

Advancing and Promoting Community Health: Opportunities for Accountable Communities for Health and Community Health Centers

The Funders Forum on Accountable Health and Geiger Gibson/RCHN
Community Health Foundation Research Collaborative

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Helen Mittmann, MAA

Jeffrey Levi, PhD

Janet Heinrich, DrPH, RN, FAAN

Feygele Jacobs, DrPH, MS, MPH

Rebecca Morris, MPP

Peter Shin, PhD, MPH

Milken Institute School
of Public Health

THE GEORGE WASHINGTON UNIVERSITY



About the Funders Forum on Accountable Health

The [Funders Forum on Accountable Health](#) is a project of the Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health. The Forum is a common table for the growing number of public and philanthropic funders supporting accountable communities for health initiatives to share ideas, experiences, and expertise. It is a shared venue for funders to explore potential collaborations and consider how to assess the impact of these investments over time.

About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The [Geiger Gibson Program in Community Health Policy](#), established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at the George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The [RCHN Community Health Foundation](#) is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a longstanding commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Executive Summary

Accountable Communities for Health (ACHs) are multi-sector, community-based partnerships that aim to address community health and social needs, and Community Health Centers (CHCs) provide important community-based healthcare services for underserved and medically vulnerable populations. Given the critical role that both ACHs and CHCs play in addressing health-related social needs and social determinants of health, a survey of ACHs on CHC engagement was conducted to better understand opportunities and challenges for CHC participation in ACHs. This survey, along with follow-up conversations with ACH and CHC representatives, confirmed that ACHs and CHCs are natural partners in the effort to advance community health by building multi-sector coalitions that address health-related social needs and social determinants of health. A majority of ACHs that responded to the survey reported CHC participation in their ACH under contract or other formal engagement, and CHCs frequently participate in ACH governance. Despite this level of participation, however, the research also revealed that the nature of this participation varies greatly, and strong partnerships do not always exist. This may be less because the ACHs and CHCs do not share the same vision for a community's health, and more because of a need to build relationships, provide financial incentives, remove practical obstacles, and better define the shared value of such partnerships.

Background

Accountable Communities for Health (ACHs) are multi-sector partnerships that bring together health care, public health, social services, and other local partners to address the unmet health and social needs of the individuals and communities they serve. The Funders Forum on Accountable Health has identified more than 100 ACH-type initiatives across the country, which may also be referred to as accountable care communities, coordinated care organizations, and accountable health communities, among other titles. As one example, the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS) seeded the

[Accountable Health Communities model](#) in 28 sites across 22 states, which supports bridge organizations to serve as “hubs” in local communities to address the health-related social needs of Medicare and Medicaid beneficiaries by linking clinical and community service providers. A second example is the [California Accountable Communities for Health Initiative \(CACHI\)](#), a privately funded demonstration that currently supports 13 unique ACHs in communities across the state.

While ACHs may differ in regard to their funding sources, their focus, and the populations they serve, they share a number of common elements (**Figure 1**). This includes an emphasis on bringing different sectors together in a collaborative and shared governance approach to address high-priority health and social needs to improve the health of individuals and their communities as a whole. This approach is consistent with that of community health centers (CHCs).

CHCs are local, non-profit community-governed health care providers which by mission and mandate offer comprehensive primary and preventive care to underserved populations and high-need communities, as well as numerous other services which address health-related social needs and social determinants. In 2019, 1,457 CHCs (both grant funded and “look-alike” health centers which meet all health center program requirements but do not receive federal grant funds) operating in more than 13,000 urban and rural locations [provided care and services to nearly 30,000,000 people](#). Approximately nine in 10 health center patients are low-income, one in five are uninsured, nearly one in two patients rely on Medicaid, and one in four are best served in a language other than English. Health center patients also include 5.2 million public housing patients, about 1.5 million homeless patients, and over one million agricultural workers. Because CHCs are federally mandated to operate in underserved communities – heavily impoverished areas where health care resources are difficult to access and where social needs such as food, employment and housing are more difficult to address – they understand the unique health and social needs of the neighborhoods

Figure 1. Essential Elements of Accountable Communities for Health



Source: George Washington University, 2020

they serve.

Given the critical role that both ACHs and CHCs play in addressing population health and social determinants and health-related social needs, it would appear that ACHs and CHCs are natural partners in efforts to elevate community health through multi-sector, collaborative work. While a review of the [Funders Forum Inventory of Accountable Communities for Health](#)—a catalog of existing ACHs and their descriptions based on both publicly available data and targeted outreach to leaders in the field—showed that CHCs participated in ACHs located in at least 16 states, the extent to which health centers participate or are invited to participate in ACHs was unclear.

