CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

— Request for Proposals —

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Request for Proposals

California Accountable Communities for Health Initiative (CACHI)

OVERVIEW

Over the last several years, there has been an acceleration of efforts both to reform the health care delivery system and address community conditions that contribute to ill health. Through the development of integrated delivery systems, such as Accountable Care Organizations, and community-based efforts, like Community Transformation Grants, it is now well recognized that it takes a broad range of partnerships—across the health care system as well as sectors that affect the social determinants of health—to make significant improvements in personal and population health and achieve greater health equity.

Until recently, however, most health care delivery reform efforts have been conducted separate from community-based efforts. Yet, all such sectors are needed to work in close collaboration to address the spectrum of contributors to ill health, improve health and, ultimately, reduce health care costs.

In response to this challenge, Community Partners, with support from a consortium of funders (The California Endowment, Blue Shield Foundation of California, and Kaiser Permanente), is releasing this Request for Proposals to support up to six Accountable Communities for Health through the California Accountable Communities for Health Initiative (CACHI).

Accountable Communities for Health (ACHs) seek to explicitly bring together key sectors and partners—from the community to the health care delivery system—in order to collectively advance a common health goal. This model builds on prior efforts to coordinate and integrate various organizations, programs and services by linking their activities together in a coherent and reinforcing portfolio of interventions across five key domains. By aligning activities to address particular health issues in a community, ACHs can achieve meaningful and lasting improvements in personal and population health. The CACHI will assess the feasibility, effectiveness, and potential value of a more expansive, connected and prevention-oriented health system.

I. BACKGROUND

In 2013, California received a Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Design Grant to develop a plan, using the Let's Get Healthy California report as a foundation, for implementing significant health system and payment reforms. This plan, the State Health Care Innovation Plan (http://www.chhs.ca.gov/pages/pritab.aspx) was prepared with input from key health and health care leaders in the state, and outlines a vision in which *"California is home to high quality, efficient, seamless health systems throughout the state, which improve health outcomes for all Californians."* The Plan includes four core initiatives and six building blocks to achieve these strategies. One of the Innovation Plan's four initiatives is the Accountable Communities for Health (ACH).

The definition of an ACH is as follows:
An Accountable Community for Health is a multi-payer, multi-sector alliance of major health care systems, providers, and health plans, along with public health, key community and social services organizations, schools, and other partners serving a particular geographic area. An ACH is responsible for improving the health of the entire community, with particular attention to achieving greater health equity among its residents.

The goals of an ACH are to 1) improve personal and community-wide health outcomes and reduce disparities with regard to particular chronic diseases or health needs; 2) control costs associated with ill health; and, 3) through a self-sustaining Wellness Fund, develop financing mechanisms to sustain the ACH and provide ongoing investments in prevention and other system-wide efforts to improve population health.

CACHI was designed to implement a new population health model that would link together health care systems, community resources and social services with primary prevention approaches in a given geographic area to address a particular health need, such as chronic disease, on a community-wide basis.

Explicit in the design of the ACH is the coordination of a portfolio of aligned and mutually reinforcing interventions that span five key domains – clinical, community, clinical-community linkages, policy and systems, and environment—in order to improve personal and population health. Moreover, the effort should pay particular attention to reducing health inequities, defined as focusing on the needs of, and gaining net positive impacts in, communities with populations most at risk for poor health outcomes.

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

To continue efforts begun during the development of the Innovation Plan, the state formed an Accountable Communities for Health Work Group, composed of representatives from community clinics, health plans, hospitals, public health, prevention, academia, and philanthropy, as well as the California Department of Public Health and other state departments. The Work Group was charged with developing recommendations for the design and implementation of the ACH program as envisioned in the Innovation Plan. A final report of the Work Group can be found at: http://www.chhs.ca.gov/PRI/ACH%20Work%20Group%20Report%20FINAL.pdf.

II. KEY ELEMENTS OF ACCOUNTABLE COMMUNITIES FOR HEALTH

Accountable Communities for Health represent a relatively new development in health system transformation, and they are being tested around the country. These projects are all in progress, so no single model has emerged. Moreover, they have embodied different approaches and areas of focus. Nevertheless, they share a commitment to population health and multi-sector collaboration:

- Massachusetts Prevention and Wellness Trust Fund
  http://www.mass.gov/eohhs/docs/dph/com-health/prev-wellness-advisory-board/annual-report-2014.pdf

- Washington State Accountable Community of Health (CMMI SIM Grant) http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx
- Minnesota Accountable Communities for Health (CMMI SIM Grant) http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_achgp
- Vermont Accountable Community for Health (CMMI SIM Grant) http://www.preventioninstitute.org/component/jlibrary/article/id-366/127.html
- BUILD Health Challenge (Kresge Foundation, RWJF, Colorado Health Foundation) http://www.buildhealthchallenge.org/

