Blue Sky
CONSULTING GROUP

ACCOUNTABLE COMMUNITIES FOR HEALTH

An Evaluation Framework and Users' Guide

October 2016

Table of Contents

ACKNOWLEDGEMENTS

This report was prepared by Katrina Connolly, PhD, Len Finocchio, DrPH, and Matthew Newman, MPA, from the Blue Sky Consulting Group and by Karen Linkins, PhD, of Desert Vista Consulting. The project was supported by a contract with the California Health and Human Services Agency in partnership with the California Department of Public Health with funding from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.[1] The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of the federal Department of Health and Human Services or any of its agencies.

The authors wish to thank the members of the expert stakeholder group that provided valuable insights into the issues discussed in this report as well as state staff and the California Accountable Communities for Health Initiative sponsors who provided valuable guidance, insights, and encouragement during the development of the evaluation framework.

[1] The project described was supported 100 percent by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services in the amount of $249,874.85.

EXECUTIVE SUMMARY

Accountable Communities for Health (ACHs) are place-based initiatives in which community, clinical, and policy strategies are coordinated with the aim of improving health outcomes and controlling health care costs. While there are many possible variations, Accountable Communities for Health generally put into practice many of the concepts associated with the theory of collective impact, the idea that a "highly structured collaborative effort" can achieve "substantial impact on a large scale social problem" that a single organization or intervention cannot achieve alone.[2] The multi-sector nature of ACHs combines strategies addressing specific chronic diseases or other health conditions in a mutually reinforcing way. The focus of these activities is on upstream prevention interventions addressing non-health care factors, such as those related to poverty and education, which have long-term impacts on health outcomes.

California has embraced the promise of ACHs through its State Health Care Innovation Plan and through funding from philanthropies. The California Health and Human Services Agency, in partnership with the California Department of Public Health, and with funding from the Center for Medicare and Medicaid Innovation, sponsored the development of an ACH evaluation framework, presented in this report. The framework provides a methodology or "road map" for communities, funders, or government agencies interested in conducting an evaluation of local ACH initiatives or understanding and interpreting the results of such an evaluation.

Overview of Evaluation Framework

Drawing from the research literature, results of similar evaluations, and input collected from subject matter experts, this evaluation framework presents an overarching logic model which presents how the actions of ACH partner organizations, combined with resources in individual communities, assistance provided by foundation partners, and interactions with

[2] Kania, John and Mark Kramer. 2012. "Channeling Change: Making Collective Impact Work," *Stanford Social Innovation Review*.

supportive health-focused state or privately funded initiatives can together contribute to meaningful and measureable change in important long-term health outcomes.

The logic model developed for purposes of the evaluation framework contains multiple elements over three stages of ACH development which an ACH may complete in its efforts to effect meaningful change in the long-term health of the population. For each key element, the evaluation framework presents broad outcomes, along with specific ways to measure an ACH's progress toward achieving those outcomes (i.e. indicators and measures). The specific long-term outcomes (e.g. improved population health, reduced disparities, and controlling health care costs) are established by individual communities and the entities that fund an ACH initiative.

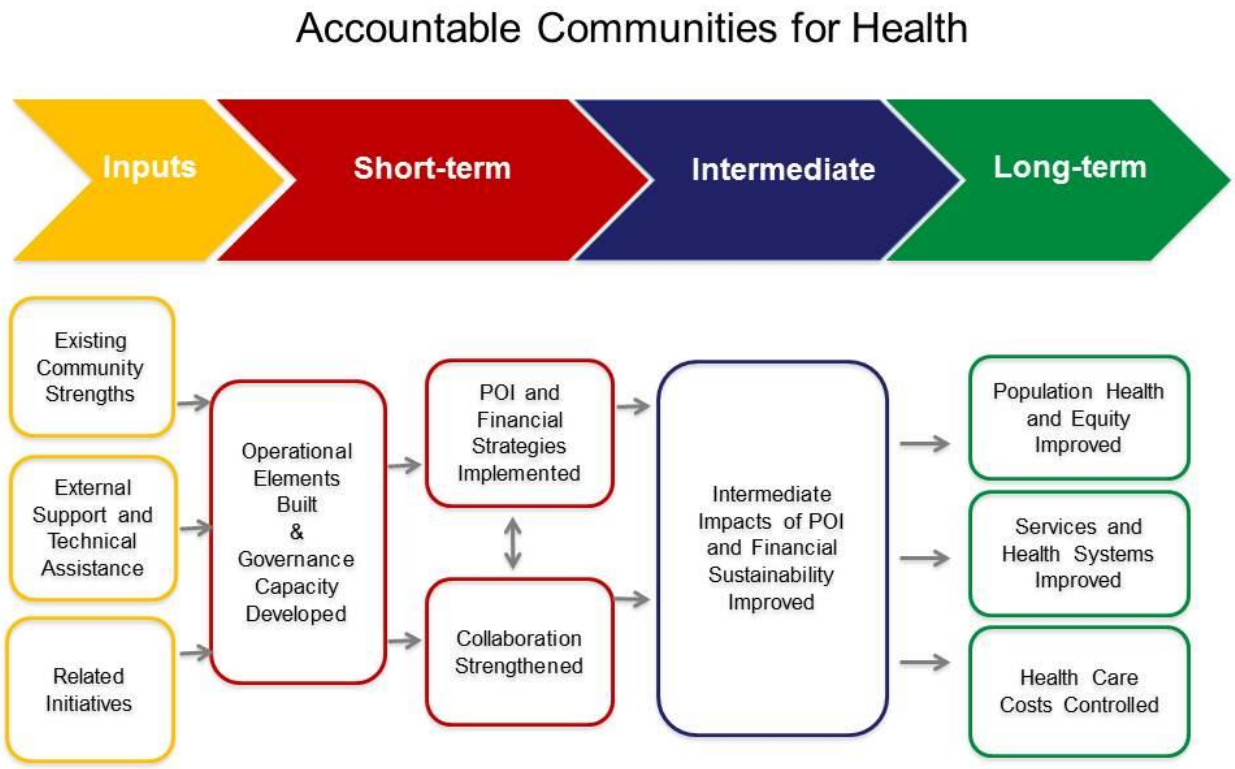
The intermediate indicators that demonstrate whether an ACH is making meaningful progress toward achieving long-term success were selected based on an assessment of existing research and the input provided by subject matter experts. Importantly, intermediate outcomes and indicators of success are linked such that achieving an early indicator of success, such as improved accountability among ACH partner organizations, is correlated with an increased likelihood of achieving a longer term indicator of success, such as sustained participation by member organizations.[3]

Figure 1 (next page) presents the logic model developed for purposes of this evaluation framework. The left most portion of the figure presents "Inputs," such as existing community strengths or technical assistance from foundation partners. Using these elements as a foundation, ACHs can develop or enhance the governance and other operational elements that needed in order to be successful. Also in the short-term (shown in red in Figure 1), ACHs will need to develop a portfolio of mutually reinforcing interventions to be delivered by health care and community partners. To be successful, these interventions as well as the governance and operational elements will need to be developed in an environment characterized by strengthened collaboration among ACH partner organizations. This infrastructure, in turn, will

[3] This framework does not prescribe the ordering of all activities, processes, and feedback loops that drive change in a community. Rather, it presents a logical ordering of key activities, while recognizing that the specific sequence of the activities undertaken by an individual ACH will vary due to many factors unique to that community.

provide the foundation for the ACH to pursue systemic change in the way the community approaches population health by implementing the portfolio of interventions, making the ACH financially sustainable, and measuring progress toward achieving the long-term outcomes shown on the far right of Figure 1.

Figure 1: Accountable Communities for Health Logic Model



Using the Framework and Users' Guide

This framework is not a specific evaluation design, but rather offers a road map to develop rigorous evaluations of ACHs. To implement the ACH evaluation framework, an evaluator would work with ACH community partners to develop a site-specific design and measures using the logic model, outcomes, and suggested measures, tools, and data sources provided here. This report (termed a "users' guide") includes a discussion of numerous design and implementation issues an evaluator must consider in implementing the evaluation as well

as an extensive annotated bibliography containing peer-reviewed papers, monographs and white papers, data sets and other work upon which this framework was developed. The section, "Operationalizing the Framework" on page 38 provides several examples of the steps required to use this framework to perform an evaluation.

BACKGROUND

Accountable Communities for Health

The prevalence of place-based initiatives known as Accountable Communities for Health (ACH) has increased in recent years due, in part, to funding available from the Center for Medicare and Medicaid Services' (CMS) Innovation Center. Some states' development of ACHs preceded CMS funding, and have provided early lessons and inspiration.

While provider and community coordination to address public health issues itself is not new, the ACH model presents an opportunity for transforming a community's approach to population health through additional coordination of environment and policy strategies as well as payment reform geared towards improving health outcomes and reducing costs. Accountable Communities for Health puts into practice many elements of collective impact, the idea that a "highly structured collaborative effort" can achieve "substantial impact on a large scale social problem" that a single organization or intervention cannot achieve alone.[4]

The multi-sector nature of these ACHs combines strategies addressing specific chronic diseases or other health conditions with a focus on upstream prevention interventions addressing non-health care factors, such as poverty and education, which have long-term impacts on health outcomes. In addition, the ACH vision for long-term impact includes more pervasive value-based purchasing and reforms to health, social services, and community systems. ACH models are underway in numerous states and communities, including in Massachusetts, Washington, Minnesota, Michigan, and Colorado.

[4] Kania, John and Mark Kramer. 2012. "Channeling Change: Making Collective Impact Work," *Stanford Social Innovation Review*.

California's Planning

In 2012, the California Health and Human Services Agency established the Let's Get Healthy California Task Force which produced a statewide plan rooted in "The Triple Aim" — better health, better care, and lower cost — with a cross-cutting focus on increasing health equity. The plan defined six key goal areas—Healthy Beginnings, Living Well, End-of-Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care—and identified 39 indicators with which to measure the state's progress.

Building upon this *Let's Get Healthy California* framework, California received two CMS State Innovation Model grants to develop the State Health Care Innovation Plan and for further targeted planning efforts. One of four key initiatives in California's State Health Care Innovation Plan is the ACH initiative.

California Accountable Communities for Health Initiative

Based on this planning work, several of California's philanthropic foundations have partnered with the state to advance the State Health Care Innovation Plan's ACH concept and create the California Accountable Communities for Health Initiative (CACHI). After a proposal solicitation and review process, CACHI selected six communities that will receive grant funding and technical assistance for three years, starting in late 2016. The CACHI request for proposals define an ACH as follows:

> *An Accountable Community for Health is a multi-payer, multi-sector alliance of major health care 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 personal and community-wide health outcomes and reduce disparities with regard to particular chronic diseases or health needs; 2) control costs associated with ill health; and, 3) through a self-sustaining*

Wellness Fund, develop financing mechanisms to sustain the ACH and provide ongoing investments in prevention and other system-wide efforts to improve population health.[5]

The CACHI initiative allows communities to define their geographic area and size, select the problem on which to focus, and select the interventions they will align in a mutually reinforcing portfolio to tackle the selected health problem.

EVALUATION FRAMEWORK DEVELOPMENT

Audiences and Users

The evaluation framework offers guidance for numerous audiences engaged in designing, implementing, and understanding ACH communities and partnerships. First, the framework presented here provides California with a means to assess ACHs developed as part of the State Health Care Innovation Plan and funded by California's philanthropies through CACHI. Furthermore, the CACHI funders can use the framework as the basis for a Request for Proposals to solicit an evaluation contractor who could apply the framework to an evaluation of the six selected sites.

Second, communities planning and implementing an ACH outside of an overarching state plan or philanthropic initiative can employ the framework. Given the framework's strong research base, the outcomes and indicators and their logical ordering can be used to guide and assess ACH development and success more broadly. In other words, the framework can be adapted to different ACH models, approaches and characteristics that fit a community's needs.

Finally, federal, state and local governments can use the framework to develop an evaluation approach to community-based initiatives that share features with ACHs, but are not specific ACH initiatives per se. For example, the framework provides outcomes and indicators that could assess community partners' governance and collaboration in any number of place-based initiatives.

---

[5] "California Accountable Communities for Health Initiative: Request for Proposals," A partnership of: Blue Shield of California Foundation, Kaiser Permanente, The California Endowment, California Health and Human Services, and Community Partners. URL: http://www.communitypartners.org/sites/default/files/documents/cachi/rfp/CACHI%20RFP%20Updated%204-6-16.pdf

Principles

With multiple audiences and evaluation challenges in mind, several principles have guided the development of this evaluation framework. Specifically, the framework is intended to be:

- *Relevant and adaptable to ACH communities and interventions nationwide* – Given the relatively nascent nature of ACHs, this evaluation framework can be adapted to different ACH models as they emerge in communities nationwide. Furthermore, the framework offers the flexibility to be adapted to different interventions and combination of interventions within an ACH.
- *Rigorous* – The framework draws upon extensive evaluation research, including the nascent literature on ACHs and community-based interventions and other evaluation designs.
- *Actionable for funders, ACH community partners and evaluation contractors* - The framework offers a straightforward and flexible model to adapt and customize into an evaluation design for a specific community's ACH, allowing for short-term, intermediate and long-term assessment. For California audiences, the framework includes components originating from the California Health and Human Services Agency ACH Work Group ACH Workgroup Report[6] and the California Accountable Communities for Health Initiative (CACHI) Request for Proposals.[7]
- *A learning tool for ACHs in development* –The framework offers evaluators and the ACH partners the mechanism to support a developmental or "learning evaluation" approach. Such an approach would provide actionable data to increase the likelihood of an ACH's success.

