings model, through statewide ACOs (launched January 2015).¹⁹ Where payment reforms, such as global capitation, are not yet ubiquitous, ACHs may find that capitated entities, such as Managed Care Organizations and some ACOs, are the most promising partners.

The steady move toward value-based reimbursement and quality over quantity should bolster interest in ACH-type initiatives and create partnership opportunities. In January 2015, the

US Department of Health and Human Services announced ambitious goals of having 30% of Medicare payments tied to quality or value through alternative payment models such as Accountable Care Organizations (ACOs) or bundled payments by the end of 2016, and 50% of payments by the end of 2018.²⁰

■ **Identify potential incentives for payers, providers, and consumers:**

Health care is increasingly moving toward payment models that reward performance and incentivize change by tying financial reward to outcomes for patient populations. An ACH could explore approaches that align shared action with shared rewards by initiating a conversation about incentives for all three constituencies—payers, providers, and consumers—if the ACH reaches certain targets. For example, the New England Asthma Innovations Collaborative, funded by a CMMI grant, brought payers and providers together to develop reimbursement methodologies tied to success of a home-visit initiative.²¹ For providers, the incentive may already be in place if ACH activities help achieve benchmarks for which they are being held accountable (e.g., HEDIS measures). In a managed care environment, the incentives could also be paid for through an agreement across health plans to pool a portion of savings associated with health improvements and reduced hospital utilization.

“The thing I really like about the portfolio approach, it’s the connection to the challenges that physicians are experiencing with managing patients that have disease or are at risk—that is the real opportunity.”

—Key Informant

A number of interviewees noted that in the absence of global budgeting, hospitals may see counter-incentives to ACH participation—for many hospitals, their business depends on filling beds. This is a significant challenge and one that an ACH may want to tackle directly through focused discussion and strategies. A few possible approaches include developing shared-savings agreements that direct a portion of savings from reduced hospitalizations back to hospitals; making avoiding readmissions penalties an ACH goal; and conducting an analysis of current and future patient and payer mix to explore whether ACH activity might result in higher paying patients with higher acuity. For example, a hospital and FQHC in Vallejo, CA, partnered to redirect patients from the emergency department, successfully reducing avoidable visits and resulting in a positive economic impact on the hospital.²²

Incentivizing individual behavior change in the ACH context may work best through group or community challenges. While extending incentives to individual patients may appeal to healthcare payers, this approach could face regulatory challenges and raises equity concerns—as those with the greatest social and economic barriers to health may essentially be penalized for not meeting benchmarks. One possible remedy would be to tie the incentive

to achieving population-wide measures and rewarding the population as a whole. For example, Kaiser Permanente's workplace wellness initiative engages employees in initiative design, measures health improvement among a defined group of employees, and provides incentives for the entire group for achieving benchmarks.²³ There are numerous examples of health challenges undertaken at a community level. For example, Cuyahoga County in Ohio initiated a Community Health Challenge among all 59 communities in the county based on improving measures from the County Health Rankings. The incentives were principally publicity related.²⁴ However, an ACH could choose to provide small financial incentives for all community members individually if collective targets are met or invest in shared resources such as a fitness trail or bike infrastructure.

II. Implementation Phase Strategies

- **Initiate a Virtual Global Budget:** Multiple interviewees cited the benefits of creating a Virtual Global Budget to establish the sense of a collective endeavor among multiple payers, monitor progress, and promote transparency. A Virtual Global Budget would require ACH partners to agree to contribute data and to track spending across sectors and payers associated with the target condition or risk factor and population. The virtual nature of the process would provide a “laboratory” for resolving data collection, analysis, and fairness issues. The Virtual Global Budget would provide an overview of how collective resources are currently being spent and could facilitate conversations about right-sizing the pools of resources. For example, stakeholders might ask collectively, are resources appropriately allocated to prevention, primary care, and behavioral health? It would also clarify which funds are tied to specific activities or services and which are flexible and could fund administrative functions or novel ACH activity. In some cases, the Virtual Global Budget may be useful in identifying opportunities for gaining efficiency through collaboration (e.g., combining community needs assessment processes currently conducted by multiple entities) or redirecting current spending to the ACH effort (e.g., a public health department aligning a public information campaign with ACH messages or a health plan investing in care management for the target population). Lastly, the Virtual Global Budget could also create a foundation for future pay-for-performance agreements or reinvestment decisions.
- **Identify opportunities for short-term cost savings/problem solving:** Developing a sustainable ACH is a complex process that needs to be approached strategically over time. However, short-term successes can bolster momentum and engagement in that longer process. A committee of ACH partners could be formed to identify immediate opportunities for collective action. For example, the Oregon Primary Care Association recently initiated the It Takes a Neighborhood project, funded by Kaiser Permanente, which supports “health

instigators” in two pilot communities. The instigators are charged with bringing together stakeholders to identify and solve inefficiencies in serving vulnerable and costly populations. Within the first year of the project, a number of results were documented, including the establishment of a link between the county jail and homeless youth service programs. Upon discharge youth receive services and transitional housing rather than returning to high-risk behavior.²⁵ The expectation is that this will reduce costs in health care and other sectors. Other examples of the type of collective problem solving that an ACH committee could engage in include:

