

The Accountable Community for Health: An Emerging Model for Health System Transformation



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Prevention Institute recognizes the following key informants for their insight—originally gathered for *Accountable Community for Health: Opportunities and Recommendations*, a report commissioned by the state of Vermont—which helped to shape this paper.

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INTRODUCTION

The Accountable Community for Health is a pioneering model designed to meet the challenges of the next phase of health system transformation. Since the passage of the Affordable Care Act in 2010, states have moved swiftly to expand insurance coverage. As a result, more Americans have become insured and are participating in the system than ever before. In California, as well as other states, this is a tremendous accomplishment and an example of true leadership by the state. At the same time, injury and illness – particularly chronic diseases impacting the most vulnerable – continue to cause unnecessary suffering and put stress on the healthcare system that is not sustainable. Leaders from public health and healthcare are asking, “What can we do to support a healthy population?” This is the fundamental question driving the next phase of health system transformation, where value will be emphasized over volume, and improved population health will be the ultimate benchmark of success. The Accountable Community for Health (ACH) model provides a powerful opportunity for healthcare institutions to prepare for the collaborations necessary to succeed in this new health ecosystem.

This brief outlines the ACH model, provides examples of relevant collaborations emerging throughout the country, and recommends several concrete actions for organizations interested in taking the next step toward adopting the ACH approach. The brief was developed to provide particular guidance to support emerging ACH implementation efforts in California. This guidance is relevant for similar efforts across the country.

An ACH is a structured collaboration between healthcare, public health, and a variety of partners outside the healthcare system. Its mission is to improve health, safety, and equity within a defined geographic area through comprehensive strategies including clinical services, behavioral health services, social services and community supports, and community-wide efforts to improve community conditions that influence health. This final point – the inclusion of community-wide change – is what makes the ACH model unique and particularly innovative. Models such as the Patient-Centered Medical Home, the Accountable Care Organization, and Oregon’s Coordinated Care Organizations have explored the integration of clinical services with behavioral health and social services, but the ACH model is one of the first frameworks to purposefully integrate public health strategies that address the community-level factors that shape population health. Through a strong integrated strategy, an ACH is a structure for both primary prevention and enhancing efficacy of medical treatment for those who are already sick or injured.

Deliberately integrating medical and public health approaches, the ACH model enables healthcare to be more effective and efficient by providing care through partnerships that stretch beyond the clinic walls and into the community – strategically transforming population health and achieving the Triple Aim.¹ Active participation in an ACH allows healthcare to complement its expertise in health and wellness with effective community strategies that improve the socio-cultural, physical/built, and economic environments that influence population health outcomes and healthcare costs. The attention to community environments is critical for advancing health equity in communities of color and economically disadvantaged communities where the inequitable distribution of power, money, and resources play out at the community level, impacting daily living conditions and, consequently, neighborhood outcomes for health, safety, and health equity.²

THE CALIFORNIA ACH PROPOSAL

In 2014, California submitted an ACH proposal to the federal Center for Medicare and Medicaid Innovation. Though it was ultimately not selected for funding, the proposed California State Health Care Innovation Plan called for the implementation of ACH pilots across the state to accelerate health system transformation. The California Accountable Communities for Health Work Group defined an ACH as “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.”³ Importantly, an ACH is “responsible for improving the health of the entire community, with particular attention to achieving greater health equity among its residents.”

The California ACH Work Group emphasized that “one of the most innovative aspects of the ACH is that it would test how a comprehensive set of mutually reinforcing strategies can improve population health.”⁴ The Work Group delineated five key domains to be included in a portfolio of strategies: (1) Clinical Services; (2) Community and Social Services Programs; (3) Clinical-Community Linkages; (4) Environment; and (5) Public Policy and Systems Change. These domains are described in FIGURE 1.

FIGURE 1. California ACH Five Key Domains



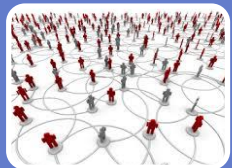
Clinical Services

- Services delivered by the healthcare system
- Includes primary and secondary prevention, disease management programs, and coordinated care that is provided by a physician, health team, or other health practitioner associated with a clinical setting



Community and Social Services Programs

- Programs that provide support to patients and community members
- Delivered by governmental agencies, schools, worksites, or community-based organizations
- Frequently target lifestyle and behavioral factors, such as exercise and nutrition habits; also include peer support groups and social networks



