ISSUE BRIEF

Accountable Care Communities

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Accountable care communities are a new health model that involves multiple stakeholders working together to improve the health and well-being of their communities by addressing social determinants of health. Stakeholders include health care delivery systems, public health organizations, and community organizations. In an accountable care community, the stakeholders commit to share responsibility, resources, and data to improve community health indicators. Accountable care communities are a promising model to both decrease medical costs and improve health outcomes by placing greater emphasis on addressing social and economic issues that ultimately define health. This issue of the NCMJ highlights accountable care communities in other states and provides an overview of how accountable care community initiatives are working in North Carolina to improve the overall health of our communities.

As part of the Patient Protection and Affordable Care Act (ACA), providers across the United States began work on delivering value-based care within Accountable Care Organizations (ACOs) and Clinically Integrated Provider Networks. However, many of these new organizations failed to deliver on the promise of decreasing costs and improving outcomes [1]. One potential explanation was their predominant focus on health care delivery systems alone, and subsequent failure to address social determinants of health.

Research has shown that clinical delivery systems contribute a relatively small amount to overall health outcomes when compared to other factors like health behavior, environment, poverty, education, and other social determinates. For example, the Robert Wood Johnson Foundation [2] and Schroeder et al. [3] have indicated that clinical care only comprises 10-20% of health outcomes (see Figure 1). If we want to truly impact health outcomes, we must address social factors, people's environments, and health behaviors. Few health providers have expertise in these domains and, therefore, will need to work with community partners who have expertise in these areas. When this happens in a coordinated, purposeful way with a commitment to working together to support and improve the health and well-being of a community, the result is an Accountable Care Community (ACC).

What is an ACC?

ACCs, also known as accountable health communities, address health from a community perspective, pulling multiple stakeholders together in a coalition that shares responsibility for addressing multiple determinants of health. ACCs add value to health care settings because they enable the health care system to reach patients in their own environments through local agencies better positioned to take advantage of the social infrastructure that already exists (eg, schools, businesses, community organizations, and faith organizations) [4].

Successful ACCs are partnerships between health care providers and community agencies to address population health issues. The most common collaboration is generally between health care providers and social service organizations, where each works to improve the lives of community members in a way that also improves health outcomes and reduces medical expenditures. A number of examples exist where communities have worked to further collaborations through physical co-location of services. In some settings, these partnerships have expanded to include alignment with other fields, such as community development [5] and the private sector, through work force interventions.

In the ideal setting, ACCs have the ability to inventory existing and needed community resources, proactively target individuals within the community and guide them towards needed resources, and allow and facilitate navigation across community and health system services. Each of these functions is dependent upon the ability to share identified and de-identified data that improves coordination and efficiency of service delivery, provides an understanding of the community's social and health needs, and allows all participants to evaluate their impact on health utilization and population-based outcomes.

Who Can Make an Impact?

Public Health. Public health agencies have new opportunities to expand beyond their traditional roles in infectious disease control and as a safety net provider of medical services. In 2014, the Public Health Leadership Forum called for state and local health departments to serve as 'Chief Health Strategists' for their communities, and lead health improvement efforts in partnership with health care clinicians and

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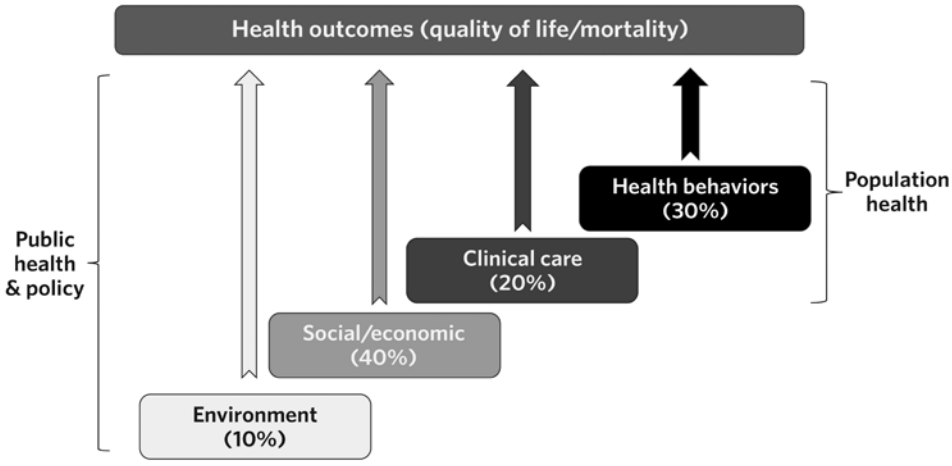
FIGURE 1.
Underlying Determinants of Health Outcomes [2]