Definitional Elements. Using the Work Group report as a foundation, as well as early findings from some of the projects cited above and research conducted in California (see for example, Hogan (2015), Hester (2015) and Prevention Institute (2015)), seven definitional elements of an ACH have been identified. They are:

- **Shared vision and goals:** A common set of goals and vision, based on a shared understanding of the problem.
- **Partnerships:** Meaningful collaboration among the health care, social services, and various community agencies and sectors dedicated to achieving the vision and goals.
- **Leadership:** At least one, but ideally several, champions at both an individual and organizational level among the core entities of an ACH.
- **Backbone:** An agreed upon entity that will serve as the collaborative's facilitator and convener.
- **Data analytics and capacity:** The infrastructure, capacity, and agreements for collecting, analyzing and sharing financial, community and population-level data across a variety of providers and organizations.
- **Wellness fund:** A vehicle for attracting resources from a variety of organizations and sectors to support the goals, priorities, and strategies developed by the ACH.
- **Portfolio of interventions:** A set of coherent mutually-supportive interventions that address a particular issue or conditions across five key domains: clinical care, community programs and social services, community-clinical linkages, environment, and public policy and systems.

For further description of these definitional elements, see Appendix 1.

Geographic area/size. Many similar initiatives around the country have supported projects in communities with populations between 100,000 and 200,000. Rather than specifying that communities should be of a particular size, the Work Group recommended that an ACH should serve a defined geographic area that generally meets the following criteria.

- The combination of ACH health care-related members, in particular commercial and public health plans and providers, would be able to reach the majority of the population;
- There are sufficient ACH members across multiple sectors, particularly those related to the selected health issue, to support the portfolio of interventions;
- The total number of ACH members and/or partners is conducive to members being able to build and maintain meaningful partnerships with each other;
- The community includes populations that experience significant disparities with regard to overall disease burden and in the condition being targeted;
- The target geographic area is large enough to be able to demonstrate a measurable impact; and,

- The geographic area is small enough such that the resources of an ACH and proposed interventions are able to meaningfully address the health need.

III. CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

The goal of CACHI is to assess the feasibility, effectiveness, and potential value of a more expansive, connected and prevention-oriented health system that links together the health care sector, public health, community resources, and a range of other sectors. This is an innovative type of system transformation, which will likely take years to achieve all of its goals. Therefore, it is critical that ACHs supported by this initiative be able to demonstrate outcomes and progress toward those goals in the timeframe of this grant in order to learn what elements, activities or milestones are most important.

Geographic Diversity and the San Joaquin Valley

The funders are committed to geographic diversity and are seeking applicants from all regions of the state. For example, proposals are encouraged from highly-motivated communities in the San Joaquin Valley and rural communities that may not yet have achieved a high level of readiness, but can, nevertheless, demonstrate a commitment to the vision of an ACH and the portfolio approach outlined in the RFP. Moreover, applicants must be able to demonstrate that they could put into place the required infrastructure with an additional year of planning support. To that end, proposals should identify key gaps in readiness and the collaborative infrastructure and how they would address them with support from this initiative. (See Hogan 2015 for more information.)

To that end, it is highly desirable that proposed ACHs already have a high degree of readiness—in particular, an existing community collaborative composed of many, if not most, of the essential partners, with a history of working together.

CACHI will support several activities:

1. Grants. Initial grants provided under this RFP will be for up to $250,000 and one year in duration, with a possibility for a six-month extension for grantees to complete their milestones. Grantees that have substantially met their milestones will be provided with the opportunity for two more years of implementation funding of up to $300,000 per ACH collaborative per year.

2. Technical assistance and research support. Depending on the needs of the ACH collaboratives, CACHI will provide technical assistance to grantees for:
   - the development of the ACH structure and governance;
   - data analytics and sharing;
   - development of a sustainability plan, including braiding and/or blending funding; and
   - aligning interventions, including assessing how various combinations of interventions can complement one another to enhance both the strength and reach—or "dose"—of their efforts (Schwartz et al 2015).

   In addition, CACHI will support research regarding the development of an appropriate Return on Investment methodology or other means of assessing the financial impact and potential savings/cost avoidance of the ACH model both within the health care sector and across other

key sectors. One of the challenges of prevention is that savings or cost avoidances often accrue to entities that don't necessarily bear the cost of the interventions. Therefore, in order to develop an optimal long term financing model, it will be important to be able to identify savings from improved health and build the case for allocating some portion for reinvestment into the Wellness Fund.

