

The Accountable Care Workforce: Bridging the Health Divide in North Carolina

Erica L. Richman, Brianna M. Lombardi, Lisa de Saxe Zerden

Accountable care communities form as health care entities partner with communities to more fully address population health. This partnership requires an adaptable, boundary spanning, and diverse workforce, as well as flexible regulatory and governing structures that adapt to changing payment models, task shifting, and new roles in health care.

In North Carolina and across the country, the health care system is aspiring to meet the Institute for Healthcare Improvement's Triple Aim [1] of being accountable for better patient experiences, improving population health, and decreasing costs by expanding beyond traditional health care settings and moving deeper into the community [1, 2]. Increasingly, health care entities are partnering with community agencies and social service organizations to break down silos of care and more fully address population health. As these rapidly emerging partnerships become established, they are referred to as accountable care communities (ACCs). ACCs are similar to the accountable health community model developed by the Centers for Medicare & Medicaid Services [3], but ACCs are not bound by the same legal, regulatory, or evaluation requirements and funding structures [2]. This multisector effort to improve health at the community level presents several workforce-related challenges. Collaboration in health care settings requires a flexible, boundary spanning workforce that not only accommodates diversity in the workers' discipline, education, and demographic characteristics, but is also committed to disease prevention strategies [4]. Furthermore, a fundamental step toward improving health through community collaboration is to address the social determinants of health (SDHs), which include social policies and environmental factors as well as the economic and community conditions that impact health outcomes [5].

The recent movement toward value-based payment models has intensified the recognition that social factors play an influential role in individual and population health outcomes. SDHs such as income, education, beliefs, and neighborhood characteristics can have a profound effect on health [6, 7] and health care costs [8]. Estimates suggest that access and quality of care received in a traditional health care setting account for only 20% of a person's health problems, while

the remaining 80% is determined by social factors [9]. The integration of medical care, prevention initiatives, and social services has the potential to both improve the health of more people and reduce health care spending by focusing on the social and economic factors affecting health [10, 11].

What is the Ideal Workforce for an ACC?

Prescribing a specific set of professionals to staff ACCs is a complicated and perhaps impossible task. The primary goal of the ACC model is to support health care by addressing the SDHs that exacerbate physical and behavioral health outcomes; however, few communities have identical sets of health care needs, socioeconomic circumstances, or health care workers. In urban North Carolina counties, there tend to be sufficient numbers of health care professionals per capita to care for the local population; but in rural counties, there may not be an adequate supply of providers. According to 2016 data, 3 NC counties do not have a single actively working physician and 32 counties do not have a working psychiatrist (based on primary practice location) [12]. Given rural providers are more isolated from other healthcare workers, it is not unusual for these professionals to perform a wider breadth of care for the patients they serve. Similarly, rural residents are likely to seek care from an alternative, more widely available health care worker when a more traditional professional is not employed nearby [13]. For example, more people may utilize social workers for behavioral health care in cases where psychologists are not available. In places where nurses are scarce, you may see them performing expanded roles like care management on top of their typical duties, with some traditional nursing tasks delegated to medical assistants. In general, a broader definition of the health workforce is needed to include workers from many disciplines—some of which may be unexpected—with diverse backgrounds and varied levels of professional training. This new definition allows for community specific com-

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Address correspondence to Dr. Erica L. Richman, 725 Martin Luther King Jr Blvd, Chapel Hill, NC 27599-7590 (elr@email.unc.edu).

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binations of professionals and lay people to work together in implementing prevention programs, services, and supports tailored to the nuances of the resources and strengths of the diverse communities across North Carolina.

Boundary Spanning Roles

ACCs add value to health care settings because they enable the health care system to reach patients in their own environments through local agencies that are better positioned to take advantage of the social infrastructure that already exists (eg, schools, businesses, community organizations, and faith organizations). Treatment of complicated social issues requires partnerships across multiple systems, yet an increase in multisector agencies will require a workforce that can move between these sectors with ease. These boundary spanning roles are essential in the coordination of care between the health care system and community partners as patient care shifts from visit-based, fee-for-service models to strategies that use community and population level approaches to focus on prevention [4]. A workforce with this kind of agility will not only assist patients in accessing and navigating clinical and community settings, but will also have the capacity to understand common goals, strengths, and barriers, and use that understanding to collectively meet the needs of individuals within their environments. This capacity includes maintaining an awareness of how systems function, using shared language to express common values and goals, and recognizing the synergies that exist to collectively work together and align goals. As such, the knowledge and flexibility of a boundary spanning workforce is better equipped than a traditional model to address complex physical and social conditions that warrant a multipronged approach.