Source: Robert Wood Johnson Foundation

widely diverse sectors, including social services, education, transportation, public safety, and community development [6]. In this role, public health must provide greater leadership on leading policy and systems change interventions to prevent and control chronic diseases. Public health professionals must also work more closely with health care providers, community-based organizations, and local advocates on community-wide health promotion efforts that reorient society toward a greater emphasis on prevention and wellness. This will require new approaches to data systems and a shift in the traditional public health role of collecting and providing public health data, to a broader role in interpreting and distributing data from a variety of different sources.

Health Systems. Health systems have many advantages that can help them engage with community partners. First, health providers understand the primary outcomes that need to be addressed for a community. Specifically, health systems have extremely valuable data that provide an in depth understanding of the disease burden within a community, and identify current outcomes in terms of cost and utilization of services, provision of preventive services, and control of chronic conditions. Second, health providers also receive the majority of funding directed towards improving health compared to current efforts that address social determinants. This is evident in the current per capita spending on health care in North Carolina ($6,444 per person, just under the national average of $6,800) [7]. Third, health providers have access to a majority of community members over the course of their lives through private and affiliated provider practices, urgent care centers, and hospital emergency rooms. This provides an opportunity and financial incentive to address the health needs of the entire community, rather than just focusing on contemporary patient populations. In the future, health care systems should establish executive level leadership roles in community health that are focused on external collaborations, providing more sophisticated data on community health needs, and addressing access issues in underserved areas through capital investments or external partnerships.

Academic Institutions. Academic institutions can be important partners when they partner with public health and health care providers. Academic institutions have resources to affect community change and have researchers interested in using data to better inform decision-making. Partnering with universities can bring in expertise and skills, as well as other resources to strengthen the work of the ACC. Additionally, since academic institutions train students in health care and social services, they can be important partners in training and engaging the emerging workforce in new roles. In many communities, academic institutions are credible and respected voices, and can play a critical role in calling for policy changes and embracing new interventions that may initially seem controversial or divisive.

State and Local Government. State and local policymakers must understand the importance of supporting ACCs in North Carolina. State and local policies can support or hinder the work of ACCs. In the immediate future, state Medicaid reform provides the single most important opportunity to expand the work of ACCs in North Carolina. It is vitally important that policymakers assure Medicaid payments are adequate to attract high quality medical home providers to participate. It is equally important that administrative and contractual responsibilities for Medicaid oversight and services include requirements for services, such as extensive case management for pregnant women and young children, that will ultimately support stronger community collaborations and help identify and address social issues.

ACC Efforts

Both the terminology and the concept of ACCs are fairly new, emerging after the passage of the ACA in 2010 [8]. Communities across the country are experimenting with

different models of ACCs to address population health. Recently, the Center for Medicare and Medicaid Innovation provided funding for several ACC models that will be implemented across the country by enrolling high-risk individuals into social services navigation programs, and testing the impact of these programs on health care utilization and spending [9]. There is also a lot of interest in ACCs in North Carolina, as communities are experimenting with various activities similar to those of an ACC. However, currently no North Carolina community has a full-scale ACC in place. This issue of the NCMJ highlights ACCs in other states and provides an overview of ways ACC-like initiatives are working to improve the health of communities across North Carolina.