[6] The California Health and Human Services Agency ACH Work Group wrote a report titled, "Recommendations for the California State Healthcare Innovation Plan Accountable Communities for Health Initiative," released in May 2015. URL: http://www.communitypartners.org/sites/default/files/documents/cachi/reports/ACH%20Work%20Group%20Report%20FINAL.pdf

[7] The California Accountable Communities for Health Initiative (CACHI) Request for Proposals was announced in February 2016. URL: http://www.communitypartners.org/sites/default/files/documents/cachi/rfp/2016%20CACHI%20RFP.pdf

Methodology

The origins of this framework for evaluating ACHs began with a report by the California Health and Human Services Agency ACH Work Group. The framework also builds upon the definition and structure of ACHs developed by CACHI. Given the relatively recent introduction of the ACH model and its innovative approaches (i.e. portfolio of interventions), the evidence specific to ACHs is limited. As a result, the framework draws broadly from the literature and commissioned papers spanning the following topics: collective impact, learning evaluation, and evaluations of place-based initiatives and interventions, governance and collaboration, financial sustainability, data sharing and use, population health outcomes, health equity, and systems change.[8]

Interviews were conducted with evaluators in other states that are implementing ACHs as part of their SIM grants and leaders of related initiatives to understand approaches to and expectations for evaluating ACHs. These evaluation efforts have primarily focused on lessons learned from the initial years of more structured collaboration and coordination among the ACH partners, rather than an assessment of the long-term impacts of ACHs on population health.[9] In addition to these interviews, an expert stakeholder process was conducted to solicit input for development of the evaluation framework. The expert stakeholder group consisted of subject matter experts representing local nonprofits and community agencies, county public health departments, the health care sector, the social services sector, philanthropy and state government agencies.

---

[8] A literature review is presented below and all scanned sources are included in an annotated bibliography, available as a companion document, entitled, "California Accountable Communities for Health Initiative Annotated Bibliography."

[9] Minnesota State Health Access Data Assistance Center (SHADAC), Donna Spencer, March 23, 2016; Michigan Department of Health and Human Services, Thomas Curtis, April 14, 2016; Washington State Health Care Authority, Chase Napier, Community Transformation Manager, May 13, 2016; Center for Community Health and Evaluation, Erin Hertel and Lisa Schafer, Washington Evaluation Team, May 6, 2016; Best Babies Zone (BBZ), University of California, Berkeley, School of Public Health, Cheri Pies, Clinical Professor and Principal Investigator of BBZ and Monica Barr, Program Manager of BBZ, May 4, 2016; Promise Neighborhoods, PolicyLink, Jessica Pizarek, Program Associate, May 23, 2016. Also, see publications from these initiatives: Center for Community Health and Evaluation, "Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health," January 2016, http://www.hca.wa.gov/assets/ach_evalreport_year_1.pdf; PolicyLink, "A Developmental Pathway for Achieving Promise Neighborhoods Results," Promise Neighborhoods Institute, 2014, http://www.policylink.org/sites/default/files/pni-developmental-pathway-final.pdf ; Harder and Company, "Best Babies Zone Initiative: Summary Evaluation Report Year 3 (2014-15)," 2015. Harder and Company, "Best Babies Zone: Year Four Evaluation Report," 2016. Both reports can be accessed at http://www.bestbabieszone.org/Data.

Challenges to Evaluating Place-Based Initiatives

The most rigorous evaluation design for measuring if an intervention (i.e. the ACH) causes an outcome (e.g., improvement in population health) is an experimental design. By randomly assigning communities into a "treatment group" that receives the intervention and a control group, the experimental design can rule out explanations for the outcome other than the intervention and establish a causal link between the intervention and the observed changes in the outcome. In the absence of random assignment, a quasi-experimental design systematically compares the outcomes of a treatment group to a comparison group. The treatment and comparison groups match on all characteristics except for the intervention, which allows for the attribution of meaningful differences between the two sites to the intervention.

While experimental or quasi-experimental evaluation designs have many advantages, the rigors of the evaluation approach may impose significant challenges on program design and implementation. Both experimental and quasi-experimental design approaches require a large number of observations (i.e. communities) to study in order to draw meaningful conclusions about the impact of the studied intervention. And, in order to effectively administer these designs, it would be necessary for all sites to focus on the same health outcome and receive the same interventions. If, instead, the goal is to allow individual communities to pursue health outcomes and interventions tailored to their specific needs and strengths, a more flexible evaluation approach is necessary.

Developing an approach that can identify possible connections between the intervention and observed outcome while allowing for each studied community to pursue an approach based on its own unique characteristics, however, presents a unique set of challenges. Where multiple coordinated interventions are deployed, it is challenging to determine which combination of interventions contributes to a measured change in the

outcome. And, cross-site comparison may not be feasible when participating communities are highly varied and target populations and interventions are unique.[10]

Optimal Evaluation Approach for Place-Based Initiatives

Evaluating a complex collaborative effort such as an ACH calls for a different approach than evaluation of a single intervention by a single actor. The most appropriate approach for evaluating multi-faceted place-based initiatives such as ACHs is with a *logic model* approach.[11] This approach hypothesizes a logical ordering of conditions that are necessary to achieve the long-term desired outcome. By doing so, the model seeks to demonstrate how a program (or intervention) contributes to a result. In applying the logic model approach to evaluation, the framework presented here maps out the antecedent conditions that theoretically must exist for the goal to be achieved, and orders them into three phases of ACH development that previous research suggests will lead to improvement in population health. The model hypothesizes that an ACH that achieves the outcomes specified in the early phase of the model is likely to achieve the outcomes highlighted in the intermediate phase of the model, and subsequently, the desired long-term outcomes, thus enabling evaluators to systematically measure progress towards the goal.

This framework does not prescribe the ordering of all activities, processes, and feedback loops that drive change in a community. Rather, it provides a logical ordering such that achieving certain initial conditions suggests an increased likelihood of achieving subsequent longer term outcomes, while recognizing that the specific sequence of the activities undertaken by an individual ACH will vary due to many factors unique to that community.

The evaluation approach described in this users' guide is based on an extensive literature review and interviews with experts. An annotated bibliography (available as a

---

[10] Cheadle, Allen, William L. Beery, Howard P. Greenwald, Gary D. Nelson, David Pearson, and Sandra Senter. 2003. "Evaluating the California Wellness Foundation's Health Improvement Initiative: A Logic Model Approach, Health Promotion Practice," *Health Promotion Practice*, 4:146. Smith, Robin E. 2011. "How to Evaluate Choice and Promise Neighborhood," Urban Institute.

[11] Preskill, Hallie and Srik Gopal. 2014. "Evaluating Complexity: Propositions for Improving Practice," Foundation Strategy Group. And Preskill, Hallie, Marcie Parkhurst, and Jennifer Splansky Juster. 2014. "Guide to Evaluating Collective Impact: Learning and Evaluation in the Collective Impact Context," Foundation Strategy Group.

companion document, entitled, "California Accountable Communities for Health Initiative Annotated Bibliography") presents the resources evaluated for this framework. These components and conditions are discussed in greater detail in later sections.

Collective Impact and the Need for a Learning Evaluation

A collective impact initiative is a collaborative "problem-solving process" in a complex system where everything is interconnected and constantly changing.[12] As a guide to evaluating these kinds of initiatives notes, "This process requires leaders to remain keenly aware of changes in context, conditions, and circumstances; to embrace curiosity and seek opportunities for learning; to openly share information and observations with others; and, most importantly, to willingly adapt their strategies quickly in response to the ever-evolving environment."[13] An effective evaluation enables this continuous learning among collaborative leaders by assessing the progress that an initiative is making as well as how and why the initiative is or is not making progress with real-time feedback on which leaders may act.

To understand how and why the initiative is making progress or facing challenges, the evaluator employs a learning evaluation that offers analytic assessments at key implementation intervals. The evaluator assesses real-time changes in context, incorporates participation from stakeholders, and provides real-time feedback to participants to facilitate and document quality improvement.[14] This learning approach also allows partners and funders to test the underlying assumptions, or logic, of the approach, recognize emerging lessons, and adapt as needed to achieve intermediate outcomes and the long-term impact.

Key Elements for Evaluating ACHs

In summary, an optimal approach for evaluating an ACH initiative includes these steps:

---

[12] Ibid.

[13] Preskill, Hallie, Marcie Parkhurst, and Jennifer Splansky Juster. 2014. "Guide to Evaluating Collective Impact: Learning and Evaluation in the Collective Impact Context," Foundation Strategy Group, page 5.

[14] Bijal A. Balasubramanian, Deborah J. Cohen, Melinda M. Davis, Rose Gunn, L. Miriam Dickinson, William L. Miller, Benjamin F. Crabtree, and Kurt C. Stange. 2015. "Learning Evaluation: blending quality improvement and implementation research methods to study healthcare innovations," *Implementation Science* 10:31.

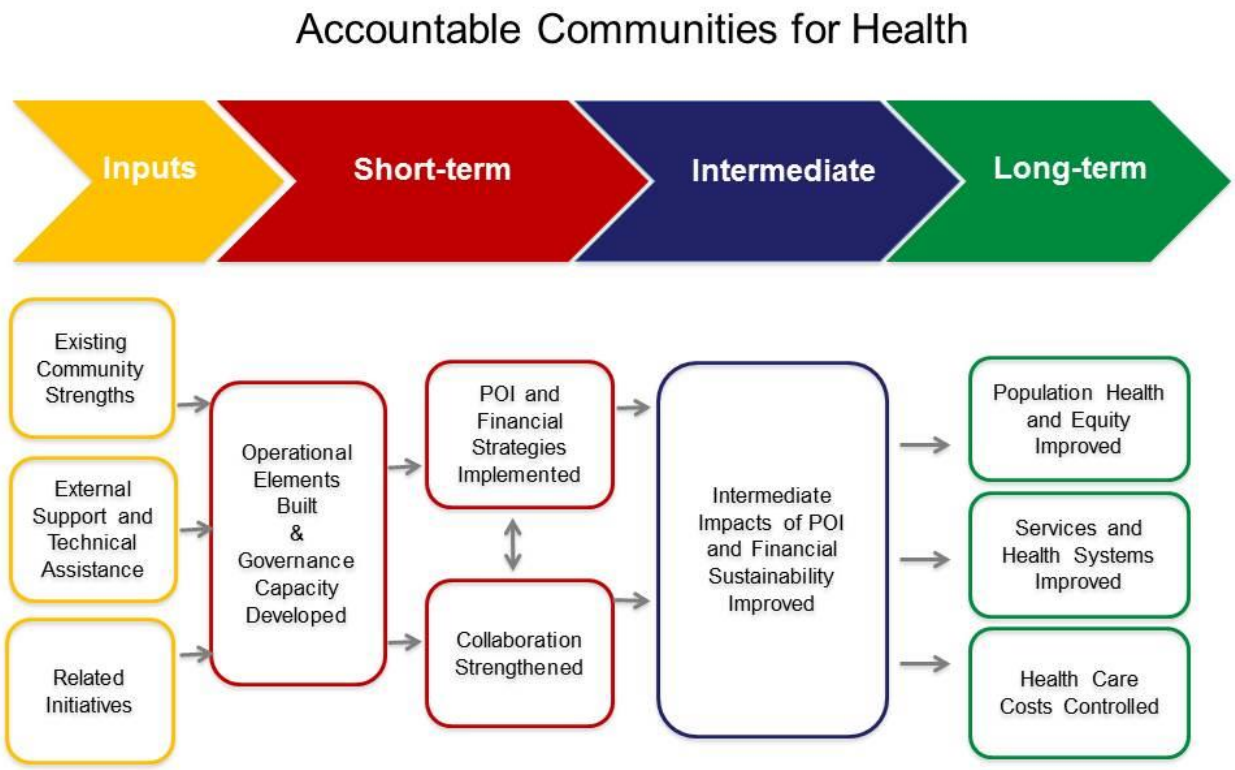
1) Develop a logic model that identifies the essential antecedent components necessary to achieve the desired outcomes
2) Use specific research-based measures, both quantitative and qualitative, to assess ACH development at key stages
3) Compare actual implementation experience to expectations as presented in the framework and adjust expectations in response to learning
4) Assess multi-level contextual factors that influence implementation and outcomes
5) Assist ACHs in using data for continuous quality improvement
6) Identify emerging principles and lessons learned through comparison of ACHs across generalizable metrics

UNDERSTANDING AND USING THE FRAMEWORK

This ACH evaluation framework, grounded in a logic model approach, identifies an overarching set of conditions necessary to achieve long-term change. Measuring these conditions at key developmental stages allows for the assessment of an ACH's progress. Because these conditions, or outcomes, are antecedents to the long-term goal, an ACH that achieves short-term (process) outcomes is more likely to achieve the intermediate outcomes. Likewise, an ACH that achieves intermediate outcomes is likely to achieve the long-term impacts or overarching goals identified by each community. Figure 2 presents the ACH Logic Model undergirding the evaluation framework.[15]

[15] Note that the outcomes presented may be measured throughout the course of ACH implementation. Further, this framework does not prescribe the ordering of all activities, processes, and feedback loops that drive change in a community. Rather, it provides an assumed logical ordering of key phases in the development of an ACH.

Figure 2: ACH Logic Model



The left-most portion of Figure 2 presents "Inputs" such existing community strengths or technical assistance from foundation partners that provide the foundation upon which an ACH will build. Using these elements as a foundation, ACHs can develop or enhance the governance and other operational elements that an ACH will need in order to be successful. Depending on the ACH approach, these and other "inputs" may influence the evolution of an ACH, both over the short- and long-term timeframes. An evaluation design would assess such inputs, particularly as part of the learning evaluation, and understand their impact. Related interventions are discussed in the section, Context: Many Factors May Influence Population Health on page 44.