- **Capacity building & training:** In Minnesota, the Healthcare-Education-Industry Partnership pooled resources and advocacy efforts to successfully establish a community health worker training program.²⁶
- **Data collection & reporting:** In the Columbia River Gorge region of the Pacific Northwest, 12 organizations agreed to work together on a shared community health assessment that would satisfy each of their regulatory requirements. The results were significant collective savings; expanded outreach and community input; a more comprehensive assessment; and identification of shared goals.²⁷
- **Program implementation:** In Hillsboro, OR, Intel partnered with Providence Health & Services, Tuality Healthcare, and Cigna to develop a program focused on fast and efficient treatment for employee back pain. Employees are guaranteed a visit with a physical therapist within 48 hours, instead of averaging a 19-day wait to see a physician. The partners reported \$2 million in annual savings.²⁸
- **Infrastructure & services:** An Oregon Coordinated Care Organization established an alternate transportation pooled fund for non-emergency health needs as a strategy for reducing avoidable ambulance utilization (a \$10 cab ride instead of a \$1,000 ambulance call).²⁹

“There are a lot of entities at the community level that have gotten their act together in terms of organizing a governing structure, having the stakeholders engaged, doing the needs assessment, prioritizing all that front end work - but it seems to be remarkably difficult for them to take that next step of actually implementing the first series of interventions to move the needle.”

—Key Informant

- **Maximize visibility through an online dashboard and reports on progress:** ACHs should position themselves as public initiatives and take regular steps to highlight progress, accomplishments, and the contributions of partners. High visibility attracts potential investors and encourages participation from additional collaborators. Raising visibility also contributes to the “dose effect” in that increasing public awareness around community health goals becomes part of the ACH portfolio of interventions. One specific visibility

strategy involves the use of user-friendly dashboards and regular progress reports aimed at a general public audience. Strong examples include the Boston Indicators Project reports³⁰ and the Jacksonville Community Council reports.³¹ Web-based dashboards that focus on providing easy-to-digest overviews of data are becoming an increasingly common and recommended practice. Examples include the soon-to-be-launched California Department of Public Health's Let's Get Healthy California dashboard, Green Mountain Care's Dashboard 2.0,³² King County's Communities Count website,³³ and the Healthy Sonoma Community Dashboard (built on the Healthy Communities Institute platform, Figure 3).³⁴ For an ACH, a dashboard or set of dashboards could serve to highlight evaluation or virtual budget information and engage partners in planning and in reviewing progress.



Figure 3. Healthy Sonoma's Community Dashboard

For an ACH, a dashboard or set of dashboards could serve to highlight evaluation or virtual budget information and engage partners in planning and in reviewing progress.

In some cases, highlighting a single indicator can be a powerful platform for focusing attention on a community health goal, which then attracts investment. For example, a number of cities including Houston and Oklahoma City have embarked on campaigns to collectively lose weight dubbed "Million Pound Challenges." The campaigns have included a number of strategies at the individual, institutional, and governmental levels, and regular reports and media coverage on progress. In both Oklahoma City and Houston, local businesses and corporations have made financial contributions to the campaigns and become partners in implementing healthy workplace policies and programs.

■ **Track “soft ROI” (return on investment):** Soft ROI was the term multiple interviewees used to refer to the host of benefits that could accumulate to ACH collaborators that are not easily quantified in dollar terms. Interviewees consistently remarked that such “soft returns” would likely be as powerful as economic value propositions in driving early-stage ACH participation and support. For example, health payers often lack a connection to communities, unless they have a hospital or administrative center located there, and the visibility of ACH participation could establish such a connection. Other soft ROI benefits mentioned by interviewees include:

“Incentives aren’t just financial. What we’ve learned is awards and public reporting – transparency – are really powerful to motivate people. It is amazing how powerful that is.”

—Key Informant

- Reputational benefit of a demonstrated willingness to partner and collaborate
- Positive public relations from affiliation with a virtuous initiative to improve health and wellbeing
- A more productive workforce due to better health of employees and their families

Soft ROI benefits could be described in detail to attract partners at the outset of the ACH. In the implementation phase, soft ROI outcomes should be collected, tracked, and explicitly shared as measures of success.

