Report to the
California Health and Human Services Agency Secretary, Diana S. Dooley

Recommendations for the California State Healthcare Innovation Plan Accountable Communities for Health Initiative

From:

The Innovation Plan "ACH" Work Group
May 2015

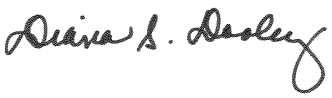
- Letter from the Secretary -

I am pleased to release this report on Accountable Communities for Health (ACH), an innovative approach to improving population health. The report was developed by a public-private sector Work Group under our State Health Care Innovation Plan design process, which was funded by a federal grant from the Center for Medicare and Medicaid Innovation. The ACH concept is one of the Innovation Plan's four key initiatives and directly relates to our *Let's Get Healthy California* goal of *Creating Healthy Communities: Enabling Healthy Living*.

The ACH is a relatively new concept, and there is significant interest around the country in it. As described in the Work Group's report, an ACH represents system-wide transformation with a focus on improving population health. An ACH brings together entities from the health care sector—clinics, hospitals and health plans—with other sectors that play a role in community health—public health departments, community organizations, social services, and education, among others—within a defined geography. By working collaboratively, community partners can align goals, interventions, and funding to achieve improvements in chronic disease and overall health. This "bottoms up" approach enables people and organizations within a community to chart the course that best meets their needs.

I am grateful to the members of the ACH Work Group who thoughtfully developed a framework with recommendations for the composition and requirements of a successful Accountable Community for Health.

Many thanks, too, to The California Endowment, particularly the foundation's Vice President, Marion Standish, for supporting this effort as well as important companion research related to ACH governance, evidence-based interventions, and sustainable financing options. Together, these documents will advance the field and our work on this initiative within California.



Diana S. Dooley
Secretary
California Health and Human Services Agency

Acknowledgements

This report and the Work Group's efforts were made possible with the generous support of The California Endowment. In addition, The California Endowment provided support for three research projects identified by the Work Group:

- A review of the evidence base for interventions for asthma, diabetes, and cardiovascular care, conducted by the Center for Healthcare Organizational and Innovation Research, University of California, Berkeley
- Governance, structural and legal considerations for an ACH, conducted by ChangeLabSolutions
- Options for financing and sustaining the ACH, conducted by JSI

The final report was prepared by Barbara Masters, who also served as the facilitator of the Work Group.

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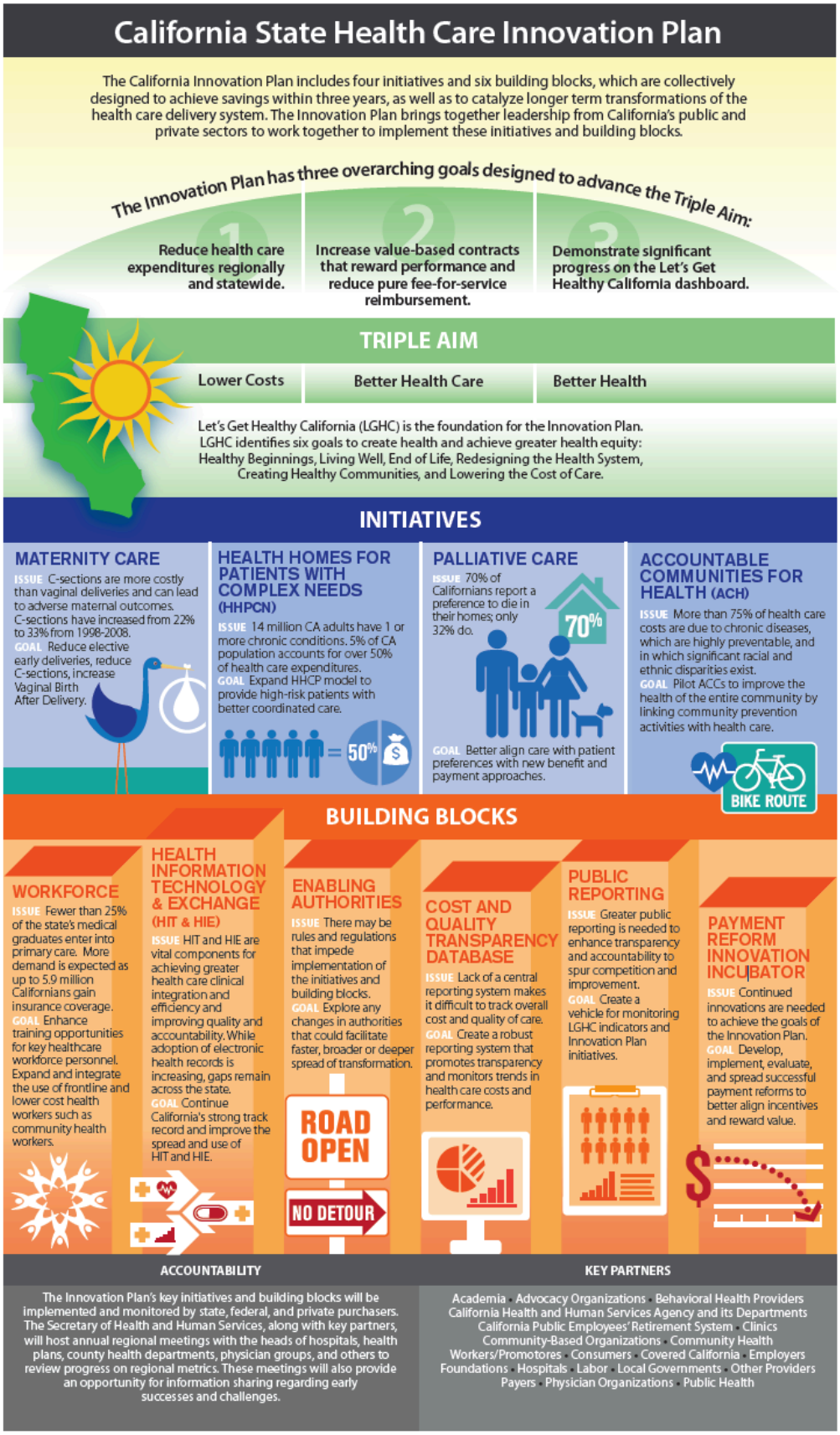
I. Introduction

In 2012, Governor Jerry Brown issued Executive Order B-19-12, establishing the Let's Get Healthy California (LGHC) Task Force, a group of more than 40 health and health care leaders in the state, to engage in a process to "*envision what California will look like in ten years if we commit to becoming the healthiest state in the nation."* Under the leadership of the Secretary of the California Health and Human Services Agency (CHHS Agency), the Task Force produced a framework for assessing Californians' health across the lifespan, focused on healthy beginnings, living well, and end-of-life. (http://www.chhs.ca.gov/Documents/ Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf.) The framework also identified three pathways that most profoundly shape the health and health care landscape — redesigning the health care delivery system, creating healthy communities and neighborhoods, and lowering the cost of care—and made clear that eliminating health disparities is critical to achieving each of the state's goals.

