

ACCOUNTABLE CARE COMMUNITIES



North Carolina Institute of Medicine

PARTNERING TO IMPROVE HEALTH:

*A Guide to Starting an
Accountable Care Community*

Funded by *The Duke Endowment* and the *Kate B. Reynolds Charitable Trust*

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DEFINITIONS

ACCOUNTABLE CARE COMMUNITY (ACC)

A coalition of cross-sector stakeholders, including health care providers and community agencies that work together to improve health in a community. ACCs integrate health care, public health, education, social services, and other sectors to address multiple determinants of health, including social determinants.

BACKBONE ORGANIZATION

An entity that takes on the responsibility of maintaining the focus of a partnership and plays a coordinating role, such as convening and facilitating meetings, and may help to manage financial resources.

DRIVERS OF HEALTH

The conditions in which individuals live, learn, work, and age; these include social and economic factors, health behaviors, the physical environment, clinical care, and the policies and programs that influence these factors.

HEALTH DISPARITIES

Differences in health status and outcomes between groups based on characteristics like race, ethnicity, gender, and income.¹

HEALTH EQUITY

The opportunity for all people to attain the highest level of personal health regardless of demographic characteristics.²

HEALTH AND WELL-BEING IN ALL POLICIES

Consideration of the effects of policies across sectors on the health and well-being of community members.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) ACT OF 1996

Details national standards for privacy of patient data.

HEALTH-RELATED SOCIAL NEEDS

The many factors that come together to affect health outcomes, including food security, transportation needs, employment, safe housing, and interpersonal violence.

HUMAN SERVICES ORGANIZATION

A non-governmental organization that provides services that help people “stabilize their life and find self-sufficiency through guidance, counseling, treatment and the providing for of basic needs.”³

LOCAL HEALTH DEPARTMENTS

Government agency, typically county-based, that serves the public health needs of of an area.

MEDICAID TRANSFORMATION

The transition to managed care for the state Medicaid and NC Health Choice programs, as mandated by the North Carolina General Assembly in 2015; the Centers for Medicare & Medicaid Services approved the 1115 Medicaid Waiver to incorporate this transition on October 24, 2018.⁴

NCCARE360

A web-based resource and referral platform being developed and implemented by NCCARE360 partners: the Foundation for Health Leadership & Innovation, North Carolina Department of Health and Human Services, United Way of NC/NC 2-1-1, Expound, and Unite Us.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (NC DHHS)

The state department responsible for managing health- and human-related services in North Carolina; there are 30 divisions and offices in NC DHHS, including:

- Aging and Adult Services
- Child Development and Early Education
- Health Benefits (NC Medicaid)
- Health Service Regulation
- Human Resources
- Mental Health, Developmental Disabilities, and Substance Abuse Services
- Office of Rural Health
- Public Health
- Services for the Blind
- Services for the Deaf and Hard of Hearing
- Social Services
- State Operated Healthcare Facilities
- Vocational Rehabilitation Services

PREPAID HEALTH PLAN

Commercial health insurance plans and Provider-Led Entities that will enter into capitated contracts with the North Carolina Department of Health and Human Services as part of Medicaid transformation.

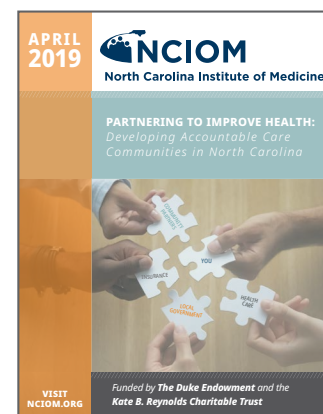
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INTRODUCTION

In 2018, the North Carolina Institute of Medicine, with funding from the Kate B. Reynolds Charitable Trust and The Duke Endowment, convened the Task Force on Accountable Care Communities. The purpose of the Task Force was to make recommendations that would support the development of a new model of community partnership to address the social, environmental, and behavioral issues in people's lives that affect their opportunity to be healthy. This new model is called Accountable Care Communities. In addition to the recommendations made by the Task Force (*found in the final report [HERE](#)*), we have developed a guide for communities in North Carolina. This guide is intended for those that are interested in implementing an Accountable Care Community-style model to develop stronger partnerships that address health and well-being for all people in the community. This guide provides information about what an Accountable Care Community is, the process of developing partnerships and who to partner with, important things to consider along the way, how these models can fit into Medicaid transformation occurring in the state of North Carolina, and lots of resources for more information or assistance.