During the summer of 2020, the Funders Forum, in consultation with the Geiger Gibson Program in Community Health Policy, conducted a survey of ACHs to better understand CHC engagement within ACHs and identify opportunities and challenges for CHC participation. This survey was distributed electronically to all sites included in the Funders Forum inventory of ACHs, and representatives from 33 sites responded for a response rate of approximately 22%. Respondents were geographically diverse and represented a range of ACH-type initiatives. The survey results were presented to a subset of eight ACH and CHC representatives from four states, and a number of policy recommendations emerged from these discussions. (See Appendix I for a detailed description of the survey methodology, and Appendix II for the

survey instrument.)

This report reviews key findings from the survey and a set of actions federal policy makers could undertake to increase the likelihood of ACHs and CHCs working more closely toward a shared goal.

Key Findings

The survey was conducted to identify health centers participating in ACHs, determine the structures and processes established for CHC engagement, understand the roles and functions played by CHCs within the ACH, and identify opportunities for and challenges to CHC participation. Respondents were permitted to skip questions, and the data presented is analyzed based on the number of respondents who answered each question, not the number of respondents who submitted the survey. This study was institutional review board exempt.

ACHs frequently partner with CHCs, and CHCs often participate in the governance of ACHs.

While there is great variation in the nature of CHC participation in ACHs, 25 of the 33 survey respondents reported that CHCs participated in their ACH under contract or other formal engagement. Respondents identified a total of 77 participating CHCs; the number of participating CHCs varied with each ACH's geographic scope and ranged from one to 12 with an average of three participating CHCs per ACH. Additional information about the nature of CHC

engagement was provided by 23 ACH respondents, with 19 reporting that at least one CHC participates in the governance of the ACH. In addition, 12 sites reported that they do not provide funding for CHC programs, nine provide funding for at least one of their participating CHC’s programs, and two did not know if they provide funding.

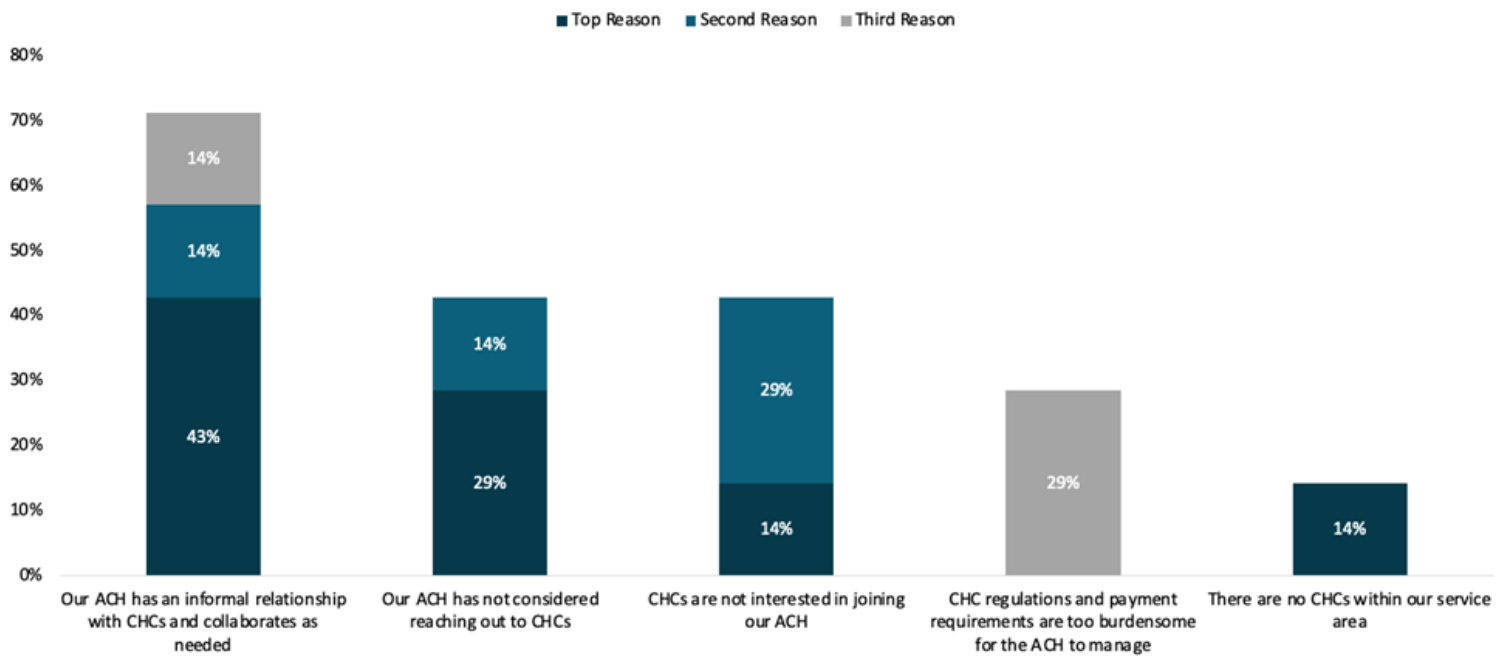
Eight respondents reported no current CHC participation in their ACH under contract or other formal engagement, but of the seven sites that provided additional information five reported that they maintained informal relationships with CHCs and collaborated as needed (Figure 2).