In 2013, California received a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Design Grant and developed a plan, using the LGHC report as a foundation, for implementing significant health system and payment reforms. This plan, the State Health Care Innovation Plan (Innovation Plan, http://www.chhs.ca.gov/pages/pritab.aspx) was prepared with input from key health and health care leaders in the state, and outlines a vision where *"California is home to high quality, efficient, seamless health systems throughout the state, which improve health outcomes for all Californians"*. The Plan is guided by the Triple Aim and outlines transformation strategies that reward value and innovation, improve quality of care, promote care coordination, create transparency, reduce disparities, and foster competition. The Plan includes four core initiatives and six building blocks to achieve these strategies, as displayed below.


California State Health Care Innovation Plan
The California Innovation Plan includes four initiatives and six building blocks, which are collectively designed to achieve savings within three years, as well as to catalyze longer term transformations of the health care delivery system. The Innovation Plan brings together leadership from California's public and private sectors to work together to implement these initiatives and building blocks.
The Innovation Plan has three overarching goals designed to advance the Triple Aim:
1 Reduce health care expenditures regionally and statewide.
2 Increase value-based contracts that reward performance and reduce pure fee-for-service reimbursement.
3 Demonstrate significant progress on the Let's Get Healthy California dashboard.
TRIPLE AIM
Lower Costs
Better Health Care
Better Health
Let's Get Healthy California (LGHC) is the foundation for the Innovation Plan. LGHC identifies six goals to create health and achieve greater health equity: Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, and Lowering the Cost of Care.
INITIATIVES
MATERNITY CARE
ISSUE C-sections are more costly than vaginal deliveries and can lead to adverse maternal outcomes. C-sections have increased from 22% to 33% from 1998-2008.
GOAL Reduce elective early deliveries, reduce C-sections, increase Vaginal Birth After Delivery.
HEALTH HOMES FOR PATIENTS WITH COMPLEX NEEDS (HHPCN)
ISSUE 14 million CA adults have 1 or more chronic conditions. 5% of CA population accounts for over 50% of health care expenditures.
GOAL Expand HHCP model to provide high-risk patients with better coordinated care.
50%
PALLIATIVE CARE
ISSUE 70% of Californians report a preference to die in their homes; only 32% do.
70%
GOAL Better align care with patient preferences with new benefit and payment approaches.
ACCOUNTABLE COMMUNITIES FOR HEALTH (ACH)
ISSUE More than 75% of health care costs are due to chronic diseases, which are highly preventable, and in which significant racial and ethnic disparities exist.
GOAL Pilot ACCs to improve the health of the entire community by linking community prevention activities with health care.
BIKE ROUTE
BUILDING BLOCKS
WORKFORCE
ISSUE Fewer than 25% of the state's medical graduates enter into primary care. More demand is expected as up to 5.9 million Californians gain insurance coverage.
GOAL Enhance training opportunities for key healthcare workforce personnel. Expand and integrate the use of frontline and lower cost health workers such as community health workers.
HEALTH INFORMATION TECHNOLOGY & EXCHANGE (HIT & HIE)
ISSUE HIT and HIE are vital components for achieving greater health care clinical integration and efficiency and improving quality and accountability. While adoption of electronic health records is increasing, gaps remain across the state.
GOAL Continue California's strong track record and improve the spread and use of HIT and HIE.
ENABLING AUTHORITIES
ISSUE There may be rules and regulations that impede implementation of the initiatives and building blocks.
GOAL Explore any changes in authorities that could facilitate faster, broader or deeper spread of transformation.
ROAD OPEN
NO DETOUR
COST AND QUALITY TRANSPARENCY DATABASE
ISSUE Lack of a central reporting system makes it difficult to track overall cost and quality of care.
GOAL Create a robust reporting system that promotes transparency and monitors trends in health care costs and performance.
PUBLIC REPORTING
ISSUE Greater public reporting is needed to enhance transparency and accountability to spur competition and improvement.
GOAL Create a vehicle for monitoring LGHC indicators and Innovation Plan initiatives.
PAYMENT REFORM INNOVATION INCUBATOR
ISSUE Continued innovations are needed to achieve the goals of the Innovation Plan.
GOAL Develop, implement, evaluate, and spread successful payment reforms to better align incentives and reward value.
ACCOUNTABILITY
The Innovation Plan's key initiatives and building blocks will be implemented and monitored by state, federal, and private purchasers. The Secretary of Health and Human Services, along with key partners, will host annual regional meetings with the heads of hospitals, health plans, county health departments, physician groups, and others to review progress on regional metrics. These meetings will also provide an opportunity for information sharing regarding early successes and challenges.
KEY PARTNERS
Academia · Advocacy Organizations · Behavioral Health Providers · California Health and Human Services Agency and its Departments · California Public Employees' Retirement System · Clinics · Community-Based Organizations · Community Health Workers/Promotores · Consumers · Covered California · Employers · Foundations · Hospitals · Labor · Local Governments · Other Providers · Payers · Physician Organizations · Public Health

One of the Innovation Plan's four initiatives is the Accountable Communities for Health (ACH). The Initiative was designed to test a new population health model that would link the health care systems with community resources to address a chronic condition on a community-wide basis; in addition, the model would maintain a focus on prevention. Explicit in the design of the ACH is the coordination of a portfolio of interventions that span five key domains – clinical, community, clinical-community linkages, policy and systems, and environment—in order to improve community health and, in particular, reduce health disparities. An ACH, as envisioned in the Innovation Plan, would also develop a local Wellness Fund, a novel payment reform that would act as a vehicle for pooling resources to sustain the ACH over the long term and fill needed gaps in financing prevention interventions.

Although an ACH would incorporate accountability as a key driver of change, it is distinguished from an Accountable Care Organization in two critical ways. As the name implies, an ACH's focus would be on 1) health and wellness, not care, and, 2) on an entire community, as opposed to an organization's enrollees or panel.

Formation and Charge of the Work Group

To continue efforts begun during the development of the Innovation Plan, the state formed an Accountable Communities for Health Work Group, comprised of representatives from community clinics, health plans, hospitals, public health, prevention, academia, philanthropy, as well as the California Department of Public Health and other state departments (see Appendix 2 for the roster).

The Work Group was charged with developing recommendations for the design and implementation of the Accountable Communities for Health (ACH) pilot program as envisioned in the Innovation Plan.

The Work Group held an initial in-person meeting in November 2013 and monthly hour-long calls thereafter, except for July. A final in-person meeting was held on November 13, 2014. Notes from the meetings can be found at (http://www.chhs.ca.gov/pages/pritab.aspx).

This report summarizes and synthesizes the discussions held by the Work Group. It also draws from innovative approaches and models, where applicable, being implemented around the country. For example, several states are advancing similar population health models as part of their SIM projects:

- The Minnesota Department of Public Health just released an RFP for an Accountable Communities for Health grant program. The $4.4 million effort will fund up to 12 projects for 2 years. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_189328
- Washington State is providing a small grant for regional collaboratives, called Accountable Communities of Health, to plan their strategies for improving community health. http://www.hca.wa.gov/Documents/rfp/14-015_Community%20of%20Health%20Planning_GOA.pdf
- Massachusetts provided $40 million over four years to nine community population health improvement collaboratives out of the state Prevention and Wellness Trust Fund.

There are many other individual efforts that have been developing over the last several years both within California and elsewhere.

There is significant interest and momentum in these models to provide innovative communities in California the opportunity to advance the field about what approaches can best improve community health and reduce disparities.