3. Learning Community. Because a primary goal of CACHI is to identify indicators and outcomes of success and share best practices, CACHI will sponsor activities to promote active peer exchange of ideas, successes, challenges and progress. There will be annual convenings of all CACHI grantees as well as small meetings among specific stakeholders within each ACH, pending discussion with grantees to identify the most useful activities. For example, Backbone organizations or organizations hosting the ACH Wellness Funds may be brought together to learn from each other as well as outside experts. In addition, the funders are exploring bringing CACHI grantees together with similar initiatives from around the country to share experiences, promote cross-site learning, and disseminate findings.

4. Evaluation. The Initiative will sponsor a cohort evaluation of all grantees, based on a framework being developed by the California Department of Public Health with funding under the CMMI State Innovation Model grant. The goal of the evaluation is to document the development and operations of ACHs, assess the impact of implementing a portfolio of interventions to address a particular health need, and identify the structural and programmatic elements for success and strategies for sustainability to spread and scale the ACH model.

   There is no requirement that each ACH develop its own evaluation plan. However, CACHI grantees must agree to work with the cohort evaluator to select readily available measures and indicators to assess progress related to goals of each ACH and to collect and submit local data to the evaluator. Applicants should consider the time requirements associated with participating in the evaluation (and learning community) in developing their staffing plan and budget.

5. Relationship with the federal Accountable Health Communities initiative. The federal Centers for Medicare and Medicaid Services Innovation Center recently released a notice of funding availability for an initiative called Accountable Health Communities https://innovation.cms.gov/initiatives/ahcm/). The federal program is focused on supporting health care systems to systematically screen and address health-related social needs as a strategy to reduce health care utilization. Because there is potential for synergy between the federal AHC initiative and CACHI, applicants are encouraged to apply for both awards. Should an applicant receive awards from both solicitations, CACHI would provide flexibility to the grantee to adapt the workplan under this grant to ensure it minimizes duplication and complements the federal initiative.

IV. PROPOSAL

CACHI is a three-year initiative, and this RFP is soliciting grant proposals for the first year. The first year's activities should be designed to put the seven definitional elements in place, focusing in particular on addressing gaps, to ensure that in the second and third years, the ACH will be able to fully implement the portfolio of interventions.

It is expected that the first year will involve significant planning activities, including starting up the Backbone and Wellness Fund and formalizing governance. In addition, it is anticipated that ACHs will identify the selected health issue (see page 10), a set of short- and medium-term goals, and make significant progress toward aligning and identifying the portfolio of interventions. In many cases, some strategies and implementation-related activities will likely already be underway prior to this proposal. Therefore, grantees may propose to use some funding to fill gaps or connect and align activities, particularly in the clinical, clinical-community linkages and community and social services domains, to the degree that they are ready and able. It is anticipated that some planning and refining as well as implementation activities will be carried out throughout the course of the initiative.

Funding may be used for any or all of the following activities listed below, depending on the existing capacity, history of collaboration and work already underway:

- Staffing and facilitation of ACH collaborative and governance structure
- Start up of key ACH structures, such as Wellness Fund
- Coordination of systems to identify, refer, and report community/resident participation in program interventions
- Development and implementation of data analytics and sharing plan
- Development of a sustainability plan
- Alignment and implementation of a portfolio of interventions or particular gaps in the portfolio to address the identified health issue
- Participation in the evaluation
- Participation in the ACH learning collaborative

Key milestones for year one include:

1. Creation of the infrastructure of the ACH, including the Backbone organization, Wellness Fund and the commitment and roles of core partners to the ACH.
2. Establishment of governance structure, agreements, and a leadership team.
3. Agreement on the selected health issue and development of a comprehensive plan that includes a coherent portfolio of interventions with significant reach and strength. Identification of activities—those already underway as well as gaps—plus an understanding of how they interrelate and will be linked.
4. Identification and alignment of interventions in at least three of the five domains—clinical, community and clinical-community linkages.
5. Documentation of data capacity among the ACH members and development of strategies for data sharing.
6. Identification of outcomes, indicators, and relevant baseline data, in coordination with the evaluator.
7. Significant progress toward the development of a sustainability plan, which identifies funding sources and is designed to support the ACH infrastructure and invest in priority activities for which there are few, if any, resources.

Proposals for funding and participation in CACHI include a narrative, budget, budget narrative, workplan and other attachments, all described below.

A. Proposal Narrative

The proposal narrative should consist of the following four sections. Suggested page lengths for individual sections are provided. The entire narrative should not exceed 15 pages, excluding figures, tables, and attachments.

