
Accountable Communities of Health

What is an Accountable Community of Health (ACH)?

Answer:

An Accountable Community of Health is a group of leaders from a variety of sectors in a given geographic area with a common interest in improving health and health equity. Participating, among others, are health and long-term care providers, health insurance companies, public health agencies, school districts, criminal justice agencies, non-profit social service agencies, legal services organizations, tribes, and philanthropic agencies. With support from the state, they are voluntarily organizing to coordinate activities, jointly implement health-related projects, and advise state agencies on how to best address health needs within their area. They are not intended to duplicate or replace existing services.

There are nine ACHs that together cover the entire state, with the boundaries of each aligned with the state's Medicaid Regional Service Areas.

What is the history of the ACHs? Where did the idea come from?

Answer:

Community-based, cross-sector coalitions dedicated to improving health at the local level have existed in Washington for many years. Recognition or support from the state has been limited and inconsistent, including a grant program in statute since 2006, but not funded since 2008. Their potential was explicitly revisited and acknowledged in Washington's 2013 State Health Care Innovation Plan. It called for creating a new partnership between the state and these types of organizations that would draw on the unique strengths of each.

At the same time, other states were moving in a similar direction with their health reform efforts, and their success with "Accountable Communities" gave Washington further reason to pursue its own version – built on existing organizations, but designed to serve other interests called out in the Innovation Plan. State legislation passed in 2014 provided criteria and funding for two community of health pilot sites. Additional specifications and funding to support ACHs were included in the State Innovation Model Test Award received by the state from the federal government later that year.

Why is Washington State supporting ACHs?

Answer:

Because working with community-based, cross-sector coalitions is an effective and efficient way to transform the health system in the state. In developing its Innovation Plan, the state sought an approach which: (i) takes advantage of local knowledge and relationships to drive change in places where individuals are directly served; (ii) allows those involved at the local level to each focus on what they do best, but in ways connected to and

complementary of the contributions of others nearby; and (iii) addresses through this collaboration both clinical care and social factors affecting health such as poor nutrition and inadequate housing. The state understands these things will not happen if they depend solely on random, informal contacts, but require the structure and intentional action brought by ACHs.

What state agencies are supporting the development of ACHs and how are they doing so?

Answer:

Primary support for ACHs, in the form of grants and technical assistance, comes from the Health Care Authority (HCA), the state agency leading the implementation of Healthier Washington. Working with the Department of Social and Health Services and the Department of Health, HCA establishes grant criteria, evaluates applications and makes the awards, and monitors performance and compliance with the terms and conditions of the grant. Technical assistance to support the development and initial operation of ACHs is being provided by a team of outside experts and consultants under contract with the HCA. Internally, these three agencies are looking at their own programs to determine if and how they might be better aligned to model the same collaboration expected at the local level, while eliminating any inadvertent obstacles to ACH success.

Are all ACHs the same?

Answer:

Each ACH, for example, shares the same general purpose, has (or will have) a formal governance structure and bylaws, and includes representation from a diverse and broad cross-section of entities. Each ACH will also play a similar role in projects implemented statewide, such as the [Practice Transformation Support Hub](#). ACHs are different in matters related to regional preference, such as the details of their governance structure, the particular entities participating, and the projects each undertakes in response to the unique health concerns of their region. Examples of this regional variation and shared priorities can be found in the year one evaluation report executive summary of the [Year One evaluation report](#).

Who administers and governs the ACHs?

Answer:

ACHs are administered and self-governed at the regional level consistent with general guidelines established by the state in its funding criteria. This gives each ACH discretion to do what works best for its region, but also means that none are organized or operate in exactly the same way.

In many cases, the organization that stepped forward to apply for the initial “Community of Health” planning grant beginning in July 2014 continues to be the sub awardee providing the ACH with staff and administrative support. For some ACHs, this entity is a local public health agency. For others, it is a non-profit organization with a history of health reform activity in the region.

