

# Building the Foundation for Regional Health Improvement: Evaluating Washington’s Accountable Communities of Health

Center for Community Health and Evaluation  
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## Overview

An Accountable Community of Health (ACH) is a regional coalition consisting of leaders from a variety of different sectors working together to improve health in their region. As part of the Healthier Washington Initiative, nine ACHs began formally organizing across Washington in 2015. They are intended to strengthen collaboration, develop regional health improvement plans and projects, and provide feedback to state agencies about their regions' health needs and priorities. The Health Care Authority (HCA) is supporting ACH development through guidance, technical assistance (TA), and funding from the State Innovations Model (SIM) grant.

### ACH structures created, first steps taken in collaboration and community engagement.

All nine regions were formally designated as ACHs. Requirements for designation included establishing operations and governance structures, multi-sector and community engagement, regional health improvement plan (RHIP) efforts, and initial sustainability planning.

HCA encouraged ACHs to be creative and community-driven when establishing their governance and operations. Each ACH formed a different structure, resulting in a natural experiment where best practices can emerge from various ACH approaches.

**Governance.** ACHs have governing bodies that range in size (15-44 participants) and decision-making procedures. Some ACHs have additional groups at the region or county level that provide input to the governing bodies.

**Backbones.** There are three types of organizations providing operational support to ACHs: local public health, community-based organizations, and nonprofits that play a dual role as backbone and ACH.

**Community engagement.** ACHs are all working towards multi-sector engagement, but have defined sectors differently and incorporated representation at differing levels of their governance structures. ACHs are also using various strategies for public participation, ranging from comment periods during board meetings to open events where all attendees can engage in discussion.

**Regional priorities and projects are emerging.** Collaborative work towards a shared regional agenda has been challenging, but ACHs have developed regional needs inventories and are identifying health priorities that will inform their RHIPs. A few ACHs are selecting and planning their first projects, which all the ACHs will focus on in 2016. The aim of their projects is to improve regional health, promote health equity, and advance the Triple Aim. The long-term impact will be assessed using Washington's Common Measure Set.

**Moving forward – ACHs demonstrating their value.** In the coming year, ACHs will turn their attention from building a strong foundation to active collaboration on local health improvement projects. ACHs will also be involved in broader Healthier Washington strategies as other programs become more defined. Both ACHs and the state consider sustainability a key focus and the shift to more action-oriented activities will provide ACHs with opportunities to demonstrate their value propositions to both regional and statewide stakeholders. Support, guidance, and partnership from the state to the ACHs will continue to develop as the state, regional, and Healthier Washington landscapes evolve.

## Introduction

### What are ACHs?

An Accountable Community of Health (ACH) is a regional coalition consisting of leaders from a variety of different sectors working together to improve health in their region. With support from the state government, nine ACHs began formally organizing across Washington in 2015 to build capacity to work collaboratively, develop regional health improvement plans, jointly implement or advance local health projects, and advise state agencies on how to best address health needs within their geographic areas.

The ACH premise is that community-based, cross-sector coalitions can be an effective part of health system transformation since they:

- Take advantage of local knowledge and relationships to drive change in places where individuals are directly served;
- Allow 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,
- Facilitate collaboration to address both clinical care and social factors affecting health such as poor nutrition and inadequate housing.

This collaborative and synergistic work will not happen if regions depend solely on random, informal contacts between stakeholders, but instead requires the structure and intentional action brought by ACHs to achieve regional health improvement. Washington is not alone in moving forward with this new ACH approach. Variations on the model are being tested in a few other states (see Appendix A).

ACHs are an essential component of Washington’s Health Innovation Plan, known as “Healthier Washington,” a five-year plan, funded through a \$65 million State Innovation Models (SIM) federal grant. In addition to ACHs, Healthier Washington includes several other large scale initiatives, including improving how Washington pays for health care services by testing models that emphasize paying for value, integrating physical and behavioral health care, and implementing a practice transformation hub to improve health care delivery (for links to Healthier Washington resources, see Appendix B).

Washington’s nine ACHs are at different stages of development as they each search for ways to improve health, given their regional context and priorities. This report is an overview of development during the first year of SIM funding. The Health Care Authority (HCA) contracted with the Center for Community Health and Evaluation (CCH) to evaluate the ACHs’ progress, provide formative feedback to support ACH development, and document and disseminate best practices.

It’s going to require a paradigm shift for everyone and our stakeholders. It’s more than saying we’ll work together. It’s a new way of thinking.

Healthier Washington will help people experience better health throughout their lives and receive better – and more affordable – care when they need it.

– Healthier Washington Website

### Where are they? ACH regional boundaries

There is wide variation in what comprises an ACH region, both in terms of geography and population. Seven of the nine ACHs are multi-county areas, ranging from two to ten counties. Washington’s two most populous counties – King and Pierce – comprise their own region. While some regions have a history of collaboration, others are incorporating new communities or counties into their identities as ACHs.

Figure 1. Map of ACH regions



### How do ACHs achieve their impact? ACH Theory of Change

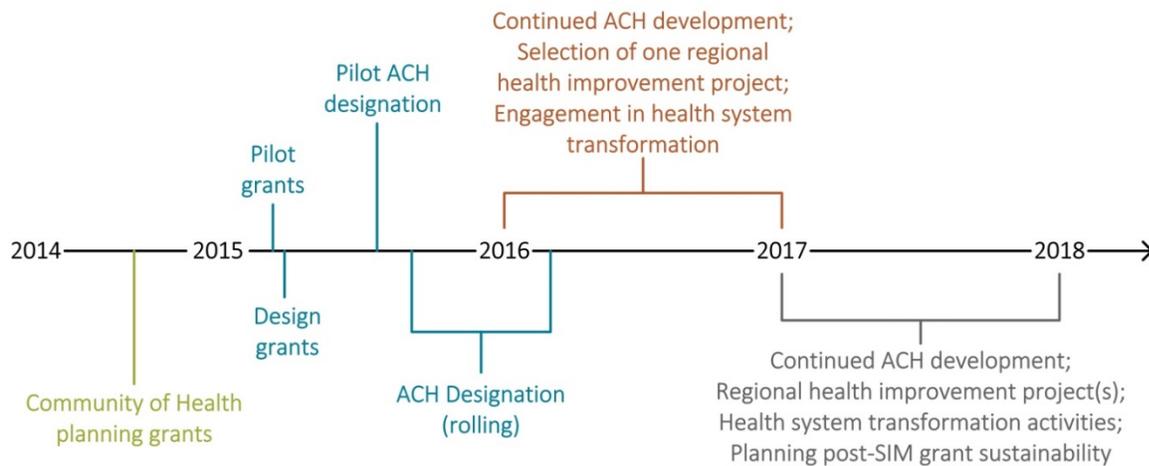
CCHE worked with HCA and the ACHs to develop an ACH “theory of change”, or model for how Healthier Washington envisions the ACHs will achieve their impact, as illustrated in Figure 2 (see Appendix C for a detailed version). Reading from left to right, during this first year, ACHs began by establishing operational and governance infrastructure in order to function effectively as a coalition. Building this organizational capacity is necessary to support the ACHs’ work across their regions. They also worked on establishing and broadening cross-sector engagement, and began to develop the components of regional health improvement plans (RHIPs).

As ACHs move forward, they will continue regional planning and strengthening partnerships to carry out health improvement strategies. By fostering these collaborative activities, ACHs are expected to lead their regions through a continuous cycle of implementing targeted projects and strategies that will grow, spread, and be sustained over time. This continuous expansion of health improvement efforts will require a high degree of regional collaboration, funding, and synergy between individual activities. The goal is to achieve widespread policy, practice, and systems change that supports health improvement.



The two pilot regions were formally designated ACHs by the HCA in July 2015 and the design grant regions were designated on a rolling basis November 2015 – January 2016. Over the remaining years of the SIM grant, ACHs will receive \$220,000 per year. ACHs will implement their regional projects and facilitate project growth and spread. ACHs will also continue developing sustainability plans. As other Healthier Washington initiatives develop, such as health system transformation efforts, ACHs will begin to play a role that is not yet clearly defined.

Figure 3. ACH development timeline



### Evaluation methods

The HCA has contracted with CCHE to evaluate the ACHs. The ACH evaluation closely coordinates with the evaluation of the overall Healthier Washington initiative, led by a team at the University of Washington.

CCHE aims to understand the function and contribution of the ACHs – how they form, agree on community health priorities, engage in health improvement activities, contribute to the Healthier Washington initiative, and work towards becoming sustainable coalitions. As an evaluation partner, CCHE provides timely feedback from multiple data sources to Healthier Washington and HCA staff about success factors, challenges, and lessons learned to inform program improvement. CCHE will also assess the ACHs' impact at the end of the project.

Qualitative and quantitative data were collected from multiple sources to document ACH capacity and progress in 2015, including site visits, interviews with backbone staff and ACH members, participant surveys for each ACH, ACH meeting observation, and extensive document review. When not otherwise attributed, quotes within this document are from ACH backbone staff and participants, or ACH designation applications (for a more detailed description of methods, see Appendix D).

## Building the foundation: Formalizing ACH structure

Efforts to formalize ACH mission and vision statements, governance structures, sector participation, backbone roles, and initial pathways to sustainability were the main activities of 2015. This work culminated in nine successful proposals to HCA to be formally designated as Accountable Communities of Health. HCA provided guidance for ACH development, but left significant room for ACHs to grow in ways that reflected their communities, which resulted in variation across the state.

### 2015: The year of designation

All regions awarded a pilot grant or design grant for ACH development and planning were required to submit a Readiness Proposal to be formally designated as an ACH by the HCA during 2015. The criteria for designation included six categories of ACH readiness (Figure 4), which were shared with all the regions as guidance for preparing their proposals. Formal ACH designation qualifies the coalition for additional grant funding from the state. Proposals were reviewed by a multi-agency state team (DOH, DSHS, and HCA staff) to assess whether each ACH is a functional coalition with a strong foundation for collaboration, governance, and operations to support regional health improvement efforts.

The two pilot grant regions, Cascade Pacific Action Alliance (CPAA) and North Sound ACH, were designated in July 2015. The seven design grant regions were designated on a rolling basis, from November 2015 to January 2016.