Clinical-Community Linkages

- Mechanisms to connect community and social services and programs with the clinical care setting to better facilitate access to and coordination between healthcare, preventive, and supportive services
- Can help form strong bonds between community and healthcare practitioners and, ideally, involves bi-directional feedback systems between the two



Environment

- Social and physical environments that facilitate people being able to make healthy choices
- May include community improvements such as building parks or bike lanes, making farmers markets more available, or transforming corner stores to carry more fruits and vegetables



Public Policy and Systems Change

- Policy, regulatory, and systems changes that affect how the healthcare and other systems operate and influence the overall ability of people to be healthy
- Address environmental issues, school policies, health and social systems coordination, and financing to support prevention-related activities

THE INTEGRATION OF INDIVIDUAL SERVICES WITH COMMUNITY-WIDE EFFORTS

Healthcare transformation has served as the impetus for integrative approaches that promote high-value care among individual patients. The more healthcare participates in comprehensive, collaborative interventions that address the many determinants of health, the greater the benefit in addressing preventable injury and illness – not just for individuals, but across the entire population.

Imagine this scenario, which is common in too many places around the country. A child experiencing difficulty breathing arrives to the emergency department (ED). Upon speaking with his grandmother, the nurse practitioner learns the child has a primary care provider, an asthma treatment plan, and a nebulizer at home. However, the family lives on a busy street with high levels of particulate matter in the air due to traffic patterns that route heavy trucks through the residential neighborhood on the way to the city's port.

In this situation, despite the child's access to care and providers who do everything right by implementing evidence-informed clinical practices – community-level factors continue to impact the child's health outcomes. As value-based payment models are further introduced into the healthcare system, providers may be held financially accountable for preventable visits like this, despite the root cause of the ED visit was influenced by community conditions currently outside the influence of the provider. It is therefore in the provider's interest to begin to influence these root causes. Value-based payment models hold the potential to reward the formation of an ACH that includes public health, key community and social services organizations, local government, schools, and other partners serving a particular geographic area. This multi-payer, multi-sector alliance can influence the root causes of health and improve not only the health of individual patients, but also the health of all those who experience similar exposures and living conditions within the community.

The ACH model is unique in that it integrates activities occurring at an individual-level (such as medical services, behavioral health interventions, and social services and supports) with community-wide efforts (such as policy and practice change, environmental interventions, and planning). The healthcare sector is largely engaged at the individual-level; the ACH model provides a framework for healthcare to better contribute to community-based work as well. This represents a major

The ACH model represents a major paradigm shift for healthcare institutions as they invest and collaborate in a systemic way to improve conditions in the surrounding community.

paradigm shift for healthcare institutions, as they invest and collaborate in a systematic way to improve conditions in the surrounding community. Attention to these conditions not only improves treatment outcomes for patients, it also helps reduce future incidence of illness and injury in the community. Such an approach is fundamentally in line with the core values of healthcare and society as a whole: creating a healthier and more equitable population. The ACH model therefore provides a structured framework for healthcare to plug into non-clinical resources – including public health, community organizations and coalitions, and faith-based organizations – to introduce systems of community-wide prevention throughout the country.

Health promoting strategies that span from clinical to community-wide are supported by the evidence. The last several decades of prevention research and practice have demonstrated that engaging in integrated, cross-sectoral strategies to improve policies, practices, and community conditions can lead to improved health, greater health equity, and can decrease the demand for costly health services. This has been recognized by numerous Institute of Medicine committees and roundtables identifying the primacy of community conditions on population health outcomes, and urging greater investment in positively changing the community factors impacting health.^{5 6 7 8 9 10 11} Additionally, studies show that access to parks, transportation systems, walkable streets and access to affordable, healthy food – among other neighborhood characteristics – have at least as much to do with the development of chronic disease as individual knowledge and skill-building.¹² Research has also shown that a comprehensive, public health approach can effectively prevent and lower rates of violence.¹³

California is recognized as a leader in using the community-wide prevention approach to improve population health outcomes. For example, since the state introduced its multi-faceted tobacco control program in 1988 (which includes tobacco taxes, smoking cessation interventions, smoke-free zones, and media campaigns), lung cancer incidence in California has dropped twice as fast as the rest of the United States, resulting in a savings of \$86 billion in healthcare costs for the state.^{14 15} Similarly, a recent study in the *New England Journal of Medicine* documented that 20 years of state and local “Clean Air” efforts in the Los Angeles area – including emissions regulations and community outreach – have resulted in improved lung function in children in the most polluted areas.¹⁶ Lung function in childhood is directly linked to the prevalence of childhood asthma and pulmonary and cardiovascular disease later in life. These community measures are therefore expected to translate into a reduced demand for resources from the local clinics and the larger healthcare system throughout the life course.