While the sub awardee may help develop the governance structure, in most regions, it does not itself govern the ACH. In two regions, the sub awardee is itself the ACH entity and retains decision-making authority and multi-sector representation according to the contract with the state. The governance structure of the ACH typically

involves a board or committee, made up of a subset of these participants, with whom final decision-making authority rests. The challenge for each ACH is to involve enough people in governance that appropriate regional interests are represented, but to do so in a way that decisions get made and the organization remains functional. Achieving this balance will continue to result in creative, bottom-up approaches, the merits of which Healthier Washington is in-part intended to test.

How are ACHs funded? What does this money buy?

Answer:

ACHs are funded partly with grants from the Washington State Health Care Authority (HCA), using money from the State Innovation Model (SIM) grant issued by the federal Center for Medicare and Medicaid Innovation (CMMI). These funds allow each ACH to have part-time staff for design and initial development, and hold regional meetings, including planning for the reinvestment of any savings that ACHs help generate in health care or other areas. In 2014, the legislature also made a state general-fund appropriation to the HCA for two pilot ACHs. Recognizing the importance of the ACH and sustainability planning, private and public sector organizations supplement the SIM funds with in-kind contributions and grants. The SIM grant also funds staff and consultants at the HCA and other state agencies who partner with and support ACHs statewide.

Do ACHs have regulatory authority? What are they otherwise authorized to do?

Answer:

ACHs do not have regulatory authority. They are community-based organizations acknowledged in state statute and in documents related to the state's federal grants. They will be called on, as are many others, to provide state agencies with advice and recommendations and help implement state programs. Although some receive administrative support from a local public health agency, ACHs themselves are not political subdivisions of the state and have not been delegated any independent authority to regulate or otherwise control activities of individuals or institutions within their region.

Although not granted any unique statutory authority, ACHs otherwise have the same general powers enjoyed by any organization. What each does is determined by agreement of their local participants based on their governance structure and process. Among other things, they can agree to accept grants or otherwise contract with outside parties, including the state. An ACH doing so would then be expected to execute the contract, and be subject to any of its terms and conditions, including performance standards.

What role will ACHs play in Medicaid purchasing? What is their relationship to Medicaid Managed Care Organizations?

Answer:

Core functions of ACHs are to evaluate health needs within their region, take local action on those needs, and where appropriate, advise state agencies. Given Medicaid's importance to health, ACHs will join others in providing feedback on the design and operation of the program, and how it might be improved, particularly from a local perspective.

As Medicaid moves under Healthier Washington to better integrate physical and behavioral health care, and to link clinical care with other community services, the collective, multi-sector insights of ACHs will be critical to designing a supportive payment structure. However, ultimate legal and financial responsibility for Medicaid contracting, including monitoring and oversight, will remain with the state.

Medicaid Managed Care Organizations (MCOs) are active participants in ACHs throughout the state, and some have contributed funding and other resources. Independent of their participation in ACHs, however, the state will continue to contract with MCOs as the risk-bearing entities for Medicaid. There is no intent to transfer this risk-bearing function to ACHs.

More details on expectations surrounding the ACH-MCO partnership can be found on the [Healthier Washington website](#).

What role do the ACHs play in Washington’s Medicaid Transformation Demonstration?

Answer:

The role of ACHs is similar to that of their role in the State Innovation Model project with a larger scope. The ACHs serve as the regional lead entity and single point of performance accountability for the Demonstration projects. They facilitate Demonstration project selection, considering regional and community health priorities, with all stakeholders and partners including but not limited to health and long-term care providers, health insurance companies, public health agencies, school districts, criminal justice agencies, non-profit social service agencies, legal services organizations, tribes, and philanthropic agencies. The ACHs will oversee project design fund budgets and incentive payments to partnering providers. More information about the Demonstration can be found on the [Healthier Washington website](#).

What does it mean for an organization to be formally “designated” an ACH by the Health Care Authority? Does it change its responsibilities or authority?