1. Applicant (2 pages). In this section, please provide an overall description of the proposed ACH collaborative. This should include:
   a. The lead applicant and recipient of the grant. Please indicate if the lead applicant has been designated as the Backbone organization.
   b. A listing of the collaborative participants, name and title of representative, and their proposed roles in the ACH.
      - The ACH collaborative must include:
        - Health plans, hospitals, private providers or medical groups and community clinics serving the geographic area. Although not all health care organizations in a geographic area need to be part of the ACH, please indicate the degree to which the health care sector partners collectively provide services to residents of the proposed geographic area in 1(d) below.
        - Government health and human services agency/public health department
        - Grassroots, community and social services organizations that include authentic and diverse representation of residents, particularly from underserved communities
      - It is desirable that every ACH include broad representation of several of the following types of entities or constituencies, depending on the goals of the ACH. The ACH does not need to include all of these entities, but it should focus on those that relate most directly to the selected health issue. Potential partners may include:
        - County and/or city government leadership, including elected officials
        - Behavioral health providers
        - Housing agencies
        - Food systems
        - Employers and other business representatives
        - Labor organizations
        - Faith-based organizations
        - Schools and educational institutions
        - Parks and recreational organizations and agencies
        - Transportation and land use planning agencies
        - Dental providers
        - Local advocacy, grassroots organizations or policy-focused organizations
   c. The existing leadership team and plans to expand it or include additional partners
   d. A description of the community, which includes the general boundaries of the community that is to be covered by the ACH. In addition:
      - Identify the approximate size of the population that resides in the target community.
      - Describe the general demographic characteristics of the geographic area, e.g. age, race and ethnicity, income, as well as any disparities that exist within the geographic area.
      - Provide a rationale for the size of the community that will be the target of the ACH. The following considerations should guide potential applicants.
        - The combination of ACH health care-related members, in particular commercial and public health plans and providers, would be able to reach the majority of the population;

- There are sufficient ACH members across multiple sectors to support the portfolio of interventions;
- The total number of ACH members and/or partners is conducive to members being able to build and maintain meaningful partnerships with each other;
- The community, as a whole or in part, experiences significant disparities with regard to overall disease burden and in the health need, chronic condition or set of conditions being targeted;
- The target geographic area is large enough to be able to demonstrate a measurable impact; and,
- The geographic area is small enough such that resources of an ACH and proposed interventions are able to reach the target population(s).

2. History of collaboration and activities (2-3 pages). In this section, please describe the past experiences and collaborations of proposed ACH partners.
   a. Describe the **history of collaboration** among proposed ACH partners, including any past or current collaboratives that may overlap, at least in part, with the proposed ACH collaborative. The following issues should be addressed:
      - An example of a specific activity or set of activities that the collaborative has engaged in (e.g. development of the Community Health Needs Assessments) and any outcomes of that endeavor;
      - How the proposed ACH collaborative under this grant may build on or relate to any existing collaboratives; and
      - Any experience partners have with integrated care, e.g. ACOs, integrated behavioral health, health homes etc.
   b. Describe any past or current experiences **engaging community residents and agencies** in any similar collaborative effort.
   c. Describe any experiences of proposed ACH collaborative partners in implementing **community, environmental or policy change strategies** to address community-wide population health, such as through a Community Transformation Grant or similar effort, or other Health-In-All-policies efforts.
   d. Describe any widely adopted **local strategic plans for health improvement** (e.g. Community Health Needs Assessments), or major local policies or civic entities aimed at health improvement.
   e. Describe existing **data analytics capacity** of key proposed ACH partners and past experience, if any, developing and **sharing data,** including community health needs assessments.

3. Infrastructure (4 pages). In this section, please describe the structures and operations related to ACH implementation and oversight, including specific details about how you will use this funding opportunity to develop or expand these capacities over the next year.
   a. Describe proposed **ACH governance or the process for developing governance structure and agreements**. Include information about how the governance of the ACH collaborative, the Wellness Fund, and the Backbone organization may inter-relate. In addition, describe how decisions will be made by the ACH (e.g., how funding will be prioritized, what program interventions will be included, etc.) or how such a decision-making process will be developed. For more information, please refer to "Accountable Communities for Health: Legal and Practical Recommendations" in Appendix 2.