### Developing a shared mission and vision

One of the initial steps for emerging ACHs was to refine and agree on a mission and vision to guide their development and new collaborations. This step helped clarify why ACH participants were coming together and began to build their regional ACH identity.

Figure 4. Designation criteria

**Operational governance structure:** At a minimum, an interim operational governance structure and decision-making process with bylaws, charter(s) or other documentation, and a plan for ongoing testing/adjustment.

**Balanced, multi-sector engagement:** A governing body membership that reflects balanced, multi-sector engagement that includes participation from key community partners representing systems that influence public health, health care, and the social determinants of health (SDOH).

**Community engagement:** Activities underway and future plans to engage diverse community representatives through the governance structure.

**Financial and administrative operations:** An appointed backbone organization, or group of organizations, performing operational activities in support of the ACH. Includes backbone accountability to the ACH governance structure and a process for reviewing the backbone and/or selecting another.

**Initial regional health improvement planning:** Identified priority areas as part of ongoing regional needs inventory and assessment activities. Initial regional health improvement plan or project(s) identified for future development.

**Initial operating budget and sustainability planning:** Demonstrated capacity for financial management and an initial sustainability planning strategy that includes considerations for enhancing the ACH's revenue base.

For the **Pierce ACH**, developing a mission statement and operating principles was a collaborative process that brought partners together to make a commitment towards a shared understanding of improving population health. The ACH's governance work group drafted recommendations and proposed them to the larger Health Innovation Partnership stakeholder group, who discussed, revised, and eventually finalized the ACH mission and operating principles via consensus.



provided a level of trust and shared purpose from the start. Other ACHs struggled to build new relationships, particularly when the ACH boundaries added new counties to what they had historically understood as their region. Some ACHs purposefully incorporated existing coalitions into their governance structure so that they could leverage wider networks.

**Diversity of governance structures and processes.** As a result, a range of creative approaches to governance emerged, with no single governance structure dominating across the ACHs. All the ACHs developed a region-level governing body, board, or council, but the details varied widely:

***Size and sector composition differences.*** Determining who had a seat on the governing body was a challenge, both in terms of the size and sector composition. Most have 15 to 23 members, one has 29 members, and another has 44 members. As one ACH representative stated, “there are two schools of thought: that everyone needs to be represented and have large boards, and that the group needs to be small enough to make progress.” Seven of the nine ACHs define specific sector representation requirements within their bylaws, although the definitions of sector vary. Two ACHs did not focus on size and sector composition during the year because they were utilizing the existing board of the backbone organization as the ACH governing body.

***Decision-making approaches.*** Decision-making procedures range from groups that start with a majority vote to those that work towards reaching consensus and only vote if necessary. Only one group uses a strict consensus-based model, where members poll using a thumbs-up/thumbs-down process and continue discussion until consensus can be reached. Recognizing the need for expedited decision making when necessary, a few ACHs with larger governing boards identified a subset of members that meet more often to provide support for the backbone. In some ACHs these subsets also have decision making powers.

***Incorporating a range of community voices.*** To encourage grassroots engagement in governance, many ACHs also established a range of broader stakeholder groups that convene to discuss ACH development, contribute ideas for ACH activities, develop partnerships, and feed input to members of their decision making body. Some ACHs have one region-wide group, other ACHs have multiple county-level groups, and a few have both. The size of the stakeholder groups range from about 30 to 50 participants. These groups generally do not have decision making power, but instead convene to brainstorm ideas and give feedback for the region-level, decision-making body to consider.

There is no pattern between these various aspects of ACHs governance structure. One ACH has a large decision making group and numerous county-level stakeholder forums. Another has a medium-size decision making group

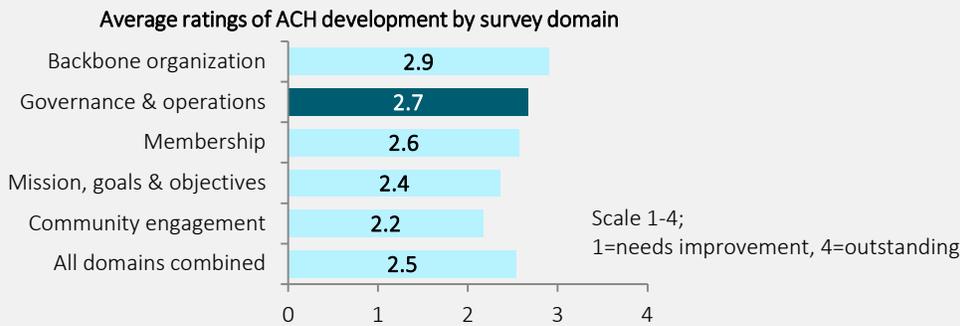
The support team was in response to when we need to act faster than our regular meetings. The team has even representation from each of the counties. They work with [the backbone] to think through things, but they are not a decision-making group.

Structuring it the way we did kept it really authentic and created a safety valve where the smaller, rural, or less well-resourced players are at the table because they feel like they have just as much of a voice.

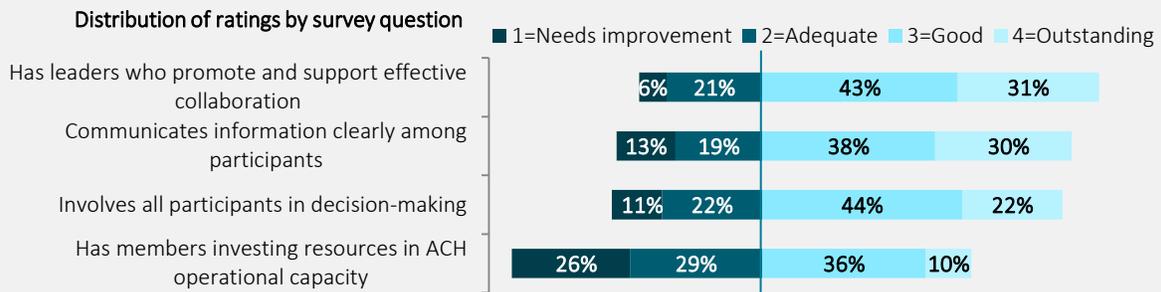
and a steering committee to expedite day-to-day decisions, but no broader stakeholder groups across its counties. The variety of governance structures, and the attitude that there is no ‘one size fits all’ for the ACHs, is a reflection of Healthier Washington’s efforts to let creative, locally-driven coalitions emerge.

**ACH participant survey responses: Feedback on governance and operations effectiveness**

The governance and operations domain received the second highest rating overall out of five survey domains, with a statewide average rating of 2.7, which corresponds to a score of *good* on the survey rating scale (1=needs improvement, 2=adequate, 3=good, 4=outstanding).



Respondents rated these aspects highly: leaders who promote and support effective collaboration, clear communication among ACH participants, and involving all members in decision-making. However, respondents indicated opportunities for growth such as ACH participants investing resources in operational capacity.



**Backbones: Facilitating progress and collaboration**

All ACHs are required to select one or more organizations to serve as their backbone. This backbone organization is responsible for ACH operational functions, such as administrative and financial activities. While the backbone staff may help develop the governance structure and serve as a neutral convener of stakeholders, the backbone staff does not govern the ACH. These staff are also most closely involved in cross-ACH conversations.

Since HCA did not require a specific type of organization to serve in the backbone role, the organization selected for this role varies and none are organized or operate the same way. The organizations serving as the backbone can be classified into three types: public health agencies, community-based organizations, and a single non-profit with a dual role, where there is not a separate backbone organization.

[The backbone’s] other role is to help the ACH innovate and grow and succeed at being functional. Our leaders see that.

**Public health backbones.** Four ACHs were convened by local public health agencies, where staff provide operational support and, in some cases, data and analytical support to the ACH. In these regions, local public health was often seen as already working on similar issues and/or a neutral convener that brought needed expertise to the table. A few described their role as an interim position. While they thought it made sense for them to be the initial convener of the ACH, they are not sure if it will make sense for them to remain in that role over time and are considering alternative backbone organizations for the future arrangements.

For the **North Central ACH**, the Chelan-Douglas Health District – one of the local public health agencies in the region – stepped up to apply for a design grant and served as the initial backbone organization. The health district took on a leadership role in reaching out to stakeholders and getting people from across the four-county region to convene. Backbone staff have continued to work on broadening community engagement and getting diverse representatives to participate in the ACH. As stated in their designation proposal, “There is a diversity of opinion in North Central Washington about health care reform, but one common principle informs [the ACH’s] work: major changes are coming to our health care system, and it is critical for our communities to have a strong voice in that process.”

**Community-based organization backbones.** Three ACHs have selected community-based organizations to serve as their backbones. These organizations have a history of promoting community health improvement and fostering partnerships between stakeholders. Some backbone staff from these ACHs specifically identified their organization’s history as a collaboration agent in the region as a helpful factor because past leadership on collaborative projects or existing relationships across the region helped stakeholders trust the backbone and the emerging ACH.

For the **Greater Columbia ACH** the Benton-Franklin Community Health Alliance (BFCHA) is the community-based organization serving as the ACH’s backbone. BFCHA has been promoting community wellness and accessible health care in the Tri-Cities area for many years and has experience taking a collaborative approach. BFCHA supported stakeholders from across the ten-county region in successfully developing an ACH that includes both existing partners and new colleagues representing a range of cross-sector interests. The backbone is facilitating a governance structure that is focused on regional identity, and intentionally does not include individual county councils because “we are stronger by working together as a region.”

**Single non-profit with a dual-role.** Two of the regions have a single, existing non-profit organization that provides their backbone support and is also identified as the ACH. In these instances, there is not a separate backbone organization, but instead the operational support is provided by some of the organization’s staff who in essence serves as the backbone. The non-profit’s board is the decision making body for both the existing nonprofit and the ACH. A few other ACHs are considering becoming independent non-profits as well and took this potential pathway into consideration when building their bylaws.