Participating CHCs provide a number of services and have leading or supporting roles in various programs. Respondents reported that in addition to providing core health care and related services (Figure 3), participating CHCs also play important roles in various ACH functions (Figure 4). Respondents reported that two areas where participating CHCs most often play leading roles include reaching underserved areas and populations and managing chronic diseases and coordinating care.

Other areas where CHCs often play leading or supporting roles include assessing community health needs, serving as a resource/linkage to other human services, building community engagement and trust, providing expertise in addressing social determinants, and sharing data. Alternatively, transportation, training community health workers, and training community leaders and advocacy were areas in which participating CHCs were reported as playing the fewest lead or supporting roles. (Figure 4)

In addition, 20 respondents described the types of social and support services their ACHs offer through collaborating organizations (Figure 5). The services ACHs most often provided through CHCs participating in the ACH were mental health services (12 sites) and substance use services (nine sites). Approximately half of the ACH respondents also reported providing services related to family and community support (10 sites), housing support (nine sites), food security and nutrition (nine sites), transportation (nine sites), and personal and interpersonal safety (nine sites) through referral to CHCs not participating in the ACH. Services frequently provided through other non-CHC organizations

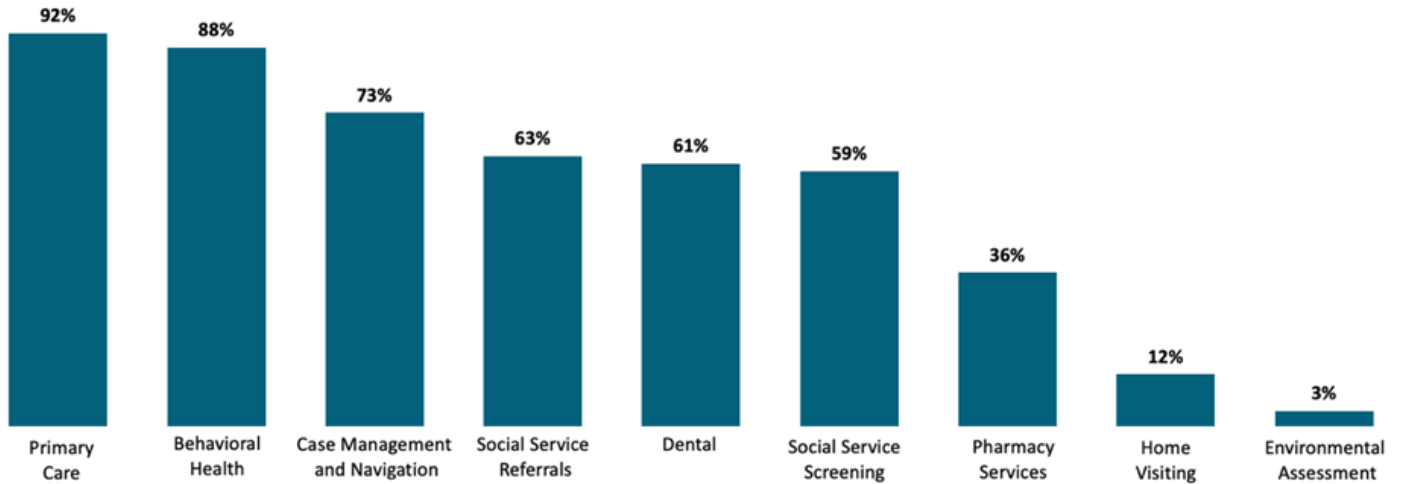
Figure 2. ACH-Reported Reasons CHCs Do Not Participate Under Contract or Other Formal Engagement



Notes: Results reflect the responses of 7 ACH representatives from across the country. Respondents were permitted to identify up to three reasons CHCs do not participate under contract or other formal engagement, and some respondents only identified one or two.