This guide is just a start to thinking about the growing place Accountable Care Communities may have in the work to acknowledge and address whole-person health and well-being. The staff of the North Carolina Institute of Medicine and the members of the Task Force on Accountable Care Communities are committed to seeing these models flourish in North Carolina. If you are interested in scheduling a presentation about this model, please contact Brienne Lyda-McDonald (blydamcd@nciom.org).



[CLICK TO DOWNLOAD](#)

WHAT IS AN ACCOUNTABLE CARE COMMUNITY?

Shifting the focus from health care to population health and well-being

For too long in the US, discussions around health have focused on health care: who can access care, what type of care, how much care, who delivers care, and who pays for it. What often gets left out is that health care is only a piece of the greater puzzle of health and wellness. Although access to medical care is important, health begins long before medical care is needed. Health begins in families and communities, in the places where we live, learn, work, and play. The social, behavioral, and economic factors that affect health include safe families and communities, housing, transportation, access to healthy food, education, and health behaviors. These factors are called **drivers of health** (also called social determinants of health). They directly affect health outcomes like development of disease and life expectancy. They also influence the health behaviors people engage in, like diet and exercise, which then impact health outcomes. Difference in experience with drivers of health can lead to **health disparities**. Health disparities are differences in health status and outcomes between groups based on characteristics like race, ethnicity, gender, and income¹. Most traditional health care settings and stakeholders are not designed to address these drivers of health. Long-term sustainable improvements in the health and well-being of community members will not occur without addressing the physical, social, and economic challenges that keep people from achieving optimal health.



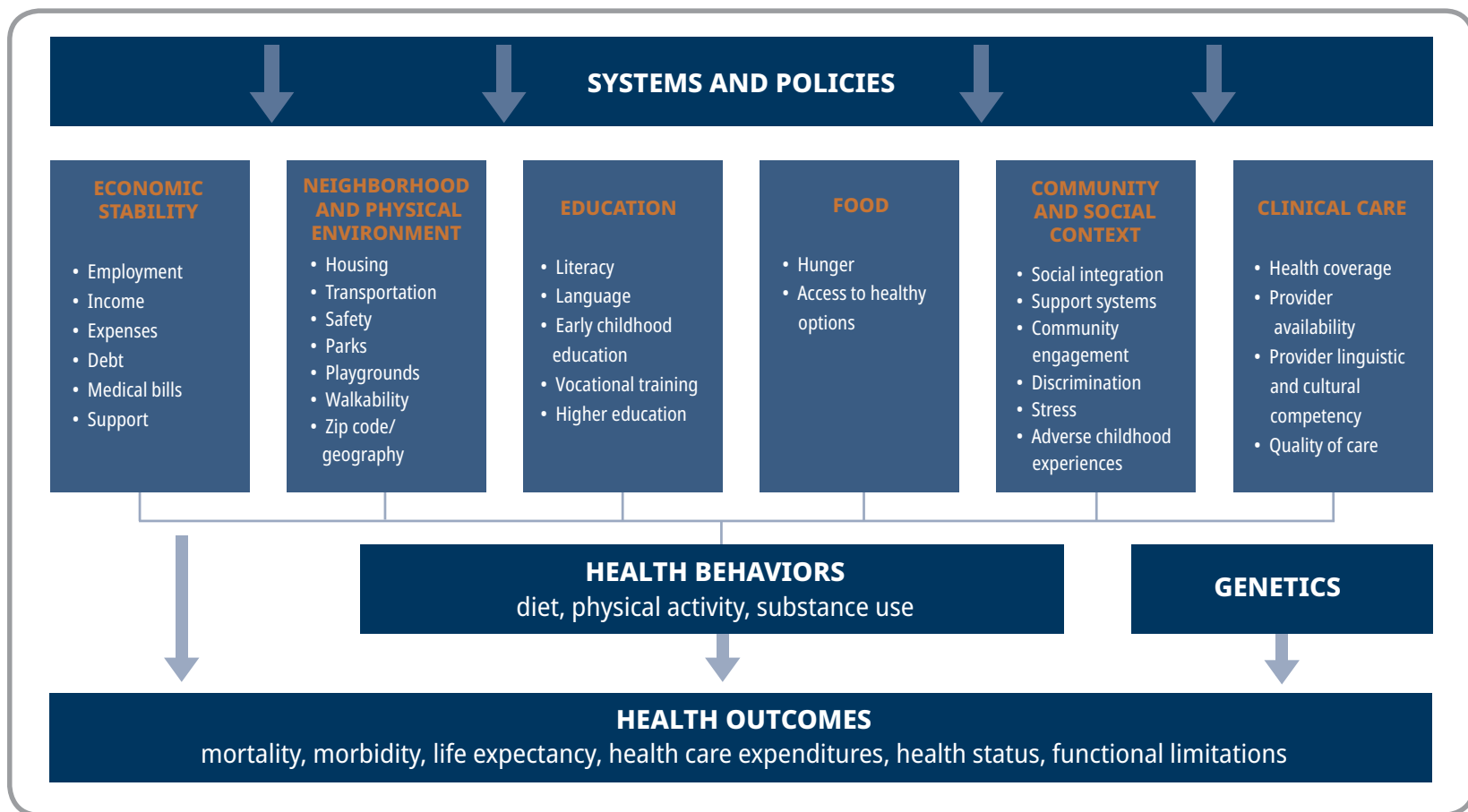
Additionally, federal, state, and local systems and policies create the context within which the drivers of health exist. The results of some public policies are more easily seen or discussed: traffic and public safety laws, tax policies, education financing, and public assistance programs. Others may be harder to see in our daily lives but shape them nonetheless: zoning and land use policies; food safety regulations; agriculture policies; regulations around banking, communications, and air and water quality; and laws around health insurance access and coverage. **Figure 1** depicts how systems and policies, drivers of health, health behaviors, and genetics all come together to impact health outcomes.