Federal Response to California's SIM Application

On December 16, 2014, Secretary Dooley was informed by the Center for Medicare and Medicaid Innovation that California would not be receiving a testing grant for which it had applied in order to implement the State's Innovation Plan. Nevertheless, this report, in conjunction with the commissioned research, can serve as a foundation for efforts to advance the concepts embedded in the ACH design.

This report reflects the deliberations of the Work Group, which operated under the parameters set forth by the federal SIM program, including a three-year implementation the time frame, Return on Investment requirement, and proposed funding levels. Although new ACH efforts may wish to modify some of the aspects of the proposed program described in this report, the basic tenets of the ACH should be applicable to variety of scenarios.

II. Defining an Accountable Community for Health

The Work Group's working definition of an Accountable Community for Health is as follows:

> *An Accountable Community for Health is a multi-payer, multi-sector alliance of the 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 community-wide health outcomes and reduce disparities with regard to particular chronic diseases; 2) reduce costs associated with the health care and, potentially, non-health sectors; 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.*

The mission of the Accountable Communities for Health Initiative, as developed by the Work Group, would be to demonstrate the value of a more expansive, inclusive and connected health system that links together the health care sector, public health, community resources, and a range of other sectors. This is a long-term vision and endeavor. Therefore, the first goal of an ACH should be to show proof of concept with early documented outcomes that can lay the groundwork for broader transformation efforts.

The Work Group recognized the tension between the demands of showing a Return on Investment in three years and the longer timeframe associated with the realization of the impacts from prevention activities. ACHs must balance these needs.

That is, they must prioritize goals and strategies that can show results during the a short time frame (e.g. three years), while also putting into place interventions that can drive longer-term improvements.

The Work Group also recognized that ACHs will need to balance requirements regarding a number of key elements associated with successful population health initiatives with the need for a certain amount of flexibility to enable early adopters to build on their past experiences and projects already underway in their communities.

III. Structure of an ACH

It will be critical that a proposed ACH already have in place a high degree of readiness. In particular, an ACH should build upon an existing community collaborative or other formalized structure with a history of working together. Moreover, the Work Group identified six key structural elements of an ACH:

- Shared vision
- Leadership
- Collaboration and partnerships
- Trusted backbone or integrator organization
- Data and analytics capacity
- Wellness Fund

The first five elements are described in the following paragraphs, while the sixth element, Wellness Fund, is described in Section V. A visual depiction of an ACH can be found in Appendix A.

A. Shared Vision

One of the primary aims of an ACH is to bring a range of organizations and other stakeholders together around a common set of goals, focusing specifically on improving community health. This will require a significant level of trust and alignment of efforts. It is critical, therefore, that the ACH develop a shared vision to ensure that all participants have a clear understanding of the goals and expectations. Community

needs assessments, developed by both the county/city public health departments and non profit hospitals could provide the ACH with a starting place for developing the vision and subsequent goals.

B. Leadership

As with any project, leadership is critical for success. However, an ACH has the added complexity associated with being a multi-sector collaborative effort. To succeed, there must be at least one strong champion—both at an individual and organizational level—who can shepherd the project. However, the more leadership can be vested in multiple organizations, the stronger the ACH will be over time, as leaders can turnover. Moreover emerging literature speaks to the importance of collaborative leadership, which recognizes that individual organizations cannot achieve their goals alone; collaborative leaders are deeply committed to the importance of partnerships, a common vision and alignment of activities.[1] Finally, support from local government officials, schools and colleges, and civic leaders will enable the ACH to be cross-sectoral and tackle policy, systems, and environmental changes.

C. Collaboration/Partnerships

Collaboration is at the heart of the ACH. No single entity or single intervention can, on its own, improve the health of an entire community. Rather, it takes many organizations that are aligned toward a common set of goals to make real progress. Moreover, medical care only contributes about 20 percent toward population health outcomes. Therefore, while the health care sector does have an important role to play, partnerships with other health-related organizations, as well as non-health sectors, are needed to improve population health. As will be described in the next section, the vision of an ACH is for it to implement a portfolio of interventions across five domains further requiring the active engagement of leaders and organizations across many fields and sectors.

[1] "National Approaches to Whole Person Care in the Safety Net." John Snow Inc. March 2014

The following entities were identified as critical for an ACH to succeed:

- Health care entities, including hospitals, community clinics, health plans, and physician groups. Collectively, these health care organizations should be able to reach the vast majority of the population within the designated geography.
- Public health departments/county health agencies
- Other governmental agencies and leaders
- Community-based organizations, such as the YMCA, consumer advocacy groups, and those representing the community's diverse populations
- Faith-based organizations
- Social services agencies, both governmental and non profit
- Educational institutions, including local schools/school districts, as well as any colleges serving the community
- Businesses, including major employers, chamber of commerce, etc.
- Labor unions
- Residents

To be successful, partners must build trust with each other and the process; without it, shared accountability for population health will be difficult to achieve. Moreover, it can be difficult to sustain interest and engagement without financial investments or legally-binding obligations.[2] Therefore, members of an ACH will need to establish formalized partnerships with each other. Generally, a shared accountability model includes some type of governance agreements among participating members and provides for inclusive decision-making, as will be described in later sections (see also ChangeLab Solutions report, accompanies this report) for a detailed discussion of governance options)[3].

It is optimal that the health care partners within the geographic area covered by the ACH would have some experience with integrated delivery systems and/or a track

[2] Prybil, L. et al. "Improving Community Health through Hospital-Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships." Commonwealth Center for Governance Studies. November 2014

[3] See also Fisher, E and Corrigan, J. "Accountable Health Communities: Getting There from Here." Journal of the American Medical Association. November 26, 2014.

record of integration. For example, the presence of an Accountable Care Organization (ACO) and one or more patient-centered medical homes (PCMH) would enable the ACH to build upon and leverage that knowledge and experience.

At the same time, one of the challenges of this type of collaborative is that, oftentimes, health care organizations view each other competitors. Nevertheless, leading hospitals are increasingly recognizing the value of collaboration in order to address broader community needs.[4] The requirement under the ACA for non profit hospitals to conduct and make public Community Health Needs Assessments has prompted many hospitals to explore greater coordination and collaboration with each other when they serve the same community.[5] California has had a long-standing law in place on community benefits, and the ACA's provisions may provide greater attention and visibility for how hospitals can work together to address the requirements. The ACA requirement may also prompt hospitals to reach out to public health departments and share their Community Health Needs Assessments as well as their Community Benefits Plans.

D. Trusted Backbone

Increasingly, population health initiatives recognize the important role of a strong facilitator and convenor[6]. This role has been called various things—integrator[7], backbone[8], hub, and quarterback[9]. For the purposes of this report, it will be referred to

[4] Nolte, C. "Collaboration versus Competition: Lessons from a Banker for Hospitals." Federal Reserve Bank blog. October 1, 2014. http://www.frbsf.org/community-development/blog/collaboration-versus-competition-lessons-from-a-banker-for-hospitals/

[5] Hospitals in New York reported collaborating on CHNAs. National Forum on Hospitals, Health Systems and Population Health. October 2014. For more, see Nelson, G. et al. "Hospital Community Benefit After the ACA: Addressing Social and Economic Factors that Shape Health". The Hilltop Institute. May 2014.