Source: George Washington University analysis, 2020

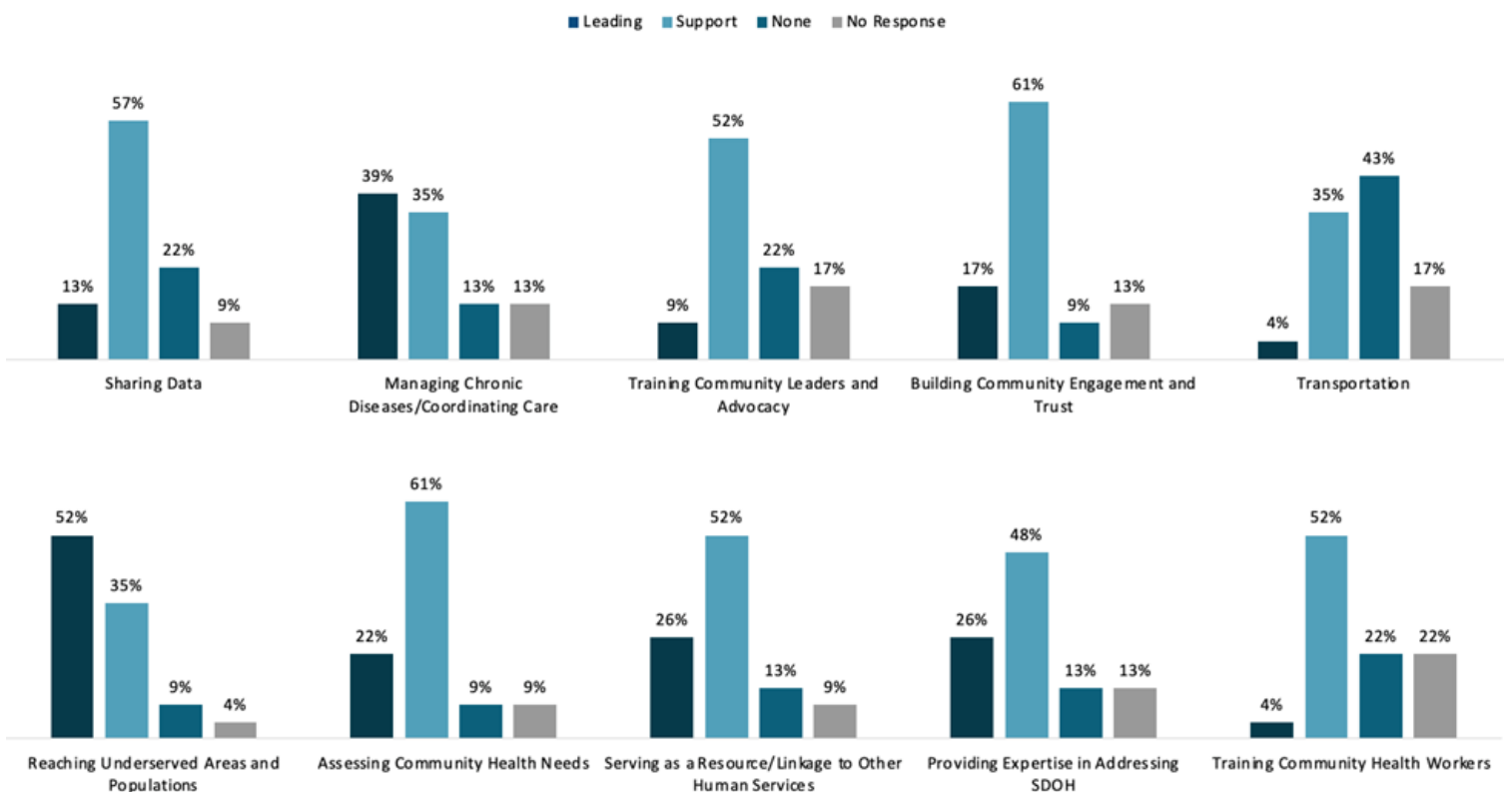
Figure 3. Top ACH Services Provided by Participating CHCs



Notes: Results reflect the responses of 23 ACH representatives from across the country about 59 of 77 participating Community Health Centers.