**Better Health Together (BHT)** – the ACH for the region spanning Adams, Ferry, Lincoln, Pend Oreille, Stevens, and Spokane counties – is an established nonprofit organization that includes both the backbone organization and the ACH’s decision-making board. BHT decided to leverage its existing governance structure and collaborative relationships across the region as a foundation to build the ACH upon. BHT states this approach to ACH development lets the backbone organization’s work be fully aligned with the priorities of the ACH, as well as leveraging additional backbone resources and broader investment for programmatic development.

**Backbone contributions to the ACH.** Some backbone staff focused on facilitation as a key contribution; bringing people together and helping them feel heard was essential. A few talked about the backbone’s role in promoting decision-making. As one staff member commented, “Everyone is still willing *not* to be pressed hard on decisions; they can continue talking about it forever. It is our obligation to press that. Backbone staff can get push-back when they try to move [things] forward.” A few also noted their responsibility for coordinating resources, such as hiring external consultants when needed. ACHs differed on the level of visibility, leadership, and neutrality that backbones have in the ACH work.

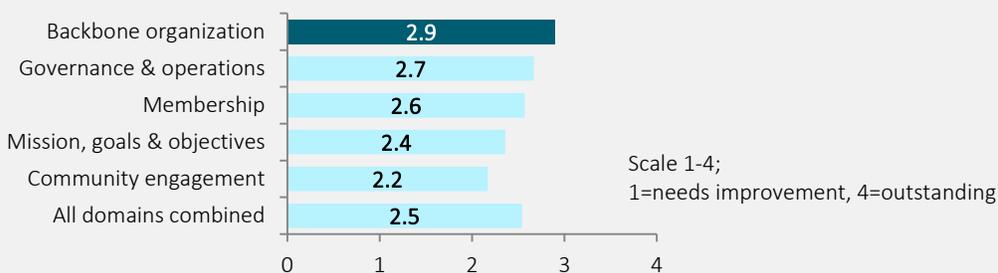
As the backbone, we don’t have an agenda going in. We are open to changing to what [the ACH participants] want.

Although the types of backbone organizations and their roles vary across regions, ACH participants overall are pleased with the performance of their backbones (see survey results below), suggesting that most ACHs have developed a backbone infrastructure that is responsive to their needs and expectations.

**ACH participant survey responses: Assessment of backbone support**

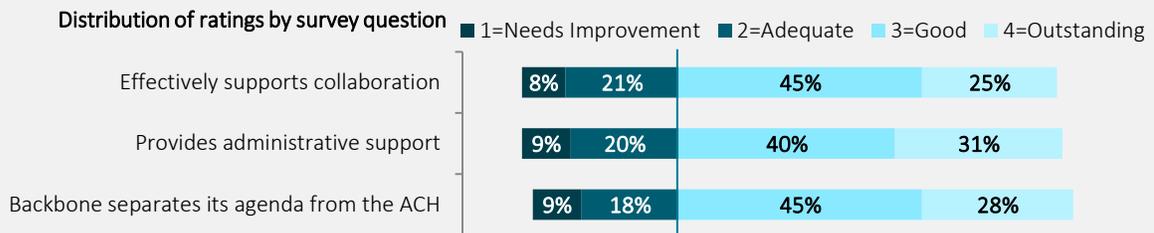
Survey respondents rated the backbone organization domain highest overall out of five survey domains, with a statewide average rating of 2.9, which corresponds to a score of *good* on the survey rating scale (1=needs improvement, 2=adequate, 3=good, 4=outstanding).

**Average ratings of ACH development by survey domain**



Over two-thirds of respondents also rated their backbones as *outstanding* or *good* in providing ACH support.

**Distribution of ratings by survey question**



## Developing a sustainability pathway

Healthier Washington envisions ACHs continuing their regional collaboration beyond the initial financial investment provided by the SIM grant funds, which continue through early 2019. Designation criteria required a description of the pathway for sustainability under development by each ACH, including current community support as well as future potential resources.

**Current community support.** All of the ACHs are receiving in-kind support, primarily from the backbone organization or ACH participants that are playing key roles such as fiscal agent or administrative support. Over half the ACHs described specific grant funds or philanthropy partners that support ACH work, with a wide variation from a few thousand dollars to several hundred thousand dollars per year. Many ACHs also reported receiving financial contributions from some of their participants, but only one ACH currently requires board member dues/contributions.

**Future potential resources.** Overall, ACHs are in the early stages of developing their sustainability pathways and level of initial detail in the plans varied widely. Ideas for future resources for sustainability included: increasing local community financial support, seeking grant funds, developing fees for services, exploring methods for capturing savings or developing social impact bonds. A few ACHs are exploring requiring participant dues, but one ACH described this as difficult given the variation in financial resources their partner organizations bring to the table. ACHs are also struggling with essential questions such as, “How will health care savings really be reinvested into the community?” as they think about future finances.

A set of pathways is developed that envisions a balanced funding model, braiding together resources contributed by funders from various sectors, sustaining the engagement of stakeholders, and undertaking meaningful work that results in real progress being made on our region’s shared health priorities.

– ACH designation proposal

### ACH participant survey responses: Sustainability planning

Many survey respondents (36%) indicated their ACHs *need improvement* with regards to executing a sustainability strategy. Another quarter (26%) rated their ACH’s performance on this item as *adequate*. Less than one-third (30%) of respondents said their ACH’s sustainability strategy was *good*.

**Sustainability requires demonstrating ACH value.** Many ACHs talked about the need to demonstrate their value as an ACH before they could ask the community or partner organizations to increase support at this early stage. Often this discussion was tied to the need to secure funding for their ACH project, expected to launch in 2016. Projects are seen as a way to demonstrate ACHs’ value. Some ACHs described the challenge of key stakeholders who are waiting to see where the effort goes and if the state is committed to it long-term before committing additional resources to the effort.

The push for sustainability is premature, because what are we sustaining? We haven’t had a chance to mature and produce something.

Table 1. ACH governance at-a-glance

ACH	Counties	Designation	Backbone	Governance (decision-making group in bold)
<b>Better Health Together</b> (BHT) <a href="#">website</a>	Adams, Ferry, Lincoln, Pend Oreille, Stevens, Spokane	Nov. 2015	Better Health Together <i>Non-profit with dual role</i>	<b>15-member Board of Directors</b> that governs both ACH and BHT programs. 62 regional organizations participate in an ACH Leadership Council. Rural county coalitions are emerging for local activation.
<b>Cascade Pacific Action Alliance</b> (CPAA) <a href="#">website</a>	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum	July 2015 <i>Pilot ACH</i>	CHOICE Regional Health Network <i>Community organization</i>	<b>44-member Regional Coordinating Council</b> which uses a consensus decision-making model. Seven county level forums convene local stakeholders.
<b>Greater Columbia</b> (GC ACH)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	Jan. 2016	Benton-Franklin Community Health Alliance <i>Community organization</i>	<b>17-member Board of Directors</b> (hospital & business representatives vacant). An open-participation Leadership Council that regularly includes 30-50 regional participants.
<b>King County</b> <a href="#">website</a>	King	Nov. 2015	Public Health-Seattle & King County <i>Public Health</i>	<b>23-member Interim Leadership Council</b> with an Interim Steering Committee. Workgroups include Council and community members.
<b>North Central</b> (NCACH)	Chelan, Douglas, Grant, Okanogan	Jan. 2016	Chelan-Douglas Health District <i>Public Health</i>	<b>17-member Governing Board</b> and an Executive Committee. A regional Leadership Council and three county-level Coalitions for Health Improvement (CHIs) convene local stakeholders.
<b>North Sound</b> (NSACH) <a href="#">website</a> <a href="#">Facebook</a>	Island, San Juan, Skagit, Snohomish, Whatcom	July 2015 <i>Pilot ACH</i>	Whatcom Alliance for Health Advancement <i>Community organization</i>	<b>29-member Governing Body</b> that includes regional stakeholders. A Steering Committee.
<b>Olympic Community of Health</b> (OCH) <a href="#">website</a>	Clallam, Jefferson, Kitsap	Dec. 2015	Kitsap Public Health District <i>Public Health</i>	<b>16-member Interim Leadership Council.</b> An open-participation Community of Health stakeholder group also meets and includes 40-50 regional participants.
<b>Pierce County</b> <a href="#">website</a>	Pierce	Jan. 2016	Tacoma-Pierce County Health Department <i>Public Health</i>	<b>23-member Board of Trustees</b> , to be finalized in 2016. 30-40 stakeholders engage in the Pierce Health Innovation Partnership.
<b>Southwest Washington Regional Health Alliance</b> (SWWA RHA)	Clark, Skamania	Dec. 2015	Southwest Washington RHA <i>Non-profit with dual role</i>	<b>22-member Board of Directors</b> that governs both ACH and Early Adopter Behavioral Health activities. A Community Advisory Council includes 13 Medicaid members.

## Regional collaboration for health improvement

ACHs took clear steps towards building regional collaborations to improve the health of their regions, including engaging a variety of sectors and the broader community. ACHs also started to develop the key components of a Regional Health Improvement Plan. The next step will be selecting and implementing specific health improvement projects.

### Building multi-sector collaboration

A key area of success and challenge for ACH development in 2015 was engaging ACH participants to form coalitions that reflected balanced, multi-sector engagement.

**Many sectors at the table.** Since HCA left this definition to each region, there was variation in both how ACHs formally defined “sectors” and how they were included in their bylaws. Many sectors were represented in all ACHs although some sectors were more selectively incorporated.

- All ACHs included local public health, some incorporating one representative from each county.
- All ACHs included multiple health system partners, such as hospitals, primary care providers, Medicaid managed care plans, and community health centers with most ACHs including separate seats for provider types. Some ACHs included several representatives from a given sector while others adopted a caucus model with a single representative per sector. All ACHs include behavioral health providers and a few included substance abuse/chemical dependency organizations. A few included oral health providers.
- All ACHs included social services or human services organizations. Many specifically included seats for housing, with a few calling out food systems and transportation. Many include local Area Agency on Aging or other long term care representatives. Some also included first responders.
- Most ACHs included education, although this sometimes meant school districts and other times college systems.
- Over half of the ACHs included employers or business, but not all of these seats were filled.
- Over half included at least one local government representative and several included local philanthropy organizations.
- Most of the ACHs also were actively working to engage Tribes as ACH participants but only a few currently have representatives engaged with the ACH.