■ **Braid and blend funding across portfolio categories:** An ACH will need to braid and blend resources in order to ensure adequate support for strategies in each portfolio category. Braiding funds means aligning existing funding streams to pay for services, projects, or infrastructure that could not be supported by any single stream while maintaining separate accounting for spending and outcomes by stream. Blending funds means putting resources in a collective “pool” (such as a Wellness Fund) from which they are generally spent based on the judgment of a governing body⁴ that manages that pool without tracking specific spending to specific sources. In an ACH, the backbone organization would facilitate and encourage braiding funding from participating entities but would likely depend on blended funds for its administrative functions.

Interviewees described PSE strategies and coordination between sectors as the most difficult portfolio components to fund from existing sources. Indeed, community-based, prevention-oriented efforts targeting long-term improvements in health and costs have historically received inadequate funding.³⁵ Investment in PSE strategies might increase over time, as early successes lead to broader investment, but it is important that there be substantial support from the outset in order to establish the ACH as a broad, transformative, population-focused effort rather than a narrow programmatic one.

Our research indicated that it is often possible to use existing resources for the clinical, social service, and linkage type strategies. Clinical strategies could primarily be paid for by health payers as they will largely consist of recommended, reimbursable prevention and treatment services. Linkage strategies may be supported by braided funds from, for example, private and public sector payers that are increasingly providing funding for care coordination and case management.

Multi-payer Patient-Centered Medical Home programs or federally funded Medicaid Health Home benefits, facilitated through Section 2703 of the Affordable Care Act,³⁶ could serve to support linkage activity. As part of participation in an ACH, health plans might agree to make one of their Pay-for-Performance measures a community health measure (e.g., improved physical activity levels, reduced smoking rates) in order to incentivize providers to pursue clinical and linkage strategies.

Community program and social service strategies may be supported by organizations or government agencies that are already resourced to provide services.

An ACH will likely need to use blended funds to fill gaps in order to increase the impact of braided funding. For example, Los Angeles County’s Housing for Health (H4H) Program looks to braid existing funding such as housing vouchers, social service case management, and clinical services in order to improve health outcomes and reduce costs by transitioning chronically homeless, high-utilizing individuals into supportive housing. H4H also blends county and philanthropic money to support a seamless enrollment system and a Flexible Housing Subsidy Pool to supplement existing rental subsidies and increase landlord engagement. Figure 5 depicts how PSE strategies will likely require allocation of blended funding from the Wellness Fund and strategic engagement of existing clinical, social service and linkage programs and efforts will likely need to be braided.