Answer:

Formal designation as an ACH by the Health Care Authority is a step in the organization’s development process that qualifies it for additional state grant funding. It generally recognizes the ACH has in place the basic infrastructure to continue building a successful organization. Designation requirements include:

- Balanced, multi-sector representation;
- The launch of community engagement activities;
- The ability to perform basic financial and administrative functions;
- Initial identification of regional health needs and priorities; and
- Establishment of an initial budget, including a plan for continued funding.

Designation is an important benchmark that demonstrates progress and potential, and qualifies an ACH for additional grant funding to support its ongoing development. However, it does not change the general role or legal status of the ACH, or indicate a readiness to take on all conceivable ACH functions.

For details on ACH designation, including the relevant criteria and process, see the [ACH web page](#).

What are the ACHs actually doing to improve health? Are there concentrate examples?

Answer:

Many ACHs are still in the planning and development stage and have not decided which health improvement projects they will pursue. The Health Care Authority's Community Transformation Team will compile a list and share information about all of the projects as they are identified. In the meantime, the project being implemented by the Cascade Pacific Action Alliance (CPAA) as a pilot ACH offers an example of the type of work ACHs across the state will be doing.

The CPAA has begun a pilot project that identifies children with behavioral health challenges (mental health and chemical dependency) as early as possible in both education and health care settings, and connects at-risk youth with community-based interventions and treatment services. A work group of school district representatives, social service organizations, health care providers, and others has worked together in four counties to get the project off the ground. The work group has selected behavioral health screening tools, identified treatment resources within the region, and developed work plans for four pilot site schools.

So far in 2016, the Monticello Middle School pilot site in Cowlitz County has identified and served 46 students in the program. In Mason and Thurston counties, the Capital Region Educational Service District 113 (CR-ESD 113) has been meeting with school officials, administrators, and behavioral health providers to create work plans and bring together resources for the two pilot sites of Black Lake Elementary School and Pioneer Elementary and Middle schools. Community members in Wahkiakum County, including the county sheriff and prosecutor, have been actively engaged in planning project specifics for the fourth pilot site, John C. Thomas Middle School.

The goal of the CPAA's Youth Behavioral Health Coordination project is to improve care coordination in order to decrease the number of youth with unmet behavioral and physical health needs, and thereby increase school attendance and academic achievement.

Who should be involved with ACHs? What types of entities are already involved?

Answer:

If you or your organization have any responsibility for the health of your community, through clinical care, social services or otherwise, you should consider becoming involved with ACHs. ACHs represent a formal opportunity to achieve results you will not get working alone. They do this by connecting those with similar concerns and goals, allowing them to share information and coordinate activities. They are also a place to discuss what is expected, and from whom, in transforming health care in the region. Becoming involved will keep expectations of you reasonable and aligned with your strengths. And with the cross-sector representation, you will learn when and how to engage others to help residents whose needs are beyond your responsibility or expertise. Becoming involved will also give you a greater voice in identifying regional health needs and advising how to address them.

Those already involved include but are not limited to: health and long-term care providers, health insurance companies, public health agencies, school districts, criminal justice agencies, non-profit social service agencies, legal services organizations, tribes, and philanthropic agencies.

Are ACHs only about Medicaid? Should those whose interests are primarily related to commercial health coverage also be involved?

Answer:

Healthier Washington is intended to transform all parts of the state's health system. As such, ACHs focus not only on a particular sub-population or payment system but represent health across the entire continuum and population within the region, from babies to seniors. Medicaid is expected to lead by example, primarily by changing the way it purchases care and services, with ACHs contributing to this process. However, Medicaid payment reform and corresponding changes in care delivery will influence – and be influenced – by what goes on in the commercial market. With the right people involved, ACHs can help keep all participants appropriately aligned, avoiding inconsistent approaches that serve primarily to confuse. If you or your organization have any responsibility for the health and well-being of your community, either for Medicaid enrollees or otherwise, you should consider becoming involved with ACHs.

What is the best way to become involved with ACHs? Is it too late? Are there any prerequisites?