**Figure 6. Multi-sector engagement requirements**

At a minimum, balanced engagement refers to the participation of key community partners that represent systems that influence health; public health, the health care system, and systems that influence the social determinants of health (SDOH), with the recognition that this includes different spheres of influence.

We are trying to build this from the ground up and getting people working together who haven't before.

The established relationship helped us get going. We also already had trust built-in, which made it easier to establish trust with new people to loop in.

- About half of the ACHs specifically included a space on the decision-making body for at least one consumer representative, although not all of these spaces were filled.
- Individual ACHs included a variety of other partners: labor, faith-based organizations, workforce development, criminal justice, rural health organizations, existing coalitions that work on equity, and specifically the Hispanic community.

**Successes and challenges in building collaboration.** Building a collaborative structure was portrayed by ACH backbones as being the most time intensive and challenging aspect of the year. Many ACHs described seeing progress, including examples of new sectors that are now committed, passionate participants. They described consistent attendance at meetings and collaborative discussions as indicators of success. Most describe the benefit of creating a forum for disparate stakeholders to figure out the interconnections that are being missed in their region. One ACH specifically described seeing more cross-sector communication around topics that would otherwise not happen. A few pointed to the ability of ACHs to create space around the table for voices that are often missing, such as consumers.

All of the ACHs described how difficult it is to build these new multi-sectoral coalitions. Some described tension around engaging stakeholders at the table while there was still significant ambiguity about what ACHs would be doing in the region. As one ACH said, “it’s hard to have those stakeholders stay engaged when they don’t know what they’re signing up for.”

Many ACHs described significant challenges of building trust and a shared sense of purpose among new sectors and counties that did not have a history of working together. Some ACHs highlighted the challenge of getting the necessary decision-makers to the table so the ACH participants could make decisions on behalf of their organizations. As one ACH said, “I know a big challenge is just getting the right people in the room at the right time.” ACHs pointed to different learning curves for participants as they learned about each other’s sectors. Educating new participants can be time consuming and resource intensive.

Many ACHs talked about how “we have to prove our value proposition” if they are to keep participants engaged. Some ACHs described this to mean elevating the social determinants of health and health equity issues, while some see it as a need to focus on demonstrating their ability to show cost savings or control health care costs.

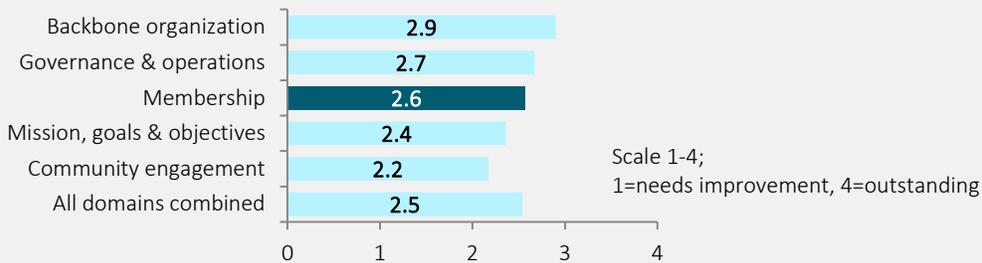
We’re still trying to make sure we don’t fall into token engagement for community outreach... it’s important to us, but we don’t have resources right now.

What is the value proposition we are going to use to get stakeholders involved? ...Creating a community voice is a project – it’s fragile, we are only in the middle of it, agreeing to sit together and work on common goals.

**ACH participant survey responses: Reflections on stakeholder engagement**

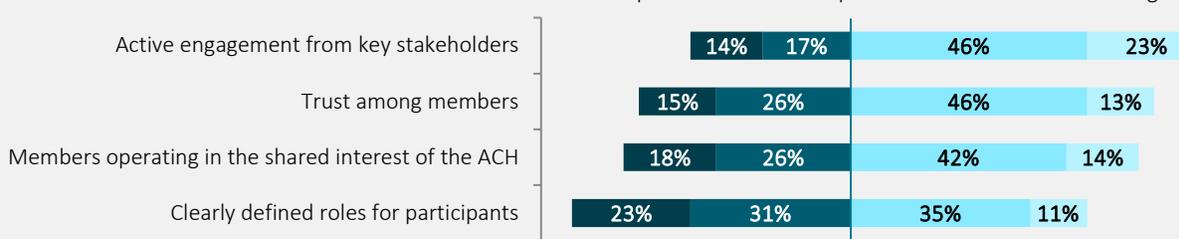
Survey respondents rated the ACH membership third out of the five survey domains, with a statewide average rating of 2.6, which corresponds to a score split between *good* and *adequate* on the survey rating scale (1=needs improvement, 2=adequate, 3=good, 4=outstanding).

**Average ratings of ACH development by survey domain**



Over two-thirds of respondents indicated the active engagement from key stakeholders in their ACHs was *outstanding* or *good*. Respondents also rated their ACHs highly in having trust among participants and participants who operate in the shared interest of the ACH.

**Distribution of ratings by survey question**



**Building community engagement**

Demonstrating that community engagement activities are underway and that additional activities are planned was an ACH designation criterion. These activities are in addition to the engagement that is already occurring through their governing body.

ACHs described a strong commitment to community engagement, but acknowledged that they are still developing methods to achieve this goal. This was seen as an opportunity for improvement in the participant survey. Several ACHs described the challenge of implementing community engagement strategies under resource constraints.

Most of the ACHs include methods for the public to add their voice to ACH meetings, that can be loosely grouped into three main categories: 1) board meetings that are open to the public and contain public comment periods, 2) frequent ACH regional meetings that are open to public participation, or 3) county-level groups that are designed to collect input for the regional body. Some ACHs adopt multiple methods. Currently there is no requirement for ACHs to adopt a single method for public input.

The **Olympic Community of Health (OCH)** has an Interim Leadership Council as their decision-making body, but also holds open participation stakeholder group meetings for broader community engagement (40-50). These meetings give a broad range of regional stakeholders the opportunity to participate in the ACH’s development. Activities have included: informational presentations with Q&A; small group discussions; regional assets, needs, and priorities brainstorming; and relationship building.

In addition, most of the ACHs deliberately leverage existing coalitions that have relationships with key populations as a way to bring more voices to the ACH table. One ACH described how focusing on organizations was the first step and that, “Increasing engagement of hard-to-reach, underserved, and underrepresented populations who are not traditionally at the decision making table is a priority for upcoming work.”

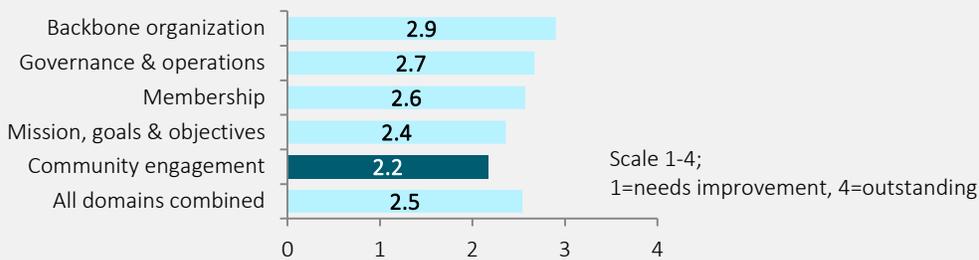
All of the ACHs have internal and public communications plans that are at varying levels of implementation. Almost all of the ACHs described frequent presentations to local organizations and community groups as significant time commitments last year. Many of the ACHs conducted one or more public forums last year and are planning to continue that work in coming years. Two thirds of the ACHs have an active web presence, but the content varies from including detailed ACH materials (e.g. designation proposals, board minutes) to simply describing the ACH vision or event dates. A few ACHs regularly distribute newsletters or targeted communication to their broader stakeholder lists.

Our local community forums are an important venue for interaction with the broader community in each county. They intentionally build on existing community health improvement planning processes and other existing community structures that facilitate cross-sector communication.

**ACH participant survey responses: Feedback on community engagement**

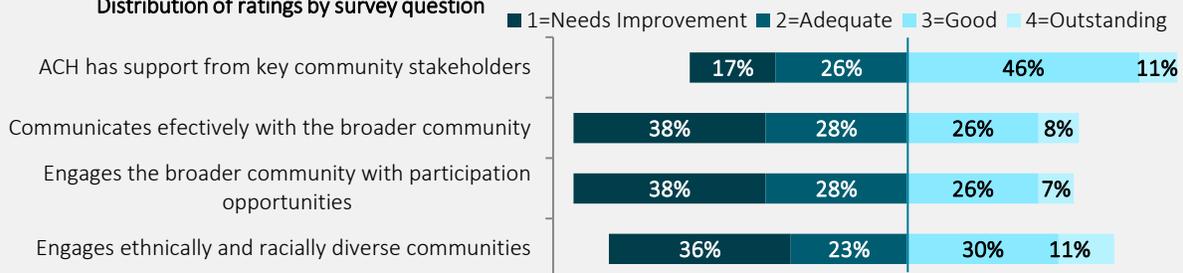
Survey respondents rated community engagement the lowest out of five survey domains, with a statewide average rating of 2.2, which corresponds to a score of *adequate* on the survey rating scale (1=needs improvement; 2=adequate; 3=good; 4=outstanding).

**Average ratings of ACH development by survey domain**



Respondents rated their ACHs well for getting support from key community stakeholders. However, more than one-third of respondents indicated their ACHs *need improvement* with regards to communicating effectively with the broader community, engaging the community with participation opportunities, and engaging ethnically and racially diverse communities in the ACH.

**Distribution of ratings by survey question**



### Focusing ACH work: Health planning and priority setting

To obtain designation, ACHs were required to develop a Regional Health Needs Inventory (RHNI) that reflected their entire regional service area and demonstrate planning for a regional health improvement plan.

**Needs and asset assessment.** All of the ACHs leveraged multiple existing data inventories, including recent hospital and public health district community health needs assessments, to identify health priorities or service gaps. Several multi-county ACHs looked at various county-level assessments to identify common priorities across the region.