The California ACH proposal was inspired by efforts around the country to implement innovations in healthcare delivery and payment reform that address health needs on both an individual and a population level by emphasizing prevention as well as treatment. While this is still a concept under development, formal ACH pilots are underway in the states of Washington and Minnesota, both funded by the CMS State Innovation Model initiative.

Prevention Institute has identified several examples of clinical-community partnerships across the country consistent with the ACH model and reflective of the five domains proposed by California. One important finding is that strong engagement and commitment of healthcare and public health leaders provides the know-how and influence to ensure their success. Below are synopses of Rise VT^{17 18} (Franklin and Grand Isle Counties, Vermont) and the Pueblo Triple Aim Coalition¹⁹ (Pueblo County, Colorado). For more detailed information on these efforts and other examples of ACH-related activities, please see a report prepared for the State of Vermont titled, “[*Accountable Communities for Health: Opportunities and Recommendations.*](#)”

Rise Vermont

Northwestern Vermont is home to Rise VT, the brainchild of Jill Berry Bowen, Northwestern Medical Center CEO, and Judy Ashley, Director of the local district for the Vermont Department of Health. Recognizing that their district had some of the worst outcomes in the state for preventable chronic conditions such as diabetes and cardiovascular disease, the pair invited a variety of community stakeholders to the table to figure out what to do. Their solution was Rise VT, a cross-sector collaboration of stakeholders committed to changing community norms and conditions around tobacco, food, and physical activity. Currently in the early implementation phase, the collaborative is promoting a broad set of educational activities and has developed a strategy to create healthy environments in schools, workplaces, and municipalities through the use of an “optimal practices” scorecard.



While hospital leadership is essential, all parties acknowledge that it is the Rise VT partnership that will ultimately make the greatest difference. Elisabeth Fontaine, a physician and Director of Northwestern’s Lifestyle Medicine program, understands how critical Rise VT is to reducing hospital utilization. “People will listen to their physician’s advice, yet without this group it is only going to go so far. I need the community, the health department, the school, the Safe Routes to School program, and all of these people to be involved to touch the epidemic of obesity and inactivity.”

According to Northwestern Vice President Jonathan Billings, Rise VT not only supports the hospital’s mission and values, it also makes good economic sense. “Our hospital survives by providing value to the community. We look at wellness and prevention and say it’s improving quality of life, not just quality of care. We think it reduces costs long term by keeping people out of the [hospital].”

Pueblo Triple Aim Coalition

Pueblo Triple Aim Coalition's mission is to make Pueblo the healthiest county in Colorado. Catalyzed by local meetings around the Institute for Healthcare Improvement's Triple Aim model and the work of ReThink Health, the coalition was launched by multiple healthcare organizations and the local public health department. The partners decided to form a new nonprofit-- the Pueblo Triple Aim Corporation-- to facilitate community health improvement efforts in the county. Priority health issues are obesity, teenage pregnancy prevention, adult smoking, and reducing hospital readmissions and emergency department visits. Executive leadership representation on the Board of Directors ensures the highest-level commitment from the healthcare, public health, and community organizations guiding this effort. The Coalition supports multifaceted strategies to meet its health improvement goals, including community-based health education, communications, service coordination, organizational practice change, and policy work.



The Coalition worked with the Pueblo County Planning Office to transform the built environment to encourage biking and other forms of active transportation. Through the policy making process, the county amended existing zoning laws to allow businesses to reduce the number of parking spaces they were required to provide if they installed cycling infrastructure.

The Triple Aim Coalition also manages the data system that monitors collective efforts so that all partners can assess needs, coordinate more effectively, and evaluate outcomes. The emphasis on data sharing has attracted both hospitals and businesses to the coalition as it allows them to measure the impact and value of their cooperative efforts.

Donald Moore, CEO of Pueblo Community Health Center, Inc. sees the healthcare system engaging more in efforts that directly improve population health as a result of this collaboration. As Moore sees it, "The health status of the population in Pueblo County is unacceptably low. From the data we evaluated on the factors that drive health outcomes, we learned that socio-economic factors, rather than quality and access to health care, are the predominant reasons our community's health care costs are higher and health outcomes are poorer... the Triple Aim Coalition allows us to be part of a bigger discussion and draw on community resources that in the future will help us maximize the way we address the social determinants of health."