Answer:

It is certainly not too late to become involved. The only prerequisites are that you have an interest and/or role – through clinical care or other community services – in the health of residents within the region covered by the ACH, and a willingness to abide by its process. How to best become involved depends on who you are, the resources you have available, and in which of the nine ACHs you are interested.

Statewide associations (such as health care provider associations) should encourage their individual members to engage with their local ACH, with the association's leadership working with Healthier Washington partners and state agency staff. Other statewide organizations that provide services to residents of more than one region (such as health insurance companies or health systems) will want to be involved at the state level, and at the regional level with as many corresponding ACHs as their resources allow.

Because each ACH is structured differently and is at a different stage of development, it is best to seek advice on becoming involved directly from those ACHs in which you have an interest. Contact information for the ACH leads and administrative support team can be found on the [Healthier Washington website](#). ACHs who already have a governing board in place will suggest other meaningful ways to engage or have your interests heard, in particular the opportunity to become involved in specific health improvement projects. Those at the earliest stage of development may simply take your name as an interested party wishing to be contacted as they get more organized. In some cases, individuals representing your organization or interests may already be involved.

Frequent mention is made of ACH “members.” Do members have responsibilities or privileges others involved with ACHs do not? How does one become a member?

Answer:

“Member” was the term initially used in Health Care Authority documents to describe any individual or organization formally involved with ACHs. It was not meant to imply a preferential status for some in the region over others. Going forward the intention is to use the term “participants” rather than “members.”

Like any organization, however, ACHs have an operational structure in which participants may each have different roles. It is not practical to give everyone a position on the governing board, and a position on the governing board is not the only way to meaningfully participate. Involvement at the project level will become increasingly important as ACHs develop. ACHs are confronting the challenge of collectively but effectively engaging the large number of entities across multiple sectors with a role in improving health. And as with any innovation, the ACHs will evolve as they determine what works and what does not.

How can state agency policies concerning the role and operation of ACHs be influenced?

Answer:

Because agencies are looking to ACHs themselves to help shape relevant state policies, participating at the regional level is a way to influence them. For those (such as statewide associations) more appropriately involved directly with the state, engagement opportunities to date have been informal or a byproduct of the feedback sought on Healthier Washington generally. These opportunities will remain, and you may continue to contact the Community Transformation Team or other agency staff directly. In the meantime, however, the agencies are considering development of a more structured, efficient and timely process for gathering state level input on ACH policy. Thoughts on what this should look like are welcome.

What is meant by “whole person health” and “health” – are these the same as it relates to ACH priorities?

Answer:

Whole-person health and whole-person care are often used interchangeably. These terms mean that health care is expanding beyond hospital and clinic settings and focusing on linking patients to comprehensive physical, and behavioral and substance use disorder care that extends to personal, family, and community-based health needs. Examples of whole person care can include nutrition, housing, child-care, neighborhood safety, chronic disease prevention, social supports, substance use, oral health, primary care, etc.

ACHs are interested in the broadest definition of health because many sectors, organizations and services contribute to health in one way or another. One benefit of the ACH is that the community can take on health issues by drawing from the many different aspects of health represented within the ACH, rather than independently addressing separate issues.

How is the ACH initiative being evaluated throughout the state under SIM?

Answer:

The Health Care Authority (HCA) has contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the ACH initiative. As evaluation partners, CCHE works with HCA and the HCA and the ACHs to

understand in real time how the ACH initiative is working and what barriers are getting in the way of success. The evaluation aims to understand how ACHs form and grow, agree on community health priorities, engage in regional health improvement activities, contribute to Healthier Washington, and work towards becoming sustainable coalitions.

Data about ACH capacity and progress are being collected from multiple sources, including: site visits, interviews, ACH participant surveys, extensive ACH document review, and ACH project measurement. CCHE is using this data to provide timely feedback to Healthier Washington and HCA staff about lessons learned and regional variation to health with ongoing program improvement. CCHE is also assessing the ACHs' outcomes and short-term impact on regional health improvement over the course of the SIM grant period. The ACH evaluation closely coordinates with the evaluation of the overall Healthier Washington initiative, led by a team at the University of Washington.