FURTHER READING: For more information on drivers of health and how they affect health outcomes, please see the North Carolina Institute of Medicine's [Final Report from the Task Force on Accountable Care Communities](#).

EXAMPLES OF DRIVERS OF HEALTH:

- People with lower incomes are more likely to live in substandard housing or unsafe communities.
- Low access to stores that sell fresh fruits and vegetables affects options for healthy meals.
- Communities with low access to outdoor recreational facilities provide fewer opportunities to exercise.
- People with higher incomes are more likely to live near high-achieving schools.

Figure 1. How Systems and Policies Impact Drivers of Health and Health Outcomes



Source: Developed from Figure 1 in *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, Henry J Kaiser Family Foundation Report. May 10, 2018. <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

As the United States health care system wrestles with how to rein in costs and improve outcomes, health care systems and communities across the country have been testing new models of payment and care delivery. One promising strategy to address social and economic drivers of health is the Accountable Care Community model. ***Accountable Care Communities (ACCs) address health from a community perspective. ACCs bring together a coalition of cross-sector stakeholders that share responsibility to address the drivers of health while reducing, or holding steady, health spending.***

The goal of an ACC is to facilitate broad changes in what is considered health, and, therefore, how health care dollars are allocated. Improving the health of the whole community requires the development of new ways for traditional health care, with its focus on preventing and treating illness, to work together with non-traditional partners, whose focus is on creating the conditions necessary for good health (e.g., public health, social services, education, business, and other community-based organizations).

TO ACCOMPLISH THEIR GOALS, ACCS TYPICALLY HAVE THE FOLLOWING CORE FEATURES:

1 ASSESSMENT OF COMMUNITY HEALTH:
Analysis of community health issues to determine priorities (i.e., what health issues and health-related social needs are most urgent in the community; which populations have the most risk and need).

2 EDUCATION AND ADVOCACY:
A plan and mechanism to advance community health and health equity by advocating for local policies and communicating with local government agencies about the health effects of policy across sectors.

3 SCREENING TOOL:
A questionnaire (ideally shared across members of the ACC) to screen people for needs within the drivers of health domains.

4 REFERRAL PROCESS:
Protocols to refer clients to other providers/organizations that can help meet their needs when their screening results indicate they could benefit from additional resources.

5 NAVIGATION SERVICES:
Assistance for clients who have trouble accessing community services.

6 TRACKING SYSTEM:
A system with the ability to capture information about whether individuals referred to services receive them and what services are received.