Source: George Washington University analysis, 2020

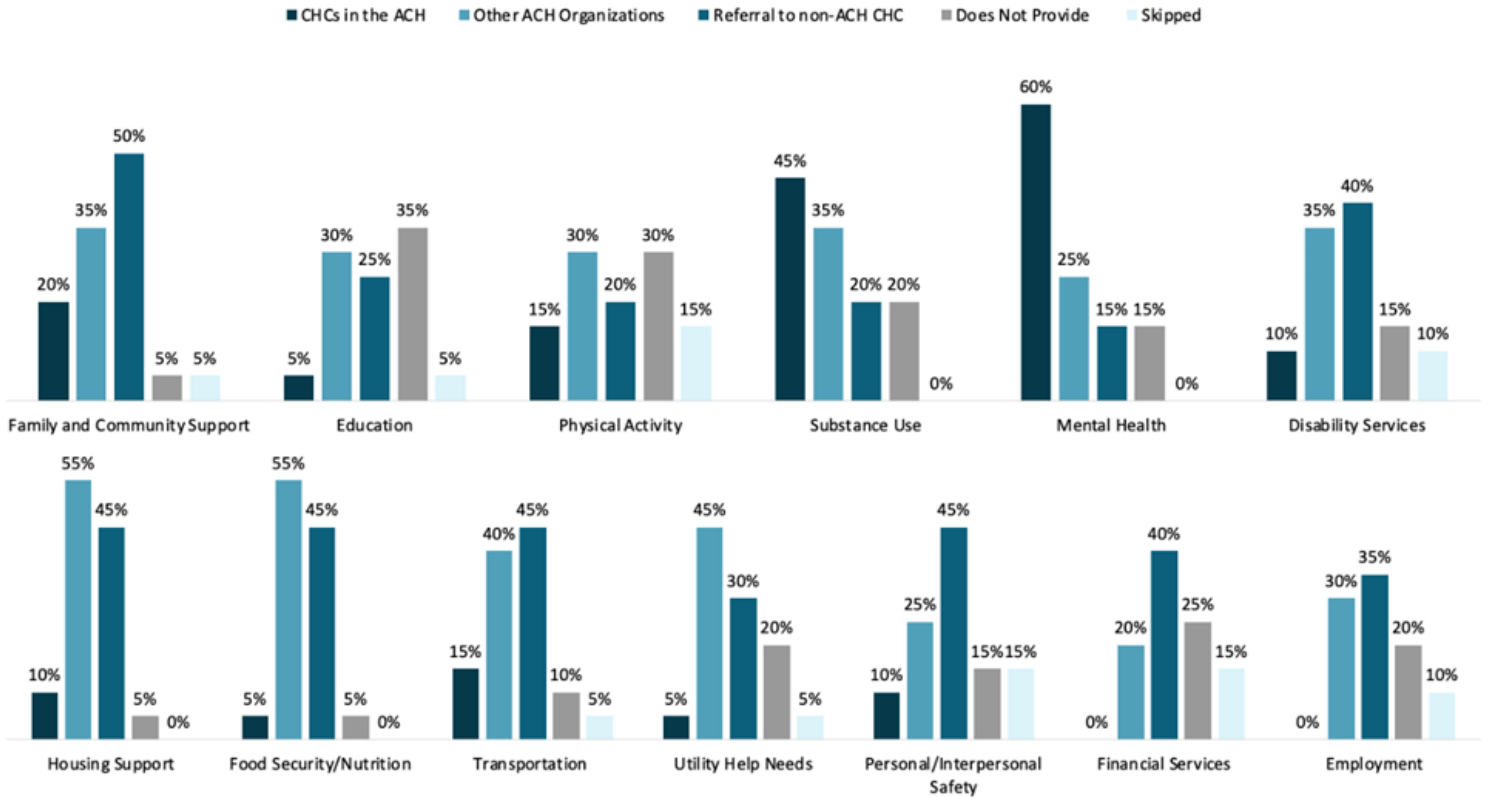
Figure 4. CHC Participation and Roles in ACH Functions



Notes: Results reflect the responses of 23 ACH representatives from across the country about the types of roles CHC play in their ACH.