Also in the short-term (shown in red), ACHs will need to develop a portfolio of mutually reinforcing interventions to be delivered by health care and community partners. To be successful, these interventions, as well as the governance and operational elements, will need to be developed in an environment characterized by strengthened collaboration among ACH partner organizations. These elements, in turn, will provide the foundation for implementing

the portfolio of interventions and measuring progress toward achieving the long-term outcomes shown on the far right of Figure 2.

While this framework includes some ACH elements specific to California's initiative, it remains flexible enough to accommodate ACH designs envisioned and implemented by other planning processes in other states and communities. To implement the ACH evaluation framework, an evaluator will work with the ACH partners to develop a site-specific logic model and site-specific measures using the outcomes, tools, and data sources provided in this framework.

The evaluator must work with the ACH to collect baseline data at the outset for comparison to outcome measures in later years and develop a learning evaluation plan (including a plan for measurement frequency) with the site to implement over the course of the evaluation. The evaluator will document the sequence of activities and outcomes as they occur, how the relationships between ACH partners evolve, and the feedback loops of interconnected development such as how the action plan for the interventions and financial strategies evolve over time in response to learning. The evaluator will also assist the ACH community in understanding the interaction between their efforts and other efforts external to the ACH, which may influence the community. The framework can also be extended to measure impacts outside of the ACH communities themselves, such as impacts on other communities that learn about and respond to the success of ACHs and opt to develop their own ACH initiative. Below, we present the evaluation framework in detail. The section, "Operationalizing the Framework," on page 38 uses specific examples to demonstrate how to use this framework to perform an evaluation.

Research Questions

This evaluation framework is designed primarily to assess the following questions of short-term feasibility and long-term impact of ACHs, as well as assessing a cohort of ACHs across different communities that share programmatic elements. The most important research questions that can be answered using this evaluation framework include the following:

Short-Term Feasibility

1. Is the ACH operationally successful in the first few years?
2. What factors have contributed to the ACH's success or hindered its progress?
3. How has the ACH model evolved relative to initial expectations?
4. Have relationships between ACH partners evolved?

Intermediate and Long-Term Impact

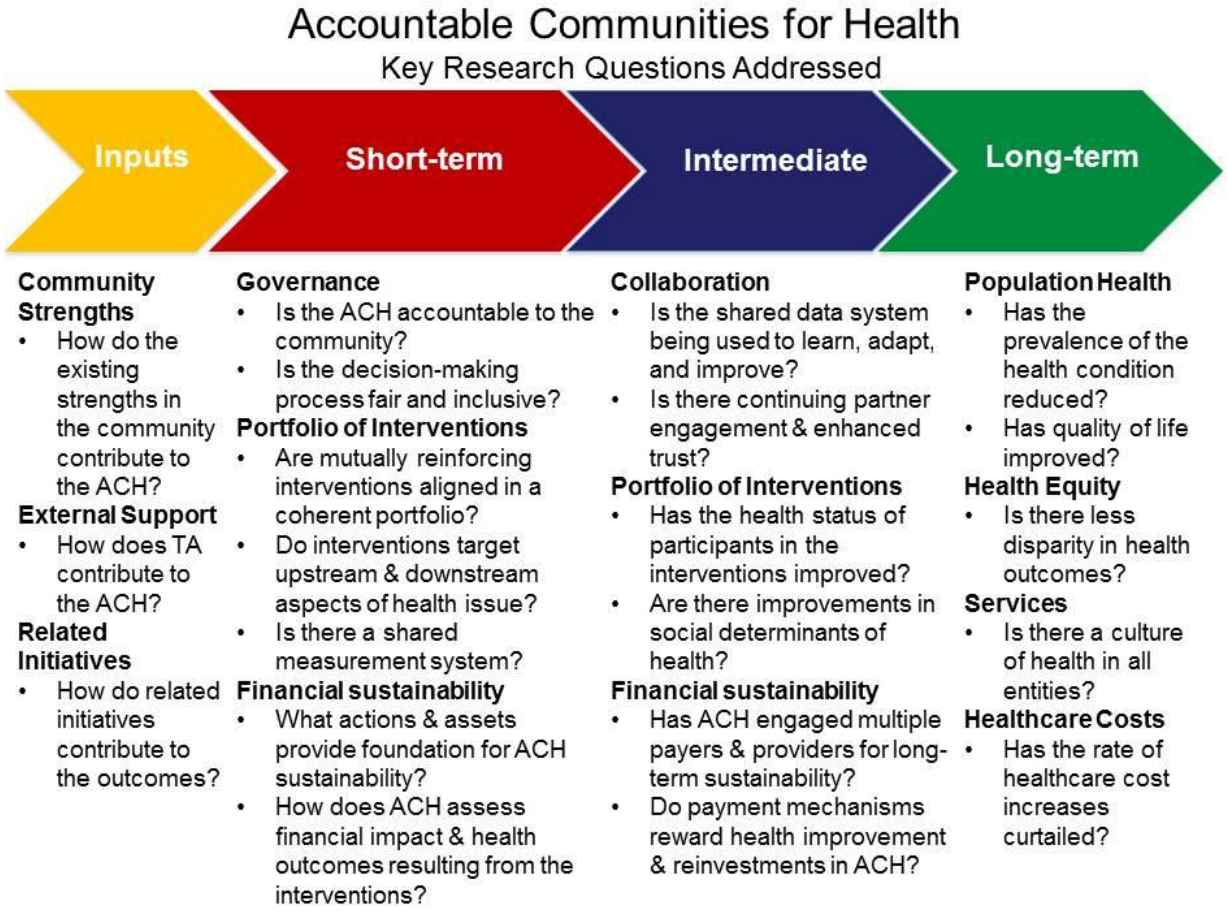
4. What intermediate and long-term impacts are associated with the portfolio of interventions?
5. Have health inequities been reduced in communities?
6. Have systems and organizational cultures changed to reflect the vision of the ACH?

Cohort Assessment

7. How do ACHs compare according to cross-cutting outcomes provided in this framework?
8. What principles and lessons learned can be identified by comparing ACH experiences?

Figure 3 presents the key research questions in each stage of the framework that can be assessed by employing the outcomes and indicators presented in this framework.

Figure 3: Key Research Questions



Outcomes, Indicators, and Measures

For each element of the evaluation framework (represented as an individual box in the model shown in Figure 2 on page 17) outcomes, indicators, and measures were developed. The *outcomes* represent the broadest concept, which is deconstructed into more specific categories referred to as *indicators* of that outcome. For each indicator, *measures* were designed that identify the specific data that should be collected to demonstrate the extent to which that indicator has been met.

Collecting Baseline Data

Collecting baseline data allows the evaluator to develop a reference point that can be used to assess the progress the ACH has made. The baseline for each short-term indicator (e.g.,

those pertaining to governance and collaboration) must be measured before the ACH has begun its work, or at the earliest possible stage thereafter. The baseline of the intermediate and long-term indicators pertaining to implementation and impact of the portfolio of interventions must be measured once the ACH decides on the portfolio and on site-specific measures related to the specific health condition that is the focus of the ACH partners' efforts.

The tables below present the cross-cutting outcomes and indicators corresponding to the elements in the ACH evaluation framework presented in Figure 2 on page 17.[16] Outcomes, indicators, and measures of governance, collaboration, and financial sustainability are cross-cutting and can be measured uniformly across ACHs for a cohort assessment. Other aspects of an ACH require customized measures: assessing changes in business as usual associated with implementation of the portfolio of interventions, the degree to which the portfolio is mutually reinforcing, and some of the long-term population level impacts. This users' guide also includes suggested measures, examples of measures, tools for measurement, and suggested data sources in Appendix A – Proposed Measures.

Each *outcome* developed for this framework represents a key achievement of ACHs or a fundamental condition necessary for achieving the desired long-term changes; therefore, all of the outcomes identified should be incorporated into an ACH evaluation. Of these, evaluators and ACH partners can select indicators for measurement that are most useful for each individual ACH. Measuring all of the numerous *indicators* of these outcomes, however, may not be feasible. As such, this framework recommends the most important *indicators* for measurement as a guide to ACHs for successful development. These recommended indicators are presented in **bold** in the tables below.

Framework Component: Operational Elements Built

Like any enterprise, a successful ACH will be built on a strong foundation. This evaluation framework identifies a set of essential operational aspects of an ACH that require concerted effort early on to establish this foundation for success. Examples of these operational

[16] Note that these tables contain just outcomes and indicators. The specific measures – the items on which data can be collected – are presented in the appendix.

elements include agreeing on a clear vision, having the right people at the table, establishing a governing infrastructure or "backbone", developing a mutually reinforcing portfolio of interventions, developing a data sharing plan and measures, measuring the baseline, and developing a plan for financial sustainability.[17]

Governance Structure, Clear Vision and the Right Participants

As envisioned by California's ACH model, each ACH will select an organization from among the community partners to serve as the organizing and governing nexus, or "backbone" organization. Depending on the nature of the goals, interventions and partner capacity, this role may fall to a public health or social services department, hospital, clinic system or health plan, or community-based organization with broad relationships and leadership experience. Contracts or memorandums of understanding (MOUs) will establish ACH structures and partnership roles and responsibilities.

Research conducted in preparation for development of this evaluation framework suggests that an agreed upon, clear, and widely understood vision is a fundamental element for development of a successful ACH. Without such a shared vision, an ACH is unlikely to succeed in making progress in its long-term desired outcomes. In addition, an ACH must select the right organizations needed for the effort and ensure that representatives have the power to make decisions on behalf of their organizations. Equally important to long-term success, research suggests that ACH partner representatives must have the ability to lead changes within their own organizations by disseminating the values and methods of the ACH.[18] Figure 4 on page 25presents suggested outcomes and indicators in each of these key areas.

---

[17] Community Partners. 2016. *California Accountable Communities for Health Initiative Request for Proposals*, URL: http://www.communitypartners.org/sites/default/files/documents/cachi/rfp/2016%20CACHI%20RFP.pdf

[18] In addition to the sources discussed in subsequent sections, see the following two sources: Association for the Study and Development of Community. 2007. "Scope, Scale, and Sustainability: What it Takes to Create Lasting Community Change Part 1," URL: http://www.issuelab.org/resource/scope_scale_and_sustainability_what_it_takes_to_create_lasting_community_change; Lawrence Prybil, F. Douglas Scutchfield, Rex Killian, Ann Kelly, Glen Mays, Angela Carman, Samuel Levey, Anne McGeorge, and David W. Fardo. 2014. "Improving Community Health through Hospital – Public Health Collaboration," Commonwealth Center for Governance Studies, Inc. URL: http://www.aha.org/content/14/141204-hospubhealthpart-report.pdf ; ChangeLab Solutions. 2015. "Accountable Communities for Health: Legal and Practical Recommendations." URL: http://communitypartners.org/sites/default/files/documents/cachi/reports/ChangeLab%20Solutions_TCE_ACH_Report_FINAL_20151217.pdf

Mutually Reinforcing Portfolio of Interventions

The work of the ACH is to implement an evidence-based, mutually reinforcing portfolio of interventions. While many single interventions have evidence of improving outcomes and reducing disparities, as of yet, there is little evidence demonstrating that aligning multiple interventions will have a greater impact than delivering similar interventions in isolation.[19] As such, assessing this element of the ACH will require an evaluator to work with sites to assess the logic of aligning particular evidence-based interventions in a portfolio. In order to implement a mutually reinforcing portfolio of interventions, each organization must fully understand the portfolio in its entirety, the role of their intervention(s), and how their interventions link to and support other interventions. Other issues with evaluating a portfolio of interventions are addressed in the "Considerations" section on page 37.

Data Sharing and Measures Developed

ACH sustainability depends, in part, on the ability to measure, both quantitatively and qualitatively, and communicate the impact and value of the interventions and structured collaboration. This is essential to sustaining stakeholder buy-in (measured as part of collaboration) and to making a "business case" to external funders (measured as part of financial sustainability).[20] Communicating these impacts depends on development of mutually agreed upon measures of success and collecting and sharing the data needed to evaluate success toward achieving those outcomes. In addition, reducing disparities in health, a value embedded in the ACH model, requires detailed and nuanced data collection on subpopulations. This need for explicit subpopulation data was documented in a paper published in the journal,

[19] Squires, Janet E, Sullivan K, Eccles M, Worswick J, and Grimshaw J. 2014. "Are multifaceted interventions more effective than single-component interventions in changing health-care professionals' behaviours? An overview of systematic reviews," *Implementation Science*, 9:152. ; A paper commissioned by the ACH Work Group from CHOIR, University of California, Berkeley to examine the evidence base for interventions of asthma, diabetes, and cardiovascular care by Neil Sehgal, Thomas Huber, Margae Knox, and Stephen Shortell in 2015, titled "Resource Guide for California Accountable Communities for Health (ACH) A Review of Emerging Evidence On Interventions for Asthma, Diabetes, and Cardiovascular Care."

[20] Robert Wood Johnson Foundation. "Driving an Aligned Agenda for Quality Improvement," last accessed September 2016, URL: http://forces4quality.org/driving-aligned-agenda-quality-improvement.html ; "Driving Sustainability: The Role of the Funder and Program Design," last accessed September 2016, URL: http://forces4quality.org/driving-sustainability-role-funder-and-program-design.html

Preventing Chronic Disease Public Health Research, Practice, and Policy, which emphasized subpopulation data as a prerequisite to addressing health disparities.