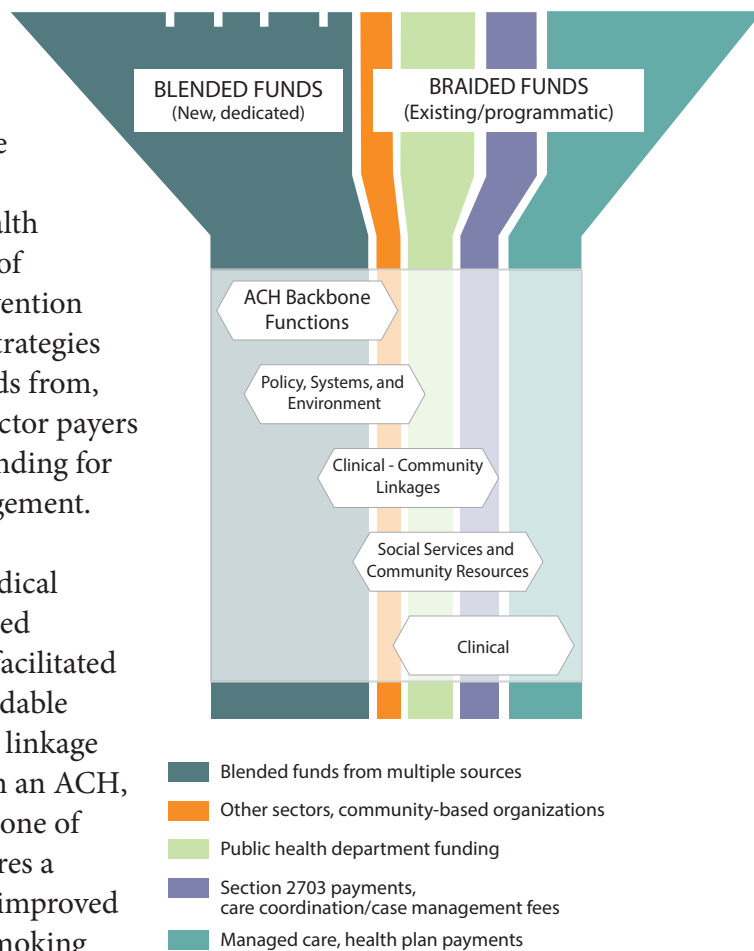


Figure 5. Braided and blended funds

III. Reinvestment Phase Strategies

- **Tie reinvestment to factors other than actual cost data:** Many interviewees emphasized the importance of demonstrating both an ACH's health achievements and the financial implications for all stakeholders. However, there was significant trepidation about tying investment in an ACH to actual cost savings, particularly early on. Challenges cited included collecting comprehensive data, potential time lag before cost results may become evident, and hesitancy from payers to reveal cost of care data (due to its link to proprietary prices negotiated with hospitals and providers). In fact, while many interviewees agreed that reducing spending is a central ACH goal, many acknowledged that relying on an aspirational data tool such as an all-payer claims database could weaken short-term sustainability if such data infrastructure does not yet exist for the community. Mitigating strategies include:
 - **Link reinvestment to an economic model:** With support from a neutral economic analyst, an ACH may be able to build a simple economic model that translates agreed upon metrics into cost projections based on reasonable assumptions. Stakeholder agreement on an economic model could facilitate sustained investment in the Wellness Fund. Unfortunately, no “off the shelf” economic model exists, partly due to limited evidence on multi-strategy initiatives, though significant resources are being applied to the challenge.^{37, 38, 39} A number of models created for specific initiatives could provide a blueprint. For example, The Way to Wellville,⁴⁰ a multi-stakeholder initiative to improve health in five communities over five years, has engaged ReThink Health to create an “our town” model that simulates health and health system changes. Appendix II includes three examples of economic models developed to forecast changes in health status and costs.
 - **Allow payers to make a simple “yes/no” decision based on a “price of portfolio:”** The “price” would be based directly on the cost of the backbone organization functions and the portfolio of interventions funded through the blended Wellness Fund. The process could also include considerations for sizing the portfolio to a price in line with what stakeholders are willing to pay. This strategy has the benefit of allowing stakeholders, such as health payers, to make ROI calculations without revealing competitive pricing information and internally consider both “hard ROI” and “soft ROI” in making a reinvestment decision.
 - **Link reinvestment to process and outcome metrics expected to show change in the implementation timeframe:** If stakeholders can agree on a set of realistic metrics, this strategy meets the need for accountability to outcomes and secures sustained investment before total cost can be reliably and cost-effectively reported.

- Identify and pursue a range of funding sources:** ACHs should systematically engage the most likely significant investors (health payers, local government, philanthropy) while also remaining creative and entrepreneurial about funding opportunities. Support from multiple sources increases sustainability by decreasing dependence on any single funder and aligns with the ACH mission of achieving collectively what is impossible individually. Table 2 below lists a menu of potential ACH funding sources that emerged from our research.

Table 2. Potential funding sources

Funding Source	Description
Philanthropy	Foundation funding: Health foundations are increasingly interested in the notion of collective impact and in leveraging their resources to bring multiple sectors and strategies into alignment. Community foundations may be ideal partners in supporting ACH strategies, either financially or through acting as conveners. Foundations from sectors other than health may be willing to support an ACH if they have a connection to the geographic area or an interest that cuts across sectors.
	Impact and program-related investment: In addition to charitable giving, many philanthropies invest funds from their endowments in alignment with their mission. These funds require a reliable return on investment and may be available through social impact bond/pay-for-success mechanisms.
Non-Profit Hospital Community Benefits	In exchange for maintaining tax-exempt status, state law requires that all private, non-profit hospitals direct community benefit funds to activities intended to address community needs and priorities. ⁴¹ Hospitals have discretion over the process for dispersing funds though they are required to conduct a community health needs assessment. Some community benefit offices conduct competitive grant processes while other funds are dispersed discretionarily.
Federal Government	Federal grants: Several federal grant programs could support ACH activity. CMMI awards grants to state and local entities to test innovative care and payment approaches. For example, Minnesota and Washington received CMMI support for ACH initiatives. CDC is administering Partnerships to Improve Community Health (PICH) Grants, which are available to cities, counties, and American Indian tribes.
	Section 1115 waiver: States can apply to CMS for Section 1115 waivers, ⁴² which allow for flexibility in the use of Medicaid resources. States such as Texas have used the waiver to set aside resources for population health, and other states, including California in their March 2015 proposal, include resources for regional partnership development and infrastructure building.
	Inter-governmental transfers (IGTs): In the Medicaid context, “rate range” IGTs are used to draw down federal funds to help increase the per member/per month rates the state pays managed care Medicaid insurance plans. Funds are transferred from local governmental entities (counties, cities, district hospitals, healthcare districts) to the state’s Medicaid program, are federally matched, and are then paid to the Medicaid health plans serving the region. These additional funds are used by the plans to reimburse local entities that provide services to plan members. However, there is some flexibility in the use of these funds and some portion could be allocated to prevention services including an ACH.
Providers and Hospitals	Investment in a portfolio of strategies in response to real or projected cost savings: Hospitals may be incentivized to invest in strategies that will reduce low-acuity, low-cost admissions. Globally capitated hospitals have a financial incentive to invest in strategies that prevent hospitalization. Hospitals with high Medicare readmissions might invest in linkage strategies that prevent readmissions to avoid penalties. Public systems might also use Delivery System Reform Incentive Program (DSRIP) funds for some ACH activities.
	Tie provider bonuses to ACH outcomes and investment: Improvements in population health may help payers meet benchmarks such as HEDIS measures for which they are held accountable.