b. Identify the **Backbone** entity and describe its proposed operation. Include information about existing and proposed new capacities and operations as well as how this funding opportunity will support the Backbone. If the Backbone entity is different from the lead applicant, describe the relationship between the two.
c. Describe how the ACH will **share data** in support of ACH activities or the process that would be undertaken to develop a data-sharing plan across a broad range of data, such as community health, clinical, and cost data to support the goals of the ACH. Include information regarding any existing and potential new mechanisms to share data as well as how this funding opportunity will support data sharing. It is recognized that few, if any, applicants will have in place all the necessary data-sharing capacities between the various member entities and that developing a plan would be a likely first year activity. To assist in that effort, the California Department of Public Health, with funding under the CMMI SIM grant, is conducting an assessment of data capacity and sharing practices, which will inform a toolkit for use by ACHs.
d. Describe the proposed development and operation of a **Wellness Fund** or what factors would be considered in developing the Fund. Include information about the vision and goals of the Wellness Fund and its role in sustainability of the ACH.
e. Describe the approach you will take to developing a **sustainability plan**.
    - Describe potential sources of funding and programs that may be braided and/or potentially blended to support the overall ACH (Backbone and Wellness Fund operation as well as the implementation of the comprehensive plan described in 4c).
f. Describe what level and types of **financial or in-kind resources** will be brought to the initiative. (Note that there are not matching requirements; however, there is an expectation that applicants will bring some level of resources, including time, logistics and/or actual dollars to the effort, as a demonstration of commitment.)
g. Describe any remaining **gaps** in capacity and operations.

4. Program (5 pages). In this section, please describe the vision and goals of the ACH, including the types of interventions that will be aligned to achieve such vision and goals.
    a. Describe the **vision and goals** of the ACH, to the extent they have been identified and recognizing that they will be further developed and refined during the first year.
    b. Identify the potential **health need, chronic condition, set of related conditions, or community condition** that will be the focus of the ACH (hereinafter referred to as the *selected health issue*) and the basis for its selection, such as data from a Community Health Needs Assessment. Identify any particular disparities that exist for the selected health issue.

c. Describe the process for how the ACH will develop or build on an existing **comprehensive plan** to address the selected health issue of the ACH. Although the plan should primarily focus on activities over the next three years, it should also lay out a longer-term vision for the selected health issue, recognizing that many prevention-related interventions may take many years to manifest. Describe how the comprehensive plan will promote an aligned and mutually reinforcing **portfolio of interventions across the five domains** to address the selected health issue. Please use **Table 1** (below) to identify potential interventions for each domain, as well as the likely timeframe associated with being able to assess the impact from each intervention to create a balanced portfolio of activities covering different timeframes. The portfolio of interventions should, to the greatest degree possible, span various population groups and disease or condition states (e.g., already present, at-risk, not yet developed). In the table, please include potential metrics, which have or could have data readily accessible. *Note that these do not need to be new interventions and that many may already be underway through other initiatives*.
d. Proposed efforts in the first year should span a minimum of three of the five possible domains—clinical, community, and clinical-community linkages—and begin to address at least one, preferably both, of the policy-systems and environmental domains.
e. Describe how the **portfolio of selected interventions connect** and, potentially, reinforce each other to enhance the strength and reach of the interventions and achieve the desired outcomes.
f. Describe how the proposed plan/portfolio of interventions will address **health equity** in the geographic area identified in 1(d) above.
g. Describe how **grassroots organizations and residents** will be meaningfully engaged to help shape **the overall effort and be engaged in** the interventions.
h. Describe the relationship of the proposed portfolio of interventions with other existing programs, such as PICH, REACH, CMMI grants, health homes, section 1115 Waiver, etc.

ISSUE SELECTION

Although the vision of the ACH is to improve the overall health of the population, it is essential that any such effort initially focus on a specific issue. Communities are encouraged to select a health issue that has broad support among collaborative partners and residents and with which members already have experience. The purpose of the ACH is to explicitly link together interventions across the five domains such that they are mutually reinforcing, with the goal enhancing impact and reach. ACH partners should encompass a full range of upstream and downstream activities to address all stages and aspects of the issue across all populations. Communities may have different entry points to an issue, depending on their history. What is important is that the health care delivery system, as well as community organizations and other sectors are highly engaged in addressing the issue.

For example, three chronic conditions—diabetes, cardiovascular disease/ hypertension, and asthma—have been identified as potential candidates for an ACH because they each have a strong evidence base, range of interventions across the five domains, including the health care delivery system, and potential for achieving cost savings. Violence and/or trauma could be a potential community condition, while depression and diabetes together represent a set of related conditions that could also be a potential candidate for an ACH.

Criteria for selecting any health issue should include being:

- Amenable to having interventions, which are evidence-based to the greatest extent possible, across the five domains, and
- Inclusive of a variety of populations within a community, not just high need, high cost populations.