Sharing data to support implementation of aligned interventions, effective Plan-Do-Study-Act (PDSA) improvement cycles, and measuring impact and financial value requires planning, negotiation, contracts, and trust. Sharing data between organizations is a major undertaking that requires an inter-organizational team devoted to analyzing data sharing capacities and governing the process, as well as technical assistance from the evaluator.[21]

Measuring the performance of an ACH is only possible with a baseline measurement with which to compare over time. The baseline indicators of governance and collaboration should be measured, ideally, before the ACH first convenes in order to measure the impact of the ACH on those conditions. Subsequent to the selection of the portfolio of interventions, baseline measures should be taken of all indicators of interest, focusing especially on the baseline measure of the area's population health.

Financial Sustainability

Launching a Wellness Fund or similar mechanism that pools resources (i.e. blends, braids or otherwise aligns funding) to support common goals is a fundamental component of the ACH model.[22] For an ACH to become financially sustainable beyond the initial start-up grant, the ACH will need to focus on developing financial goals, strategies, and action plans. Strategies would be geared towards building a diverse portfolio of resources including in-kind

[21] Limlingan, Maria Cristina, Todd Grindal, Michael Lopez, Michelle Blocklin, Erin Bumgarner, "Integrated Data Systems: An Emerging Tool to Support Services for Low-Income Hispanic Families with Young Children," National Research Center on Hispanic Children and Families, August. URL: http://www.childtrends.org/wp-content/uploads/2015/08/IDS-Brief.pdf ; DASH National Program Office. 2015. "Early Learnings from an Emerging Field," Prepared for the Robert Wood Johnson Foundation, September. URL:
http://dashconnect.org/wp-content/uploads/2016/03/DASH-Environmental-Scan-Executive-Summary.pdf ; Elson, Mark and Alex Horowitz. 2016. "Channeling the Flow: Data Infrastructure for Population Health in the Safety Net," California Healthcare Foundation.

[22] The Innovation Plan "ACH" Work Group. 2015. "Accountable Communities for Health Initiative Work Group Report," California Health and Human Services Agency. URL:
http://www.communitypartners.org/sites/default/files/documents/cachi/reports/ACH%20Work%20Group%20Report%20FINAL.pdf

commitments from partners, grants, braided funds, and reinvested health care cost savings.[23] Pursuit of these resources begins with clear financial goals and a comprehensive plan.[24]

Figure 4: Outcomes and Indicators for Operational Elements

Operational Elements	
Outcome	**Indicator**
Governance Structure Established	**Backbone, leadership, and partner roles, responsibilities, and commitments are documented and clear**
	Necessary agreements are in place and modified as needed over time (e.g. data sharing, MOUs)
	Intentional policies and procedures in place (e.g. by-laws, communication channels, decision-making processes, etc.)
	The right organizations are partners
	The right leadership representatives from partners are at the table with the necessary skills and institutional role
Vision, Goal, and Strategy are Agreed Upon	The vision, goal, and strategies incorporate community input
	ACH members agree on the vision, goal, and strategies
	ACH members agree on strategy to align interventions and meet the goal
Data Sharing and Measures Developed	A comprehensive plan of strategies for ACH data sharing has been developed
	Key audiences have been identified and a plan for strategic communication to engage each group has been developed
	Identify relevant baseline data sources and develop useful indicators for assessing health disparities and site-specific outcomes
	A common set of feasible measures that are agreed to by ACH members and can be collected within existing resources are developed

[23] 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" (Cantor et al. 2015, 17). For this quote and a discussion of strategies an ACH can use to pursue financial sustainability, see Cantor, Jeremy, Rachel Tobey, Kiely Houston, and Eliana Greenberg. 2015. "Accountable Communities for Health: Strategies for Financial Stability," JSI Research and Training Institute, Inc. URL: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

[24] See the following webpages of Robert Wood Johnson's website titled, "Aligning Forces for Quality," last updated May 31, 2015. "Key Driver's Scorecard: Economic Viability," URL: http://forces4quality.org/key-drivers-scorecard-economic-viability.html ; "Insights and Recommendations for Collaboratives: Economic Viability," URL: http://forces4quality.org/insights-and-recommendations-collaboratives-economic-viability.html ; "Sustainability Framework," URL: http://forces4quality.org/sustainability-framework.html

	Valid and reliable measures are tied specifically to the portfolio of interventions and the target population
	The measures assess the process outputs, intermediate financial and health outcomes, and long term impacts of the interventions
	Data governance team supervises data sharing by ensuring protection of confidential data and managing policies related to data exchange, quality, and use
	Strategies for data sharing have been systematized and agreements formalized
	Baseline data collected
Mutually Reinforcing Portfolio of Interventions is Developed	Desired changes in social, community, or physical environments decided upon
	Service gaps and barriers to care that contribute to population health disparities are identified
	Evidence-based and mutually reinforcing interventions are identified and strategically aligned in multiple domains for target population in a logically coherent portfolio
	Interventions address multiple upstream and downstream aspects of the targeted health issue (e.g. social determinants of health, risk reduction, healthy behaviors, chronic care management)
	A coordinated, collective action plan is developed to implement the desired changes/interventions in environments
	Each partner understands the role of their interventions in the greater portfolio and how to link their interventions
Financial Sustainability Strategy Developed	**Financial performance goals have been set and management tools developed**
	Formal process and plan developed and adopted with strategies to pursue and manage financing and other resources for short and long-term operational and intervention sustainability.
	Financial data identified and indicators selected for sustainability assessment and reporting (e.g. dashboard)
	Existing intervention-specific funds are identified for ACH interventions
	Partner in-kind resources identified and committed (e.g. FTEs)
	Start-up funding and other financial resources deposited into Wellness Fund
	Wellness Fund contracts signed with backbone and partner organizations
	Accounting and financial controls in place

*Note: Indicators in **bold** are recommended priorities for an evaluation design. Proposed measures for each indicator are presented in Appendix A* – Proposed Measures.

Framework Component: Governance Capacity Developed

A successful ACH will develop the capacity to govern by establishing clear and transparent procedures that create inclusive and effective decision-making, accountability, and effective leadership. These core principles of ACH governance are based on a review of studies published from an ACH-like initiative grounded in collective impact theory and funded by the Robert Wood Johnson Foundation (RWJ) called Aligning Forces for Quality and a report by an organization engaged by the CACHI funders, ChangeLab Solutions.[25] [26]

This research established that developing governance capacity in terms of leadership, fair and inclusive decision-making, and accountability, is a prerequisite to strengthening collaboration, another important ACH outcome. Alexander et al. identified the leadership skillset that is unique to leading collaboratives relying on voluntary participation. Hearld et al explained that fairness in the decision-making process leads to agreement about the distribution of costs and rewards among partners, and sustains member participation.[27] Meaningful community engagement from those affected by decisions in the target population is also critical to developing legitimacy and sustaining momentum.[28]

Research also emphasizes that ACH accountability contributes to success. An ACH can develop a culture of accountability by scheduling structured opportunities for reflection, such as those envisioned by the Plan-Do-Study-Act or the Results-Based Accountability Framework approaches.[29] Building on this research, we developed indicators (presented in Figure 5)

---

[25] RWJ provided 16 communities with four rounds of funding that totaled $64 million (see RWJ's website on Aligning Forces for Quality for more information: http://forces4quality.org/sustaining-af4q-efforts.html)

[26] See the webpage titled, "Lessons Learned," on the Robert Wood Johnson's website for Aligning Forces for Quality, last updated May 31, 2015. URL: http://forces4quality.org/lesson-learned.html

[27] Alexander, Jeffrey A., Larry R. Hearld, and Jessica Mittler. 2011. "Measuring Leadership in Multisector health Care Alliances," Nonprofit Management and Leadership, 21(4). ; Larry R. Hearld, Jeffrey A. Alexander, Laura Bodenschatz, Christopher J. Louis, Jennifer O'Hora. 2013. "Decision-Making Fairness and Consensus Building in Multisector Community Health Alliances, A Mixed-Methods Analysis," Nonprofit Management and Leadership.

[28] Association for the Study and Development of Community, "Scope, Scale, and Sustainability: What It Takes to Create Lasting Community Change," November 1, 2007. URL: http://www.communityscience.com/pubs/Scope%20Scale%20and%20Sustainability%20report%20FINAL.pdf

[29] ChangeLab Solutions. 2015. "Accountable Communities for Health: Legal and Practical Recommendations." URL: http://communitypartners.org/sites/default/files/documents/cachi/reports/ChangeLab%20Solutions_TCE_ACH_Report_FINAL_20151217.pdf ; Bijal A. Balasubramanian, Deborah J. Cohen, Melinda M. Davis, Rose Gunn, L. Miriam Dickinson, William L. Miller, Benjamin F. Crabtree, and Kurt C. Stange. 2015. "Learning Evaluation: blending quality improvement and implementation research methods to study healthcare innovations," *Implementation Science*, 10:31.

designed to measure if an ACH is developing the governance capacity, accountability, and effective leadership needed for long term success.

Figure 5: Outcomes and Indicators for Governance Capacity

Governance Capacity	
Outcome	**Indicator**
Governance Procedures Support an Inclusive and Effective Decision-Making Process	**Governance procedures are standardized, transparent, and clear to all members**
	Necessary information for decisions is communicated in a timely manner to members and broader community
	Discussions and decisions are inclusive of all ACH members
	The decision-making process is inclusive of community members who reflect the demographic characteristics of the service area
ACH is Accountable to the Community and ACH Partners are Accountable to the ACH	Member organizations live up to their commitments to the ACH (e.g. staff time, resources)
	Member organizations engage in the practices of a "learning" collaborative
	ACH is accountable to broader community
Effective Leadership in Place	**Leadership effectively builds consensus and manages conflict**
	Leadership creates a climate of expected performance and productive accomplishment in the ACH
	Leadership connects vision to focused activity by facilitating strategic planning for the ACH
	Leadership encourages prioritization of collective goals over individual organizational interests

*Note: Indicators in **bold** are recommended priorities for an evaluation design. Proposed measures for each indicator are presented in Appendix A* – Proposed Measures.

Framework Component: Collaboration Among Partners

Collaboration is a cornerstone of an effective ACH. Collaboration in such undertakings is characterized by effective working relationships, sustained partner engagement, and partner support for the ACH vision and goals. The strength of partner relationships can be measured by how trust has been developed, maintained, and enhanced between ACH partner organizations.[30] Multiple means of assessing collaboration exist, including measuring the

[30] Trust between partners is a common theme in papers about ACH-like initiatives, but one paper in particular emphasizes the role of trust in partnerships. The Robert Wood Johnson Foundation funded a survey and analysis of successful partnerships

strength of social networks utilizing a method developed by Frey et al. titled "Levels of Collaboration Scale." [31]

For deeper and more long-term change to community health, ACHs may seek to reorient a community's health care and social services systems towards one that is prevention-focused and addresses the social determinants of health.[32] To engage in such systems change, collaborating partners may reflect on their underlying beliefs and assumptions, and their respective roles and responsibilities in the system as a whole. This requires understanding system and service interconnectedness and power dynamics among partners and the community.[33] The process of developing the portfolio of interventions in the context of the current system and ensuring that each partner understands the role of their interventions in the portfolio (see Figure 4: Operational Elements), engaging in reflection as part of the learning collaborative (see Figure 5: Governance Capacity), and using tools to analyze the social network among the partners (see Figure 6: Collaboration) support the partners' work towards systems change. (Appendix A – Proposed Measures offers more detail of these indicators in the descriptions of measures.)

To realize systems change, collaborations develop collective accountability wherein partners share an identity, prioritize the community concern and not just the self-interest of their respective organization, and take ownership of the ACH vision.[34] [35] [36] Taking ownership

---

conducted by Commonwealth Center for Governance Studies in 2014 titled, "Improving Community Health through Hospital – Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships."

[31] Bruce B. Frey, Jill H. Lohmeier, Stephen W. Lee, Nona Tollefson. 2006. "Measuring Collaboration Among Grant Partners," *Measuring Collaboration Among Grant Partners*.

[32] Indication of a reorientation can be detected in the assessment of the vision and the portfolio of interventions developed (see Figure 4: Operational Elements) and specific changes to "business as usual" selected by the evaluator (see Figure 7: Strategies Implemented). Indication of systems change can be detected through indication of payment reform, such as reinvesting cost savings into the ACH (See Figure 8: Intermediate Impacts), and ultimately in the long-term, indication that partners have institutionalized ACH practices and taken on issues beyond the initial health issue and that a culture of health pervades organizations in the broader community (See Figure 9: Long Term Impacts).

[33] Jessup, Patricia, Beverly Parsons, Marah Moore. 2016. "Partnerships, Paradigms, and Social-System Change," *The Foundation Review*, 8(2).

[34] Linkins, Karen W., Lynda E. Frost, Becky Hayes Boober, and Jennifer J. Brya. 2013. "Moving from Partnership to Collective Accountability and Sustainable Change: Applying a Systems Change Model to Foundations' Evolving Roles," *The Foundation Review*, 5(2) ; Larry R. Hearld, Jeffrey A. Alexander, Laura Bodenschatz, Christopher J. Louis, Jennifer O'Hora. 2013. "Decision-Making Fairness and Consensus Building in Multisector Community Health Alliances, A Mixed-Methods Analysis," *Nonprofit Management and Leadership*.

[35] See Key Lessons Learned from the Robert Wood Johnson Foundation's initiative, Aligning Forces for Quality, URL: http://forces4quality.org/insights-and-recommendations-collaboratives-capacity-deliver.html.

means the partner organizations adopt the ACH vision as part of their organization's vision and, accordingly, make intra-organizational changes in policies, programs, and personnel that support the vision (see Figure 6: Collaboration).[37] This collective vision and accountability contributes to ACH sustainability and girds it against changes in leadership.[38] Figure 6 presents the research-based outcomes and indicators of collaboration developed for the framework.