Photo Credit: Extremeshots

WHAT DOES IT TAKE TO ESTABLISH AND IMPLEMENT AN ACH?

Based on a review of national sites engaging in collaborative activities consistent with the ACH approach, Prevention Institute has identified nine core elements of the ACH model that support its successful development and implementation as illustrated in FIGURE 2.²⁰ The full incorporation of each of these elements is aspirational; the early work of an ACH can begin with only some of the elements in place.

FIGURE 2. Core Elements of an ACH



1. **Mission** - An effective ACH mission statement provides an organizing framework for the work. A strong mission defines the work as pertaining to the entire geographic population of the ACH's region; articulates the ACH's role addressing the social, economic, and physical environmental factors that shape health; and makes health equity an explicit aim.
2. **Multi-Sectoral Partnerships** - An ACH comprises a structured, cross-sectoral alliance of healthcare, public health, and other organizations that impact health in its region (FIGURE 3). Partners include the range of organizations that are able to help it fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in its defined geographic area.

FIGURE 3. Accountable Communities for Health Multi-Sectoral Partnerships



3. **Integrator Organization** - To maximize the effectiveness of the multi-sectoral partnership, it is essential for the ACH to have a coordinating organization, known as an integrator or backbone. The integrator helps carry the vision of the ACH; builds trust among collaborative partners; convenes meetings; recruits new partners; shepherds the planning, implementation, and improvement efforts of collaborative work; and cultivates responsibility for many of these elements among collaborative members.
4. **Governance** - An ACH is managed through a governance structure that describes the process for decision making and articulates the roles and responsibilities of the integrator organization, the steering committee, and other collaborative partners.
5. **Data and Indicators** - An ACH employs health data, sociodemographic data, and data on community conditions related to health (such as affordable housing, food access, or walkability) to inform community assessment and planning, and to measure progress over time. It encourages data sharing by partners to inform these activities. Equally important, an ACH seeks out the perspectives of residents, health and human service providers, and other partners to augment and interpret quantitative data.
6. **Strategy and Implementation** - An ACH is guided by an overarching strategic framework and implementation plan that reflects its cross-sector approach to health improvement and the commitment by its partners (healthcare, local government, public health, business, and non-profits) to support implementation. Frameworks to support strategy development includes the Spectrum of Prevention²¹ (FIGURE 4.), which encourages complementary, sustainable activities that range from individual to community-wide interventions, resulting in greater effectiveness of population health transformation, and The Three Buckets of Prevention,²² proposed by John Auerbach, CDC Associate Director of Policy (FIGURE 5.), which can maximize the balance between traditional clinical prevention, innovative clinical prevention, and community-wide prevention.

FIGURE 4. Spectrum of Prevention



FIGURE 5. The Three Buckets of Prevention



7. **Community Member Engagement** - Authentic community engagement is a well-recognized best practice in the field of community health that requires commitment from the highest levels, designated staff, and commensurate resources to ensure effective integration into ACH processes and systems. Authentic community engagement recognizes and harnesses residents' own power in identifying and addressing challenges, while also creating leadership for and buy-in of the work in a manner that acknowledges and builds upon existing community assets and strengths.
8. **Communications** - An ACH employs communications platforms to build momentum, increase buy-in amongst its partners, recruit new members, and attract grant investment to support its work, as well as to share successes and challenges with others. Communications is also a key tool for framing solutions in terms of community environments and comprehensive strategies.
9. **Sustainable Financing** - An ACH requires resources to support both its integrator function and ACH implementation work by others. An ACH makes use of existing and new funding sources and better aligns them to advance broad community goals.

CALIFORNIA IS READY FOR ACHs

California has made huge strides in healthcare reform and has served as a national model for reining in costs and improving health outcomes. In 2015, California was ranked the 16th healthiest state in the U.S., according to a report released by the United Health Foundation, and is the ninth lowest when it comes to per capita healthcare spending.²³ Among all states, California ranked second lowest in the percent of the adult population who currently smoke.²⁴ In the last two years, lack of health insurance has fallen from 19 percent to 14.8 percent of the total population, and preventable hospitalizations decreased from 57.0 to 40.7 per 1,000 Medicare beneficiaries.²⁵ Despite these advances, there are still large segments of California's population that experience high rates of preventable injury and chronic disease. Approximately 40 percent of California adults reported having at least one of five chronic conditions (asthma, diabetes, heart disease, high blood pressure, and serious psychological distress); adults living under 138 percent of the federal poverty level are more likely to have two or more chronic conditions; and approximately 30 percent of American Indian/Alaska Native and 19 percent of African American adults reported having two or more chronic conditions.²⁶