Table 1. Portfolio of Interventions Matrix

	Intervention or Program	Timeframe (e.g. short, med, long)	Potential metrics to measure outcome
Clinical services (services delivered in the health care setting, including primary and coordinated care, primary prevention, and secondary prevention)			
Community programs, social services, etc. (programs that provide support to community members and take place outside of the health care system in community settings, schools, CBOs, etc.)			
Community-clinical linkages (programs or activities that connect clinical services with community programs or social services e.g. community health workers; referral systems; screening for social determinants of health)			
Public policy and system change (public and private practices, rules, laws, and regulatory changes, e.g. zoning rules, health plan incentives, etc.)			
Environments (changes in social, community, or physical environments that support healthy behaviors, e.g. walking and biking trails)			

B. Budget and Budget Narrative

Please use the provided forms for the budget and budget narrative. The forms are available for download from the CACHI website. (http://www.CommunityPartners.org/CACHI-RFP) Further instructions can be found on the first tab of the Excel budget template.

C. Workplan

Please fill out the workplan template below. For each major objective, identify key activities as well as outcomes and indicators at both the 6-month and 12-month timeframe.

Three Year Objectives and Year 1 Activities	Outcomes and Indicators	
Objective 1: Develop and implement the infrastructure and governance of the ACH		
Activity 1.1: Activity 1.2:	Month 6:	Month 12:
Objective 2: Develop a financing and sustainability plan for the ACH		
Activity 2.1: Activity 2.2:	Month 6:	Month 12:
Objective 3: Develop and implement a comprehensive plan that includes a portfolio of interventions to address the selected health issue		
Activity 3.1: Activity 3.2:	Month 6:	Month 12:

D. Other attachments

1. **Audited financial report of lead applicant.** If the lead applicant is a government agency, then an audited financial report is not required.
2. **Support letters** from collaborative partners, potential partners, civic and elected leaders outlining their commitment to participate in the ACH as well as any specific contributions to the ACH.

V. SELECTION CRITERIA AND SCORING

Proposals will be assessed based on their level of readiness, comprehensiveness of proposed effort and the overall geographic diversity of the cohort. Specifically,

- A high degree of readiness is preferred.
- The community, as a whole or in part, experiences significant disparities with regard to overall health burden regarding the specific issue(s) being targeted.

- Proposed efforts should span a minimum of the following three domains—clinical, community, and clinical-community linkages—and address at least one, preferably both, of the policy-systems and environmental domains. Moreover, proposals should make a compelling case for how the portfolio of interventions addresses the particular issues on a community-wide basis.
- Geographic diversity of the selected cohort as a whole and the contribution of each applicant within the cohort to inform spread and scaling of ACH.

The scoring rubric provides an overview for how proposals will be evaluated.

Scoring rubric (100 points total)	
ACH Partners (10 points)	
	Required partners, including: the major health plans, hospitals, private providers or medical groups and community clinics serving the geographic area; public health department; community and social services organizations; organizations representing or able to engage residents o Demonstration of the active engagement, support and commitment from a majority of the health plans and health systems serving the defined geographic area
	Additional partners, as determined by the selected health issue, which may include: behavioral health providers, housing agencies, food systems, employers, labor organizations, faith-based organizations, schools and educational institutions, transportation and land use organizations, parks and recreation agencies, dental providers and policy advocacy organizations
	Strong champion(s) and leadership team representing multiple organizations
History of Collaboration (10 points)	
	Evidence of a high-functioning collaborative, including community engagement, shared goals, mutual respect, timely and problem-focused communication
	Evidence of existing efforts to integrate clinical care and/or link clinical care to community services
	Evidence of successful community/environmental change strategy implemented on a community-wide basis
	Clear understanding of existing data analytics capacity and data sharing capacity among proposed ACH partners
Proposed Program and Portfolio (45 points)	
	A long-term vision and comprehensive plan for population health improvement, priority goals, and specific steps to achieve it
	Strong evidence for addressing the selected issue and rationale for how addressing it will contribute to eliminating disparities and advancing equity
	Compelling rationale for population size proposed
	Geographic area includes mixed incomes and includes areas where disparities and overall burden with regard to the target condition are higher
	Portfolio of connected and coordinated interventions for the selected health issue includes a minimum of three domains (clinical, community, clinical-community linkage) and preferably includes all five domains (policy and/or environmental change), as well as interventions that span different timeframes in which outcomes may occur
	The portfolio of interventions aligns the proposed program approaches with existing initiatives and related grants such as CMMI, PICH, REACH to present a comprehensive continuum to address the health need or community conditions
	Interventions represent best practices and demonstrate knowledge of local resources
	Meaningful resident engagement and a process for ongoing engagement throughout the funding period
Infrastructure (30 points)	
	Plan for defining ACH governance specifies decision making structures and organizational relationships between the ACH collaborative, the Wellness Fund, and the Backbone organization
	Backbone entity and its plan for convening, communication and development of essential program structures