Figure 6: Outcomes and Indicators for Collaboration

Collaboration	
Outcome	**Indicator**
Relationships Among ACH Partners Strengthened	The social network evolves to support the ACH vision
	Trust enhanced
	Communication among partners improved
	Cross-organizational support increased
Partners Embrace ACH Vision and Goals	Partner organizations have incorporated ACH goals into their own organizational goals
	Partners' organizational agendas are aligned
	Partners take ownership over achieving results
Partner Organization Participation Sustained	**Participation is sufficient and reliable**
	Partners believe participation brings them value
	Perception that the distribution of contributions and rewards is fair

*Note: Indicators in **bold** are recommended priorities for an evaluation design. Proposed measures for each indicator are presented in Appendix A* – Proposed Measures.

Framework Component: Implementation of Strategies

ACH partners will design a "portfolio of interventions" whereby strategies for clinical services and care coordination, community-based prevention, social services, policy development and environmental conditions are logically organized and mutually reinforcing to

[36] Jessup, Patricia, Beverly Parsons, Marah Moore. 2016. "Partnerships, Paradigms, and Social-System Change," *The Foundation Review*, 8(2).
[37] Jessup, Patricia, Beverly Parsons, Marah Moore. 2016. "Partnerships, Paradigms, and Social-System Change," The Foundation Review, 8(2).
[38] Hearld, Larry R. , Jeffrey A. Alexander, Yunfeng Shi. 2014. "Leadership transitions in multisectoral health care alliances: implications for member perceptions of participation value," *Health Care Manage Rev*. ; Association for the Study and Development of Community. 2007. "Scope, Scale, and Sustainability: What it Takes to Create Lasting Community Change Part 1," URL: http://www.issuelab.org/resource/scope_scale_and_sustainability_what_it_takes_to_create_lasting_community_change

drive measurable and sustainable improvements in population health. This coordinated and strategic approach means partners' "business as usual" approach to addressing health issues evolves to impact the health of the target population and meet the vision of ACH. ACHs would assess such outcomes in the short-term to understand whether their efforts are moving toward achieving desired impacts in the long-term. Evaluators will work with ACHs to develop measures of changes in "business as usual" specific to their portfolio of interventions guided by the suggestions provided in Appendix A and discussed further below.

Various aspects of the patient experience in health care may be important to an ACH and call for effective measurement.[39] This framework includes indicators of equitable and culturally competent care built on the National Quality Forum.[40]

This section of the framework also includes indicators of financial sustainability and data sharing designed to signal whether an ACH is making early progress. A crucial strategy for an ACH to become sustainable is to calculate cost savings associated with the portfolio of interventions. Demonstrable cost savings perpetuate partner buy-in, encourage investment from external funders, and sustain the ACH through payer reinvestment. Developing a method for calculating the cost savings (in the table below) as well as a payment method for reinvestment (see Figure 8: Intermediate Impacts) are important ACH challenges.[41]

[39] The website for Aligning Forces for Quality offers extensive guidance on using patient experience surveys, see the following webpage for resources last updated May 31, 2015, "Making Patient Experience Meaningful," URL: http://forces4quality.org/topic-statement/making-patient-experience-meaningful.html

[40] National Quality Forum. 2012, "Healthcare Disparities and Cultural Competency Consensus Standards," A Technical Report, NQF, September. URL: http://www.qualityforum.org/Publications/2012/09/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Technical_Report.aspx ; National Quality Forum. 2014. "Priority Setting for Healthcare Performance Measurement Addressing Performance Measure Gaps in Person-Centered Care and Outcomes," August 15. URL: http://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Person-Centered_Care_and_Outcomes.aspx

[41] For guidance on implementing a method for health care savings reinvestment, see Miller, George, Paul Hughes-Cromwick, and Ani Turner. 2014. "Clarifying Feasible Procedures for Reinvesting Health Care Cost Savings," *Issue Brief*, Altarum Institute, September 18. URL: http://altarum.org/sites/default/files/uploaded-publication-files/CSHS_Reinvesting%20Issue%20Brief_Final.pdf

Figure 7: Outcomes and Indicators for Portfolio and Financial Strategies Implemented

Strategies Implemented	
Outcome	**Indicator**
Measurable Change in "Business as Usual" Due to Portfolio of Interventions	**Clinical partners address target population's social services needs as well as clinical needs**
	Community partners address target population's clinical needs as well as social services needs
	Care coordination among clinical providers improved
	Linkages between community and clinic providers established
	Social, community, and physical conditions support healthy behaviors
	New or changed public and private practices, rules, laws, and regulatory changes support ACH vision
Patient Experience Improved	Providers engage clients through patient-centered and culturally competent communication
	Equitability of access to and quality of care is improved
Sustainability Strategies Have Led to Funding that Supports the ACH Beyond Initial Grant	**Method for measuring and calculating cost savings/financial gains of interventions is agreed upon and applied**
	Financing is braided to fund interventions in the portfolio
	Deposits to Wellness Fund in addition to original grant award
	In-kind commitments (e.g. FTEs) from partners extended into future years
Data Collection and Sharing Systems Implemented	Data are being collected and shared on all measures in a timely way
	Shared data are used by ACH partners in performance assessment and decision-making processes

*Note: Indicators in **bold** are recommended priorities for an evaluation design. Proposed measures for each indicator are presented in Appendix A* – Proposed Measures.

Framework Component: Intermediate Impacts

In the intermediate term, an ACH utilizing this framework will measure and demonstrate improvement in risk factors, individual health status, and social determinants of health compared to the baseline measured prior to implementation of the portfolio of interventions.

The ACH would measure the "dose" of an intervention as the reach (exposure of the target population to the intervention) multiplied by the strength of the intervention (a percent increase in the intended effect, such as healthy behavior, among the treated population).[42] This method has been used to calculate short-term impacts of community-based interventions in order to predict long-term benefits.[43] To the calculations of reach and strength, this framework adds an indicator for detecting a result among the treated population. The evaluator will work with the ACH partners to compose measures specific for the ACH portfolio of interventions.

The construct of "mutually reinforcing" interventions is operationalized by measuring an increase in individuals exposed to multiple interventions and directing the evaluator to cumulatively assess the evidence of exposure overlap as well as increased strength and results of the coordinated interventions.

The framework measures ACH financial sustainability by assessing how payers and providers are adopting new payment methodologies and reinvesting cost savings into the ACH.[44] In addition to assessing if payers contribute to the ACH, the framework evaluates the ACH as financially sustainable according to an assessment of the sufficiency of current and future committed funds to support ACH operations and interventions.[45] An ACH with diversified funds is more likely to be financially sustainable.[46]

---

[42] Schwartz et al 2015, "Dose Matters: An Approach to Strengthening Community Health Strategies to Achieve Greater Impact," *National Academy of Medicine.*

[43] Soler, Robin, Diane Orenstein, Amanda Honeycutt, Christina Bradley, Justin Trogdon, Charlotte K. Kent, Kristina Wile, Anne Haddix, Dara O'Neil, Rebecca Bunnell. 2016. "Community-Based Interventions to Decrease Obesity and Tobacco Exposure and Reduce Health Care Costs: Outcome Estimates from Communities Putting Prevention to Work for 2010-2020," *Preventing Chronic Disease Public Health Research, Practice, and Policy*, 13:150272.

[44] The Innovation Plan "ACH" Work Group. 2015. "Accountable Communities for Health Initiative Work Group Report," California Health and Human Services Agency. URL: http://www.communitypartners.org/sites/default/files/documents/cachi/reports/ACH%20Work%20Group%20Report%20FINAL.pdf ; Miller, George, Paul Hughes-Cromwick, and Ani Turner. 2014. "Clarifying Feasible Procedures for Reinvesting Health Care Cost Savings," Issue Brief, Altarum Institute, September 18. URL: http://altarum.org/sites/default/files/uploaded-publication-files/CSHS_Reinvesting%20Issue%20Brief_Final.pdf

[45] See the following webpages of Robert Wood Johnson's website titled, "Aligning Forces for Quality," last updated May 31, 2015. "Key Driver's Scorecard: Economic Viability," URL: http://forces4quality.org/key-drivers-scorecard-economic-viability.html ; "Insights and Recommendations for Collaboratives: Economic Viability," URL: http://forces4quality.org/insights-and-recommendations-collaboratives-economic-viability.html ; "Sustainability Framework," URL: http://forces4quality.org/sustainability-framework.html

[46] See the following webpage of Robert Wood Johnson's website titled, "Aligning Forces for Quality," last updated May 31, 2015. "Key Driver's Scorecard: Economic Viability," URL: http://forces4quality.org/key-drivers-scorecard-economic-viability.html ; For a list of potential revenue sources, see 1) a survey by ReThink Health that assembled financing strategies from over a hundred multi-sector partnerships: Erickson, Jane, Jane Branscomb, and Bobby Milstein. 2015. "Multi-sector

Figure 8: Outcomes and Indicators of Intermediate Impacts

Intermediate Impacts	
Outcome	**Indicator**
Improvement in Risk Factors, Individual Health Status, and Social Determinants of Health	**Reach of Interventions in portfolio increased**
	Strength of the interventions in the portfolio increased
	Result of interventions on targeted population improved
Interventions in the Portfolio are Mutually Reinforcing	**Interventions overlap on target population**
Payers are Financially Contributing to ACH	Payment methodologies developed with providers that measure and reward population health outcomes based on interventions
	Contracts with providers in place codifying new payment methodologies
	Health care cost savings are reinvested into the ACH
ACH is Financially Sustainable	Revenue is diversified
	Current and future committed funds are sufficient to support ACH operations and interventions

*Note: Indicators in **bold** are recommended priorities for an evaluation design. Proposed measures for each indicator are presented in Appendix A* – Proposed Measures.

Framework Component: Long-Term Impacts

Ultimately, ACHs seek to improve the "Triple Aim": improve population health and reduce health disparities, improve services and the health care delivery system, and control health care costs.[47] Specific measures of these long-term impacts will depend on the health issue addressed by the ACH; this framework proposes some indicators and measures as well as data sources for ACHs to consider in developing further specific outcome measures for their respective communities.[48]

Partnerships for Health: 2014 Pulse Check Findings," ReThink Health. URL: http://www.rethinkhealth.org/wp-content/uploads/2015/09/RTH-PulseCheck.pdf ; and 2) Cantor, Jeremy, Rachel Tobey, Kiely Houston, and Eliana Greenberg. 2015. "Accountable Communities for Health: Strategies for Financial Stability," JSI Research and Training Institute, Inc. URL: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

[47] California Health and Human Services Agency, "Let's Get Health California Task Force Final Report," December 19, 2012. URL: http://www.chhs.ca.gov/LGHC/___Let's%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf

[48] Sources for measuring the Triple Aim specific to the ACH's selected issue include Let's Get Healthy California (2012), which developed a dashboard of indicators for overall health, lifestyle, smoking, obesity, diabetes, cardiovascular disease, and mental health. As a companion, the Institute for Healthcare Improvement published a guide to measuring the Triple Aim. Centers for

This framework prioritizes the key indicator of improved population health as a reduction in the percentage of the population with the targeted condition and a reduction in the incidence of new cases. Detecting improvement requires measurement of the baseline of population health before the ACH begins implementing the portfolio of interventions.

To measure changes in disparities in population health, baseline measurements that stratify the populations of interest into selected groups will also be crucial. This evaluation framework underscores equity and emphasizes cultural competency with measurement of community engagement in developing the ACH vision, strategies, and goals (see Figure 4: Operational Elements), data collection on subpopulations (see measurement descriptions of Operational Elements in Appendix A – Proposed Measures), inclusive decision-making processes (see Figure 5: Governance), equitable access and quality of care for the target population (see

Figure 7: Strategies Implemented), linguistically appropriate and culturally competent provider-patient communication for the target population (see

Figure 7: Strategies Implemented), access to linguistically and culturally appropriate care for broader population (see Figure 9: Long-term Impacts), and ultimately, a reduction in disparities of health outcomes (see Figure 9: Long-term Impacts).[49]

Medicare and Medicaid Innovation defines measures of population health and identifies data sources for the CMS State Innovation Model Initiative's priority areas of tobacco, obesity, and diabetes. Other efforts to identify core metrics of health include the National Research Council's "Vital Signs: Core Metrics for Health and Health Care Progress," and the National Quality Forum publications of measures for multiple areas including health and well-being, person- and family-centered care, effective communication and care coordination, and affordable care. See: Stiefel M, and K. Nolan. 2012. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost, IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. URL: http://www.jvei.nl/wp-content/uploads/A-Guide-to-Measuring-the-Triple-Aim.pdf ; "Suggested Population Level Measures for the CMS State Innovation Model Initiative," Centers for Medicare and Medicaid Innovation, 2015. URL: https://innovation.cms.gov/Files/x/SIMPopHlthMetrics.pdf ; Institute of Medicine. 2015. Vital Signs: Core Metrics for health and Health Care Progress, Washington, DC: The National Academies Press. URL: https://www.nap.edu/catalog/19402/vital-signs-core-metrics-for-health-and-health-care-progress ; See an index of National Quality Forum publications at "Including Health and Healthcare," http://www.qualityforum.org/Topics/Improving_Health_and_Healthcare.aspx

[49] National Quality Forum. 2012. "Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment," *A Technical Report*. Washington, DC: NQF. November 15. ; National Quality Forum. 2009. *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report.*

Among the long term goals of an ACH, and one that is fundamental to achieving success in the other outcomes, is establishing a "culture of health" among organizations in the community whereby partner organizations and their workforces understand and embrace roles they can play in improving health in the community. Determining whether and to what extent a culture of health has been established can be achieved through a combination of surveys and structured interviews. These tools would be used to assess the extent to which organizations have in place policies and programs that reflect a focus on preventative health and wellness, whether employees (even in non-health care delivery organizations) consider health in the course of their interactions with clients or patients, and whether the patient population (measured through a population survey) has been activated to take a role in improving their own health.[50]

Finally, the framework prioritizes measurement of the third goal in the Triple Aim, controlling health care costs, through measures of the extent to which the rate of increase in health care costs per capita has been curtailed and the utilization of services for preventable hospitalizations has decreased.