7 OUTCOMES DATA AND ANALYSIS:
Data at the individual or population level tracking health outcomes (e.g., number of hospital visits; school days missed); and analysis of the data captured (screening questions, tracking system, outcomes data) to determine where investments in one area create positive outcomes and/or reduce cost while maintaining or increasing value (identifying the return on investment of various services provided).

8 FINANCING:
Analysis of return on investment can be used to develop financial models to support service delivery of both clinical and non-clinical services.

9 GOVERNANCE:
Collaborative organizations in an ACC should have a shared governance structure that affords shared decision-making, shared risk, and shared reward. In advanced ACC models, a backbone organization serves as a convener that makes driving multi-sector collaboration its main priority by overseeing the day-to-day operations of the ACC, including planning, implementation, and improvement efforts. Characteristics of an ideal backbone organization include a strong connection to community stakeholders, data and financial management capacity, ability to guide strategy and vision, and support of aligned activities.

WORKING TOGETHER TO CREATE CONDITIONS FOR GOOD HEALTH:

In an ACC, cross-sector stakeholders join together to address health from a community perspective. This is accomplished by forming a coalition that shares responsibility for addressing the drivers of health. By not only looking at health care services, but also considering how to support community health and well-being across other sectors, ACCs can organize and engage partners to improve health outcomes and reduce costs. ACCs work to leverage the contributions of all members by strengthening links between existing programs and services and coordinating resources and efforts.

BENEFITS OF THE ACC MODEL:

Early adopters of ACC models have shown that partnering social service, public health, and health care providers can reduce health care utilization while improving outcomes. For communities, there is significant interest in partnering with health systems to improve health. Health care systems and providers are moving away from fee-for-service payments toward global payments tied to health outcomes. This change demands that they begin to look for opportunities to achieve cost savings. Often, opportunities for cost savings come by creating conditions for people to be healthy in their homes and communities. This work is typically done by community social service providers and others outside the health care system.

CHALLENGES OF THE ACC MODEL:

Improving health outcomes in the community is a goal that many organizations can support. However, agreement about the specific details of how to do this can be challenging. ACCs need to develop a shared vision and establish a leadership structure, prioritize health outcomes, agree on financing, develop and implement strategies for integrating/coordinating services, share data, and develop a plan for performance measurement, among other challenges.

DRIVE INNOVATION TO IMPROVE POPULATION HEALTH:

Despite the challenges, ACCs have the opportunity to transform the health care landscape in North Carolina and across the country. Reaching the goal of improved health for the whole community requires stepping outside the bounds of traditional health care. It requires addressing patients' social needs with the same intention as their health care needs. ACCs provide a model for how various community systems and organizations can work together to improve the health and well-being of their communities.

CORE PRINCIPLES OF AN ACC:

FOCUS ON THE COMMUNITY

The purpose of the ACC coalition of cross-sector partners is to improve the health and well-being of a particular community. Community member participation and input must be at the heart of ACC activities.

TRUST

ACC partners must trust each other and must sustain the trust of the community they represent. ACCs should always include members of the community in the partnership and decision-making process.

COMMITMENT

Partners are committed to making a difference in community health and well-being.

COLLABORATION

ACCs are only successful as a collaborative effort with no one entity making all of the decisions or doing all of the work.

COLLECTIVE VISION AND IMPACT

All ACC partners collectively develop an understanding of the needs of the community and how they will be addressed.

ACCOUNTABILITY

ACC partners need to be accountable for the work they commit to do as part of the overall ACC strategy to improve community health.

EXAMPLES OF EXISTING ACCOUNTABLE CARE COMMUNITIES

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 individuals enrolled in Medicare and Medicaid to identify unmet health-related social needs,
- Referring these beneficiaries to 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.).² 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.”³ There are currently 31 organizations participating in these 5-year models that represent rural and urban communities across 23 states.⁴ An independent evaluation will review the model’s effects on quality of care and spending.³ 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.

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 CMS 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.⁵ 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.⁶ 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 payers⁷. As of last year, the information exchange portal had facilitated more than 800,000 services including housing, job training, and food for clients.⁸

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, North Carolina, 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.⁹ The Alliance has also worked with food pantries to enhance their ability to provide more food and increase healthy food options.¹⁰ 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' needs¹⁰.

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.¹¹

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. Mission Health in Western North Carolina is one such example. 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 population 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.¹² Over time, Mission Health has invested over \$76 million in community health improvement programs through services and grants, memorandums of understanding (MOUs), and in-kind contributions to community groups.¹² Other health systems that are working to address the drivers of health in their communities include Bon Secours Baltimore Health System in Baltimore, Boston Medical Center, and Spectrum Health in West Michigan.