[6] See, for example, break out session at National Forum on Hospitals, Health Systems and Population Health. http://www.populationhealthandhospitals.com/agenda/day2.html

[7] "The Integrator: Who Convenes Stakeholder to Improve Health." Nemours. For National Forum on Hospitals, Health Systems and Population Health. October 2014.

[8] The Backbone organization is separate from participating organizations and plans, manages, and supports the initiative through ongoing facilitation, communication, data collection and administrative support. Kania, J. and Kramer, M. "Collective Impact". Stanford Social Innovation Review. Winter 2011.

[9] Andrews, N. and McHale, B. "Community Development Needs a Quarterback". Stanford Social Innovation Review. July 2014

as the backbone. A backbone entity must, first and foremost, be a trusted leader within the community who is viewed as neutral among the various partners and being able to conduct the ACH's business on behalf of the entire collaborative.

The Work Group does not believe that any one type of entity is the preferred backbone. Rather, the selected organization to fill this role should depend upon the capacities and market dynamics within the individual community. In Delaware, Nemours health system acts as an integrator for child health.[10] In other communities, the county health department plays that role. The Accountable Care Community in Akron, Ohio, one of the first population health collaboratives in the country, utilized an independent non profit organization as the backbone entity.[11]

Key functions of a backbone entity include:

- Guiding development of a common vision, goals and strategy
- Ensuring the engagement of community residents in the process
- Facilitating development of agreements across collaborative partners
- Coordinating and supporting implementation of aligned activities
- Managing the budget
- Serving as convenor, including facilitating conflict resolution and problem solving and maintaining a culture of learning and collaboration
- Building support
- Ensuring effective internal and external communications
- Facilitating data collection, quality assurance, analysis and evaluation
- Identifying data needs, establishing shared measurement practices and facilitating data-sharing mechanisms
- Mobilizing funding through the Wellness Fund
- Ensuring transparency of goals, activities and outcomes

[10] Nemours. 2014

[11] "Healthier by Design: Creating Accountable Care Communities: A Framework for Engagement and Sustainability." Austen BioInnovation Institute. Akron, Ohio. February 2012. http://www.abiakron.org/1accountable-care-community

E. Data and Analytics Capacity

Measuring population health improvement in an ACH will require the sharing and aggregation of health and financial data from disparate clinical and nonclinical services and programs, as well as community and population-level data, across a variety of providers and organizations. Data sharing will be needed at all stages of development and implementation from needs assessment and understanding the baseline, to monitoring and evaluation; ultimately, data-sharing will be necessary to inform delivery and payment innovations. For example, baseline data will need to be collected in order to track individual and population health improvements and determine an ROI. ACHs will also need to identify core data needs and metrics, including general population data related to the target geography; community health data; prevalence data[12]; and clinical and cost data.

Ideally, the ACH should have some type of platform for data sharing, such as a Health Information Exchange, or the ability to facilitate the collection and sharing of data through a centralized database, such as a data warehouse or registry. However, that capacity may not be present. Nevertheless, the ACH, potentially through the backbone organization, should have or be able to develop reporting and analytics capacity sufficient to be able to assess health outcomes and ROI, as well as to develop strategies for facilitating data-sharing without overburdening providers and other entities. Another data-sharing-related challenge is compliance with the Health Insurance Portability and Accountability Act (HIPAA). Although strategies are being developed to be able to share data while complying with HIPAA and other privacy laws,[13] further investigation into HIPAA implications for data-sharing is needed.

The ACH should also, during the course of the pilot, begin to identify and track key non-health care outcomes and cost data—e.g. such as increased attendance at

[12] Public health departments already collect and analyze a variety of prevalence and health outcome data, much of it required by state law.

[13] Owen, R. "Improving Care, Ensuring Patient Privacy: Hennepin Health Data-Sharing Case Study." Blog, Center for Health Care Strategies. June 11, 2014. http://www.chcs.org/improving-care-ensuring-patient-privacy-hennepin-health-data-sharing-case-study/

school, reduced workplace absenteeism, reduced injuries/traffic accidents, etc.—in order to be able to assess potential savings accrued to other sectors from the interventions. This process will be critical to engaging non-health sectors as participants in the ACH and, ultimately, as investors in the Wellness Fund.

IV. Program and Portfolio of Interventions

A. A Portfolio of Interventions

One of the innovative aspects of the ACH is that it would test how a comprehensive set of mutually reinforcing strategies can improve population health. Experts are increasingly recognizing that what happens in the doctor's office is only one part of improving health. In fact, evidence is accumulating that what happens where people work, live, go to school, and recreate—the social determinants of health—has a larger impact on their health. Moreover, there is growing interest in how to enhance the delivery of preventive services in clinical settings by coordinating and collaborating with external nonclinical organizations such as local health departments and community-based organizations that share goals related to improving health and preventing disease.[14]

Therefore, similar to projects in Massachusetts, Oregon, Minnesota and elsewhere, an ACH should seek to align evidence-based interventions across multiple clinical and community domains with regard to a particular chronic disease. Specifically, the Work Group identified five key domains and recommends that an ACH implement a "portfolio of interventions" across all five domains. They are:

- *Clinical services*: Services delivered by the health care system, including primary and secondary prevention, disease management programs, as well as coordinated care, provided by a physician, health team, or other health practitioner associated with a clinical setting.
- *Community and social services programs*: Programs that provide support to patients and community members. These can be based in governmental

[14] "Clinical-Community Relationships Measures Atlas." Agency for Healthcare Research and Quality. AHRQ Publication No. 13-00334-EF March 2013

agencies, schools, worksites, or community-based organizations, such as the YMCA. Community-based interventions frequently target lifestyle and behavioral factors, such as exercise and nutrition habits, and also include peer support groups and social networks.

- *Clinical-community linkages*: Mechanisms to connect community and social services and programs with the clinical care setting to better facilitate access to and coordination between health care, preventive, and supportive services. Interventions in the community-clinical linkages domain can help form strong bonds between community and health care practitioners and, ideally, involve bi-directional feedback systems between the two.

  In particular, there is growing evidence that Community Health Workers are effective in providing a bridge between the health care system and community resources and can help improve patient health outcomes and achieve savings. One of the Innovation Plan's six building blocks is workforce, and increased utilization of CHWs and other frontline workers is a key goal of that building block; a separate Workforce Work Group explored issues associated with how to expand the use of CHWs in the various initiatives. CHWs could play a number of critical roles in an ACH, and ACHs should strongly consider mechanisms for incorporating them.
- *Environment*: Social and physical environments that facilitate people being able to make healthy choices. Environmental interventions may include community improvements such as building parks or bike lanes, making farmers markets more available or transforming corner stores to carry more fruits and vegetables. Such environment changes aim to improve opportunities for physical activity, social connectedness, and support healthy behaviors.
- *Public policy and systems change*: Policy, regulatory and systems changes that affect how the health care and other systems operate and influence the overall ability for people to be healthy. These interventions can address environmental

issues, school policies, health and social systems coordination, as well as financing to support prevention-related activities.