Source: George Washington University analysis, 2020

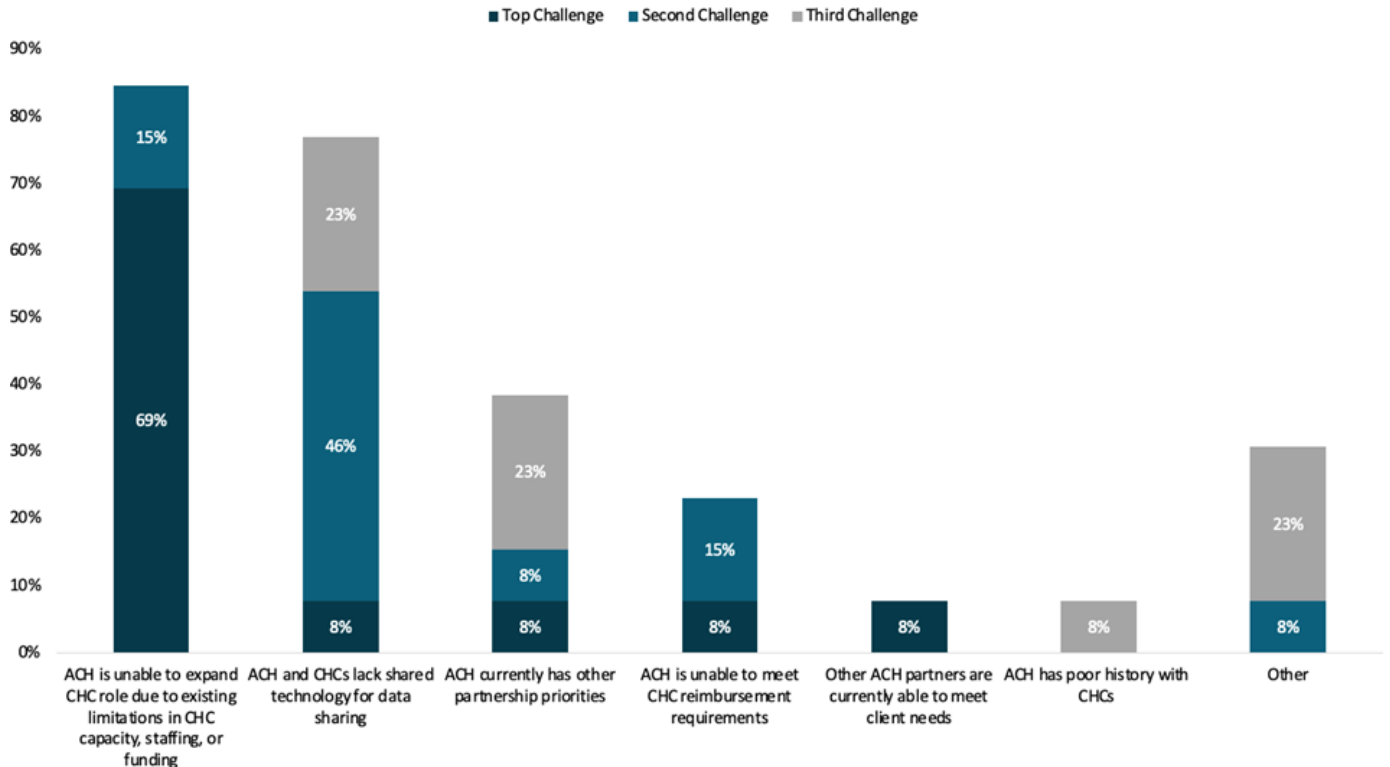
Figure 5. Social or Support Services the ACH Provides Through Collaborating Organizations



Notes: Results reflect the responses of 20 Accountable Communities for Health representatives from across the country. Respondents were able to indicate if they provided a service through more than one type of collaborating organization.

Source: George Washington University analysis, 2020

Figure 6. ACH-Reported Challenges to Active and Broader CHC Participation in ACHs



Notes: Results reflect the responses of 13 ACH representatives from across the country. Respondents were permitted to identify up to three challenges, and some respondents only identified one or two.

Source: George Washington University analysis, 2020

Strengthened CHC capacity, staffing, and funding, as well as shared technology for data sharing, are needed in order to achieve active and broader CHC participation in ACHs.

Respondents were asked to identify and rank challenges to active and broader CHC participation in their ACH, and of the 13 that answered the question nine identified existing limitations in CHC capacity, staffing, or funding as their top challenge (**Figure 6**). The second most-cited challenge was a lack of shared technology for data sharing, followed by the ACHs stating that they have other partnership priorities. Eight respondents described missed opportunities resulting from these challenges, citing capacity issues, resource limitations, and competing interests and priorities that “prevent or delay [CHC] engagement in transformation.”

Policy Findings

A majority of ACHs that participated in the survey reported CHC participation in their ACH under contract or other formal engagement, and CHCs frequently participate in ACH governance. Despite the level of participation, however, the research also revealed that the nature of this participation varies greatly, and strong partnerships do not always exist. Based on these findings, federal policy makers could undertake a series of steps that together could increase the likelihood of ACHs and CHCs working more closely. These include:

Provide opportunities for stronger relationship building between CHCs and other key stakeholders that may participate in an ACH.

Trust and pre-existing opportunities to work together are often the “magic sauce” of a successful ACH coalition, and some ACHs reported in the survey that trust with participating CHCs has been built over time. However, opportunities for active and broader CHC participation in ACHs is often limited by CHC capacity, staffing, and insufficient funding (either from the ACH or in the CHC’s operating budget) to support ACH-type activities. Federal agencies should provide funding to communities that will permit coalition

building that engages CHCs with public health, other health care providers, and social services – the building blocks of an ACH. In other assessments done by the Funders Forum, we have found that communities that received funding under the now-defunct Communities Putting Prevention to Work and Community Transformation Grant programs had a leg up in building their ACH capacity. The Centers for Disease Control and Prevention, along with the Health Resources and Services Administration (HRSA), should re-engage in such community-building efforts.