HOW ACCS FIT IN NORTH CAROLINA'S EVOLVING HEALTH CARE SYSTEM

The North Carolina Department of Health and Human Services (NC DHHS) has a vision to “optimize health and well-being for all people by effectively stewarding resources that bridge our communities and our health care system.”¹³ To do this, NC DHHS is taking a multi-layered approach to addressing health-related social needs, including:

- 1) **Developing standardized screening questions for unmet resource needs,**
- 2) **Supporting the development of the NC Resource Platform (NCCARE360),**
- 3) **Mapping social drivers of health indicators,**
- 4) **Building infrastructure to support the recommendations of the Community Health Worker Initiative,**
- 5) **Implementing Medicaid transformation through Medicaid Managed Care, and**
- 6) **Testing public-private pilots of ACC-style models focused on people enrolled in Medicaid.**

Items 1-3 on this list will be described in greater detail throughout this guide.

North Carolina Medicaid transformation: Instead of reimbursing health systems and providers directly, under Medicaid Managed Care NC DHHS will contract with Prepaid Health Plans to deliver health services to enrollees [1]. Prepaid Health Plans will receive a monthly capitated payment for each enrollee. NC DHHS will provide monitoring and oversight of the Plans, which will be required to meet quality and outcome metrics and other requirements.

NC DHHS has integrated screening and referral for needs into the transition to Medicaid Managed Care. Under Medicaid transformation, all Prepaid Health Plans will be required to use standardized screening questions to measure beneficiary needs around housing stability, food security, transportation, and interpersonal violence. Results will be used to determine the need for care management and will be shared with primary care providers. Care managers with Prepaid Health Plans will use the web-based NCCARE360 resource platform to connect people to community resources to meet their needs. NCCARE360 will also be available to all other North Carolina residents, regardless of insurance status. In North Carolina, Medicaid transformation is being used as a vehicle to help fundamentally change what is considered “health care” and how that care is delivered.

For this change to occur, health care payers and providers, community-based organizations, and other stakeholders will need to work together in new ways. The NC DHHS plan provides a structure for how needs and resources will be identified and connected, however, it does not provide a structure for building the types of relationships and alignment of processes, outcome goals, and financing that will be needed for long-term changes in the nature and delivery of care. The ACC model can address the larger issues of how to change the way health care is perceived and delivered in communities.

To test various evidence-based programs in community settings, 2-3 regions in the state will be selected to participate in regional pilots involving some groups enrolled in Medicaid. Outcomes to be measured include improved community infrastructure, collaboration between social and health care systems, and healthcare utilization, among others. Prepaid Health Plans in each region will be required to participate in the pilots, at a minimum screening Medicaid beneficiaries for social needs and connecting them to resources. While the NC DHHS will not explicitly require the level of community partnership inherent in an ACC for these pilots, the requirements set out standards that encourage communities to develop an ACC-style model. The results of these pilots are intended to guide similar investment of Medicaid dollars, as well as other health care spending, and development of ACC-style models throughout the state in years to come.

DEVELOPING AN ACCOUNTABLE CARE COMMUNITY TO ADDRESS THE DRIVERS OF HEALTH

LEADERSHIP: CATALYZING COLLABORATION

A community may unite around the concept of an ACC for a variety of reasons. It can be a response to health disparities, financial incentives, changing patient populations, or opportunities to collaborate on health assessments.^a Regardless of the reason, creating an ACC recognizes the need to address the physical, social, and economic challenges that keep people from achieving optimal health. It also addresses the role many sectors play in influencing these challenges.¹⁴

The first step in building a partnership is identifying champions in key sectors to lead collaborative efforts. A successful ACC will bring together the leaders who can gather buy-in from other stakeholders, leverage community relationships, facilitate the development of a common vision for the group, and attract investment. There is no one sector that is most appropriate to initiate cross-sector partnerships in every case: it will vary depending on the needs, resources, and strengths of the community. However, in practice, most models are organized through joint leadership by two or more representatives from health care delivery, local health departments, and/or human services organizations.^{15b}

Local health departments have a natural role in driving partnerships, given their overall mission to improve community health and the specific charge to complete a Community Health Assessment. Health systems, hospitals, and other health care delivery organizations similarly have an interest in participating because ACCs seek to transform how health care is understood and delivered. Non-profit hospitals are required to perform a periodic community health needs assessment and spend some of their surplus on community needs. This is known as the community benefit requirement and is necessary to maintain their tax-exempt status. Finally, human services organizations are uniquely positioned to serve as a bridge between communities and traditional health care organizations. These organizations can bring an understanding of the real barriers the community faces in achieving health and well-being.