A few ACHs talked about how time consuming it is to create a regional look at health. In particular, they described the challenge of using health needs assessments created by a variety of local entities or counties since each employed a different methodology and conducted them on different timelines. After this initial process, one ACH began working to align the assessment structure so that they would be better able to think and plan as a region in the future.

All of the ACHs recognized a need to move beyond existing data and conducted some type of asset inventory to identify existing programs, services or initiatives related to regional health priorities or advancing the Triple Aim. They saw this as a first step in alignment of local efforts.

“To foster collaboration and to avoid duplication, **North Sound ACH** reached out to local health jurisdictions and hospitals to invite them to participate in a **Regional Health Needs Inventory Work Group**.” Together this group looked across existing local Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs) to better understand the region’s needs. The workgroup also expanded existing inventories of programs, tasked staff with interviewing health leaders and service providers. This work has led to the selection of two projects that align with their region’s shared goals and will be early ACH wins: 1) care coordination via emergency medical services and 2) prevention of unintended pregnancies through education for primary care providers on long-acting reversible contraception.

**Priority setting.** At the time of this report, about half of the ACHs had established formal priorities that were clearly driving their ACH efforts; the other half had done some prioritizing, but had not formally finalized their list. On average, ACHs had identified five regional priorities; the most common ones (each identified by 6-7 ACHs) were access to care, behavioral health (including behavioral health integration), care coordination, and social determinants of health or health equity. Three of the ACHs selected chronic disease prevention and/or management as a priority and three additional ACHs identified diabetes prevention and/or management specifically. A few ACHs identified housing, oral health care, substance abuse, and adverse childhood experiences (ACEs) as priorities.

We know the priorities across all the counties, we’ve vetted them with stakeholders, and cross-walked them to get a clear idea of regional priorities. But regional work is a bit of a challenge because a lot of the work is going on locally. I’m not sure how that will work.

Part of the overall vision is to just develop a better understanding of what process it will take to do engagement on [our priorities]. What does it take to develop a collaborative approach for an initiative like this?

### ACH participant survey responses: Assessing progress toward regional health priorities

Survey respondents were split in rating their ACHs' progress towards regional health priorities. About half (55%) of respondents rated their ACHs *good* or *outstanding* for agreeing on health priorities based on identified regional health needs. The other half (45%) of respondents rated their ACHs as *adequate* or *needs improvement*.

### Early wins: Developing regional projects

ACHs are expected to implement at least one regional health improvement project designed to create measurable progress toward a regional health improvement goal. Many of the ACHs discussed the importance of moving forward with a project as a mechanism from maintaining partner involvement and demonstrating the value of the ACH. As one ACH backbone staff member stated, "The planning phase is encountering impatience because they want to be done and start doing something."

While ACHs are in different stages of project selection, several have developed a formal process that uses criteria and ranking to explore possibilities, engage participants, facilitate discussion and decision making. Some ACHs saw project selection and implementation as an opportunity to build trust and strengthen collaboration. They also recognized the difficulty in getting partners to work effectively across sectors and move away from thinking about their sectors in silos, which keep organizations from aligning.

Both of the pilot ACHs – North Sound and Cascade Pacific Cascade Alliance (CPAA) – selected initial projects and have moved forward with implementation. North Sound selected and is in the planning phase for two regional projects – a care coordination project targeting high utilizers of emergency medical system and emergency departments and a prevention project partnering with primary care providers to increase awareness and accessibility of long-acting reversible contraception. CPAA also implemented two projects, both targeting youth – a pilot project responding to adverse childhood experiences (ACEs) in six local schools (see below) and a youth marijuana prevention and education project.

I think we have a good understanding of the key issues, but I think it's going to be a challenge when we start talking about breaking down silos and barriers. We need to find small projects where they can collaborate and build trust more.

**Cascade Pacific Action Alliance (CPAA)** – In January 2015, CPAA launched the Youth Behavioral Health Coordination Pilot project to identify children with behavioral health challenges as early as possible and connect at-risk children with community-based intervention and treatment services. Six schools (including elementary, middle and high schools) in four counties were selected as pilot test sites.

An initial work group consisting of representatives from school districts, social services organizations and health care providers selected behavioral health screening tools, identified treatment resources within the region, discussed the roles of school staff and treatment providers, and mapped how these roles would be coordinated on behalf of the children. Then multi-sector work groups in each of the four counties (Cowlitz, Mason, Thurston and Wahkiakum) worked to customize project work flows to be responsive to local conditions.

By January 2016, implementation had begun in Cowlitz County and 25 students had been served by a cross-disciplinary intervention team led by a Registered Nurse care coordinator who works closely with various partners including school staff members, school district nurses, local pharmacies, county youth services, law enforcement, child protective services, and physical and oral health providers.

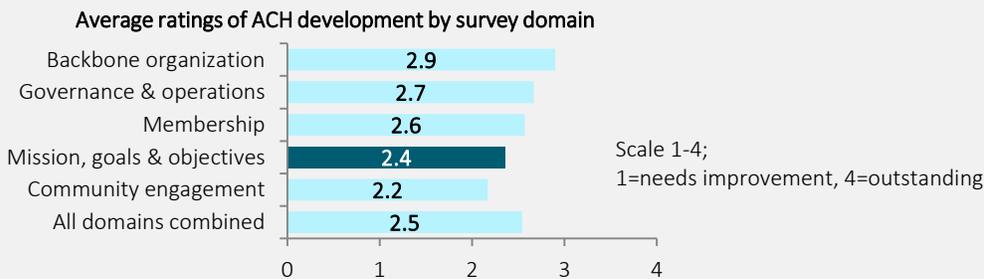
It is anticipated that all ACHs will submit project proposals to HCA for review and approval in early 2016. However, most ACHs have already expressed strong concerns about insufficient funding to conduct the level or type of projects necessary to improve or transform population health in their region. In addition, they are concerned projects with more limited scope will produce smaller changes, which will not demonstrate the ACH’s value to stakeholders and keep them at the ACH table.

ACHs see insufficient funding as both a short term problem for launching projects and a long term problem for developing sustainably and achieving regional change. As one ACH said about the current level of funding, “Realistically we can only do small things now, on the margins.” Another said, “There isn’t serious money in the system for population health improvement that goes beyond health care delivery...A disconnect between the reality and the accountability rhetoric.”

The projects are deliberately cross-sectoral and are seeking to demonstrate what can be achieved through mutually supportive and aligned actions of diverse stakeholders within our region.

**ACH participant survey responses: Feedback on regional projects**

Survey respondents across the state gave the mission, goals & objectives domain an average rating of 2.4, which corresponds to a split between an *adequate* and *good* rating on the survey scale (1=needs improvement; 2=adequate; 3=good; 4=outstanding). Within the mission, goals & objectives domain are three survey questions about ACHs developing regional projects.



More than half of respondents rated their ACHs as *adequate* or *needs improvement* on survey questions related to project development.

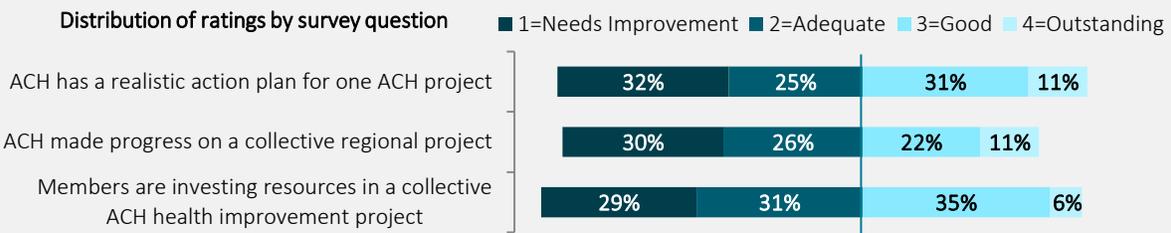


Table 2. ACH regional priorities at-a-glance

ACH	Counties	Regional Priorities (as of January 2016, may be interim)
<b>Better Health Together</b> (BHT) <a href="#">website</a>	Adams, Ferry, Lincoln, Pend Oreille, Stevens, Spokane	<ul style="list-style-type: none"> <li>• Access to oral health care</li> <li>• Community-based care coordination</li> <li>• Linkages in housing, food security &amp; income stability systems</li> <li>• Obesity reduction &amp; prevention</li> <li>• Whole-person care; integration of physical, behavioral &amp; oral health care</li> </ul>
<b>Cascade Pacific Action Alliance</b> (CPAA) <a href="#">website</a>	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, Wahkiakum	<ul style="list-style-type: none"> <li>• Access to care &amp; provider capacity</li> <li>• Adverse childhood experiences (ACEs) prevention &amp; mitigation</li> <li>• Chronic disease prevention &amp; management</li> <li>• Economic &amp; educational opportunities</li> <li>• Health integration &amp; care coordination</li> </ul>
<b>Greater Columbia</b> (GC ACH)	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Walla Walla, Whitman, Yakima	<ul style="list-style-type: none"> <li>• Behavioral health</li> <li>• Care coordination</li> <li>• Healthy youth &amp; equitable communities</li> <li>• Obesity/diabetes</li> <li>• Oral health – primary caries prevention</li> </ul>
<b>King County</b> <a href="#">website</a>	King	<ul style="list-style-type: none"> <li>• Physical/behavioral health integration</li> <li>• Care coordination for complex needs</li> <li>• Health equity</li> <li>• Housing-Health intersections</li> <li>• Prevention – chronic disease &amp; social determinants of health</li> </ul>
<b>North Central</b> (NCACH)	Chelan, Douglas, Grant, Okanogan	<ul style="list-style-type: none"> <li>• Diabetes prevention and management</li> <li>• Health care transformation</li> </ul>
<b>North Sound</b> (NSACH) <a href="#">website</a> <a href="#">Facebook</a>	Island, San Juan, Skagit, Snohomish, Whatcom	<ul style="list-style-type: none"> <li>• Behavioral health integration &amp; access</li> <li>• Care coordination</li> <li>• Dental &amp; primary care access</li> <li>• Health disparities</li> <li>• Housing</li> <li>• Prevention</li> </ul>
<b>Olympic Community of Health</b> (OCH) <a href="#">website</a>	Clallam, Jefferson, Kitsap	<i>Regional priorities not selected. Broad areas of focus include:</i> <ul style="list-style-type: none"> <li>• Access to care (coverage &amp; capacity)</li> <li>• Population health improvements</li> <li>• Access to “Whole person” support (clinical coordination &amp; integration)</li> <li>• Data management &amp; infrastructure</li> </ul>
<b>Pierce County</b> <a href="#">website</a>	Pierce	<ul style="list-style-type: none"> <li>• Access to care</li> <li>• Behavioral health</li> <li>• Chronic disease</li> <li>• Health equity &amp; social determinants of health</li> </ul>
<b>Southwest Washington Regional Health Alliance</b> (SWWA RHA)	Clark, Skamania	<ul style="list-style-type: none"> <li>• Access to care</li> <li>• Behavioral health integration</li> <li>• Care coordination</li> </ul>

## ACHs and the Healthier Washington initiative

ACHs are an essential component of Washington’s Health Innovation Plan, known as “Healthier Washington,” which aims to transform the health system in the state to bring better health, better care, and lower costs to Washington residents. By 2019, the five-year Healthier Washington plan, funded through a federal \$65 million State Innovation Models (SIM) grant, has goals to:

- See improvements in health for 80% of Washington residents and communities.
- Achieve improved health outcomes and lower costs for Medicaid clients with physical and behavioral health co-morbidities.
- Limit annual state-purchased health care cost growth to 2 percent less than the national health expenditure trend.