Boundary spanning roles in health care vary by job title and provider type. A nurse, social worker, or medical assistant may be hired as a patient navigator, case manager, care manager, or panel manager, and their responsibilities might be identical or distinct. For example, social workers, professionals whose roles have typically been narrowly defined in health care settings, have recently become more involved partners in the ranks of health care workers; the responsibilities of these social workers are likely to bridge clinical and community settings [14]. A social worker working in a care management position might provide behavioral health treatment in a hospital, while also coordinating a necessary inspection of the rental home of a patient with chronic asthma to assess for unhealthy levels of asthma-causing mold. These boundary spanning roles and positions are new, and the functions, tasks, and payment mechanisms associated with these positions are not yet well-defined [14].

Panel managers, another example of a newly created boundary spanning role, can be filled by a variety of professionals. Between or before hospital visits, a panel manager acts proactively to identify and provide education and

extra support to high-risk patients or those with chronic disease. Often, panel managers will use specialized panel management software and other information technology tools for stratifying, identifying, and engaging patients in need of outreach [15]. They frequently engage in outreach to patients to help identify unmet care needs, to encourage medication compliance, or to promote screening appointment attendance. Ultimately, the position of panel manager promotes health outside of the hospital as one means of reducing unnecessary hospital readmissions; however, they can also help build relationships between patients and the health care system. New roles will inevitably create misunderstanding and confusion related to task shifting, responsibilities, and trust. Thus, it is imperative that all members of the health workforce become familiar with the goals and capacities of these boundary spanning roles so the ACC can function smoothly.

Non-Health Care Professionals and Lay Health Workers

Historically, the health care workforce has consisted of licensed health professionals such as doctors, nurses, dentists, pharmacists, and allied health professionals. Innovative partnerships in North Carolina are enabling agencies to tap into the expertise of people in disciplines not generally associated with health care. These lay professionals come from the community with the goal of tackling real-life issues, which can appear to be ordinary or minor inconveniences, but actually can become insurmountable barriers to wellness. The Cabarrus Health Alliance for example, which used to be the Cabarrus County Health Department and remains responsible for the provision of usual county health department services, has an increased focus on innovation and collaboration and has implemented several specialized health-promotion programs and practices. One such illustration is the hiring of individuals with expertise in communications and marketing who prioritize creative interventions, like teaching corner store owners display strategies for siting healthful foods in ways that increase the items' visibility and appeal. This increases the likelihood that consumers will choose and purchase these better options.

North Carolina is also promoting health by employing physical trainers and dieticians to work in local initiatives aimed at helping low income people combat diabetes after their physician prescribes an exercise regimen. Other health professionals and hospitals in North Carolina are partnering with community agencies like the Greensboro Housing Coalition, an agency that advocates for safe housing for lower income people and those with special health needs. The Greensboro Housing Coalition keeps building maintenance experts and property managers on staff as their understanding of regulations helps ensure people's homes are safe from health risks such as mold, rot, and dangerous building materials. Additionally, North Carolinians are using

health educators and community health workers to do outreach, translate complicated health information into accessible forms, and facilitate access to services.

In addition to non-health care related disciplines, ACCs require the work, cooperation, and support of nonprofessionals who live, breathe, and engage with their own communities [16]. Lay workers go by many names: care coordinator assistants, peer-support specialists, members of faith organizations, or community health workers. Whatever the name, these lay workers are essential to creating sustained, successful partnerships between health care systems and communities [16, 17]. Lay workers are more likely to come from a similar socioeconomic and racial or ethnic background as the people in the communities in which they work, more likely to use similar and familiar language as community residents, and more likely to have a shared history and experiential knowledge related to the patient—all of which are likely to increase the chances of securing buy-in from the patient [18]. Inclusion of lay workers is a growing strategy for the health care workforce and one that is already common in behavioral health care. For example, North Carolina has more than 2,353 certified peer support specialists who can provide support, based on their lived experiences, to people living in recovery with mental illnesses or substance use disorders [19]. Although lay community members might not have formal training, their value comes from their knowledge of the community culture and agencies. For individuals who work in a top-down health care system, using lay people as health workers might seem a radical, unusual approach. For other health care models, lay workers are paramount, particularly so for ACCs because of the model's fundamental requirement for collaboration.