Give CHCs (and other federal grantees) more flexibility in how they spend their grants if they participate in an ACH.

CHCs derive most of their revenue from patient services, primarily through the encounter-based Prospective Payment System (PPS). They also receive grant funding from HRSA that supports core functions, care for the uninsured, and special purposes. With greater flexibility in how they may spend their grants, health centers might be able to devote more resources to the essential work of addressing social determinants and community need.

Explore support for CHCs as backbone organizations for ACHs.

Most CHCs engage in community-based partnerships that focus on social needs, many CHCs convene these partnerships, and some take the lead in developing and fostering community-based capacity to address those needs. In some communities, CHCs are already performing an ACH-like function. In addition to clarifying the role of current CHC core grant funding in supporting ACH participation, one-time quality improvement grants could be given to individual CHCs or a consortium of CHCs that wish to be the “start-up” backbone organization for a nascent ACH. Primary Care Associations, nonprofit state or regional membership organizations that provide training and technical assistance to CHCs and in some cases other safety-net providers, might also be engaged to support or help lead local CHC-ACH engagement and development. Similarly, if COVID-19 recovery funding is made available to support CHCs in the rebuilding of

health systems, a permissible or encouraged use of those funds could be to build an ACH-like infrastructure that could assure more resilient systems in the future.

Alternative Payment Methods (APMs) for CHCs should incentivize participation in ACH-type coalitions and delivery of ACH-supported services and community-level interventions.

APMs should support ACH participation and grow over time with cost and demand. More than 20 states currently use an APM to reimburse health centers for services provided to Medicaid patients. If the goal of an APM approach is to reward improved health outcomes, CMS and HRSA should create an environment that encourages, along with the delivery of high-quality primary care, addressing the root causes of poor health. CHCs, which were founded to support healthy communities, can be leaders in doing so; they are likely to be more successful if they partner with others under the umbrella of an ACH.

Policy makers should standardize approaches to data systems and data collection so it is easier for entities participating in ACHs to work together.

As multiple parties come together, they often arrive at the partnership with data systems that do not connect and communicate, and these interoperability issues impede information exchange and data sharing. ACH survey respondents identified the lack of data-sharing technology as one of the most common challenges to active and broader CHC participation in ACHs. Each new government initiative may impose new and different data collection requirements, and the layering effect often makes participation too burdensome for those already working within the health care system. Creating closed-loop referral systems that are truly integrated with existing data systems (as opposed to working in parallel) is even more challenging for less well-resourced partners, such as social service organizations. A truly committed CHC, for example, could end up being funded to use multiple screening tools to determine social needs of their clients. This chaotic situation is resolvable, if

federal agencies would agree to standardize metrics and data collection approaches.

Concluding Thoughts

The Funders Forum has found through this study that CHCs could be a critical, necessary and able building blocks for ACHs. Implicit in the ACH model is a recognition that long-term, prevention-oriented improvement in health outcomes occurs only if we combine both community-level interventions addressing social determinants of health with a focus on the health-related social needs of individuals. Like ACHs, CHCs are fundamentally about changing how the health system in a community functions, by providing greater access to more diverse and comprehensive care and social services, which improves health outcomes. However, this shift and transformation toward addressing social determinants requires policy makers to break free of the current “return on investment” definitions that are confined to short-term interventions addressing individual health outcomes. A social intervention may improve health outcomes; a health intervention may improve the social condition of an individual. Accordingly, improvement of health outcomes and social conditions must be valued together.

Policy makers should quickly take steps to incentivize ACH-CHC relationships, particularly as safety-net providers seek to recover from the devastating impact of the COVID-19 pandemic on their operations and their communities. ACHs and CHCs are playing important roles in pandemic response, serving the very communities hardest hit by the pandemic and that have also experienced historical inequities and discrimination. ACHs and CHCs are both embedded in and governed by the communities they serve and are therefore uniquely positioned to respond. However, the pandemic has taken a financial toll on this essential safety net; over an eight-month period from April-December 2020, [health centers have lost an estimated \\$4 billion in patient revenue, or nearly 13% of annual revenue](#). If health care financing and safety-net funding continue to focus on medical care alone, community providers will continue to struggle to address the underlying and contributing causes of poor health. ACHs and CHCs may currently lack critical

resources and incentives necessary to address the wide and diverse range of social needs together, but the policy recommendations laid out in this brief present a significant opportunity to facilitate these partnerships and improve the health and well-being of the communities they serve.