Interventions implemented by the ACH should all be evidence-based. While some interventions and programs have a strong evidence base and have been rigorously tested through randomly controlled trials and published in peer reviewed literature, the Work Group believes that that standard would exclude other interventions that have been evaluated, but may not appear in the peer reviewed literature. Moreover, there is, unfortunately, little published literature on the potential synergistic impacts of multiple reinforcing interventions. Kaiser Permanente, for example, has been examining the concept of "dose" and suggested that the dose of particular interventions can be increased by implementing complementary strategies that target the same defined population.[15]

Measuring "Dose"
The combination of the ***reach*** or number of people touched and the ***strength*** of intervention.

To assist ACHs in designing their strategies, Work Group member Dr. Steve Shortell of the Center for Healthcare Organizational and Innovation Research (CHOIR) at the University of California, Berkeley School of Public Health, conducted a literature review of the strength of evidence for interventions associated with three chronic disease conditions identified by the Work Group and further described below—asthma, cardiovascular disease, and diabetes. Dr. Shortell and his team reviewed both the peer-reviewed literature as well as the so-called grey literature, and interventions were categorized by:

- Setting for the intervention
- Strength of evidence
- Ease of implementation
- Time
- Cost

[15] "Measuring and Increasing the 'Dose' of Community Health Interventions." Kaiser Permanent and Group Health. June 2012

Moreover, Dr. Shortell provided an assessment of the complementary and potential synergistic impacts among the different interventions. The results of the research review can be found in the accompanying report, "Resource Guide for California Accountable Communities for Health: A Review of Emerging Evidence on Interventions for Asthma, Diabetes, and Cardiovascular Care."

The Work Group developed a matrix (Table 1) to help guide the development of the portfolio of interventions across the five domains. The matrix also makes clear the importance of including a mix of interventions across a spectrum of time frames during which the intervention may likely have an impact.[16] As described previously, the ACH must balance the need to demonstrate outcomes in the short term, while making investments in interventions that have greater potential for population-wide impacts over the long term. Although not included in the matrix, a recent discussion paper titled, "A Sustainable Financial Model of Community Health Systems" prepared by James Hester and Paul Stange for the Institute of Medicine also recommends that a portfolio include interventions with a range of risk and/or strength of evidence, out of recognition of the emerging literature in this field.

[16] Hester, J. and P. Stange. "A Sustainable Financial Model of Community Health Systems." Discussion paper for IOM Roundtable on Population Health Improvement. Discussion paper for IOM Roundtable on Population Health Improvement. March 6, 2014.

Table 1

	Intervention or Program	Time frame (e.g. short, med, long)	Projected Savings/ROI	Metrics to measure outcomes and impact
Clinical ▪ **Primary prevention** ▪ **Secondary prevention** ▪ **Care teams**				
Community programs, social services, etc. (e.g. YMCA diabetes program; worksite wellness)				
Community-Clinical Linkages (e.g. community health workers; referral systems; e-referral systems)				
Public policy and System change(legal and regulatory changes, e.g. zoning rules, smoke free envir., health plan incentives etc)				
Environments (e.g. Walking and biking trails; access to healthy food in food deserts)				
OVERALL STRATEGY	**Describe how the portfolio of selected interventions connect and, potentially, reinforce each other, including which ones specifically may act in concert to enhance dose and reach.**			

B. Selection of a Chronic Condition

As described previously, in 2013, the state convened several Work Groups to make recommendations for initiatives that could be included in the State Health Care Innovation Plan. In the initial deliberations that ultimately led to a recommendation for the Accountable Communities for Health, the Work Group discussed whether the project should focus on a single condition, be able to choose one of a limited number of conditions, or be able work on several conditions, recognizing the interrelated nature of chronic disease and prevention strategies. The Work Group was concerned that, with a limited number of projects, the innovative nature of the ACH, and a relatively short time frame in which to demonstrate results, initial projects should focus their efforts on a single condition. Such a targeted approach would enable ACHs to better coalesce resources, organizations, and strategies.

The Work Group also recognized the importance of an ACH being able to build on an existing collaborative and focus on an issue that the community has prioritized. Therefore, there was also support for offering a limited number of conditions for which there is a strong evidence base and that are amenable to multiple interventions across the five domains. Three chronic conditions met those criteria: **asthma**, **diabetes,** and **cardiovascular disease**. In all cases, the Work Group believes that interventions should address all members of the community across the age spectrum. To be clear, many of the interventions will have impacts across a variety of conditions. For example, several activities needed to address and prevent diabetes will also apply to cardiovascular disease or even some mental health issues. Therefore, ACHs may want to measure outcomes in other related areas as well.

The ACH Work Group revisited this issue and similarly concluded that pilots should initially focus on one condition and that they should be able to select from among the three conditions and associated behaviors. Dr. Steve Shortell's research confirmed that there is a sufficient evidence base for interventions for each of the three conditions. However, the Work Group also recommends that an ACH be afforded the opportunity to make the case for selecting a different condition. Such a case would

require 1) a strong evidence base for interventions, 2) the ability to implement a portfolio of interventions across the five domains, and 3) experience working on this condition, demonstrating a base of activity and a community commitment to the issue.

V. The Wellness Fund, Financing and Sustainability of the ACH

There are two pillars of service delivery transformation: practice changes and payment reform. The payment reform included as part of an ACH is the creation of a local Wellness Fund. The Wellness Fund would serve as the vehicle for attracting and blending[17] resources from a variety of organizations and sectors, and aligning them with the goals, priorities and strategies developed by the ACH. The Work Group envisioned that a portion of an initial grant to establish the ACH would help "seed" the Wellness Fund, in order to enable the ACH to leverage those resources and attract additional investments. For example, a local community foundation could potentially make a grant to the Fund, as could the local health department. Similarly, nonprofit hospitals could contribute a portion of their hospital community benefits toward the Fund, and health plans serving the geographic community could similarly make a contribution[18]; other sectors, as well, could make investments to leverage their own funding for greater impact. Another approach would involve some or all of the ACH partners agreeing to voluntarily assess themselves, with assessments based on the overall budget of the member partner. Over the long-term, it's possible that a portion of community reinvestment funding or government grant funds could also go to the Wellness Fund. Other creative approaches, such as leveraging purchasing power and influence of ACH members to attract a new grocery store or other assets to a community, may emerge as elements of a sustainability plan.

[17] Blending funds is a funding and resource allocation strategy that uses multiple existing funding streams to support a single initiative or strategy. Blended funding merges two or more funding streams, or portions of multiple funding streams, to produce greater efficiency and/or effectiveness. Funds from each individual stream lose their award-specific identity.

[18] Chockhi, D. et al. JAMA Forum: Using Community Health Trusts to Address Social Determinants of Health. April 16, 2014. http://newsatjama.jama.com/2014/04/16/jama-forum-using-community-health-trusts-to-address-social-determinants-of-health/

At a minimum, collaboratives seeking to establish an ACH should demonstrate some level of local investment in the ACH through, for example, a combination of voluntary, membership or in-kind contributions. This would serve as a foundation for the development of a sustainability plan. To assist in the development of such a plan, John Snow, Inc. (JSI) is exploring issues related to how to incentivize investment in a geographic, multi-sector, multi-payer approach to population health. It will be released during the second quarter of 2015.