North Carolina has a long history of addressing population health issues by reaching outside the walls of traditional health care institutions. Community Care of North Carolina (CCNC) has made significant inroads into this domain [10]. Care coordinators working within CCNC use Medicaid claims data to identify high-risk patients and then assist them through enhanced preventative services within a primary care medical home and navigation into social services. A similar approach in this Issue is described by Jennifer DeCubellis in her article on Hennepin Health, a Medicaid ACO in Hennepin County, Minnesota that provides intensive care coordination and the integration of social services with the delivery of health care [11].

Many initiatives in North Carolina have expanded on the CCNC model and focus on improving outcomes for patients with chronic disease. For example, as Fields describes in his commentary, Mission Health ACO has built a community-based care coordination approach where medical providers make referrals to community social service agencies through a care coordination center called a hub [12]. Blenco describes how the YMCA of Western NC partnered with Mission Health ACO on their diabetes prevention program and ultimately opened an innovative health and wellness facility on a hospital campus [13].

Health care systems have shown considerable leadership in developing accountable care models. Cole describes an unexpected partnership between 2 health care systems in Charlotte that are long-term competitive rivals [14]. The partnership builds on an innovative health needs assessment conducted with the UNC Institute for Public Health. The assessment uses a hotspotting technique to identify and develop more targeted community interventions to maximize impact on health outcomes.

Many partnerships have focused on issues that impact health by making resources available to support healthy behaviors. As Mardovich describes in her commentary, Cabarrus Health Alliance initially formed partnerships to implement a major diabetes initiative focused on case management and self-management [15]. Efforts later expanded into community based initiatives such as a corner store initiative, support of farmer's markets, and development of joint use agreements to expand access to physical activity resources. Hardy shares how an initial partnership between Halifax Regional Medical Center and the county health department to impact child obesity ultimately led to a combined, multi-partner effort to provide healthy, accessible, affordable foods and easy access to exercise and physical activities through marketing, community and workplace programming, and school interventions [16].

Communities have also focused more widely on core social issues that underlie basic human needs. In addition to dealing with housing needs, Byerly and Williams describe how the Greensboro Housing Coalition has sought to address a wide range of environmental factors that influence health, including lead poisoning and pediatric asthma [17]. Lewis highlights how Ashe Memorial Hospital developed a food pantry project for patients identified as being 'food insecure' [18]. Cutts explains how Wake Forest Baptist Medical Center has sought to engage the community through faith based interventions, and has expanded this approach regionally [19]. A hospital based navigator identifies patients with community resource needs and works with local church liaisons to help arrange and support these services post discharge.

ACCs have tremendous opportunities to work with and expand efforts of businesses engaged in employee wellness. Adcock highlights how SAS has a longstanding engagement, commitment, and culture of employee health with programs that include an onsite health center and careful tracking of employee health care claims [20]. As described by Salamido, the North Carolina Chamber of Commerce has also taken interest in these approaches and is now implementing a strategic roadmap to engage employers with partners along their health benefit supply chain to drive greater health care value [21].

Perhaps most importantly, as we move towards implementing the ACC model across North Carolina and the US, new skill sets must be developed and existing staff/providers need to be better trained in the holistic provision of care that spans behavior and environment, addresses social determinants of health, and helps navigate increasingly complex health care systems. In their commentary, Richman and co-authors explore boundary spanning roles that will be required of the accountable care workforce, and the important roles of non-health care professional and lay health workers in reaching and impacting our increasingly diverse communities [4].

The examples above reflect some, but not all, of the tremendous progress North Carolina has made towards creating ACCs. In the future, strong leadership will be needed to realize the opportunities for innovation and ultimately shift societal emphasis and resource allocation from advanced health care interventions to investments in core social and economic needs.

Conclusion

In summary, the accountable care community is an exciting approach that has tremendous potential to improve health outcomes by addressing social determinants of health. As can be seen in this Issue, many groups across North Carolina are moving quickly to improve their communities by taking this innovative and essential approach to transforming the way we provide health and social services within our communities. NCMJ

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