Washington, DC: NQF. URL: http://www.qualityforum.org/Topics/Disparities.aspx ; National Quality Forum. 2014. "Priority Setting for Healthcare Performance Measure Gaps in Person-Centered Care and Outcomes. Washington, DC: NQF, August 15. URL:
http://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Person-Centered_Care_and_Outcomes.aspx

[50] Lindeblad, MaryAnne, "Using the Patient Activation Measures Tool (PAM)," Center for Healthcare Strategies, Inc. URL: http://www.chcs.org/media/Lindeblad_PAM.pdf

Figure 9: Outcomes and Indicators for Long Term Impacts

Long-Term Impacts	
Outcome	**Indicator**
Population Health Improved	**Prevalence and incidence of health condition reduced**
	Management of condition improved
	Quality of life Improved
Health Equity Improved	**Disparity in health outcomes reduced**
Services and Health Systems Improved	Partners have institutionalized practices and policies resulting from successful ACH interventions and collaboration
	ACH continues to improve population health beyond initial target issue
	A culture of health pervades organizations, schools, clinics, and government agencies in broader community
	Access to culturally and linguistically appropriate social services and health care for broader population improved
	Patient experience improved for broader population
Health Care Costs Controlled	**Health care costs for preventable conditions and hospitalizations controlled**
	Value-based payment methods are used pervasively

*Note: Indicators in **bold** are recommended priorities for an evaluation design. Proposed measures for each indicator are presented in Appendix A* – Proposed Measures.

CONSIDERATIONS FOR THE FRAMEWORK AND EVALUATION DESIGN

From Evaluation Framework to Implementation

This section presents the important issues that funders, ACHs, and evaluators will need to consider in operationalizing the framework presented in this guide. The framework presented is not the evaluation design itself, but rather offers a road map and presents a logic model needed to develop rigorous evaluations of ACHs. Evaluation is integral to understanding ACHs at the developmental, formative and summative stages. A broader evaluation scope increases the understanding of ACH successes and measures the contributing factors, as well as where and why ACHs face challenges.

Operationalizing the Framework

The outcomes, indicators, and measures presented here – together with the logic model that underlies the ACH concept – provide the foundation for a comprehensive evaluation of ACHs. To operationalize this framework, individual communities and ACH funders would work with an evaluator (whether internal or external) to adapt the framework to the specific contexts of each community and the health issue targeted by the ACH efforts. The evaluator would work with the partner organizations to create a specific logic model for that ACH, select relevant outcomes, indicators, and measures based on this framework, and implement the evaluation design.

Where specific requirements imposed by funders or others are present, the evaluation design would be refined accordingly. For example, where an initiative funds a cohort of ACHs simultaneously rather than a single ACH, the evaluation design would require measurement of the same cross-cutting indicators (e.g. governance, collaboration, financial sustainability) at each site to enable cross-site comparisons. In these cases, selecting a single evaluator to evaluate multiple sites is preferable to the selection of multiple evaluators. For some ACHs, measures may be specified, such as ACHs supported by CMMI State Innovation Model funding, which typically include "The Triple Aim" as long-term goals to achieve. With these considerations in mind, the evaluator would first review and revise (as needed) the research questions, tailor the logic model to the ACH, select priority indicators, measure the baseline, and develop a schedule for ongoing data collection and evaluation. To evaluate an ACH, the evaluator would perform the following tasks:

- Select research questions
- Customize the logic model
- Select priority indicators and measures
- Determine baseline and recurring measurements
- Use collected data to address the research questions

Select Research Questions

Working with the ACH partners, an evaluator would identify and prioritize the overarching research questions to be answered by the evaluation design. This process would take into account funder and community goals, the ACH timeframe, and available resources for the evaluation. These questions then inform the selection of outcomes and indicators, the "learning evaluation" process, and focus of the final analysis and reporting.

Customize the Logic Model

The first step in the evaluation approach would be to customize the logic model (see Figure 2) based on individual community characteristics and the health issue that will be the focus of the ACH. Each community would consider individual community assets, its own governance structure, and, most importantly, the portfolio of interventions which the community would develop and implement.

Select Priority Indicators and Measures

Based on the research questions and customized logic model, the evaluator and ACH leaders would select the priority indicators and associated measures (see Appendix A – Proposed Measures) most relevant to the ACH's community strengths, targeted health issues, and selected interventions. For example, an evaluator may choose to measure more indicators of financial strength and sustainability where ACH partners have identified this as a priority.

The evaluator may not select some indicators until well into the first year. For example, an ACH will likely develop its portfolio of interventions during the first year. After it has been finalized, the evaluator would develop specific indicators for assessing the implementation and intermediate impacts of the portfolio of interventions using the framework as a guide (discussed further below). Likewise, external support and technical assistance may develop during the first year, indicators of which would also be specific to that support (See Inputs in Figure 2). For example, the evaluator could provide a survey before and after workshops on data sharing that assess partners' knowledge and the importance of the technical assistance to their work in the ACH. Analysis of technical assistance would contribute to answering the question, "What factors have contributed to the ACH's success or hindered its progress?"

Determine Baseline and Recurring Measurements

While identifying priority indicators and associated measures, the evaluator would also create a schedule for measuring the indicators. The baseline for indicators of collaborative relationships (e.g. trust, communication, and cross-organizational support) would be measured first, ideally before the first ACH convening, to allow for analysis of the extent to which relationships among the partners strengthen over time. The baseline of indicators for the implementation, intermediate impact, and long-term population health impacts of the portfolio of interventions would be measured before the partners begin implementing the portfolio, which may be toward the end of the first year.

Beyond measuring the baseline, the evaluator will determine the frequency of data collection for each measure. For example, measurement of care coordination as an indicator that the portfolio of interventions is changing "business as usual" may be collected quarterly as part of the learning evaluation (See

Figure 7: Strategies Implemented). The evaluator would provide this information to the ACH in real-time and facilitate ACH partner reflection on how actions led to measurable results. ACH partner engagement in these reflective meetings indicates that the ACH functions with accountability (see Figure 5: Governance Capacity).

Address the Research Questions: Short-term Feasibility

With priority indicators selected and measurement timing determined, the evaluator would collect data to address the research questions. The logic model (see Figure 2) hypothesizes that an ACH found to be operationally feasible in the short-term is likely to be successful in improving population health in the long-term, thus the first four questions assess the short-term feasibility of an ACH. To answer the first question, "Is the ACH operationally successful after the first few years?", the evaluator will analyze the data collected on short-term measures of the portfolio of interventions and financial strategies as well as the strength of collaboration.

The evaluator would determine that an ACH is operationally successful, and thus likely to improve population health, if the ACH demonstrates enhanced trust among partners, sustained partner participation, measurable change in "business as usual", an improvement in patient experience, an increase in funds beyond the initial ACH grant, and productive use of shared data (See Appendix A – Proposed Measures). For example, the logic model posits that enhancing trust among partner organizations is a critical prerequisite for the ACH to achieve financial sustainability. Trust is necessary to pursue critical activities, such as sharing data, developing methods for calculations of cost savings, and reinvesting cost savings into the ACH, that are likely to bring about financial sustainability (See

Figure 7: Strategies Implemented). These activities, in turn, can further enhance trust among partners. A financially sustainable ACH supports successful implementation of the portfolio of interventions, which leads to improved population health.

If the short-term outcomes show mixed results, an evaluator would analyze data collected on those and other indicators to investigate areas in need of improvement. If the evaluator detects weakening trust among partners, they can work with the ACH to investigate possible sources of conflict by analyzing indicators of operational elements, governance capacity, and strategies implemented. For example, partners may not view the decision-making process as transparent and inclusive, which could lead to a breakdown in trust. By measuring these indicators and informing the ACH partners of the analysis in real-time, the evaluators can facilitate learning among the ACH partners to enable them to address problems as they unfold.

Address the Research Questions: Intermediate and Long-Term Impact

One of the questions the evaluator would address to examine the impact of the ACH is, "How does the portfolio of interventions contribute to the intermediate and long-term impacts?" The logic model hypothesizes that an evidence-based and aligned portfolio of interventions (assessed in Figure 4: Operational Elements) that changes "business as usual" and patient experience when implemented (assessed in

Figure 7: Strategies Implemented), improves risk factors, individual health status, and social determinants of health, and is mutually reinforcing (assessed in Figure 8: Intermediate Impacts) will contribute to an improvement in population health (assessed in Figure 9: Long-term Impacts). Analysis of the data collected on these measures over time in conjunction with analysis of supplemental qualitative data collected by the evaluator would enable the evaluator to address this question.

The framework presents outcomes and indicators of the portfolio of interventions that can be applied to any issue targeted by an ACH, though the evaluator would develop measures specific to the ACH in a particular community. To demonstrate this rubric, Figure 10 offers an example of a portfolio of interventions that targets cardiovascular disease (CVD):

Figure 10: Example of a Portfolio of Interventions Designed to Reduce Cardiovascular Disease

Portfolio of Interventions for Cardiovascular Disease	
Domain	**Intervention**
Clinical Care	Standardized primary care screening for Body Mass Index and refer for interventions
Community Programs and Social Services	Nutrition classes for residents on healthy food choices for CVD prevention that promote healthy options available from local retailers through "Healthy Retail" program
Community-Clinical Linkages	Develop a referral tracking system with bidirectional feedback between primary care organizations and community health programs
Public Policy and Systems	Encourage food and beverage policies in schools
Environment	Expand the "Healthy Retail" program that encourages local retailers to offer healthy food and beverage options

An evaluator would assess that these interventions are logically aligned (see Figure 4: Operational Elements) because the "linkages" intervention enables the clinic to refer patients and family with high BMI to community nutrition classes that promote and make accessible

healthy food options. Healthy food and beverage policies in schools then reinforce healthy eating habits among children to prevent later onset of CVD.[51]

To assess the portfolio's intermediate impact, the evaluator would measure results from each intervention by calculating the percent change in the number of participants experiencing a decrease in BMI after the intervention relative to the baseline measure. If resources allow, the evaluator would also measure the reach and strength of each intervention relative to the baseline measures (see Figure 11).[52] To determine if the interventions in the portfolio are mutually reinforcing, the evaluator will measure the extent to which they overlap on the target population over and above the extent of overlap measured at the baseline (i.e. before the ACH implemented the interventions as an aligned portfolio). See Figure 11 for measures of this example.[53]

Figure 11: Intermediate Impacts of CVD Portfolio

Example of Intermediate Impacts of CVD Portfolio

Outcome	Indicator	Measure
Clinical Services Reduce CVD Risk Factor	**Reach of interventions in portfolio increased**	**Increased percent of target population that is screened for high BMI and referred to appropriate services**
	Strength of the interventions in the portfolio increased	**Percent increase in frequency of healthy behaviors of the participants**
	Result of intervention on targeted population improved	**Percent increase in # of participants with decreased BMI**
Community Program Reduces CVD Risk Factor	Reach of Interventions in portfolio increased	Percent increase of target population that participates in nutrition classes
	Strength of the interventions in the portfolio increased	Percent increase in frequency of healthy food choices made by participants
	Result of intervention on targeted population improved	**Percent increase in # of participants with decreased BMI**
Clinical-Community Linkages Improve	Reach of Interventions in portfolio increased	Percent increase in target population participating in referred services

[51] This portfolio would not be judged as comprehensive, however, since it addresses only one risk factor for CVD (high BMI), but simplifying the issue helps explain the methodology through this example.
[52] Note that the denominator for Reach in Figure 11 is the target population and the denominators for Strength and Result are the participants of the intervention.
[53] Some ACHs may be able to show some intermediate impacts after the first few years, such as an increase in the reach and strength of the interventions in the portfolio.

Health	Strength of the interventions in the portfolio increased	Percent increase in frequency of healthy food choices made among referred participants
	Result of intervention on targeted population improved	**Percent increase in # of referred participants with decreased BMI**
Public Policies and System Changes Support Healthy Behaviors	Reach of Interventions in portfolio increased	Percent increase of school-based target population in schools with food and beverage policies
	Strength of the interventions in the portfolio increased	Percent increase in healthy food and beverage consumed daily by participants; percent reduction in unhealthy food and beverage consumed
	Result of intervention on targeted population improved	**Percent increase in # of participants with decreased BMI**
Environments Altered to Support Healthy Behaviors	Reach of Interventions in portfolio increased	Percent increase in target population whose nearest retailer meets the standards of the Healthy Retail program
	Strength of the interventions in the portfolio increased	Percent increase in healthy food and beverage purchases made by participants
	Result of intervention on targeted population improved	**Percent increase in # of participants with decreased BMI**
Interventions in the Portfolio are Mutually Reinforcing	**Interventions overlap on target population**	**Increased percent of the target population reached by multiple interventions using program data or a community survey; evaluator assess reach, strength, and result of individual interventions and determines impact of multiple coordinated interventions**

In the long-term, an evaluator can measure the contribution of the portfolio of interventions to improving population health. By comparing the baseline percentage of the target population with CVD, for example, to the prevalence of CVD ten years after implementing the portfolio, the evaluator can assess the contribution of the ACH to the change in population health.