Appendix I: Survey Approach and Methodology

The Funders Forum in consultation with the Geiger Gibson Program in Community Health Policy developed a web-based survey (Appendix II) administered via SurveyMonkey to better understand current community health center (CHC) engagement within Accountable Communities for Health (ACHs) and identify opportunities and challenges for effective CHC participation with ACHs across the country. This study was Institutional Review Board exempt. With the emergence of COVID-19 in the US, the project timeline was modified and extended in acknowledgement of the fact that many lead organizations in the ACH community were (and are) at the front lines of the pandemic response, and largely focused on responding to the immediate crisis.

In May 2020, an invitation to participate in the study was distributed electronically to a subsample of 20 sites from across the country to gauge response rate amid the ongoing pandemic. The response rate was relatively favorable (40%), and in June 2020 the invitation was distributed to sites included in the Funders Forum inventory of ACH-type initiatives. As of May 2020, the inventory included 152 sites. Several rounds of emails were sent to site representatives to encourage participation. Ultimately, representatives from 33 sites responded, for a response rate of approximately 22%.

In August 2020, Funders Forum staff analyzed the survey results collected in SurveyMonkey. Respondents were permitted to skip questions, and the data presented is analyzed based on the number of respondents who answered each question, not the number of respondents who submitted the survey.

Appendix II: Survey Instrument

1. Name of your Accountable Community for Health (ACH)
2. Name of person filling out the survey
3. Job title of person filling out the survey
4. Organization
5. Email
6. City
7. State
8. Have Community Health Centers (CHCs) ever participated in the ACH?
 - a. Yes
 - b. No
 - c. Don't Know
9. Do CHCs currently participate in the ACH under contract or other formal engagement?
 - a. Yes
 - b. No, CHCs participated in the past but do not currently participate
 - c. No (skip to question 22)
10. How many CHCs currently participate in your ACH?
11. What is the name of the most active CHC? (Respondents may answer questions 11 to 16 about up to 5 CHCs.)
12. Does the CHC participate in the governance of the ACH?
 - a. Currently
 - b. Previously
 - c. No
13. Is there a contractual arrangement with this CHC?
 - a. Yes
 - b. No

14. What type of services does this CHC provide? Check all that apply.

- a. Primary
- b. Dental
- c. Behavioral Health
- d. Pharmacy Services
- e. Case Management/Navigation
- f. Home Visiting
- g. Environmental Assessment
- h. Social Services Screening
- i. Social Services Referrals
- j. Other (please specify)

15. Does the ACH provide funding for CHC programs?

- a. Yes
- b. No
- c. Don't know

16. If yes, what CHC programs does the ACH provide funding for?

17. Does the CHC participate in other programs or roles? Check all that apply.

Activities	Role		
Sharing data	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Managing chronic diseases	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Training community leaders and advocacy	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Building community engagement and trust	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Transportation	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Reaching underserved areas and populations the ACH has otherwise not been able to serve	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Assessing community health needs	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Serving as a resource/linkage to other human service organizations	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Providing expertise in addressing social determinants of health	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none
Training community health workers	<input type="radio"/> leading	<input type="radio"/> support	<input type="radio"/> none

18. Which of the following types of social or support services does the ACH provide through referrals to local organizations and/or CHCs?

	Provide through CHCs in the ACH	Provide through other ACH providers	Provide through referral to non-ACH CHC organizations	Does not provide
a. Housing support				
b. Food security/nutrition				
c. Transportation				
d. Utility help needs				
e. Personal/interpersonal safety				
f. Financial services				
g. Employment				
h. Family and community support				
i. Education				
j. Physical activity				
k. Substance use				
l. Mental health				
m. Disability services				

19. In what other ways do CHCs engage in community-wide prevention or population health initiatives? Please specify.

20. Please indicate below the top 3 challenges to active and broader CHC participation in the ACH.

- a. ACH currently has other partnership priorities
- b. ACH is unable to meet CHC reimbursement requirements
- c. ACH is unable to expand CHC role due to existing limitations in CHC capacity, staffing, or funding
- d. ACH has not collaborated with CHCs in the past
- e. ACH has had poor history with CHCs in the past
- f. ACH and CHCs lacked shared technology (for data sharing)
- g. ACH partners are currently able to meet client needs
- h. Other

21. Have there been missed opportunities as a result of these or other challenges? Please specify.

22. You indicated that CHCs do not currently participate in your ACH under contract or other formal arrangement. Please indicate the top 3 reasons why CHCs do not participate in the ACH.

- a. Our ACH has not considered reaching out to CHCs
- b. Our ACH does not have many community residents who need CHC services

- c. Our ACH has no informal relationship with CHCs and collaborates as needed
- d. There are no CHCs within our service area
- e. CHCs are not interested in joining our ACH
- f. CHC regulations and payment requirements are too burdensome for the ACH to manage