As described by Washington state, Healthier Washington “is guided by the principle that no one individual or organization alone can make it happen. Working together, we can achieve better health and better care at lower cost for Washington’s residents.” Although it is clear that ACHs will play a key role in realizing this vision, very little detail on how this will be operationalized is clear thus far. Initial statements describe ACHs as the regional forum for alignment between local activities and the broader Healthier Washington strategies, including potential implementation activities. This uncertainty has significant implications for Washington’s model since the goal is for regional ACH and state-level Healthier Washington work to be complementary and synergistic.

Figure 7. Healthier Washington



### Examples of early ACH involvement

One of the more visible examples of ACH involvement in the broader Healthier Washington initiatives is the nomination of a subset of backbone staff, representatives from the Greater Columbia, King County, and North Sound ACHs, to represent the statewide group in conversations on broader measurement initiatives. These representatives have regularly provided input on Healthier Washington’s data and analytics initiative (Analytics, Interoperability and Measurement (AIM)). This representative approach also empowered one ACH representative to provide public testimony to the Performance Measures Coordinating Committee that represented the collective needs of ACHs across the state.

HCA staff also routinely bring Healthier Washington initiatives to regular cross-ACH meetings to foster closer collaboration during both development

and implementation phases. All of the ACHs have representatives participating in the Plan for Improving Population Health’s external advisory board, which is being led by Washington’s Department of Health. ACHs have also hosted or participated in several of the Practice Transformation Support Hub Listening Sessions.

Southwest Washington is the first region in the state to adopt fully-integrated managed care, and in April 2016, people covered by Medicaid in Clark and Skamania counties will receive comprehensive physical and behavioral health services through the managed care plan of their choosing. As a partner in this effort, **Southwest Washington Regional Health Alliance** will be “participating in the development and monitoring of an ‘early warning system’ designed to provide an early alert to local health and community system issues, including access to services.” This system is likely to monitor for a wide range of issues from spikes in emergency department and jail use to drops in Medicaid enrollees seeking treatment.

### ACH feedback on participating in Healthier Washington

Feedback from ACHs on perceived benefits and challenges of partnering with HCA and participating in the Healthier Washington initiative was gathered throughout the first year and shared with HCA.

**The Health Care Authority is seen as engaged and responsive.** Overall, all the ACHs had positive feedback about working with the HCA, describing that regular communication mechanisms were an example of HCA “getting it right.” These regular touchpoints provide a venue for the HCA team and their Healthier Washington partners to provide information and solicit feedback. As one ACH commented, “It seems like the HCA is trying to live the learning model.”

**ACHs want to be seen as partners and co-creators of this new model.** ACHs appreciated HCA’s efforts to partner in the development of the new model Washington is pioneering, but continue to ask for clarity as new aspects of the role emerge. One of the strongest themes was frustration with abrupt changes in direction or timeline concerning issues that significantly impact ACH development. As one ACH said, “surprises are just bad for building trust.”

**Funding levels are a key concern for ACHs.** Most ACHs expressed strong concerns about the overall level of funding to build and sustain ACHs in their region. They see the role of ACHs as becoming more central to Healthier Washington’s overall success than originally anticipated, but the funding levels have not increased accordingly. They believe the HCA is not “resourcing in line with what they want to be improved.”

**“Giving guidance and allowing for flexibility don’t need to be mutually exclusive.”** Most ACHs talked about the desire for individual ACH flexibility while simultaneously asking for more HCA guidance in developing these complex collaboratives. Many have strong concerns about HCA deciding to impose rigid requirements on ACH function or development, but some also

The Healthier Washington group is creative, energetic, and enthusiastic. It’s been great to work with them.

I’ve never seen a government agency doing anything close to this adaptive leadership. But they are falling victim to the same things we are – the train is moving so fast.

said the lack of guidance meant each ACH had to start from scratch for development of fundamental ACH functions. The ACHs see an opportunity to gain efficiency if the state can provide more direction on how to tackle some complex tasks.

**There is confusion about the ACH role in broader Healthier Washington activities.** ACHs had many questions about other aspects of Healthier Washington and report confusion about the goals, structure, and expected ACH role in those efforts. Several ACHs experienced situations where the state agencies leading the different Healthier Washington activities were not aligning on their plans or communication strategies. Most ACHs were concerned about their capacity to participate in these other Healthier Washington efforts in addition to the work to launch and develop their ACHs.

They (the State) have a big enough challenge of showing they have the credibility to do this in the communities, and that’s without them tripping over themselves...So it seems a little tone-deaf.

### Long-term ACH impact: Achieving the Triple Aim

Over the next few years, ACHs will begin their regional health improvement work in earnest. The long term impact of this work is to improve regional health and well-being, advance health equity and achieve the Triple Aim of better health, better care, and lower costs.

**The Common Measure Set.** The Washington State Health Care Authority has adopted a set of 52 common measures as a standard way to measure the impact of the Healthier Washington initiative (see Table 3 and Appendix E).

As part of this alignment, the Common Measures are being incorporated into other state contracts, including those with health plans and providers, with the expectation that adoption of these measures will grow over time. As stated in the first report of these measures for ACH regions, “Gaining multi-organization alignment around the state’s Common Measure Set will clarify our collective understanding of health care value and send a clearer market signal regarding purchaser and payer expectations for performance on key indicators.”

**Table 3. Areas of focus in the Common Measure Set**

Prevention	Acute Care	Chronic Illness
Adult screening(s)	Avoidance of overuse/ potentially avoidable care	Appropriate use of medications
Childhood: early and adolescent	Behavioral health	Asthma
Immunizations	Cardiac	Depression
Obesity/ Nutrition/ Physical activity	Readmissions	Diabetes
Oral health	Obstetrics	Hypertension and cardiovascular disease
Tobacco cessation	Patient safety	
Unintended pregnancy	Stroke	
Cross cutting: Patient experience		

**Focus on the social determinants of health.** Many ACHs cite a focus on social determinants of health as part of their ACH’s mission and a key reason that stakeholders beyond traditional health partners are participating. Due to the focus on the Common Measure Set, these ACHs have consistently expressed concern that broader stakeholders will not see the impact of their work

I’m worried about the impact on our stakeholders if you push those clinical measures.

reflected in those clinically focused measures and clinical stakeholders will not be encouraged to think about health more broadly. One key concern is how progress on social determinants will be measured. The committee responsible for developing the Common Measure Set recently added behavioral health measures being pursued by the ACHs.

The **King County Accountable Community of Health** established a Data/Performance Work Group aimed at supporting data sharing and integration in the ACH environment. The King County ACH has placed a high priority on clarifying and building the ACH's data and information functions, which it sees as the underpinning to successfully measuring the impacts of ACH-led cross-sector initiatives. Work ranges from building relationships between regional IT leaders and state agencies to developing a successful grant proposal that supports the integration of housing and health data, in partnership with local housing authorities.

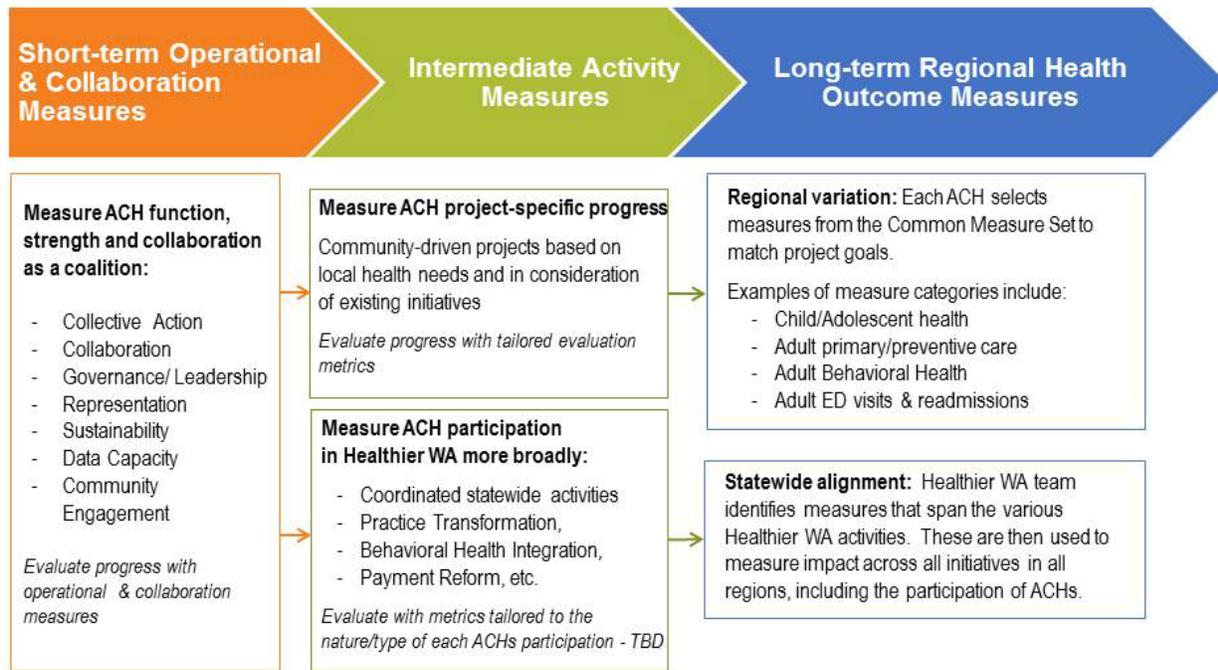
### Measuring long-term ACH outcomes

A key task of the evaluation is to develop a measurement framework that can document the long-term regional impact of ACHs on key Triple Aim measures. Measuring these regional impacts is challenging given the short time frame of the initiative, the limited scope of ACH health improvement projects, and the numerous existing regional efforts and other Healthier Washington activities occurring simultaneously, which makes it difficult to directly attribute long term health improvements to the ACHs.