	Description of how the ACH will collect and share data in support of program activities that is based on existing partner capacity. A plan to expand or build out data sharing capacity to fill gaps is identified
	Wellness Fund organizational affiliation, operating structure and its role in sustainability
	A sustainability planning process is described that includes steps to achieve a three-year financial plan to fully fund remaining ACH development and program approaches
	Budget (5 points)
	A comprehensive 12-month budget details the proposed use of CACHI funding, which includes existing funding and resources from related initiatives (e.g. PICH/REACH) and commitment of partner resources (financial or in-kind)
	Other Attachments
	Letters from collaborative partners, potential partners, civic and elected leaders includes cross-sector representation, outlines a commitment to participate in the ACH and lists specific contributions to the ACH
	Audited financial report of lead applicant is included unless lead applicant is a government agency. Government agencies are not required to submit an audited financial report.
	Additional Commitments
	Active participation in the cohort evaluation including working with the evaluator to select measures and indicators to assess progress (e.g. structure, financing, programmatic and health outcomes) and submitting local data and reports to complete the evaluation plan
	Active participation in the Learning Collaborative peer exchange and technical assistance activities.

VI. SUBMISSION INFORMATION

Submissions	www.CommunityPartners.org/CACHI
Receiving Organization	Community Partners
Eligible Applicant	Non-profit or governmental agency
Questions	Please submit questions to CACHImgr@CommunityPartners.org Responses to questions will be addressed through the FAQ. Please check back regularly for updates
Information and resources	www.CommunityPartners.org/CACHI

VII. TIMELINE

Request for Proposal Released	January 22, 2016
Bidder's conference call	February 18, 2016 at 11 am
Application Due Date	April 29, 2016
Site Visits for Finalists	3rd and 4th weeks of May
Notice of Awards	June 10, 2016
Start Date	July 1, 2016
Term of Grant	July 1, 2016 – June 30, 2017

Appendix 1: Definitions of Seven Key Elements of an Accountable Community for Health and Five Domains for Intervention

The definitional elements of an Accountable Community for Health are described below.

1. Shared vision and goals: A primary goal of an ACH is for a range of organizations, stakeholders and residents to come together around a common set of goals. A shared vision, based on an agreed-upon understanding of the nature of the health problem, is a critical first step to ensure that all participants have a clear understanding of the purpose and expectations of the ACH and to promote collective accountability for achieving its goals.

2. Partnerships: Collaboration is at the heart of the ACH. No single entity or single intervention can, on its own, improve the health of an entire community. Rather, it takes many organizations that are aligned toward a common set of goals to make real progress. Although medical care only contributes about 20 percent toward population health outcomes, the health care sector is a critical anchor partner for an ACH. Ideally, health care entities—health plans, hospitals, clinics, etc.—that collectively can reach the vast majority of the population within the designated geographic area should be active members of an ACH.

3. Leadership: At a minimum, an ACH must have one, preferably several champions at both an individual and organizational level. Although collective efforts like an ACH may include a variety of types of leaders, it is critical that they all embrace collaborative leadership.

4. Backbone: Effective community-wide initiatives, including those seeking to improve population health are increasingly including an identified entity to function as the initiative or collaborative's facilitator and convener. This role goes by many names, such as integrator or quarterback, but the key functions generally consist of:
    - Guiding development of a common vision, goals and strategy
    - Ensuring the engagement of community agencies and residents in the process
    - Facilitating development of agreements across collaborative partners
    - Coordinating and supporting implementation of aligned activities
    - Managing the budget of the ACH
    - Serving as convener, including facilitating conflict resolution and problem solving and maintaining a culture of learning and collaboration
    - Facilitating data collection, quality assurance, analysis and evaluation
    - Mobilizing funding through the Wellness Fund
    - Ensuring transparency of goals, activities and outcomes

5. Data analytics and sharing capacity: Measuring population health improvement in an ACH requires sharing and aggregating health and financial data from disparate clinical and non-clinical services and programs, as well as community and population-level data, across a variety of providers and organizations. Data infrastructure and sharing is needed at all stages of development and implementation and is necessary to inform delivery and payment innovations. It is recognized that few, if any communities, have a comprehensive data infrastructure and platform for sharing in place at this time.

6. Wellness Fund: One of the unique features of an ACH is the inclusion of a Wellness Fund to act as a vehicle for attracting, braiding, and blending[1] resources from a variety of organizations and sectors, in alignment with the goals, priorities and strategies developed by the ACH. The Wellness Fund would support two key functions: First, it would provide critical resources for the ACH infrastructure, including the Backbone organization. As described previously, the work of the Backbone organization is substantial and will continue to be needed as the ACH evolves and grows, particularly as the ACH sets its sights on longer- term outcomes that will require data collection financial modeling. Second, the Wellness Fund would support interventions that the ACH prioritizes for which there are no other funding sources. Community prevention and, especially, upstream interventions are generally under-resourced; one of the goals of the Fund is to provide ongoing resources for those endeavors.

