Below are a few of the current programs and initiatives, through government and non-governmental entities, that in design and purpose are similar to Accountable Care Communities (ACCs). It is important to note that not all are examples of ACCs; some are examples of community coalitions and health systems investing in social needs, and others are delivery and payment models that are addressing health-related social needs.

Centers for Medicare & Medicaid Services Accountable Health Communities

The Centers for Medicare & Medicaid Services (CMS) is currently piloting an ACC-style model called Accountable Health Communities. Clinical-community collaboration in these pilots takes the form of:

- ***Screening of community-dwelling beneficiaries to identify unmet health-related social needs,***
- ***Referring these beneficiaries to increase awareness of community services,***
- ***Providing navigation services to high-risk community-dwelling beneficiaries and,***
- ***Encouraging alignment between clinical and community services to be more responsive to the needs of community-dwelling beneficiaries.***

Funds are given to bridge organizations that assist with community collaborations and coordination of services but do not pay for the services themselves (e.g., housing, food, utilities, etc.).[1] Two "tracks" are supported through this model. Assistance Track models "provide community service navigation services to assist high-risk beneficiaries with accessing services to address identified health-related social needs" and Alignment Track models "encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries."[2] There are currently 31 organizations participating in these 5-year models that represent rural and urban communities across 23 states.[3] An independent evaluation will review the model's effects on quality of care and spending.[2]

One key difference between the CMS model and other ACCs is that they address the health-related social needs of Medicare and Medicaid beneficiaries whereas ACCs are not limited to these populations.

Washington State: Accountable Communities of Health

Under Washington state Medicaid transformation (Medicaid Section 1115 Waiver approved January 9, 2017)[4], Accountable Communities of Health (ACHs) are one of the three initiatives in which the state hopes to better the health of the Medicaid population. Throughout the state, nine ACHs were established that align directly with the state's regional Medicaid service area—ensuring that every part of the state is covered by an ACH.[5] These regional ACHs are meant to bring together community organizations and health care providers to work on regional goals (e.g., practice transformation) to solve the unique health problems of those regions.[5]

Washington's ACHs have built the necessary internal capacity and infrastructure to plan and carry out the work outlined in the demonstration waiver.[6] The state is currently in Phase 2 of implementation. This phase focuses on continuing to build relationships and shared decision-making with stakeholders on regional interventions.[6] The Olympic Community of Health (one of the regional ACHs), has developed a multi-sectoral effort to address the opioid epidemic within the region and is currently in the implementation phase.[7]

Parkland Center for Clinical Innovation

Parkland Center for Clinical Innovation is a non-profit health care analytic research and development organization that is participating in the Centers for Medicare and Medicaid Services' Accountable Health Communities Model program. Parkland Center for Clinical Innovation houses the Dallas Information Exchange Portal, which serves as a data bridge to better screen, connect, communicate, and coordinate patient care between health care providers and community-based organizations.[8] Developed alongside community partners addressing issues like homelessness and food insecurity, the information exchange portal's cloud-based technology allows for two-way communication to assist with eligibility verification, referrals, and service tracking. This innovative software has successfully connected community organizations and health care entities to address some of the most pressing needs of vulnerable populations in Dallas-Fort Worth (e.g., individuals who are homeless) and succeeded in lowering emergency room costs.[9] As the bridge organization for the Dallas-Fort Worth Accountable Health Communities Model, they collaborate with the Texas Medicaid Agency, five of the largest health care systems, over 289 community-based organizations, and a mix of Medicaid health maintenance organizations and private payers.[10] As of last year, the information exchange portal had facilitated more than 800,000 services ranging from housing, job training, and food for clients.[11]

Hennepin Health Accountable Care Organization

The Hennepin Health Medicaid accountable care organization is a partnership between medical providers, the county social services, the county public health provider, and the Metropolitan Health Plan in Hennepin County, Minnesota. Through this partnership, Medicaid contracts with the Minnesota Department of Human Services to provide health care coverage for individuals newly enrolled under Medicaid expansion.[12] All partners share financial risk. Eligible residents can enroll in one of three plans to address medical behavioral health, housing assistance, and social service needs.[13] Care coordinator teams for each member in each plan help navigate and connect beneficiaries to these services. Services include transportation and housing assistance

and connection to resources that provide fresh food and cell phone assistance, for example. Services for health-related social needs are funded through state and county human services and supplemented by monthly payments the accountable care organization collects for each member. Hennepin receives a per member per month capitation payment for the costs for Medicaid services for its enrolled population. State and county funding sources pay for the social services covered under the plans.[12]

Cabarrus Health Alliance

The Cabarrus Health Alliance, formerly known as the Cabarrus County Health Department, is the public health authority created by the Cabarrus County Board of Commissioners. Their mission is to use collaborative action to achieve the highest level of individual and community health. This alliance is comprised of more than 25 community partners with funding from the Cabarrus County government and Atrium Health in North Carolina.