The Wellness Fund would support two key functions: First, it would provide critical resources for the ACH infrastructure, including the backbone organization. As described previously, the work of the backbone organization is substantial and will continue to be needed as the ACH evolves and grows, particularly as the ACH sets its sights on longer- term outcomes that will require data collection financial modeling. Second, the Wellness Fund would support interventions that the ACH prioritizes for which there are no other funding sources. Community prevention and, especially, upstream interventions are generally under-resourced so the Fund could be an important resource for those endeavors. Similarly, implementing some types of community-clinical linkages may require initial investments from the Wellness Fund. For example, Community Health Workers who bridge the community and clinical settings could be funded by the Wellness Fund while a sustainable financing source is developed. Another potential use of Wellness Fund resources is building a data base of community resources and programs that would be available to clinicians. It will be up to the ACH to prioritize the strategies, goals and projects for investment.

Although the Wellness Fund will be a crucial financing and sustainability strategy, it alone cannot support the goals of an ACH. Rather, it should be viewed as complementary to a second financing strategy that will very likely support the majority of the activities undertaken by the ACH: braiding. In a braiding strategy, ACH members align existing funding streams and programs in support of the goals and initiatives that are prioritized by the ACH. Although organizations still maintain separate accountability for each funding stream, they would be coordinated and integrated to the greatest

extent possible, with assistance from the backbone organization. Sources of braided funds include, but are not limited to: the section 1115 Medi-Cal Waiver, prevention programs from the Centers for Disease Control, and clinical programs sponsored by health systems. See Appendix A for a schematic depicting the various elements of an ACH, including the role of braided funding.

With regard to long-term financing, there is a growing body of literature that is exploring how to develop payment incentives that reward systems and other sectors for improved population heath outcomes, and enable further investment in evidence-based disease prevention programs.[19,20] This financing concept builds on, but differs from, shared savings approaches currently being implemented in Medicare Accountable Care Organizations. A population health financing scheme would create incentives to improve health for a community-wide population versus only persons enrolled within a given provider organization in an ACO arrangement. The Accountable Care Community (ACC), in Akron, Ohio, for example, was one of the first community-wide population health collaboratives in the country and focused initially on diabetes. It calculated savings using an *Impact Equation*, and a portion of those savings were reinvested into the ACC for sustainability.[21] In contrast, most current payment models do not focus on broad population health. Alternatively, JSI's preliminary research suggests that an economic model may provide an interim means to estimate ROI; this approach removes potential barriers associated with payers and providers needing to share confidential cost data and extensive data collection and analysis. Such a model would build upon evidence from the field on cost savings associated with interventions, e.g., research conducted by Shortell et al. Clearly, more research is needed in this area to develop ROI formulas and approaches.

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[19] See for example, Cohen, L. and Iton, T., "Closing the Loop: Why We Need to Invest and Reinvest in Prevention." Discussion paper prepared for the Institute of Medicine Roundtable on Population Health Improvement. September 9. 2014.

[20] Kindig, D and Isham, G. "Population Health Improvement: A Community Health Business Model That Engages Partners in All Sectors." Frontiers of Health Services Management. Volume 30: 4 Summer 2014

[21] Since the initial data were presented, the ACC has undergone a leadership change and restructuring, and no further updates are available at this time with regard to implementation of the Impact Equation.

Moreover, Akron's *Impact Equation* only focused on health care costs. To date, the Work Group is unaware of any examples that apply the concept of shared savings to a whole community and incorporate non-health care sector partners, even though it is being increasingly recognized as important to providing long-term sustainability for population health improvement efforts.[22] Such an approach would need to be able to calculate savings accrued to non-health sectors (e.g., fewer sick days to an employer or fewer missed days for students at schools) and link them to the portfolio of interventions.

Nevertheless, in the interim, an ACH could be designed to conduct the first steps necessary to demonstrate a Return on Investment and build a business case. Key steps include:

- Identify target population(s)/condition(s)
    - Stratify by risk and potential costs
- Identify costs—direct and indirect—associated with target populations and conditions
    - Identify health care and other organizational impacts, and potential savings for providers, plans, employers, schools, etc.
- Identify program costs, including one-time and ongoing implementation costs
- Track all costs and outcomes
- Identify savings from a reduction in both direct and indirect costs to various organizations and sectors
- Calculate Return on Investment based on the savings and cost of intervention
- Develop a business case for sustaining contributions to the Wellness Fund.[23]

Finally, the Work Group discussed the challenging role and governance issues associated with hosting and administering the Wellness Fund. It will need to have

[22] See, for example, Hester, J. and P. Stange. "A Sustainable Financial Model of Community Health Systems." March 6, 2014

[23] See for example, Miller, H. "Making the Business Case for Payment and Delivery Reform." Network for Regional Healthcare Improvement. 2014.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf411117

several key capacities, such as the ability to receive and distribute resources both from and to a variety of entities as well as track investments. The Wellness Fund and the backbone could be housed within the same entity. However, there may be situations in which no single organization could successfully perform both functions. In those situations, clear governance and memoranda of understanding will need to be in place. In order to identify the governance, legal and policy issues that may arise, ChangeLab Solutions researched these issues and produced a report, which accompanies the Work Group report, that addresses the:

- Roles, functions, and relationships of the Wellness Fund, the backbone organization, and the other partners of an ACH;
- Legal issues and other governance parameters that should be considered for establishing a Wellness Fund; and,
- A recommended framework of operational components of an ACH and Wellness Fund.

VI. Criteria

Given the challenging nature of the proposed ACH model, a high degree of readiness and capacity must be present. As noted in a recent paper on approaches to population health, "it will be important to target communities where the 'soil has already been tilled' ...by ongoing collaboration."[24]

Table 2 includes draft criteria developed by the Work Group based on the discussions of the Work Group described previously related to the key elements.

The Work Group engaged in several discussions regarding the geographic boundaries of an ACH. Other states exploring ACH-like projects have taken a variety of approaches. Massachusetts Prevention and Wellness Trust initially set a population range of between 30,000 to 120,000 people in soliciting applications.[25] That range was

[24] Shortell, S. "A Bold Proposal for Advancing Population Health". Discussion paper for IOM Roundtable on Population Health Improvement. July 24, 2013

[25] "Health Care Cost Reform in Massachusetts: Prevention Wellness Trust Fund and Health Planning." National Academy for State Health Policy conference 2014. October 8, 2014.

based on the amount of funding that it had available, the target ROI and an estimated ROI based on the literature that could be achieved by the proposed interventions. Most of the funded projects had populations between 100,000 and 120,000.

Minnesota recently released an RFP for its Accountable Communities for Health program.[26] It did not specify a target size or population, but rather left it to the applicant. Akron's Accountable Care Community claims that the health system partners were able to reach 80 percent of the population of the city, which is just under 200,000.

Because of the vast geographic diversity of the state, there was concern about being too prescriptive in defining geographic parameters, which might exclude communities who would otherwise be interested in developing an ACH. Therefore, the Work Group recommends that an ACH should serve a defined geography, although it does not recommend a specific population size. However, proposed ACHs should demonstrate that:

- The combination of ACH health care-related members, in particular commercial and public health plans and providers, would be able to reach the majority of the population;
- There are sufficient ACH members across multiple sectors to support the portfolio of interventions;
- The total number of ACH members and/or partners is conducive to members being able to build and maintain meaningful partnerships with each other;
- The community, as a whole or in part, experiences significant disparities with regard to overall disease burden and in the condition being targeted;
- The target geography is large enough to be able to demonstrate a measurable impact with an ROI; and,
- The geography is small enough such that resources of an ACH and proposed interventions are able to achieve a sufficient level of dose and reach.