Funding Source	Description
Payers (public, commercial, and self-funding employers)	<p>Cover specific health services: Preventive care is increasingly being incorporated into standard healthcare provisions and provided at no charge. New additions to recommended preventive practices, such as the Diabetes Prevention Program, create opportunities to fund specific clinical and linkage strategies. Payers in a given geography could also agree to collectively pay for certain health benefits and activities if they believe those activities will improve health and reduce costs. New CMS rules expanding potential reimbursement for non-traditional providers could also support expansion of prevention services and deployment of community health workers.</p>
	<p>Investment in a portfolio of strategies in response to real or projected cost savings: Payers could pay a set price for a portfolio of strategies in proportion to their share of the population, make payments for achieved performance targets, and/or base payments on real or estimated ROI.</p>
Private Investors	<p>Social Impact Bonds (SIBs):⁴³ SIBs involve an investor putting up capital to fund a specific set of activities with an agreement that their investment will be returned, with interest, if the activities result in certain outcomes. SIB is an emerging field and has been garnering significant attention as a potential mechanism for attracting resources for health initiatives. The practice is still developing, and currently such investments are typically for targeted interventions, not collective action. Given the necessary financial and contractual sophistication, SIBs are likely more appropriate for ACH reinvestment than for seed funding.</p>
	<p>Community Development Financial Institutions (CDFI): CDFIs are financial institutions committed to providing financing and services in low-income and underserved communities. The investments generally require a return at a very low interest rate and must meet general community development guidelines.</p>
Local or State Government	<p>Establish new local or state tax or fee: Options include:</p> <ul style="list-style-type: none"> ➤ Sales or property tax increase. Such measures have successfully supported hospital expansion, public and active transportation, public health, general public safety, and more. ➤ A tax on a specific activity such as disposal of medical waste or elective surgery. ➤ A tax on a specific product, such as alcohol, firearms, or sugar-sweetened beverages. ➤ Massachusetts initiated collection of a fee on insurers and private hospitals as part of a broader “cost-containment” bill.⁴⁴
	<p>Redirect existing taxes or fees: Existing taxes/fees could be redirected to support an ACH, or an existing authorization to collect taxes or fees could be activated. For instance, California’s Healthcare Districts were initially established and authorized to collect local property tax revenue to ensure access to health facilities but have evolved to employ a more flexible set of strategies to improve health within their districts and could potentially support ACH initiatives. Hospital provider fees have been used to support access to care, improving health, and addressing health disparities and so are thematically aligned with ACH goals. Potentially a portion of provider fees could be designated to support an ACH.</p>
Employers	<p>Employers may be willing to invest in an ACH as illness and injury affect their employees and finances in direct and indirect ways, including absenteeism, presenteeism (reduced efficiency while at work), disability claims, and ability to attract a skilled workforce. Large employers and employers who self-insure are particularly likely to see the potential value of an ACH.</p>
Crowdfunding	<p>Large numbers of people making small investments or donations through web-based crowdfunding platforms such as citizinvestor.com and indiegogo.com have increasingly been supporting large-scale projects and initiatives. For example, the city of Seaside Heights, NJ, raised over \$1 million to support their “Restore the Shore” campaign.⁴⁵ Generally, crowdfunding efforts focus on tangible projects that catch investors’ attention such as parks and gardens.</p>

In evaluating funding options, it may be useful to categorize sources as:

- **Voluntary:** Funds provided prospectively at the discretion of the funder or payer
- **Contingent:** Funds provided if an ACH achieves agreed upon milestones
- **Mandatory/Automatic:** Funds allocated to the ACH through a predictable, required mechanism

It is likely that an ACH will rely upon voluntary funds when launched. However, voluntary funds depend on the continued interest of the funder and do not provide long-term sustainability. Contingent funding provides a predictable trigger for investment but still requires regularly renewed agreements. Mandatory/automatic funds (such as taxes and fees) provide a higher level of sustainability but may take longer to establish, require a political process, and/or involve careful stakeholder engagement.