Persistently high rates of chronic disease, especially within economically disadvantaged communities and communities of color, suggest that the existing clinical service delivery models are not fully addressing the health needs of these vulnerable populations and that a broader, population-based approach is needed. The introduction of value-based payment models, which reward hospitals and providers for keeping patients healthy, helps create incentives for the healthcare system to address the social, economic, and physical environmental factors affecting their patients' health.²⁷ California's transition toward value-based capitated payments has moved at a rapid clip, with 80 percent of Medi-Cal beneficiaries served through managed care delivery to ease access to care and improve the quality of care.²⁸ Nationally, the U.S. Department of Health & Human Services has set a goal of tying 85 percent of all traditional Medicare payments to value by 2016 and 90 percent by 2018.²⁹ While this payment structure is motivated by the need to improve quality of care while controlling high per capita medical expenditures, it will require that providers focus on improving the health conditions of the total population of their catchment area rather than simply delivering clinical services to those who come into their facility.

This expanded focus raises new opportunities for healthcare systems to positively impact the health of the total population by forming multi-sector alliances with providers, health plans, public health, community and social services organizations, schools, and other civic-minded groups serving a particular geographic area. An ACH is precisely this type of system and leaders in California are well poised to set the stage for further innovation that promotes community-wide prevention in concert with traditional clinical prevention. As declared by the Let's Get Healthy California Taskforce:

The time is ripe to build on what California has already accomplished to set ambitious goals for the next ten years and develop a plan to systematically collect, prioritize, and share information. With California's talent, expertise, and history of innovation, we can bring stakeholders, employers, and diverse communities together to catalyze action that will reduce the burden of disease and stem the rise in health care costs. By promoting a culture of health in our homes, our workplaces, our schools, and our communities, as well as reforming the medical care delivery system to place health promotion at its core, we can succeed in making California the healthiest state in the nation.³⁰

While the ACH concept is in its early stages of development, it is clear that many communities and healthcare organizations in California have many of the core elements in place, and are poised to form some of the state's first ACHs. California has a rich local fabric of experienced community and public health leaders that have collaborated around critical health issues such as food and activity environments, tobacco control, asthma, traffic safety, and prevention of violence. Seeded by philanthropic and community benefit dollars – as well as federal funding streams including REACH (Racial and Ethnic Approaches to Community Health), Communities Putting Prevention to Work, Community Transformation Grants, and Partnerships to Improve Community Health – these multi-sector efforts are grounded in comprehensive strategy that marshals the synergy between clinical care, community education, organizational practices, and policy to improve population health. At a statewide level, there are well-defined strategic priorities and indicators reflected in the plans of the Let's Get Healthy California Task Force, the Health In All Policies Task Force, California Department of Public Health Wellness Plan, and the Office of Health Equity.^{31 32 33 34}

Below are two examples, Live Well San Diego³⁵ and California Hospital Medical Center³⁶, among many initiatives engaging healthcare in ACH-related activities to transform community health across California. These examples, along with Rise VT and Pueblo's Triple Aim Coalition, highlight how the ACH model is not just a series of short-term or standalone projects but rather a well-planned partnership between health systems, providers, education, local government, and community-based organizations with the goal of advancing population health on an ongoing basis. This model supports current trends in quality improvement and value-based payments, and is especially beneficial in geographic areas where vulnerable populations continue to experience the burden of health disparities. Healthcare offers institutional credibility, data management expertise, financial and human resources, and deep and varied ties to other sectors across the communities they serve.

Live Well San Diego

Live Well San Diego was adopted in 2010 by the San Diego County Board of Supervisors as the 10-year plan to improve the well-being of county residents. Live Well San Diego includes over 120 recognized partners aligning their efforts to improve health and wellness across the county. The initiative has a cross-cutting strategy that guides efforts to achieve its vision of a healthy, safe, and thriving county. The Live Well strategy encompasses actions to support economic prosperity and community safety as pivotal to health improvement, along with more traditional clinical and community health promotion efforts. The “Building Better Health” component includes the development of better service delivery systems through strong partnerships with hospitals, clinics, and other healthcare providers. As an example, “Be There San Diego” – an initiative of local medical groups, hospitals, health plans, Naval Medical Center San Diego, community clinics, the local medical society, and the county – has established regional standards of care and treatment protocols for more effectively managing hypertension, and preventing heart disease and stroke. Under the umbrella of Live Well, these clinical improvements go hand in hand with strategies to improve access to healthy food and to establish built environments that support physical activity - thus strengthening efforts of physicians to help patients manage their own health outcomes and to improve the health of the whole population in their service area.