They have tackled a variety of issues through this partnership. To reduce health disparities among minority residents of Cabarrus County, the Racial and Ethnic Approaches to Community Health (REACH) project is implementing strategies that increase access to healthy foods and recreational areas/facilities and strengthen clinical and community linkages.[14] The Alliance has also worked with food pantries to enhance their ability to provide more food and increase healthy food options.[15] Through their Network of Care initiative, a directory was created with available resources in the community (e.g., legal, transportation, housing, etc.) and then health care, social service, community, and faith-based agencies were trained on how to help find services to meet individuals' needs.[15]

DC Positive Accountable Community Transformation

The DC Positive Accountable Community Transformation (DC PACT) coalition is working in Washington, D.C., to create a health system that identifies and addresses health-related social needs of individuals in the community and maximizes community resources and collaboration between health care providers and community service providers. DC PACT is a partnership between area human services organizations, faith-based organizations, health care providers, and DC government agencies. They have arranged for the DC Primary Care Association to serve as a central coordinator for their collective impact model.[16]

Health Care System Investments

Many health systems are working collaboratively with community organizations to address social determinants of health without formal governance structures for community collaboration. Boston Medical Center has invested over $6.5 million over 5 years in community partnerships to support affordable housing initiatives in neighborhoods across the Greater Boston area.[17] Funding will be used to help families avoid eviction through the support of community-based organizations, develop a food market in a new housing development, and create a housing stabilization program for people with complex medical needs, among other programs.[17] Nearly a quarter of Boston Medical Center's hospital admissions are for patients who are homeless and 1 in 3 families who are seen in the pediatric emergency department is housing insecure, so they have a strong interest in serving these needs for the community.[17]

Spectrum Health in West Michigan is another health care system dedicating funds to improving various drivers of health. Spectrum Health dedicates $6 million every year to their Healthier Communities initiative.[18] This initiative targets vulnerable and under-served populations who may lack access to health care or are at risk for poor health outcomes. The dedicated yearly funding goes towards professional development and education, as well as community health education. Healthier Communities also coordinates with various community-based organizations such as community centers, food clubs, faith-based organizations, farmers' markets, public schools, higher education institutions, YMCAs, and many others, to provide programs—such as Programa Puente, Healthy Homes Coalition of West Michigan, or Community Food Club—that provide services to meet health-related social needs and maximize the impact of this initiative.[19]

Mission Health in Western North Carolina also invests heavily in population health and social needs. Through the Mission Community Health and Investment grant, Mission Health is able to continue investing and partnering with programs and organizations with a shared focus on improving health. Through this grant, they have addressed a variety of health-related social needs. For example, Mission helped lead a community-wide domestic violence initiative with various community organizations that led to the creation of the Buncombe County Family Justice Center.[20] Over time, Mission Health has invested over $76 million in community health improvement programs through services and grants, MOUs, and in-kind contributions to community groups.[20]

In Baltimore, Maryland, Bon Secours Baltimore Health System is also dedicating resources to addressing health disparities and the drivers of health through the West Baltimore Primary Care Access Collaborative. The Collaborative is a partnership between the health system, the state of Maryland, and 12 other institutions to reduce health disparities in four neighborhoods in West Baltimore. These four neighborhoods have some of the highest disease burden and greatest health-related social needs in Maryland. Through the Collaborative, Bon Secours and its partners look to improve access to health care and to increase the health care workforce in these neighborhoods. Individuals who are high utilizers of health care emergency services are connected with community health workers and primary care providers. Members of the community are being trained to work in the health care field and health care providers are being incentivized through state tax credits to set up practices in the area. In addition, the Collaborative is working to increase screening for hypertension and diabetes among the residents of the targeted areas.[21]

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