7. Portfolio of Interventions: In order to improve the health of the community, an ACH would implement a set of coherent mutually-supportive interventions across five key domains. By aligning, connecting, and, where appropriate, integrating the interventions, these interventions would reinforce each other and drive toward a common set of goals and outcomes at both the *individual* and *systems* levels.

   The ACH Work Group identified five domains for interventions that, together, constitute a portfolio. Working in concert, they will advance coordination goals for both the individual and systems. Definitions of the five domains are:

   - *Clinical services*: Services delivered by the health care system, including primary and secondary prevention, disease management programs, as well as coordinated care, provided by a physician, health team, or other health practitioners associated with a clinical setting.
   - *Community and social services programs*: Programs that provide support to patients and community members and take place outside of the health care system. These can be based in governmental agencies, schools, worksites, or community-based organizations, such as the YMCA. Community-based interventions frequently target lifestyle and behavioral factors, such as exercise and nutrition habits, and also include peer support groups and social networks.
   - *Clinical-community linkages*: Mechanisms to connect community and social services programs with clinical care to better facilitate, support and coordinate health care, preventive, and supportive services. Interventions in the community-clinical linkages domain can help form strong bonds between community and health care practitioners. Examples include incorporation of Community Health Workers to bridge the community and primary care setting; development of a community and social services inventory and resource guide; referrals systems (including e-referrals) between the clinical setting and community based programs or social services; development of screening tools for social and economic determinants of health and integration of such determinants in a provider's electronic health record.

[1] Blending funds is a funding and resource allocation strategy that uses multiple existing funding streams to support a single initiative or strategy. Blended funding merges two or more funding streams, or portions of multiple funding streams, to produce greater efficiency and/or effectiveness.

- ***Environment***: Social and physical environments that facilitate healthy behaviors. Environmental interventions aim to improve opportunities for physical activity, social connectedness, and otherwise support healthy behaviors.
- ***Policy and systems change***: Public and private practices, rules, laws, and regulatory changes that affect how the health care and other systems operate and influence people's health. These interventions can address environmental issues, school policies, health and social systems coordination, as well as financing to support prevention-related activities. Social norms changes regarding the understanding and prioritization of the social determinants of health are an outcome in this domain, although they are influenced by all of the interventions carried out by an ACH, not just public policy and systems changes.

Appendix 2: Resource Materials

Primary Resources

1. Accountable Communities for Health Initiative Work Group Report. May 2015
   http://www.chhs.ca.gov/PRI/ACH%20Work%20Group%20Report%20FINAL.pdf

2. "Accountable Communities for Health: Legal and Practical Recommendations." ChangeLabSolutions. December 2014.
   http://www.chhs.ca.gov/PRI/ACHLegalPracticalRecommendationsReportFinal.pdf

3. Sehgal, N. et al. "Resource Guide for California Accountable Communities for Health (ACH) A Review of Emerging Evidence On Interventions for Asthma, Diabetes, and Cardiovascular Care" February 2015
   http://www.chhs.ca.gov/PRI/ResourcesforACHsReportFINAL.pdf

4. Cantor, J. et al. "Accountable Communities for Health: Strategies for Financial Stability" JSI, Inc. May 2015
   http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

5. Hogan, L. "Accountable Communities for Health: A California Scan". December 2014

Additional Resources

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

7. Hester, J., et al. "Opportunity Knocks Again for Population Health: Round Two in State Innovation Models". Discussion paper for IOM Roundtable on Population Health Improvement. April 15, 2015
   http://nam.edu/wp-content/uploads/2015/06/SIMsRound21.pdf

8. Hester, J. and P. Stange. "A Sustainable Financial Model of Community Health Systems." Discussion paper for IOM Roundtable on Population Health Improvement. March 6, 2014.
   http://nam.edu/perspectives-2014-a-sustainable-financial-model-for-community-health-systems/

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

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

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

12. Institute of Medicine Vital Signs: Core Metrics for Health and Health Care Progress

13. "Accountable Communities For Health: Opportunities and Recommendations". Prevention Institute. July 2015

14. Roman, J. K., "Solving the Wrong Pockets Problem: How Pay for Success Promotes Investments in Evidence-Based Best Practices". Urban institute. September 2015

15. Schwartz, P., Rauzon, S., and Cheadle, A., "Dose Matters: An Approach to Strengthening Community Health Strategies to Achieve Greater Impact". Institute of Medicine Discussion Paper. August 26, 2015