Context: Many Factors May Influence Population Health

One of the most important contextual factors that an evaluator will need to consider is the presence of other programs, policies, and initiatives that may also have an influence on population health in ACH communities. These contextual factors can confound the analysis and understanding of outcomes and impact. For example, California, like other states, is advancing other patient care and system change initiatives through Medicaid waivers (e.g. a Section 1115 Waiver focused on "whole person care") and ACA implementation (e.g. Section 2703 Health Home State Plan Option). The interventions and statewide initiatives may overlap with

interventions pursued by the ACHs, making differentiation from the ACH challenging. These are referred to as "relative initiatives" in the logic model presented earlier.

In addition, CACHI ACH communities were selected in part due to the partners' history of collaboration and their plans for leveraging existing interventions. These are referred to as "existing community strengths" in the logic model. In this case, it will be particularly important for the evaluator to carefully measure a baseline and track changes from business as usual, which may be difficult to detect in cases where pre-existing collaboration is strong. In general, in order to determine whether and to what extent external factors influenced measured changes in key outcomes, evaluators will need to carefully chronicle and assess these external influences in order to identify and differentiate aspects of governance and collaboration resulting from the ACH model that contributed to any observed changes. Furthermore, the evaluator will need to differentiate health and other impacts resulting from the ACH portfolio of interventions as opposed to those resulting from the interventions which would have occurred absent the ACH strategies that link or coordinate interventions.

Impact of Technical Assistance

Lastly, ACHs may also receive on-going other support for their development. For example, the California ACH Initiative plans to provide technical assistance in several areas identified by the ACH communities and the funders. These might include technical assistance for data sharing, improvements to a health information exchange, strengthening governance, and developing a portfolio of interventions. For the evaluation, it would be important to measure and understand the role of such support in the evolution and success of the ACH. In other words, the evaluation would consider whether an outcome could have been achieved without focused technical assistance. This understanding will be important to generalize the results and spread the ACH model elsewhere.

Intermediate ACH Feasibility and Long-term Impact

Evaluating the feasibility of an ACH in the short-term is an important step in assessing whether continuing the ACH is a good use of resources or whether changes need to be made. The logic model presented in this framework offers a way to assess intermediate success as a

tool for evaluating the evolution and adaptation of an ACH at critical junctures and assessing its pathway to longer-term impacts. Specifically, the framework presented in this Users' Guide identifies important foundational elements, which are correlated with achieving the intermediate and long-term outcomes that will make an ACH successful.[54] Recognizing that ACHs will begin with varying strengths and challenges, and their paths toward achieving their goals will vary, the evaluator can work with the individual ACHs to select near, medium, and longer-term measures of critical importance to the development of the particular ACH (guided by the key conditions outlined in this framework).

Measuring Mutually Reinforcing Interventions

An important aspect of ACHs is the expectation that collaborating partner activities and interventions will be mutually reinforcing. In other words, the activities can be implemented separately, but in a coordinated and aligned manner that will produce results that exceed the expected impact of delivering the interventions separately or through an ad hoc, uncoordinated approach.

As such, ACH evaluation designs need to address outcomes associated with the individual interventions, as well as those reflecting the impact of multiple interventions working together. For example, CACHI requires a portfolio of interventions that involves the implementation of clinical, community, environmental, and policy activities to promote community health. In each community, there will be outcomes associated with each component of the portfolio and combinations of the multiple interventions.

Given the dearth of research and evidence in this area, the evaluation challenge centers around how best to measure and assess the additive and interactive effects of multiple interventions that span different areas and levels of analysis. The following are potential concepts and indicators that can be used:

1. Directionality and Interconnectedness: What is the relationship between the activities and interventions? Are there feedback loops in terms of information sharing? Are there

[54] Note that, while research and analysis suggest that these outcomes are important indicators of future success, individual ACHs may well follow alternative paths, which may also lead to successful long-term outcomes.

specific clusters of activities and interventions that yield a measurable change? Can upstream interventions be clearly linked to downstream impacts?

2. Alignment: Are activities and interventions aligned to achieve the shared agenda, and clearly related to the vision for success? Do the strategies target the same outcome?
3. Interdependencies: To what extent do the desired outcomes depend on linkages among the activities and interventions? Do specific activities and interventions support and coordinate with the specific actions of others?
4. Synergy among Strategies: Does the activity or intervention complement or reinforce other strategies (as opposed to yield results on its own)? Are there economies of scale and/or scope?

Structuring a "Learning Evaluation"

The ACH model seeks to transform the health care system by creating cross-sector collaboratives to improve community health by aligning health care and prevention strategies. With this focus on systems change, ACHs are designed to be dynamic, experimental, and innovative in terms of activities and interventions. In any given community, the range of activities and interventions will include a combination of existing and new strategies with an evidence base that may vary in its strength. As such, there is a degree of uncertainty about what will work, where, and with whom. Ultimately, implementing an ACH will likely result in new questions, challenges, successes, and activities.

At this early stage of ACH development, it is appropriate to use a learning evaluation approach to enable the assessment of the implementation process in order to understand what works, what needs to be changed, and how contextual factors influence the process and results. Since the ACH design and implementation are not linear, the design needs to be flexible and focused on identifying the key factors – ACH characteristics, structure, capabilities, activities, and local context – that influence ACH development, implementation, and performance in order to support quality improvement, scalability, and spread. Ideally, the evaluation will continually yield information that can be used by implementers to make improvements and assess how the ACH is working.

The learning evaluation design will require a mixed method approach to collect both qualitative and quantitative data. Qualitative data will support the assessment of current practices, conditions and contextual characteristics of participating ACH organizations at baseline and throughout implementation to understand factors that influence changes in practices and outcomes. Quantitative data can be used to assess improvements achieved through the implementation process, as well as overall outcomes achieved. A central tenet of the learning evaluation approach is to provide data that are relevant both to the ACH and the evaluation, which helps engage participating organizations in the evaluation and continuous quality improvement, and improves the quality and relevance of the evaluation findings. Key steps for the learning evaluation include:

1. Establish baseline – current practices, initial conditions and context -- against which to assess changes over time
2. Collect process and outcome data
3. Analyze implementation progress and outcomes, focusing on how contextual factors impact results
4. Provide actionable results to implementers and funders for learning and real-time adjustments
5. Assess the relevance of indicators and measures, and adjust as needed, to align with key activities/interventions across the ACHs

The developmental nature of a learning evaluation approach requires an expanded role for the evaluator, which includes participating as a strategic learning partner and facilitator to funders and sites and providing technical assistance to support building capacity for using data for local quality improvement and outcomes assessment, and contributing to the overall evaluation.

Developing Requests for Proposal

This framework presented here provides the foundational elements needed to implement an evaluation of individual ACHs or an ACH initiative comprising multiple sites. To

operationalize this framework, communities, partners and funders will need to engage an evaluation team to implement a design specific to their goals, interventions, timeframe and resources.

ACH partners, funders or other sponsors could include this framework with their Requests for Proposals (RFP) documents to be sent to prospective evaluation contractors. The budget for an ACH evaluation modeled on this framework would depend upon the scope, depth and duration of the evaluation. An evaluation focused on assessing short-term governance and financial feasibility measures would cost less than a long-term design that assessed feasibility and impact on the Triple Aim and the reduction of health inequities. The evaluation scope and budget would also be influenced by the frequency and extent of data collection and the extent to which the evaluator provides technical assistance. For example, if the evaluator is expected to provide technical assistance on data sharing or serve as a strategic learning partner, the scope and budget would be correspondingly larger.

APPENDICES

Appendix A – Proposed Measures

The following section presents proposed outcomes, indicators and measures for assessing an ACH. Indicators in **bold** are recommended priorities for an evaluation design.

Operational Elements		
Outcome	**Indicator**	**Measure**
Governance Structure Established	**Backbone, Leadership, and Partner roles, responsibilities, and commitments are documented and clear**	**Evaluator reviews documents to define necessary responsibilities as well as expected staff time and financial commitments; Survey ACH members: To what extent are you clear about your responsibilities and those of your organization to the ACH?**
	Necessary agreements are in place and modified as needed over time (e.g. data sharing, MOUs)	Key informant interviews to assess necessity of agreements; Evaluator reviews documents that necessary agreements are in place
	Intentional policies and procedures in place (e.g. by-laws, communication channels, decision-making processes, etc.)	Evaluator determines that policies have been established
	The right organizations are partners	**Key informant interviews; survey ACH members: Are any critical partners missing? Do you think the ACH would be stronger excluding any of the partners?**
	The right leadership representatives from partners are at the table with the necessary skills and institutional role	**Key informant interviews; survey ACH members: 1. Has the ACH identified leader(s) to be influential champion(s)? 2. To what extent do the participants have the power to make decisions on behalf of their organization? 3. To what extent do participants fulfill the full range of skills**

		needed by the ACH?
Vision, Goal, and Strategy are Agreed Upon	The vision, goal, and strategies incorporate community input	Key informant interviews of community members and Survey of ACH members: To what extent did the choice of goal and strategy incorporate community input?
	ACH members agree on the vision, goal, and strategies	**Survey of ACH members: To what extent do you support the vision? The choice of goal? The strategies?**
	ACH members agree on strategy to align interventions and meet the goal	Survey of ACH members: To what extent do you agree with the ACH strategy to align the interventions? To what extent do you agree this strategy will achieve the goal?
Data Systems and Measures Developed	A comprehensive plan of strategies for ACH data sharing has been developed	Evaluator assesses completeness of plan to address data collection needs within existing capacity and strategy to develop more capacity (e.g. create unique identifiers for individuals to be used by all partners; expect additional data entry in shared Excel spreadsheet; Employ an Integrated Data System with a data warehouse or a federated data architecture, or hybrid)
	Key audiences have been identified and a plan for strategic communication to engage each group has been developed	Evaluator assesses completeness of audiences identified (e.g. community leaders, residents, funders, policymakers, ACH members) and strategies for communication (e.g. frequency of communication and types of tools such as dashboards, ad hoc reports, statistical analyses, maps, etc.)
	Identify relevant baseline data sources and develop useful indicators for assessing health disparities and site-specific outcomes	Evaluator confirms all relevant data sources have been identified and that useful indicators and metrics have been developed (e.g. patient surveys, claims, EHR Data, clinical data registries, manual chart abstraction); Evaluator confirms that data sources include race/ethnicity and socio-demographic variables
	A common set of feasible measures that are agreed to by ACH members and can be collected within existing resources are developed	**Evaluator confirms that the measures will assess the health outcomes resulting from the interventions and are feasible.**
	Valid and reliable measures are tied specifically to the	Population health metrics exceed clinical, encounter-based metrics and

	portfolio of interventions and the target population	address risk factors, costs, length of life, and health-related quality of life (for example) (e.g. individual level data) and stratified by race/ethnicity
	The measures assess the process outputs, intermediate financial and health outcomes, and long term impacts of the interventions	Evaluator confirms measures appropriately assesses process and intermediate and long-term outcomes
	Data governance team supervises data sharing by ensuring protection of confidential data and managing policies related to data exchange, quality, and use	Evaluator confirms the data governance team is addressing all identified concerns with data sharing and consulting legal counsel as needed
	Strategies for data sharing have been systematized and agreements formalized	Review of data sharing documents and key informant interviews
	Baseline data collected	**Evaluator confirms the baselines of all relevant metrics have been measured**
Mutually Reinforcing Portfolio of Interventions is Developed	Desired changes in social, community, or physical environments decided upon	Evaluator confirms decision made and agreed upon; all relevant domains addressed
	Service gaps and barriers to care that contribute to population health disparities are identified	Evaluator confirms inventory analyzed and gaps identified
	Evidence-based and mutually reinforcing interventions are identified and strategically aligned in multiple domains for target population in a logically coherent portfolio	**Evaluator assesses evidence and logic that POI will addresses health disparities and social inequities in a new way and individuals in the target population are expected to benefit from multiple interventions in the portfolio.**
	Interventions address multiple upstream and downstream aspects of the targeted health issue (e.g. social determinants of health, risk reduction, healthy behaviors, chronic care management)	Evaluator assessment of interventions confirms expected dose of portfolio of interventions is sufficient to address health issue; POI is expected to be different from business as usual; addresses upstream and downstream
	A coordinated, collective action plan is developed to implement the desired changes/interventions in environments	Evaluator reviews the plan to ensure it contains feasible and actionable strategies that will effectively change business as usual and adds value
	Each partner understands the role of their interventions in	Survey partners that are implementing interventions: “Please describe the

	the greater portfolio and how to link their interventions	role of your interventions in the portfolio and how they contribute to the long-term goal." ; "Please describe how your interventions reinforce other interventions and how they link to other interventions." ; "Please describe how you need to interact with other providers of interventions in order to successfully reinforce other interventions."
Financial Sustainability Strategy Developed	**Financial performance goals have been set and management tools developed**	**Review of documents and key informant interviews show that actionable financial goals have been developed based on data and that financial performance management tools are used to regularly track and report financial information.**
	Formal process and plan developed and adopted with strategies to pursue and manage financing and other resources for short and long-term operational and intervention sustainability.	Evaluator reviews governance by-laws and assesses sustainability planning products (e.g. formal plan, partners agreements, budget) and if payers have been identified to support interventions
	Financial data identified and indicators selected for sustainability assessment and reporting (e.g. dashboard)	Key informant interviews to assess partners' awareness and/or participation in developing POI business case, ROI methodology, financial dashboard, budgets, etc.
	Existing intervention-specific funds are identified for ACH interventions	Evaluator assesses budget, financial statements and other financing documents to confirm financing sources and amounts allocated
	Partner in-kind resources identified and committed (e.g. FTEs)	Survey of ACH members: What specific and dedicated resources have you committed to the ACH undertaking? For how long are these commitments?
	Start-up funding and other financial resources deposited into Wellness Fund	Evaluator reviews financial statements
	Wellness Fund contracts signed with backbone and partner organizations	Evaluator confirms that a bank account has been opened for the Wellness Fund and that the CACHI grant and other resources have been deposited
	Accounting and financial controls in place	Evaluator reviews Wellness Fund by-laws and confirms financial controls

