**The California Accountable Communities for Health Initiative**

**Background**

In 2013, California received a Center for Medicare and Medicaid Innovation State Innovation Model Design Grant and developed a plan, using the *Let’s Get Healthy California* report as a foundation, for implementing significant health system and payment reforms. This plan, the State Health Care Innovation Plan (Innovation Plan, <http://www.chhs.ca.gov/pages/pritab.aspx>), was prepared with input from key health and health care leaders in the state. One of the four core initiatives of that Plan was the development of a new population health model, called the Accountable Communities For Health.

The model links together clinical services, community programs and social services, with public health and primary prevention approaches in a given geographic area to collectively address a particular health need on a community-wide basis. Ultimately, the long-term vision of an ACH is to become an enduring infrastructure to support broad population health improvement and system transformation to create a more expansive, connected, prevention-oriented health system.

In order to assess the feasibility, effectiveness, and potential value of this model, the California Accountable Communities for Health Initiative (CACHI) was established by The California Endowment, Blue Shield of California Foundation, Kaiser Permanente, and Sierra Health Foundation, in partnership with the California Health and Human Services Agency and the California Department of Public Health.

**Defining an Accountable Community For Health**

Building on the literature and experience of other states and models, CACHI identifies six definitional elements of an ACH:

* Shared vision and goals: A transformational vision and common set of goals, based on a shared understanding of the health issues facing the community.
* Partnerships: Meaningful collaboration among the health care, social services, and various community agencies and sectors dedicated to achieving the vision and goals.
* Leadership: At least one, but ideally several, champions from individuals and organizations among the core entities of an ACH.
* Backbone: The agreed upon entity that will serve as the collaborative facilitator and convener.
* Data analytics and capacity: Infrastructure, capacity and agreements for collecting, analyzing and sharing financial, community and population-level data among providers and organizations.
* Wellness Fund: A vehicle for attracting resources from a variety of sources to support the infrastructure, goals, priorities and strategies developed by the ACH, with particular attention to upstream prevention.
* Portfolio of Interventions: A set of coherent, mutually-supportive interventions that address a particular health need, chronic condition, set of related conditions, or community condition across five key domains: clinical care, community programs and social services, community-clinical linkages, environment, and policy and systems changes.

Following a highly competitive process with 44 proposals submitted from communities across the state, six local community collaboratives were selected to receive grants, beginning September 1, 2016, of up to $850,000 each over three years. As this is an innovative model, technical assistance and peer learning, along with evaluation, are also integral elements of the Initiative.

Each of the six grantees will address a pressing community priority, including asthma, violence and trauma, and cardiovascular disease and will target a specific geographic community of 100,000-200,000 residents. The six grantees are:

* **Imperial County Public Health Department**, Imperial County *(Asthma)*
* **Merced County Department of Public Health**, Merced County *(Diabetes & Cardiovascular Disease with Depression)*
* **Be There San Diego/University of California**, **San Diego**, San Diego County *(Cardiovascular Disease)*
* **Dignity Health/St. Joseph’s Medical Center**, San Joaquin County *(Trauma/Violence)*
* **Santa Clara County Public Health Department**, Santa Clara County*(Trauma/Violence)*
* **Sonoma County Department of Health Services**, Sonoma County *(Cardiovascular Disease)*

CACHI is being supported by Community Partners, a Los Angeles-based nonprofit that helps foster, launch, and grow creative solutions to community challenges.

For additional information on CACHI, please contact Barbara Masters, Program Director at CACHImgr@communitypartners.org.

**California Accountable Communities for Health Initiative**

 **Grantee Community Summaries**

**Imperial County: North End, notably Westmorland**

With the Public Health Department serving as the backbone, Imperial County’s Accountable Community for Health aims to improve **asthma**outcomes for residents throughout the county, paying particular attention to the disparities of children and the small communities located in the northern part of the county. The Local Health Authority Commission, along with many other health care and community organizations are participating in the ACH, which will build upon the recently launched Asthma Linkages Project.  The Local Health Authority established a Wellness Fund, which is creatively funded by a portion of the monthly member premium of the California Health & Wellness health plan. The community has also mobilized to mitigate air pollution from the shrinking of the Salton Sea – a catastrophic threat to the health of this medically underserved community.