Community-Based Prevention Workforce

ACCs are dedicated to addressing the SDH of individuals in their communities and are focused on how to target upstream factors to stop preventable health conditions. For example, ACCs are working quickly to address modifiable and preventable conditions such as diabetes, obesity, and risky sexual behaviors. The community-based prevention workforce will be responsible for surveillance of health risks and the delivery, implementation, and measurement of the uptake of prevention-based programs. Indeed, ACCs will need a workforce not only trained in the framework and concepts of prevention, but also trained in evidence-based prevention interventions and the implementation skills needed to introduce large-scale initiatives into the community. Positions with potential to play a role in this effort include public health workers, health educators, macro social workers, and patient educators; similarly, these positions might be held by individuals from a variety of discipline backgrounds. ACCs will require a renewed focus on public health that moves beyond the functions of a traditional health department to embrace roles that actively approach community health needs [20].

Diversity in the Workforce

Across all health care systems, increasing the racial and ethnic diversity of the workforce is considered vital to reducing health disparities and addressing racial equity [21]. Community consumers will look for the ACC's work to be carried out by individuals who reflect the diversity of the community in which they live. However, a recent report on the diversity of the health care workforce in North Carolina reflected only modest increases in diversity across health disciplines [22]. If the ACC model is committed to community engagement and reducing the effects of SDH, then the inclusion of a diverse workforce is critical.

Barriers and Facilitators to ACC Workforce Development

Although ACCs will develop a new and retooled workforce as they grow, several factors will affect the creation of a successful and sustainable model of partnerships [4]. This includes healthcare systems and communities working together to achieve a shared mission and culture of health, valuing an interprofessional workforce, and developing administrative and governance structures to promote the work of ACCs.

Shared Mission and Culture

Community agencies and health systems operate in fundamentally different ways, and a successful partnership between the 2 requires a shared understanding of each other, consensus on goals, and a shared responsibility for the partnership model. An alignment of values and goals of ACCs will include alignment of workforce considerations.

An Interprofessional Workforce

ACCs will require interprofessional collaboration between health systems and community agencies, yet components of interprofessional practice might not transfer easily to this model of care. Because historically health professionals have been trained independent of other disciplines, collaboration is often difficult. Recent trends in interprofessional education (IPE) are helping shift this emphasis so that the health care workforce is socialized to be more collaborative at the onset of their professional development. IPE training will help the existing health care workforce transition to working in ACCs.

Administrative and Governance Structures

Ultimately, boundary spanning positions require not only a flexible workforce, but also flexible administration of health systems and new models of local and state governing structures. Health systems will need to reorganize and create new policies regarding how to collaborate with community agencies. Moreover, health systems will no longer just need to refer patients to community agencies, but also maintain open lines of communication with agency provid-

ers to ensure coordination of care. Local and state governing structures might need to assist in coordinating actions and partnerships across multiple sectors while allowing for local autonomy [23].

Breaking down the silos within health systems also requires organizational shifting within human resource departments so that the hiring and deployment of boundary spanning employees can be maximized. A critical element to the success of the ACC model will be whether health systems administrators and stakeholders will understand these models and how to harness the potential of lay community members in the deployment of programs.

Sustainable Models of Payment

ACC models of care are being deployed while the reimbursement mechanisms for cross-sector collaboration of health systems with social service and community agencies are still being considered. It is unclear how many of the current positions will be funded in the long-term because many are supported by grant funding and highly constrained community agency budgets. In North Carolina, payment models are complicated because the State opted out of Medicaid Expansion, and the future of health care reform is under debate. Although value-based models will assist with moving away from the problems of fee-for-service models, it remains unclear how cost savings will be shared between the community and the partnered health system. ACCs have great promise to make real health change at the population level; however, without a long-term and sustainable payment solution, the potential and great promise of the ACC model of care might never be realized.

Conclusion

Accountable care communities are changing the very structure of health care delivery, and the health workforce is swiftly adapting to accommodate the transformation. Broadening the definition of health workforce to include workers from non-health related disciplines, with varied levels of professional training and diverse backgrounds, is crucial to successfully improving the health of North Carolinians. Our state is already making strides to accomplish this goal by implementing creative programs that have integrated a variety of disciplines, professionals, and lay health workers. Continued communication regarding the shifting of tasks and how health care is functioning inside and outside of clinical settings will smooth the journey. **NCMJ**

Erica L. Richman, PhD, MSW research analyst, Program on Health and Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill, North Carolina.

Brianna M. Lombardi, MSW doctoral candidate, School of Social Work, University of North Carolina, Chapel Hill, North Carolina.

Lisa de Saxe Zerden, PhD, MSW senior associate dean for MSW education, School of Social Work, University of North Carolina, Chapel Hill, North Carolina.

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