[26] See RFP issued on September 2, 2014 for further information. http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_189328.pdf

Table 2: Proposed Criteria for ACH

CRITERIA	
Collaboration and Partnership	
1	An existing collaborative or alliance of health care providers, public health, and social and community organizations, who have a track record of working together.
2	A history of successful collaboration among key institutions with evidence of shared goals, shared knowledge, mutual respect, accurate, timely, frequent and problem-focused communication.
3	Experience in implementing community/environmental change strategies to address, on a community-wide basis, chronic diseases, such as through a Community Transformation Grant or similar effort.
Structure/Process	
4	Some level of development of HIT/HIE with potential for community-wide data-sharing.
5	Identification and agreement on a "backbone" organization or function, which will serve as the convenor, integrator etc. of the ACH.
6	Identification and agreement about the location and structure of the Wellness Fund.
7	Presence of some form of integrated care, including health homes, PCMH, ACOs, etc.
8	Agreed upon goals and metrics relating to the Triple Aim.
Leadership and Support	
9	Strong champion(s) at multiple levels and organizations.
10	Active engagement, capacity and support from majority of health plans and health systems serving the defined geography, below.
11	Active engagement, capacity, and support by the public health department, with a demonstrated commitment to cross-sectoral partnerships.
12	Engagement and support from diverse communities, organizations, and agencies within the identified geography.
13	Strong support from local political leaders, government officials, and other civic leaders, who share a commitment to a "health in all policies" approach.
14	Commitment of resources—either financial or in-kind—to the ACH and its activities during the first three years.
Geography/Geographic Reach	
15	Defined geography, with a goal of reaching the majority of the population, including those who may remain uninsured, through the ACH.
16	Demonstrated health disparities with regard to overall chronic disease burden—and, in particular, with regard to the target condition—in the population covered by the ACH.
Program	
17	Comprehensive and aligned portfolio of activities and programs designed to work collectively to achieve the health outcome and financial goals. Domains include: Clinical; Community; Clinical-Community linkages; Policy and Systems; and, Environment.

VII. Outcome Measures and Indicators

At one of the first meetings of the Work Group, proposed high level outcomes and metrics were identified to guide the development of ACHs. The Sample outcomes matrix in Table 3 explicitly identifies short, medium and long-term outcomes out of recognition of the need to demonstrate relatively early results, including potentially an ROI in three year timeframe, with putting into place strategies to prevent chronic disease that may take longer than three years to demonstrate results. Although the portfolio of interventions should be designed to achieve an ROI in order to demonstrate value, it is also expected that evidence-based strategies which may have a longer term time frame but can also achieve broader impacts would be included. This matrix builds on an approach that suggests a portfolio should be balanced along three perspectives, one of which is the time frame for effects of interventions, as described earlier.[27]

To that end, the majority of health outcomes that can be achieved in the short term will likely be clinically-related. These represent important milestones that demonstrate progress. However, in order to ensure that the goals of the ACH—improved health outcomes for the entire community, including a reduction in disparities—remain in the forefront, it is critical to identify population health outcomes, even though they would require a longer time frame to achieve.

In addition to health outcomes, the matrix includes program, process and financing outcomes. Since the ACH represents a new population health model, it is critical to monitor the implementation of key aspects as part of a proof of concept. However, further refinement will be needed to articulate phases of development of an ACH and the identification of metrics associated with each phase.

[27] Hester, J. and P. Stange

Table 3	Timeframe		
SAMPLE Metrics	Short term (3 years)	Med term (5-7 years)	Long term (10 years)
Outcomes			
↑ Care coordination↑ patients with priority condition who receive care coordination for their conditions ○ ↑ linkages with community and social services and programs	✔	✔	✔
↓ ED utilization[28]	✔	✔	✔
↑ Utilization of healthy behaviors by target population (e.g. ↓ in tobacco use, ↑ in physical activity/walking, other LGHC indicators), consistent with the chosen priority condition	✔	✔	✔
Improved patient satisfaction/experience with care system[29]	✔	✔	✔
Improved patient outcomes for the priority condition (to be determined by individual ACH)	✔	✔	✔
Improved community & population health outcomes (e.g., ↓ population-wide incidence of diabetes or other chronic conditions) ○ Improved community conditions, e.g. environmental changes that increase walking opportunities, that contribute to poor health outcomes (to be determined by individual ACH)		✔	✔
Reduced racial and ethnic disparities for the target condition		✔	✔
Program			
Portfolio of interventions across 5 domains identified and implemented	✔	✔	✔
Community Health Workers or other frontline workers incorporated Identification of reimbursement method and employment location	✔	✔	✔

[28] Additional measures of health care utilization still to be determined, such as inpatient utilization, pharmaceutical usage, etc.

[29] See potential patient activation measures for PCMH OR PHCC initiatives (e.g., PAM or PAS) for what is the standard of practice.

SAMPLE Metrics	Short term (3 years)	Med term (5-7 years)	Long term (10 years)
Structure/Process			
Established partnerships among health care providers, public health, community and social services agencies, and other stakeholders	✔	✔	
Data-sharing agreements ○ Linkage/communication of data between health care system, public health, community and social supports	✔	✔	✔
Inclusive governance structure ○ Shared decision-making processes	✔		
"Backbone" or "integrator" organization identified and funded	✔		
Accountability system (e.g. establishment of goals, metrics, and reporting processes)	✔	✔	✔
Financing			
Wellness Fund ○ Governance ○ Accountability	✔		
Sustainability plan, which includes revenues from a broad range of sources, to support the ACH and agreed-upon activities	✔	✔	✔
Recognition of health care cost avoidance and/or return on investment		✔	✔
Methodology to estimate savings/cost avoidance accrued to non-health care sectors, e.g. ↓ absenteeism among school aged children with asthma		✔	✔
Aligned financing to incentivize goals and fund community-wide interventions		✔	✔