For example in North County, the regional Live Well partnership supports school districts to update their wellness policies as well as establishing specific organizational policies to support Safe Routes to School. Members of the Community Leadership Team in North County have worked with cities to improve pedestrian safety laws to encourage active transportation. For example, this collaborative work in one North County city resulted in an agreement by city staff to update their crosswalk policies, which date back to the mid-1970s, as well as create new sidewalks at a critical intersection near two local schools.

Dignity Health California Hospital Medical Center (CHMC)

Dignity Health California Hospital Medical Center (CHMC) in Los Angeles serves as the safety-net hospital for 1.2 million residents, the second most densely populated area in the nation. A third of the population living in CHMC’s catchment area are uninsured, a quarter earn less than \$15,000 per year, and over 40 percent do not have a formal education. CHMC has invested in community outreach and educational programs, and established partnerships across Los Angeles to improve health. Partners of CHMC include Los Angeles Unified School District Central Adult School, LA Best Babies Network, Eisner Pediatric & Family Medical Center, and the Southside Coalition of Community Health Centers. Dr. Margaret Yonekura, CHMC’s Director of Community Benefit, emphasizes the importance of the hospital’s mission in improving community conditions and partnership, “we are a mission in action, demonstrating what our ministry should do. We are a hospital without walls that must focus on health in addition to healthcare because our entire service area is a pocket of poverty.”

GETTING READY FOR ACH

Below is a set of recommendations for organizations interested in taking the next step toward adopting the ACH approach.

Ways to Get Started

1. Learn more about the ACH model by reviewing the following resources:
 - [Recommendations for the California State Healthcare Innovation Plan: Accountable Communities for Health Initiative](#)³⁷
 - [Accountable Communities for Health: Opportunities and Recommendations](#)³⁸
 - [Healthier By Design: Creating Accountable Care Communities](#)³⁹
2. Take stock of your organization's existing activities and see how they align with the five key domains and nine core elements of an ACH described above. What are you already doing, and what more can be done?
3. Identify the highest priority medical conditions in the ACH region and analyze the social-cultural, economic, and physical-built environment factors that can help reduce these medical problems. The [THRIVE tool](#) can help support this analysis.⁴⁰
4. Identify active collaborations taking place within your geographic region, including those related to the high priority medical issues and related community factors. Is there a role for your organization at the table?
5. Advance the integration of clinical, social services and supports, and community-wide prevention initiatives across your geographic region.
6. Build relationships between healthcare, public health departments, and other government and non-governmental organizations to expand and formalize cross-sectoral partnerships that target community health priorities, data sharing, and stronger clinical-community service integration through models such as the [Community-Centered Health Home](#).⁴¹
7. Keep apprised of relevant funding opportunities for piloting an ACH that come from state, federal, or philanthropic institutions.
8. Explore sustainable funding opportunities for community-based population health improvement by reviewing the following resources:
 - [Closing the Loop: Why We Need to Invest—and Reinvest—in Prevention](#)⁴²
 - [Sustainable Investments in Health: Prevention and Wellness Funds](#)⁴³
 - [Accountable Communities for Health: Strategies for Financial Sustainability](#)⁴⁴

The Accountable Community for Health (ACH) model offers a logical next step for strengthening health systems that advance health and equity for entire communities by prioritizing access to care alongside improvements to community environments. Healthcare institutions play a critical role in ensuring the success of an ACH in their geographic area. In turn, they have a lot to gain by engaging in this process, as the ACH model supports efforts to advance population health and builds upon the efforts to reduce medical costs and improve health outcomes.

About Prevention Institute

Prevention Institute (PI) is a national nonprofit dedicated to improving community health and equity through effective primary prevention: taking action to build resilience and to prevent problems before they occur. Our work is characterized by a strong commitment to community participation and promotion of equitable health outcomes. To help shape emerging approaches, policies, and practices, PI provides training and tools to communities, policymakers, academics, funders, and coalitions focused on health system transformation, improving healthy eating and activity environments, preventing violence, reducing injury and promoting traffic safety, and supporting mental health.

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