During the March 31 meeting, I believe all of the Task Force members and everyone watching was unpleasantly shocked by the betrayals by our 'health care systems' expressed by people from some of the outreach groups. I know I was humbled in what I thought I knew and what possible relevance that it might have.

One concept mandated in SB 770 is 'regions.' Upon deeper consideration of the transitional and ongoing tasks of regions we may address some of those concerns and the realities that they reveal.

Every region will be different.

A: INVENTORY: But each of them needs to do a thorough inventory of what their resources are at present. One model below.

Stakeholder Group	Delivery Systems Committee
Provide guidance on program implementation, including	How to compare different ways of delivering care, including to subpopulations
1. Quality improvement,	
2. Opportunities to maximize impact and expand program reach,	
3. Ensuring stakeholder interests are considered and included, and	
4. Evaluating success	

Stakeholder Group	Delivery Systems Committee
Provide input on implementing Effective Health Care Program reports and findings in practice and policy settings.	What are the ingredients or elements needed for comparison of ways to deliver care?
Identify options and recommend solutions to issues identified by Effective Health Care Program staff.	Can those elements be examined across delivery organizations and systems to get a sense of what works best for patients?
Provide input on critical research information gaps for practice and policy, as well as research methods to address them. Specifically,	What components of delivery organizations and systems do researchers need to
1. Information needs and types of products most useful to consumers, clinicians, and policymakers;	1. Identify and elaborate, and
2. Feedback on Effective Health Care Program reports, reviews, and summary guides;	2. Relate to the patient-centered outcomes that are most important?
3. Scientific methods and applications; and	
4. Champion objectivity, accountability, and transparency in the Effective Health Care program.	

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4358211/

B: The Need for Community-Led Public Health Solutions

Despite trillions of dollars in healthcare spending, the achievement of population health outcomes in the US has stagnated, and inequities in well-being continue to persist (Tikkanen & Abrams, 2020). Solutions to these problems cannot come only from healthcare, but require collaboration across multiple sectors (e.g., social services, criminal justice, education, economic development) with an explicit and intentional focus on equity and justice (Wolff et al., 2016).

In their call to action to embrace a new approach to public health, dubbed Public Health 3.0, DeSalvo et al. (2017) describe the future role of public health leaders as *strategists* who can lead cross-sector collaborative efforts to address root causes of poor health, well-being and equity outcomes. This requires the focus of public health efforts to shift from being community-placed (i.e., situated in communities but with services owned and delivered in a fragmented manner by public health agencies and healthcare institutions) to being community-based (i.e., development and planning of integrated transformational solutions led by diverse community coalitions focused on local priorities, local context and local innovation). As the country struggles to overcome and build from COVID-19, the need for these approaches have even greater urgency.

1 Evaluation participants

There were three key stakeholder groups who participated in the evaluation.

Implementation team stakeholders included IHI staff and coaches responsible for developing SCALE training and tools and supporting community coalitions on their use.

Community stakeholders were members of the community coalition teams involved in SCALE, and typically one of the members of the “tripod” described earlier.

Evaluation team stakeholders planned and facilitated the synthesis sessions.

Table . **Overarching Concepts and Operational Definitions**

Concept Label	Concept Definition
Applying a theory of change to guide community efforts	The community first develops and then applies an explicit theory of change (TOC), whereby it conceptualizes specific ideas needed for change to direct its efforts towards community health and well-being improvement, create a transformational plan, and spread effective strategies to other communities.
Embedding people with lived experience into transformation work	The community engages people with lived experience in a number of roles, including as community champions, project leaders, trainers, organizers, key informants and participants throughout the course of the change process.
Building capabilities for community change by identifying and growing leaders	The community builds capability of community members to address complex community structural issues that are barriers to community well-being.
Building the capability of the core team engaged in transformation to engage in peer learning	A community works with partners as a coalition to more effectively direct its improvement efforts. Partners include people that have intimate knowledge of and/or experience in the community as residents, advocates, or through community-based organizational affiliations.
Creating access to those with specialized knowledge (e.g., in QI) for coaching and technical assistance	The community is proactive and intentionally uses support from specialists with topic specific and community-relevant knowledge.

Concept Label	Concept Definition
Creating the atmosphere for authentic dialogue within and between communities	The community leaders develop relationships and engage community members to create space for, and improve ability to have, difficult or sensitive conversations.
Facilitating the formation of personal relationships and social connections across coalitions	The community forms personal relationships with peer communities and provide and receive support to one another to discuss and problem-solve common community challenges.
Explicitly and intentionally addressing racism and inequity within the community	The community makes efforts to identify and address the systems, policies and practices working within the community that reinforce structural racism and contribute to disparities and inequities.

https://jprm.scholasticahq.com/article/29011-blending-participatory-action-synthesis-and-meta-ethnography-an-innovative-approach-to-evaluating-complex-community-health-transformation

C: Accountable Communities for Health (ACHs)

ABSTRACT Accountable Communities for Health (ACHs) are collaborative partnerships spanning health, public health, and social services that seek to improve the health of individuals and communities by addressing social determinants of health such as housing, food security, employment, and transportation. ACHs require funding not only for programs and services but also for core infrastructure functions. We conducted a legal and policy review to identify potential funding streams

specifically for ACH infrastructure activities. We found multiple and credible options at the federal and state levels and in the public health, health insurance, and philanthropic and private sectors. Such options could support ACH infrastructure directly or through reimbursement for administrative costs associated with programmatic work. Yet we also

found that there is no dedicated or explicit source of funding for these critical functions. For sustainable and long-term ACH support, policy makers and program administrators should clarify and define ACH infrastructure functions and, where appropriate, explicitly recognize supporting these functions as an allowable use of funds and facilitate their coordination across program funding streams.

Accountable Communities for Health (ACHs)

have emerged as one promising model to address social determinants of health. ACHs are collaborative, multisector partnerships that span health, public health, and social services and seek to improve the health of individuals and local communities by providing services related to health, housing, food security, employment, and transportation, among others.

'Braiding' And 'Blending' We defined braiding as coordinating distinct funding streams to pay for a variety of services and functions. The funding streams are not combined: Instead, each is used to support backbone functions in accordance with the stream's purpose, eligibility- ty rules, reporting requirements, and other considerations. Rhode Island's ACH initiative called Health Equity Zones is a good example of the use of braiding. The initiative relies on federal funds from the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and Centers for Disease Control and Prevention (CDC), as well as state and local sources.[12]

In contrast, blending allows an ACH to simplify administration by pooling multiple funding sources, although generally each funding stream still has separate reporting requirements to ensure the appropriate use of the funds.[13] The ability to braid or blend different funding sources is an important long-term strategy for ACHs, al- though both approaches require significant leadership, organizational resources, and technical expertise.

Exhibit 1 Sources of public health and social services funding for Accountable Communities for Health (ACH) infrastructure functions

Source Mechanism or program

ACF Social Services Block Grant Program

SAMHSA Substance Abuse Prevention and Treatment Block Grant

HRSA Health Center Program

HUD Community Development Block Grant Program

DOL Workforce Innovation and Opportunity Act (WIOA) of

2014 title I grants

Authority

SSA, Title XX, Subtitle A, Sec. 2001–2009

PHSA, Sec. 1921– 1935

PHSA, Sec. 330

42 U.S.C. Sec. 5301–5321

Pub. L. 113-128 (2014), Title I

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