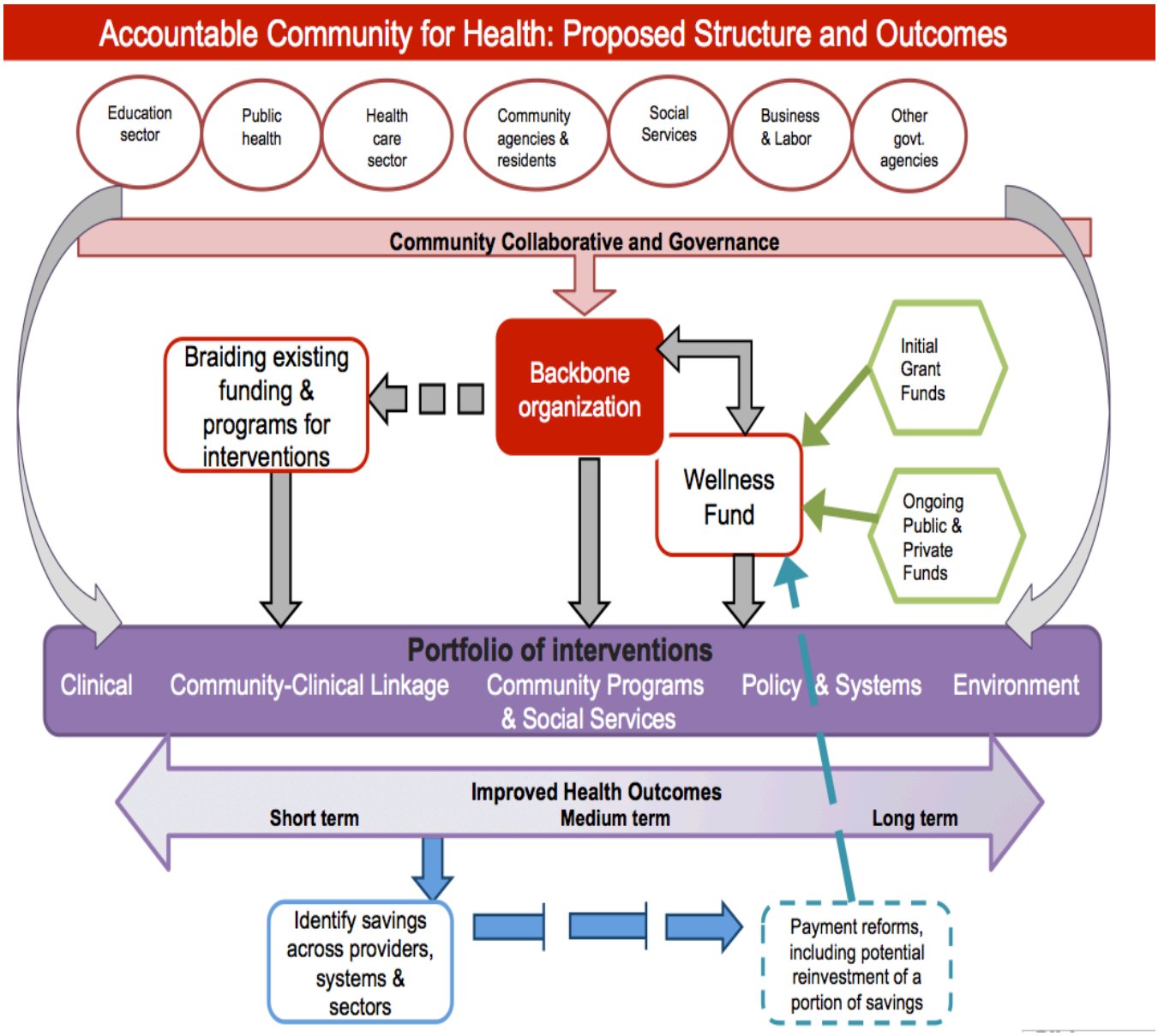
VIII. Conclusion

With the Triple Aim of better care, better health and lower cost as a guide, the health care system in California, and across the country, is undergoing an intense period of transformation. The ACH Work Group was convened to inform the design and development of a new and innovative model that seeks to connect, align and integrate various systems and organizations—including public health, health care delivery, social services and community resources—to improve a community's health. To that end, the report identifies:

- Six key elements of an Accountable Community for Health
- Five domains in which a comprehensive and aligned portfolio of interventions should operate
- Criteria for funding an ACH
- Sample outcomes and metrics

The Work Group believes that this report provides a sound foundation for designing an ACH. It further encourages the state and federal governments, academia, health care delivery systems and organizations, and private philanthropy to use these findings and recommendations to develop programs and activities that can continue to advance the field and make Accountable Communities for Health a reality.

Appendix 1


Accountable Community for Health: Proposed Structure and Outcomes
Education sector
Public health
Health care sector
Community agencies & residents
Social Services
Business & Labor
Other govt. agencies
Community Collaborative and Governance
Braiding existing funding & programs for interventions
Backbone organization
Initial Grant Funds
Wellness Fund
Ongoing Public & Private Funds
Portfolio of interventions
Clinical
Community-Clinical Linkage
Community Programs & Social Services
Policy & Systems
Environment
Improved Health Outcomes
Short term
Medium term
Long term
Identify savings across providers, systems & sectors
Payment reforms, including potential reinvestment of a portion of savings

Appendix 2
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Appendix 3
Resources and References

1. "The Integrator: Who Convenes Stakeholder to Improve Health." Nemours. For RWJF Conference October 2014.

2. "Healthier by Design: Creating Accountable Care Communities: A Framework for Engagement and Sustainability." Austen BioInnovation Institute. Akron, Ohio. February 2012. http://www.abiakron.org/1accountable-care-community

3. Shortell, S. "A Bold Proposal for Advancing Population Health". Discussion paper for IOM Roundtable on Population Health Improvement. July 24, 2013

4. Auerbach, J., et al. "Opportunity Knocks: Population Health in State Innovation Models". Discussion paper for IOM Roundtable on Population Health Improvement. August 21, 2013

5. Hester, J. and P. Stange. "A Sustainable Financial Model of Community Health Systems." Discussion paper for IOM Roundtable on Population Health Improvement. March 6, 2014.

6. "Engaging Stakeholders in Population Health". Frontiers of Health Services Management. Volume 30: 4 Summer 2014. Various articles.

7. Massachusetts Prevention and Wellness Trust. Personal Communication with Thomas Land, State of Massachusetts .

8. National Quality Forum. Improving Population Health by Working with Communities: Action Guide 1.0 August 1, 2014

9. Miller, H. "Making the Business Case for Payment and Delivery Reform." Network for Regional Healthcare Improvement. 2014.

10. Ockene, J., et al. "Integrating Evidence-Based Clinical and Community Strategies to Imrpove Health" US Preventive Services Task Force.

11. "Tipping the Scales: Engaging Community Stakeholders to Build a Culture of Health." Hope Street Group. July 2014 http://www.hopestreetgroup.org/resources/tipping-scales-engaging-community-stakeholders-build-culture-health

12. "National Approaches to Whole Person Care in the Safety Net." John Snow Inc. March 2014.

http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=14261&thisSection=Resources

13. Bachrach D. et al. "Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment." Manatt Health Solutions. May 2014

14. Christensen, A. and Bigby, J. "Improving Total Population Health: The Role of the Health Care Delivery System: Summary of Technical Expert Panel Meeting. April 3 2014. Unpublished draft.

15. Halfon, N., et al. "Applying A 3.0 Transformation Framework To Guide Large-Scale Health System Reform". Health Affairs, 33, no.11 (2014):2003-2011 http://content.healthaffairs.org/content/33/11/2003.full.html

16. Alper, Joe and Baciu, A. "Financing Population Health Improvement: Workshop Summary". Institute of Medicine, National Academies Press. July 28, 2014 https://www.iom.edu/Reports/2014/Financing-Population-Health-Improvement.aspx

17. Corrigan, Janet and Fisher, E. "Accountable Health Communities: Insights from State Health Reform Initiatives" Published by The Dartmouth Institute for Health Policy and Clinical Practice. November 2014, and
Fisher, E and Corrigan, J. "Accountable Health Communities: Getting There from Here." Journal of the American Medical Association. November 26, 2014.