Conclusion

Achieving long-term sustainability for an ACH will require strong leadership, a commitment to transparency, focused measurement of performance, and multi-payer investment in a shared vision and goals. ACHs may develop more easily in environments where payment reforms, data sharing, and analytics in the health sector are most advanced. Geographic areas with motivated healthcare partners and a history of cross-sector collaboration may also experience more rapid uptake of the ACH concept. Regardless, ACH will represent a dramatic departure from the status quo and will require much experimentation and an extended, focused process.

Financing for an ACH will also likely evolve over time: as an ACH moves from formation through implementation and reinvestment, initial funds will be supplanted by performance-based and automatic commitments from ACH stakeholders, policymakers, and potentially voters. While it will be key to evaluate ACHs as they evolve, a multi-payer approach focused on community health holds potential to increase efficiency of health and other resources; to improve the quality and coordination of services across settings; and, perhaps most importantly, to align health strategies in clinical and community-based service delivery settings with efforts to improve the environments in which people live, work, learn, and play.

Appendix I. Economic Modeling Approaches

<p>CDC Chronic Disease Cost Calculator*</p>	<p>The Chronic Disease Cost Calculator is a downloadable tool that provides state-level estimates of the medical and absenteeism costs of nine of the most prevalent and costly chronic diseases. Cost estimates by payer (Medicare, Medicaid, Private, uninsured) and forecasts through 2020 are also available. The calculator is built on an economic model that integrates data from multiple sources including the Medical Expenditure Panel Survey, Centers for Medicare and Medicaid Services, and Kaiser Family Foundation and has built-in adjustments for population differences by state, comorbidity patterns to avoid double-counting, and other factors. The methodology used for the calculator might be modifiable for smaller geographic areas. It is also an example of a model built on available data that is intended to inform elected officials and other decision makers.</p>
<p>Urban Institute's Prevention for a Healthier America Model**</p>	<p>Urban Institute researchers developed an economic model to answer three questions:</p> <ol style="list-style-type: none"> 1. How much do people with selected preventable diseases spend on medical care? 2. If the rates of these conditions were reduced, how much of these expenditures could be saved? 3. How would these savings be distributed across payers? <p>Based on a comprehensive literature review of intervention effects on behavior, health outcomes, and costs, the research team developed estimates for: 1) the costs of the most expensive diseases related to physical inactivity, poor nutrition, and smoking; 2) program cost assumptions; 3) disease rate reduction assumptions; 4) cost savings estimates. Based on those estimates and the rates of select chronic conditions in a given community, a "medical savings calculation" could be performed that would indicate potential cost savings from implementing community prevention initiatives. For example, Urban Institute concluded that in aggregate, a national investment in community prevention would return \$5.60 for every dollar invested within 5 years. A share of those savings by payer could be calculated based on share of the given population. Massachusetts' Wellness Trust used a similar calculation to estimate per-person spending and potential cost savings.***</p>
<p>ReThink Health's Systems Dynamics Model****</p>	<p>The ReThink Health model is intended to inform multi-stakeholder planning processes by providing "a realistic, yet simplified, representation of a local health system."† By incorporating multiple sources of empirical data (including US Census, Medical Expenditure Panel Survey, Behavioral Risk Factor Surveillance System, and Dartmouth Health Atlas) into a single framework, the model allows users to test how a range of conditions and inputs will change outcomes in population health, healthcare costs health equity, workforce productivity, etc.</p>

* Centers for Disease Control and Prevention. Chronic Disease Cost Calculator Version 2. Atlanta, GA: CDC; 2013. <http://www.cdc.gov/chronicdisease/resources/calculator/download.htm>. Accessed March 2, 2015.

**Trust for America's Health. Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities. TFAH; February 2009. <http://www.healthyamericans.org/reports/prevention08/Prevention08.pdf>

***Robert Wood Johnson Foundation. NewPublicHealth Q&A: John Auerbach and Cheryl Bartlett on the Massachusetts Prevention and Wellness Trust. RWJF; December 2013. http://www.rwjf.org/en/blogs/culture-of-health/2013/12/newpublichealth_qa.html.

****ReThink Health. Summary of the ReThink Health Dynamics Model. The Fannie E. Rippel Foundation; December 2013. <http://rippelfoundation.org/docs/RTH-Dynamics-Model-Summary.pdf>

† Ibid.