**Merced County: South Merced, Planada, Livingston, Le Grand, Atwater, Franklin-Beachwood, Gustine and Winton**

The Merced County Department of Public Health is leading the Merced Accountable Community for Health that aligns six well-established collaborative efforts to realize the added value inherent in coordination across sectors.  Target communities represent three County Supervisory Districts and align with the location of clinic systems and Building Healthy Communities Merced efforts.  The aim is to prevent and improve outcomes for **cardiovascular disease, diabetes, and associated depression**. Particularly relevant collaborations include: The Whole Health Partnership, working to integrate primary care and behavioral health and the Health Information Exchange Roundtable to increase data sharing capability and analytics. Other funding sources will be leveraged such as Partnerships to Improve Community Health and Lifetime of Wellness to bring in the policy, systems and environmental strategies intended to improve and extend clinical supports within the targeted communities. Because more than half of residents have Medi-Cal coverage and provider capacity is stretched, it is critical to innovate new ways to prevent and improve outcomes for these priority conditions.

**San Diego County: Southeastern San Diego**

Be There San Diego, on behalf of a broad collaboration of stakeholders, will be launching the San Diego Accountable Community for Health. The Accountable Community for Health will build upon the Live Well San Diego framework, which provides leadership on county-wide population health improvement efforts, and will partner with the Multicultural Health Foundation to focus initial efforts in Southeastern San Diego.   Recognizing the challenge posed by a large urban/suburban/rural county, the Accountable Community for Health is adopting a dual approach:  (1) Be There San Diego will serve as the backbone and assume responsibility for countywide efforts, including development of a data portfolio and sustainability planning; and (2) Be There San Diego will develop a community-based approach relying on local community leadership to implement customized local interventions starting with **cardiovascular disease**in Southeastern San Diego. Be There San Diego, formerly the Right Care Initiative, possesses a long history of collaboration to improve cardiovascular disease.

**San Joaquin County: South Stockton**

Through the Healthier Community Coalition, leaders and residents have joined together to create the Healing South Stockton Accountable Community for Health. Dignity Health, St. Joseph’s Medical Center is serving as the fiscal agent and backbone. The primary goal is to identify residents suffering from **trauma** and link them with clinical services and community supports. Healing South Stockton partners – including the justice, education, and health sectors - will develop the resources needed to ensure that successful programs are expanded and new evidence-based projects adopted. A to-be-formed Healing South Stockton Wellness Fund will ensure sustainability. Further supporting this effort, the Reinvent South Stockton prioritizes policy and systems changes to prevent trauma in the first place. Together, these initiatives will build an environment where children grow up healthy, adults thrive, and everyone lives free from trauma.

**Santa Clara County: East San Jose**

The Santa Clara Accountable Community for Health PEACE (Prevention Efforts Advance Community Equity) Partnership will be built on a subcommittee of the Mayor's gang prevention task force, itself a 25-member collaborative. The Santa Clara Public Health Department serves as the backbone organization. The goal is to migrate from an individual person approach to violence prevention to a socio-cultural, community approach that addresses environmental conditions, which result in **violence and trauma**. Key objectives include aligning existing and building new interventions, strengthening the involvement of the health care sector, creating a gun storage screening protocol, and ensuring resident engagement ~ especially youth ~ all along the way. A comprehensive community violence and trauma prevention strategy impacting people, place, and equitable opportunities will enable a healthy, peaceful, and empowered East San Jose.

**Sonoma County: Greater Santa Rosa Area**

On behalf of Sonoma County Health Action, the Sonoma County Department of Health Services serves as the backbone for its Accountable Community for Health. Using Health Action's existing multi-sector partnerships and current work as a starting point, the Accountable Community for Health will address **cardiovascular disease**, the leading chronic condition and a leading cause of death in Sonoma County. Key areas of focus include strengthening resident engagement in decision-making and leadership, along with solidifying data-sharing, referral systems, and creating an innovative, sustainable financing mechanism. This first year of work is in service of the long-term goal of using the Accountable Community for Health framework in all of Health Action's work to address social determinants of health and other root causes of health inequities.