CCHE addresses the challenge of attribution using a logic model framework (labeled a “chain of impact” model) that attributes longer-term changes in outcomes to ACHs only if there are corresponding short- and intermediate-term outcomes aligned with those longer term changes. The diagram (Figure 8), which draws on our Theory of Change (see above p.5), illustrates how this approach works.

On the left side, the chain starts with the development of the ACHs as functioning coalitions promoting collaboration among key regional organizations. The next step in the chain is to create regional health improvement projects and participate in Healthier Washington activities that ultimately lead to the spread of health-promoting programs, policies and practices. If the changes brought about are significant enough, we can expect to see movement in some of the longer-term regional health outcomes measures (panel on the right). The evaluation is developing measures for each step in the chain to assess whether ACHs are having their intended impact.

Figure 8. ACH chain of impact



## Conclusion and recommendations

ACHs met their major development goals during the first year of Healthier Washington. All nine regions successfully completed the criteria required to be officially designated as Accountable Communities of Health. They engaged a wide range of regional stakeholders, developed formal governance structures to guide their collaboration, took steps forward in health improvement project planning development, and began the conversation about sustainability. While there were many similarities in progress and approach, there was also significant variation across regions, reflecting the visions of the local leaders. While it is too early to draw any conclusions, over time the natural experiment provided by the variations in regional models will provide rich insight on how differences in approaches impact ACHs ability to improve regional health.

ACHs are well aware that a challenging year lies ahead as they turn their attention from building a strong foundation to active collaboration on local health improvement projects. The next year is also likely to bring more involvement in broader Healthier Washington strategies as those programs become better defined. These more action-oriented steps will provide ACHs an opportunity to demonstrate their value propositions to both regional and statewide stakeholders.

The potential of the ACH is immense and transformational - it's important to keep that bigger picture in mind.

The following are recommendations that emerged from CCHE's evaluation findings, for consideration by the Health Care Authority as the initiative begins its second year.

- Continue to support ACH development and cross-ACH learning through effective, regular communication channels. Leverage the understanding that can be gained by ACHs working on challenges together.

- Better define the ACH role in broader Healthier Washington activities, in consultation with the ACHs themselves. Allow ACHs to weigh in on key considerations during their development. Take into consideration the multiple Healthier Washington requests of ACHs and coordinate internally to minimize burden.
- When possible, look for timely opportunities to offer guidance to ACHs to help them be successful in ACH development and their broader role in Healthier Washington. For example, provide clear and concrete guidance on what constitutes an ACH “health improvement project”.
- Be consistent and clear about where there is flexibility and where there is a requirement, keeping in mind the tension between these two.
- Continue to develop and refine a common language and definitions for describing ACH structure and activities. For example, developing a common definition for what constitutes a “sector” may help facilitate stakeholder understanding and involvement.
- Examine the funding levels for ACHs and their projects and determine if this model will allow ACHs to impact population health in their region in the given timeframe.
- Continue to explore inclusion of broader social determinants of health measures as part of the Common Measure Set or other statewide measurement efforts, such as Washington’s Plan for Improving Population Health. Include ACHs in this discussion.

## Appendix A: ACH models nationwide

The ACH model is not unique to Washington state. Although there are no direct equivalents in other states, ACH or Accountable Care Community models that share key characteristics are active or are currently being piloted in some other states. Given the emerging nature of the ACH model and its focus on community-driven design, there are not clear guidelines for Washington's implementation. Examining the similarities/differences and challenges faced by other ACH models can inform the development of Washington's model.

At the heart of these models is the idea that improving population-level health requires collaboration between multi-sector stakeholders that reach beyond traditional health care providers. This inclusion of community-based services and an acknowledgement of the importance of social determinants of health is a hallmark of the model.<sup>1</sup> The various ACH models differ widely on elements such as governance structure, choice of backbone organization, and the scope of work or community impact anticipated. For example, Vermont primarily uses hospitals as the backbone organization for their models, since hospitals were best suited to engage their communities.<sup>2</sup> This is different from other states, including Washington, which may use existing community organizations or have developed new entities to facilitate ACH activities. Some ACH efforts are more centered in care coordination within clinical settings; however, in Ohio, Accountable Care Communities emphasize leveraging resources outside clinical settings, i.e. social services, public health, and community organizations, an emphasis similar in Washington's model.<sup>3,4</sup>

Typically, models have targeted health indicators, and are implemented within a defined region or specific population. In many cases, ACHs are implemented in only select communities within a state. Washington, however, has chosen to divide the entire state into regions for ACH implementation at the same time.

In some states the model also incorporates some form of value driven payment. Minnesota also received State Innovation Model funding (SIM) to implement an Accountable Health Model in 15 select communities.<sup>5</sup> While many of the collaborative aspects are similar to those in Washington, Minnesota's model also requires partnership with an Accountable Care Organization, a model that holds providers accountable for costs and quality of care. While payment model testing is included in Washington's broader Healthier Washington initiative<sup>6</sup>, there are not specific requirements for ACH-level strategy development in that area.

Models such as the Patient-Centered Medical Home, the Accountable Care Organization, and Oregon's Coordinated Care Organizations have explored the integration of clinical services with behavioral health and social services, but the ACH model is one of the first frameworks to purposefully integrate public health strategies that address the community-level factors that shape population health.

– Prevention Institute

As these models are relatively new, limited longitudinal data is available to show significant effects at a population level. Given the emerging nature of the ACH model and its focus on community-driven design, there are not clear guidelines for Washington’s implementation. Under the SIM grant, Washington hopes to learn more about how ACHs can successfully leverage innovation and increase collaboration in local communities.

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<sup>1</sup> Prevention Institute (2016), *The Accountable Communities for Health: An Emerging Model for Health System Transformation*. Retrieved from: <http://www.preventioninstitute.org/component/jlibrary/article/id-371/127.html>

<sup>2</sup> Mikkelsen, L & Haar, W.L. (2015) *Accountable Communities for Health: Opportunities and Recommendations*. Retrieved from Prevention Institute website: <http://www.preventioninstitute.org/component/jlibrary/article/id-366/127.html>

<sup>3</sup> St. Jean, E. (2015). *Profiles of County Innovations in Health Care Delivery: Accountable Care Communities*. Retrieved from National Association of Counties website: <http://www.naco.org/sites/default/files/documents/Accountable-Care-Communities.pdf>

<sup>4</sup> Janosky, J.E. & Douglas, F.L. (2012). *Healthier By Design: Creating Accountable Care Communities. A Framework for Engagement and Sustainability (White paper)*. Austen BioInnovation Institute in Akron, Akron, OH. Retrieved from: <http://abiakron-org.s3.amazonaws.com/Data/Sites/1/pdf/accwhitepaper12012v5final.pdf>

<sup>5</sup> State of Minnesota. (2016). *Minnesota Accountable Health Model – SIM Minnesota*. [Fact sheet]. Retrieved from [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16\\_197626](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_197626)

<sup>6</sup> Washington State Health Care Authority. (2015). *The Plan for a Healthier Washington*. Retrieved January 26, 2016, from <http://www.hca.wa.gov/hw/pages/default.aspx>

## Appendix B: Annotated Healthier Washington resources

For more information on **Healthier Washington**, including details on each Strategy and the links to the original Healthier Washington State Innovations Model grant application --

<http://www.hca.wa.gov/hw/pages/default.aspx>

For more information on the **Accountable Communities of Health**, including the Readiness Proposal Criteria, Frequently Asked Questions and updates on their progress -

[http://www.hca.wa.gov/hw/Pages/communities\\_of\\_health.aspx](http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx)

For more information on the **Common Measure Set** for Health Care Quality and Cost –