References

1. Institute of Medicine. For the Public's Health: Investing in a Healthier Future. *IOM*. April 2012. <http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx>
2. Chokshi DA, Farley TA. The Cost-Effectiveness of Environmental Approaches to Disease Prevention. *New England Journal of Medicine*. July 2012; 367:295-297.
3. Masters B. Recommendations for the California State Innovation Model (CalSIM) Accountable Communities for Health Initiative. The CalSIM ACH Work Group. Expected release in Spring 2015.
4. ChangeLab Solutions. ACH Governance Models Report. Expected release in Spring 2015.
5. Mikkelsen L, Haar WL, Cohen L, Cantor J, Bennett R, Aboelata M. Sustainable Investments in Health: Prevention and Wellness Funds. Prevention Institute. January 2015. <http://preventioninstitute.org/component/jlibrary/article/id-360/127.html>
6. Christakis NA, Fowler JH. The Spread of Obesity in a Large Social Network Over 32 Years. *New England Journal of Medicine*. July 2007; 357(4):370. <http://www.nejm.org/doi/full/10.1056/NEJMsa066082>
7. Masters B. Recommendations for the California State Innovation Model (CalSIM) Accountable Communities for Health Initiative. The CalSIM ACH Work Group; expected release in Spring 2015. (Note: California's ACH Work Group separated Policy & Systems and Environment. They are combined in this brief due to their similarities in strategies and sources of sustainable funding.)
8. Center for Community Health and Evaluation. Measuring and Increasing the "Dose" of Community Health Interventions. Kaiser Permanente. June 2012. http://share.kaiserpermanente.org/media_assets/pdf/communitybenefit/assets/pdf/our_work/global/chi/CHI%20dose%20guide%206.2012.pdf
9. Economos CD, Hyatt RR, Must A, Goldberg JP, Kuder, J, Naumova, EN, Nelson, ME. Shape Up Somerville Two-Year Results: A Community-Based Environmental Change Intervention Sustains Weight Reduction in Children. *Preventive Medicine*. 2013; 57(4):322-327. <http://www.sciencedirect.com/science/article/pii/S009174351300193X>
10. City of Somerville Health and Human Services Department. Shape Up Somerville. <http://www.somervillema.gov/departments/health/sus>
11. Atlanta Regional Collaborative for Health Improvement. Membership Agreement. Atlanta, GA. http://www.archicollaborative.org/ARCHI_MemberAgreement.pdf
12. Prybil L, Scutchfield FD, Killian R, Kelly A, Mays GP. Improving Community Health Through Hospital-Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships. Commonwealth Center for Governance Studies, Inc. November 2014. http://www.uky.edu/publichealth/sites/www.uky.edu.publichealth/files/Research/hospital-public%20health%20partnership%20report_12-8-14.pdf

13. ReThink Health. Building a Sustainable Regional Health System: A Status Report on ReThink Health: The Upper Connecticut River Valley. <http://rethinkhealth.org/ucrv/wp-content/uploads/2013/04/Building-a-Sustainable-Regional-Health-System-042913.pdf>
14. The California Endowment. Success Story: Greenfield Walking Group. Available from: http://www.ccropp.org/uploads/TCE_SuccessStories_KernCounty.pdf
15. Landy L. Skillful Convening: A Powerful Tool for Health System Redesign. *Health Affairs GrantWatch Blog*. April 2013. <http://healthaffairs.org/blog/2013/04/18/skillful-convening-a-powerful-tool-for-health-system-redesign/?cat=grantwatch>
16. Takach M, Townley C, Yalowich R, Kinsler S. Making Multipayer Reform Work: What Can Be Learned From Medical Home Initiatives. *Health Affairs*. April 2015; 34(4): 662-672.
17. Robeznieks A. Global Budgets Pushing Maryland Hospitals to Target Population Health. *Modern Healthcare*. December 2014. <http://www.modernhealthcare.com/article/20141206/MAGAZINE/312069983>
18. Vernick NH. Making Local Community Health a Financial Imperative in Maryland. *Health Affairs Blog*. February 4, 2015. <http://healthaffairs.org/blog/2015/02/04/making-local-community-health-a-financial-imperative-in-maryland/?cat=grantwatch>
19. Bielaszka-DuVernay C. Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at a Lower Cost. *Health Affairs*. March 2011; 30(3): 383-386. <http://content.healthaffairs.org/content/30/3/383.extract>
20. Burwell, SM. Setting Value-Based Payment Goals—HHS Efforts to Improve US Health Care. *New England Journal of Medicine*. January 2015. <http://www.nejm.org/doi/full/10.1056/NEJMp1500445>
21. Asthma Regional Council of New England. New England Asthma Innovations Collaborative (NEAIC). <http://asthmaregionalcouncil.org/our-work/neaic/about-neaic/>
22. Green L, Melnick GA. North Vallejo Access Partnership: “Right Care, Right Place” Project Evaluation. California HealthCare Foundation. May 2011. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/N/PDF%20NorthVallejoEvaluationSummary.pdf>
23. Krisberg K. Workplace Wellness Programs a Growing Trend for Employers. *The Nation's Health*. October 2013; 43(8):1-10. <http://thenationshealth.aphapublications.org/content/43/8/1.3.full>
24. Cuyahoga County Health Alliance. Challenge. <http://wellness.cuyahogacounty.us/en-US/Challenge.aspx>
25. Pratt J. OPCA Initiative – It takes a Neighborhood: Summary and Progress to Date. Portland, OR: Oregon Primary Care Association. February 2014. <http://public.health.oregon.gov/About/TaskForce/Documents/hb2348meetings/2-19-2014-pratt.pdf>