*Note: Indicators in **bold** are recommended priorities for an evaluation design*

Governance Capacity

Outcome	Indicator	Measure
Governance Procedures Support an Inclusive and Effective Decision-making Process	**Governance procedures are standardized, transparent, and clear to all members**	**Survey ACH members: To what extent do you agree that the decision-making process is open and clear to all members?**
	Necessary information for decisions is communicated in a timely manner to members and broader community	Evaluator reviews communication documentation and surveys ACH members: To what extent do you receive the information you need when you need it in order to weigh in on decisions?
	Discussions and decisions are inclusive of all ACH members	Survey all members: To what extent do you agree that all points of view will be carefully considered in arriving at the best solution to the problem?
	The decision-making process is inclusive of community members who reflect the demographic characteristics of the service area	Key informant interviews with community members: To what extent do you think the ACH engages community members in setting the agenda, discussion, and making decisions?
ACH is Accountable to the Community and ACH Partners are Accountable to the ACH	Member organizations live up to their commitments to the ACH (e.g. staff time, resources)	Survey ACH members: To what extent do you agree that partner organizations are living up to their commitments?
	Member organizations engage in the practices of a "learning" collaborative	**Evaluator confirms that member organizations routinely have discussions to reflect on how actions led to measurable outcomes (e.g. Plan-Do-Study-Act)**
	ACH is accountable to broader community	Through key informant interviews and document review, the evaluator confirms that ACH performance data are sufficiently publicized to the broader community such interested community members can be aware of ACH progress
Effective Leadership in Place	**Leadership effectively builds consensus and manages conflict**	**Survey ACH members: To what extent do you agree that: 1.everyone contributes from their experience and expertise to produce a high-quality solution and 2. Disagreements are ignored by leadership (reverse scored)**
	Leadership creates a climate of expected performance and productive accomplishment in the ACH	Survey ACH members: To what extent do you agree that the leadership creates a climate of expected performance and productive accomplishment in the ACH?

	Leadership connects vision to focused activity by facilitating strategic planning for the ACH	Survey ACH members: To what extent do you agree that the leadership connects the ACH vision to focused activity? How well does the leadership facilitate strategic planning?
	Leadership encourages prioritization of collective goals over individual organizational interests	Survey ACH members: To what extent does the leadership encourage partners to prioritize ACH goals over individual organizational interests?

*Note: Indicators in **bold** are recommended priorities for an evaluation design*

Collaboration		
Outcome	**Indicator**	**Measure**
Relationships Among ACH Partners Strengthened	The social network evolves to support the ACH vision	Use social network analysis measurement tool to compare over time, such as Frey et al. (2006)
	Trust Enhanced	**Survey: To what extent do people involved always trust each other?**
	Communication among partners improved	Survey of ACH members and/or key informant interviews
	Cross-organizational support increased	Survey ACH members: To what extent do you feel supported in your work by people employed by other organizations?
Partners Embrace ACH Vision and Goals	Partner organizations have incorporated ACH goals into their own organizational goals	Key informant interviews and Review of member organization's governing documents
	Partners' organizational agendas are aligned	Review member organization's governing documents and Key informant interviews using an Alignment Index, e.g. http://orsimpact.com/wp-content/uploads/2014/09/Alignment-Index-Survey-Example.pdf
	Partners take ownership over achieving results	Evaluator confirms that ACH members routinely reflect on how their organization can best serve the needs of the ACH and if any partners should alter their roles to better serve the ACH
Partner Organization Participation Sustained	**Participation is sufficient and reliable**	**Survey ACH members: What percent of members regularly participate? To what extent do you agree that partners invest the right amount of time in ACH efforts?**
	Partners believe participation brings them value	Survey ACH members: To what extent do you feel that participation brings value to your organization?
	Perception that the distribution of contributions and rewards is fair	To what extent do you agree that the distribution of rewards among members matches levels of contribution? (See Hearld et al 2013 for additional questions)

*Note: Indicators in **bold** are recommended priorities for an evaluation design*

Strategies Implemented

Outcome	Indicator	Measure
Measurable Change in "Business as Usual"	**Clinical partners address target population's social services needs as well as clinical needs**	**Increase in percent of providers serving target population that address social service needs, such as nutrition support, social support, knowledge of parenting and child development, etc.**
	Community partners address target population's clinical needs as well as social services needs	**Increase in percent of providers serving target population that address socioeconomic context and clinical needs**
	Care coordination among clinical providers improved	**Increase in types of care coordination, such as workflows for bidirectional communication, referrals, warm hand-offs, a shared team plan of care**
	Linkages between community and clinic providers established	**Increase in types of linkages, such as community health workers or health coaches; follow up between clinics and CBOs are established**
	Social, community, and physical conditions support healthy behaviors	**Measures of improved environmental conditions improve, such as housing conditions, access to healthy food, and opportunities for physical activity**
	New or changed public and private practices, rules, laws, and regulatory changes support ACH vision	**Measures changes in local zoning rules, health plan incentives, school policies, benefit coverage, payment policies, taxes, etc.**
Patient Experience Improved	Providers engage clients through patient-centered and culturally competent communication	Measure that providers engage individuals through linguistically appropriate interpersonal communication that effectively elicits health needs, beliefs, and expectations, builds trusts, and conveys information that is understandable and empowering using survey questions from the Communication Climate Assessment Toolkit (National Quality Forum)
	Equitability of access to and quality of care is improved	**Stratified access and quality of care data by race/ethnicity of the target population show improved equity**

Sustainability Strategies Have Led to Funding that Supports the ACH Beyond Initial Grant	**Method for measuring and calculating cost savings/financial gains of interventions is agreed upon and applied**	**Data have been shared and ROI and financial impacts calculated for the POI**
	Financing is braided to fund interventions in the portfolio	Separate existing funding streams are aligned to pay for interventions that could not be supported by a single funding source
	Deposits to Wellness Fund in addition to original grant award	Review Wellness Fund statements for grant awards, partner investments and other deposits with an increasing balance
	In-kind commitments (e.g. FTEs) from partners extended into future years	Review documentation: Participants report committed FTE and other in-kind contributions
Data Collection and Sharing Systems Implemented	Data are being collected and shared on all measures in a timely way	Evaluator uses key informant interviews and documentation to confirm data are being shared in accordance with agreements and that data are being collected on all measures (e.g., bi-directional communications, linking physical-behavioral health information, and eventually including social services information)
	Shared data are used by ACH partners in performance assessment and decision-making processes	**Evaluator reviews products of shared data; key informant interviews**

*Note: Indicators in **bold** are recommended priorities for an evaluation design*

Intermediate Impacts		
Outcome	**Indicator**	**Measure**
Improvement in Risk Factors, Individual Health Status, and Social Determinants of Health	**Reach of Interventions in portfolio increased**	**Increased percent of target population exposed to an intervention (e.g. "Walk to school" program: increase in percent of population that walks to school)**
	Strength of the interventions in the portfolio increased	**Increased percent of healthy behavior practiced by group exposed to intervention (e.g. Increase in frequency that population walks to school)**
	Result of intervention on targeted population improved	**Increase in physical or mental health of group exposed to intervention (e.g. BMI improved of intervention population)**
Interventions in the Portfolio are Mutually Reinforcing	**Interventions overlap on target population**	**Increased percent of the target population reached by multiple interventions using program data or a community survey; evaluator assess reach, strength, and result of individual interventions to determine impact of multiple coordinated interventions**
Payers are Financially Contributing to ACH	Payment methodologies developed with providers that measure and reward population health outcomes based on interventions	Evaluator assesses payment methodologies design's capacity to measure and reward population health outcomes based on interventions
	Contracts with providers in place codifying new payment methodologies	Assess signed contracts between payers and provider partners
	Health care cost savings are reinvested into ACH	**Funds deposited in Wellness Fund or transferred among ACH partners**
ACH is Financially Sustainable	Revenue is diversified	Wellness funds include multiple sources such as health plan contributions, grants, in-kind contributions, hospital community benefit payments, dues, legal settlements, community development financing, shared cost agreement, governmental payments (bond issue, taxes, etc.), performance based social impact investment, or loans.
	Current and future committed funds are sufficient to support ACH operations and interventions	**Current and committed annualized revenues are greater than or equal to current and committed annualized costs; Cash flow is consistently positive with sufficient reserves; track and compare budgeted, projected and actual revenues for operations and interventions**

*Note: Indicators in **bold** are recommended priorities for an evaluation design*

Long-Term Impacts		
Outcome	**Indicator**	**Measure**
Population Health Improved	**Prevalence and incidence of health condition reduced**	**Reduced percentage of population with health condition and reduced incidence rate of new cases**
	Management of condition improved	Increased percentage of population with control over condition
	Quality of Life Improved	Improvement in quality of life measures, for example, the CMS measure: improvement in percent of the target population that reports physically and mentally unhealthy days in the past month (https://innovation.cms.gov/Files/x/SIMPopHlthMetrics.pdf)
Health Equity Improved	**Disparity in Health Outcomes Reduced**	**Rates of health condition in historically disadvantaged populations are closer to the rates of the health condition in the general population (e.g. disparity in incidence/prevalence of diabetes diagnosis by race/ethnicity; disparity in ED visits for childhood asthma by race reduced)**
Services and Health Systems Improved	Partners have institutionalized practices and policies resulting from successful ACH interventions and collaboration	Successful interventions still in place after 5-10 years; new workforce positions are permanent; pilots are written policy; the ACH has taken on issues beyond the initial health issue
	ACH continues to improve population health beyond initial target issue	ACH partners address multiple health and social problems and manage multiple portfolios of interventions
	A culture of health pervades organizations, schools, clinics, and government agencies in broader community	**Key informant interviews, organizational survey with questions such as, "What, if any, mission statements, policies, or programs in your organization reflect a focus on preventative health and wellness?", and population survey measuring patient activation (See http://www.chcs.org/media/Lindeblad_PAM.pdf)**
	Access to culturally and linguistically appropriate social services and health care for broader	**Providers engage individuals through linguistically appropriate interpersonal communication that effectively elicits health needs, beliefs, and expectations,**

	population improved	**builds trusts, and conveys information that is understandable and empowering using survey questions from the Communication Climate Assessment Toolkit (National Quality Forum)**
	Patient experience improved for broader population	**Consumer satisfaction has increased (For survey tools, see http://www.jvei.nl/wp-content/uploads/A-Guide-to-Measuring-the-Triple-Aim.pdf)**
Health Care Costs Controlled	**Health care costs for preventable conditions and hospitalizations controlled**	**Rate of increasing health care costs per capita curtailed, or utilization of services for preventable conditions reduced**
	Value-based payment methods are used pervasively	Proportion of providers accepting value-based payments from payers increased (e.g. capitation, shared savings)

*Note: Indicators in **bold** are recommended priorities for an evaluation design*

Appendix B – Expert Stakeholder Group

California Health & Human Services Agency

- Katie Heidorn

California Department of Public Health

- Karen Smith, MD, MPH
- Susan Fanelli
- Dana Moore

CACHI Leadership Team

- Barbara Masters—CACHI Lead Support
- Laura Hogan—CACHI Support
- Marion Standish, Richard Figueroa, George Flores—The California Endowment
- Richard Thomason, Rachel Wick—Blue Shield of California Foundation
- Loel Solomon, Andrea Azuma, Kathryn Boyle, Pam Schwartz—Kaiser Permanente
- Linda Fowells—Community Partners

ACH Evaluation Expert Advisory Team

Local Nonprofits and Community Agencies and Residents

- Peter Barth, Director of Policy and Intergovernmental Affairs, LA First 5 Commission.
- Moira Kenny, First 5 Association
- Sarah de Guia, JD. Executive Director, California Pan Ethnic Health Network

Public Health

- Karen Milman, MD, Sonoma County Health Officer, and CCLHO representative.
- Jayleen Richards, Public Health Administrator, Solano County Health & Social Services, Public Health Division. Representing County Health Executives Association of California

Health Care

- Elizabeth Gibboney, Deputy Executive Director/COO, Partnership Health Plan
- Sarah Eberhardt-Rios, Deputy Director of Program Support Services, Department of Behavioral Health, County of San Bernardino. Representing the County Behavioral Health Directors Association
- Debbie Innes-Gomberg, Ph.D., District Chief Los Angeles County Department of Mental Health. Representing the County Behavioral Health Directors Association
- David Lown, MD, Chief Medical Officer, California Association of Public Hospitals
- Beth Malinowski, Deputy Director of Government Affairs, CA Primary Care Association
- Lance Lang, MD, Chief Medical Officer, Covered California

Social Services

- James Rydingsword, Social Services Director, San Benito County. Representing the County Welfare Directors Association
- Judith Balmin, Health Program Specialist, California Department of Public Health, Environmental Health Investigations Branch.
- Elizabeth Landsberg, JD. Director of Policy Advocacy. Western Center on Law and Poverty.