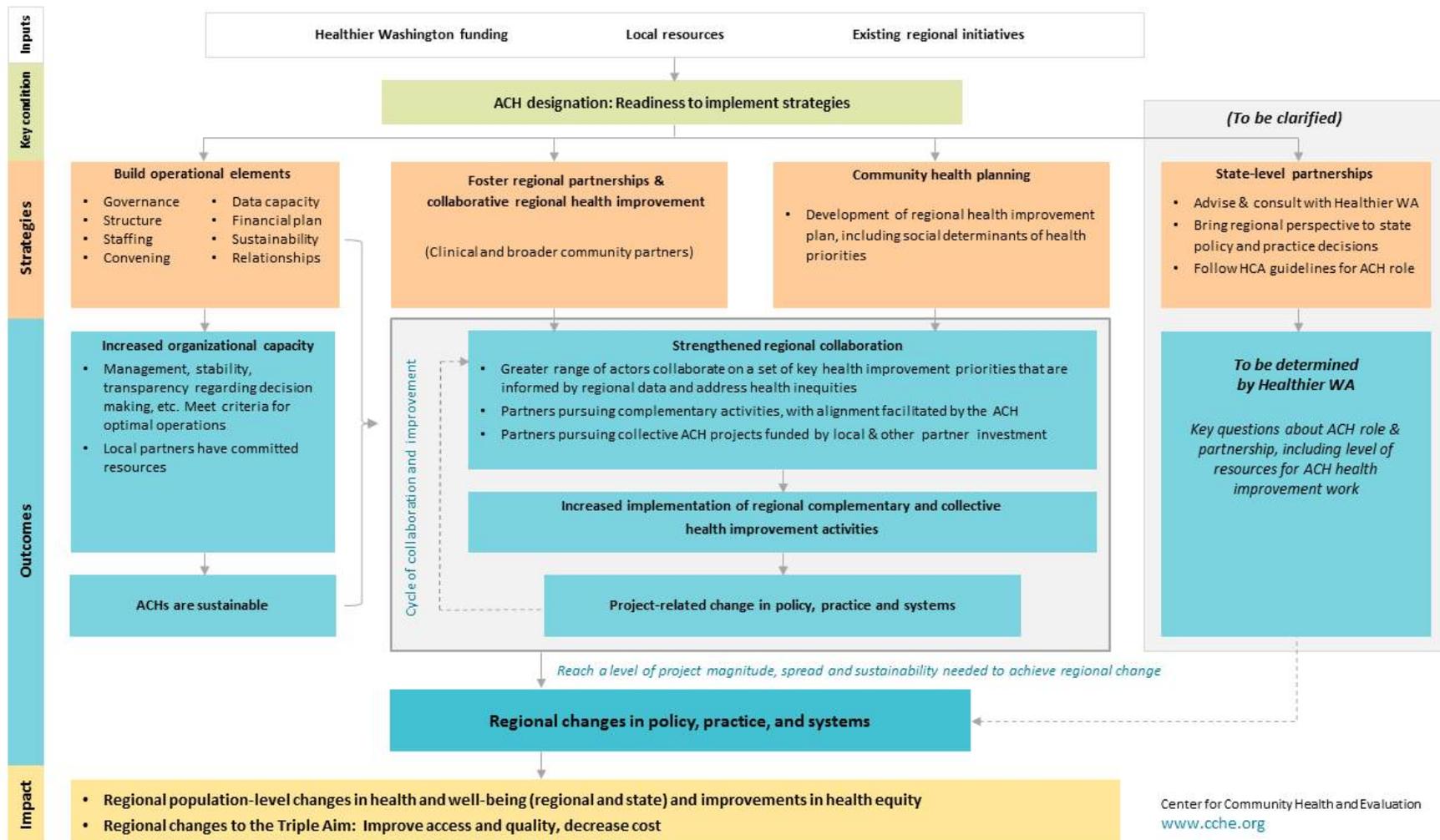
[http://www.hca.wa.gov/hw/Pages/performance\\_measures.aspx](http://www.hca.wa.gov/hw/Pages/performance_measures.aspx) . For ACH specific information, see the **2015 Performance Results for Accountable Communities of Health**.

[http://www.hca.wa.gov/hw/Documents/performance\\_results\\_achs2015.pdf](http://www.hca.wa.gov/hw/Documents/performance_results_achs2015.pdf)

## Appendix C: ACH theory of change

### Healthier Washington: Accountable Communities of Health | Theory of Change

DRAFT 1/20/2016



## Appendix D: Evaluation approach & data collection methods

In May 2015, the Health Care Authority (HCA) contracted with the Center for Community Health and Evaluation (CCHE) to evaluate the ACHs.<sup>1</sup> The ACH evaluation closely coordinates with the evaluation the overall Healthier Washington initiative, led by a team at the University of Washington.

CCHE takes a collaborative approach to evaluation and partnered with key stakeholders at HCA to develop a theory of change for ACHs within Healthier Washington (see Appendix C) and a framework for measuring short, intermediate and long-term impact ACHs' work (see p. 27).<sup>2</sup> These documents, along with input from HCA staff, informed the development of an evaluation plan for three-year initiative focused on four key questions (see Figure 9).

The evaluation plan is expected to adapt over the course of the multi-year project (2015-2019); the evaluation will flex to respond to lessons learned and shifts in ACH activities and the strategic direction of Healthier WA.

CCHE aims to understand the function and contribution of the ACHs—how they form, agree on community health priorities, engage in health improvement activities, contribute to the Healthier Washington initiative, and work towards becoming sustainable coalitions. CCHE will also assess the ACHs' impact at the end of the project. In addition, CCHE provides timely feedback to Healthier Washington and HCA staff through bi-weekly check-in calls with key program staff, regular presentations to key decision makers, and written memos about ACH success factors, challenges, and lessons learned to inform program improvement. This final report includes ACH evaluation findings from the first year of Healthier Washington – February 2015 – January 2016.

Qualitative and quantitative data were collected from multiple sources to understand ACH capacity and progress for this report. CCHE took an opportunistic approach to data collection, leveraging existing structures and convenings of ACH participants to increase understanding of relevant context and minimize burden on the ACHs. This approach generated a rich set of qualitative data, but resulted in some inconsistency in the timing and level of detail of information collected from each individual ACH. All qualitative data gathered is considered confidential and reported in aggregate as themes in this report.

Figure 9. Evaluation questions

1. Have the ACHs been successful in achieving their objectives in:
  - Governance, structure and operational capacity?
  - Developing and implementing effective, collaborative health improvement plans and at least one regional health improvement project?
  - Contributing to broader Healthier Washington activities?
2. What have been the success factors and barriers for achieving the ACH objectives?
3. What lessons have been learned in the process of ACH implementation that can help shape the future direction of the program?
4. To what extent have ACHs advanced the Triple Aim – population health, patient experience and per capita cost?

**Site visits** to all nine ACH regions to observe ACHs in action including meeting structure, decision making processes, participant engagement, and quality of discussion/collaboration.

**Interviews** with backbone staff and key ACH participants to understand ACH development, regional ACH activities, and their role in state-level Healthier Washington activities. Interviews were also conducted with key Healthier Washington staff, including technical assistance providers.

**Online survey** of regional stakeholders engaged in the ACHs to solicit individual ACH participants' opinions and perspectives about how each of the nine ACHs are developing and functioning; 391 participants responded to the survey in Year 1.

**Observing meetings** where ACH members are convened to discuss both ACH development and the statewide initiative (e.g., weekly conference calls with ACH backbone staff) to document ACHs evolution individually and as participants in Healthier Washington, including reported success factors, challenges, and lessons learned.

**Document review** of ACH grant applications, designation proposals, and reports submitted to HCA, as well as the broader Healthier Washington initiative materials necessary to understand the context in which the ACHs are developing.

Qualitative data from interviews were analyzed thematically with the aid of Atlas.ti. Quantitative data were compiled and analyzed with Microsoft Excel and STATA where appropriate.

When not otherwise attributed, quotes within this report are from ACH backbone staff and participants or ACH designation applications. When appropriate, descriptions of Healthier Washington, including the ACH initiative goals, purpose and criteria, align as closely as possible with published material such as the ACH Requests for Proposals, Healthier Washington website descriptions and the ACH Frequently Asked Questions document.

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<sup>1</sup> Washington State Health Care Authority. (2015). *Accountable Communities of Health*. Retrieved January 26, 2016 from [http://www.hca.wa.gov/hw/Pages/communities\\_of\\_health.aspx](http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx)

<sup>2</sup> Current versions of these guiding documents are included in this report. They are subject to changes as the initiative unfolds and more is learned about how the role of ACHs is operationalized.

## Appendix E: Washington State Common Measure Set

The Common Measure Set for Health Care Quality and Cost was originally approved December 2014. Detail available at: [http://www.hca.wa.gov/hw/Pages/performance\\_measures.aspx](http://www.hca.wa.gov/hw/Pages/performance_measures.aspx).

Population Measures	
1. Immunization: Influenza	4. Behavioral health: % of adults reporting 14 or more days of poor mental health
2. Unintended pregnancies	
3. Tobacco: % of adults who smoke cigarettes	5. Ambulatory care sensitive hospitalizations for COPD
Clinical Settings Measures	
<b>Children/Adolescents (Health Plan)</b>	
6. Access to primary care	27. Immunizations: Pneumonia (older adults)
7. Well-child visits in the 3rd, 4th, 5th & 6th years of life	28. Avoidance of antibiotics for acute bronchitis
8. Youth obesity: BMI assessment/counseling	29. Avoidance of imaging for low back pain
9. Oral health: Primary caries prevention/ intervention	30. Asthma: Use of appropriate medications
<b>Adults (Health Plan)</b>	
10. Access to primary care	31. Cardiovascular disease: Use of statins
11. Adult obesity: BMI assessment/counseling	32. COPD: Use of spirometry in diagnosis
12. Medical assistance with smoking and tobacco use cessation	33. Diabetes: HbA1c testing
13. Colorectal cancer screening	34. Diabetes: Eye exams
14. Diabetes care: Blood pressure control	35. Diabetes: Screening for nephropathy
15. Diabetes care: HbA1c poor control	36. Depression: Medication management
16. Hypertension: Blood pressure control	37. Medication adherence: Proportion of days covered
17. Follow-up after hospitalization for mental illness @ 7 days, 30 days	38. Medication safety: Annual monitoring for patients on persistent medications
18. 30-day psychiatric inpatient readmission	39. Medications: Rate of generic prescribing
<b>Children/Adolescents (Primary Care Medical Groups)</b>	
19. Immunization: Childhood status	<b>Additional Measures (Hospitals)</b>
20. Immunizations: Adolescent status	40. Patient experience: Communication about medications and discharge instructions
21. Immunizations: HPV vaccine for adolescents	41. 30-day all cause readmissions
22. Appropriate testing for children with pharyngitis	42. Potentially avoidable ED visits
<b>Adults (Primary Care Medical Groups)</b>	
23. Patient experience: Provider communication	43. Patients w/ 5 or more ED visits <i>without</i> care guidelines
24. Screening: Cervical cancer	44. C-section NTSV
25. Screening: Chlamydia	45. 30-day mortality: Heart attack
26. Screening: Breast cancer	46. Catheter-associated urinary tract infection
<b>Health Care Cost Measures</b>	
50. Annual state-purchased health care spending relative to state's GDP	47. Stroke: Thrombolytic therapy
51. Medicaid spending per enrollee	48. Falls with injury per patient day
52. Public employee and dependent spending per enrollee (include public schools)	49. Complications/patient safety composite (11 parts)