26. Eyster L, Bovbjerg R. Promising Approaches to Integrating Community Health Workers into Health Systems: Four Case Studies. Washington, DC: The Urban Institute. December 2013. <http://www.urban.org/UploadedPDF/413073-Community-Health-Worker-Case-Studies.pdf>
27. Columbia Gorge Regional Community Health Assessment: Collaborating for Optimum Health and Optimized Healthcare. December 2013. <http://www.klickitatcounty.org/health/FilesHtml/Columbia%20Gorge%20Community%20Health%20Assessment%20-%20December%202013.pdf>
28. Meyer H. Collaborative Efforts Can Save Money and Improve Care. *Kaiser Health News*. January 2012. <http://kaiserhealthnews.org/news/collaborative-efforts-can-save-money-and-improve-care/>
29. Pratt J. OPCA Initiative – It takes a Neighborhood: Summary and Progress to Date. Portland, OR: Oregon Primary Care Association; February 2014. <http://public.health.oregon.gov/About/TaskForce/Documents/hb2348meetings/2-19-2014-pratt.pdf>
30. Boston Indicators Project Reports. The Boston Foundation. Boston, MA. <http://www.bostonindicators.org/reports/all>
31. Jacksonville Community Council, Inc. <http://www.jcci.org/>
32. Green Mountain Care Board. Dashboard 2.0. VT: State of Vermont. 2015. <http://gmcbboard.vermont.gov/dashboard2>
33. Communities Count: Social and Health Indicators Across King County. Communities Count. 2012. <http://www.communitiescount.org/>
34. Healthy Sonoma. Community Dashboard. Healthy Communities Network. 2015. <http://www.healthysonoma.org/>
35. Committee on Public Health Strategies to Improve Health, Institute of Medicine. For the Public's Health: Investing in a Healthier Future. The National Academies Press. 2012. http://www.nap.edu/openbook.php?record_id=13268
36. NACHC. Section 2703 Health Homes and Health Centers: Providing Care for Chronic Conditions. *Emerging Issues #9*. April 2015. http://www.nachc.com/client/Emerging%20Issues%209_2703%20Health%20Homes%20FINAL.pdf (Note: Section 2703 could provide a catalytic funding source for Medicaid investment in care coordination and case management because it enables states to draw down 90% Federal matching funds for 2 years for qualifying activity.)
37. Robert Wood Johnson Foundation. Return on Investments in Public Health. December 2013. <http://www.rwjf.org/en/library/research/2013/12/return-on-investments-in-public-health.html>
38. Altarum Institute. The Value of Prevention. <http://altarum.org/our-work/the-value-of-prevention>
39. Miller W, Rein D, O'Grady M, Yeung J, Eichner J, McMahon M. Report on Economic Models of Prevention Benefits: A Review and Analysis of Economic Models of Prevention Benefits. NORC at the University of Chicago. April 2013. http://aspe.hhs.gov/sp/reports/2013/economicmodels/rpt_EconomicModels.pdf
40. Health Initiative Coordinating Council (HICcup). Challenge. <http://hiccup.co/challenge/>

41. The Hilltop Institute. Community Benefit Law State Profile: California. March 2013. http://www.hilltopinstitute.org/hcbpDocs/HCBP_CBL_ca.pdf
42. California Department of Health Care Services. Medi-Cal 2020: Key Concepts for Renewal. 2015. <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/FinalDraftMediCal2020WaiverRenewal.pdf>
43. Costa K. Social Impact Bonds in the United States. Center for American Progress. 2014. <https://www.americanprogress.org/issues/economy/report/2014/02/12/84003/fact-sheet-social-impact-bonds-in-the-united-states/>
44. Mikkelsen L, Haar WL, Cohen L, Cantor J, Bennett R, Aboelata M. Sustainable Investments in Health: Prevention and Wellness Funds. Prevention Institute. January 2015. <http://preventioninstitute.org/component/jlibrary/article/id-360/127.html>
45. “Restore the Shore” Seaside Heights, NJ. <https://www.indiegogo.com/projects/restore-the-shore--29>