Things to Consider:

A partnership's sustainability should not be contingent upon the participation of one person. While an individual may have been instrumental in bringing partners to the table and driving action, the cross-sector partnership should be organized to ensure sustainability in the event of staff turnover.

Key Roles for Leadership¹⁶

- *Establish broad-based support for collaboration, vision, and goals*
- *Build capacity for long-term sustainability*
- *Lay the foundation for organizational infrastructure to support cross-sector partnership*

a Every three or four years, county public health departments must complete a collaborative, community-based process to determine and prioritize the health needs of the county. This assessment is then used to create a multi-year community health improvement plan. These state requirements must be met for public health accreditation purposes.

b Human services organizations are those that provide services that help people “stabilize their life and find self-sufficiency through guidance, counseling, treatment and the providing for of basic needs.” (HumanServicesEdu.org. The Definition of Human Services. <https://www.humanservicesedu.org/definition-human-services.html#context/api/listings/prefilter>)

BUILDING THE PARTNERSHIP: WHO NEEDS TO BE AT THE TABLE?

THE “WHY”: An ACC addresses community health and well-being in a comprehensive way. Rather than uniting around one specific chronic disease or health issue, partners aim to address health at the population level. This shift to focusing on policy and systems change, in conjunction with efforts to better coordinate health care and social service delivery, demands participation from diverse partners with a wide range of expertise, relationships, and political capital to contribute.

Things to Consider:

- Involving non-traditional partners in health initiatives will require the development of a common vocabulary and mutual understanding of the role each sector plays in the health of the community.
 - *Breaking down siloes and avoiding technical language can reduce the tendency for health initiatives to be dominated by the traditional public health and health care sectors.*
- An ACC model is likely a culture shift for many organizations. Trust among partners is crucial for collaboration, particularly in efforts to share data, resources, liability, and financial risk.
- Health equity, defined by the Robert Wood Johnson Foundation as everyone having a “fair and just opportunity to be healthy,” is a central objective of an ACC.
 - *The partners around the table should reflect the diversity of the community and elevate the voices of populations most impacted by health disparities.*

THE “WHO”: Some partners may be at the table throughout the health assessment and prioritization process. Other partners may be incorporated gradually as priorities emerge. Also, the geographic area an ACC is serving will affect the number of partners and representation of the sectors listed below. As the “community” in an ACC may be a region, a county, a municipality, or even a neighborhood, the scope of the partners at the table will vary depending on the target population. Community members should always be included in ACC partnerships to provide guidance and input on what is important to that community and what activities the ACC should engage in. ***Other representatives may include:***

■ Public health

■ Health care delivery organizations

■ Social services

■ Community-based organizations

- *Food pantries*
- *Legal aid*
- *Advocacy organizations*
- *Domestic violence shelters*
- *Child advocacy centers*
- *Employment agencies*
- *Early care/ education providers, early childhood collaboratives*
- *Other community-based nonprofits*

■ Education

■ Academic research

■ Philanthropy

■ Faith communities

■ Local government

- *Elected officials*
- *City planners*
- *Transportation*
- *Housing*
- *Economic Development*
- *Parks and Recreation*
- *Cooperative Extension*

■ Local business

■ Law enforcement

■ Grassroots organizations/ neighborhood coalitions

■ Unions

■ Insurers

PARTNERSHIP STRUCTURE AND GOVERNANCE: THE “HOW”

The overall structure of an ACC will depend on the needs and resources of the community. Due to the complexity of addressing the many drivers of health, partnerships will progress along a continuum over multiple years as trust is established, capacity is built, and sufficient sustainable funding is identified. However, there are key entities that must be in place for an ACC to organize among multiple organizations.

BACKBONE ORGANIZATION: A backbone organization (also known as a coordinating, anchor, or integrator organization) is an essential component of an ACC. The backbone serves the role of driving the multi-sector collaboration. This is done by overseeing the day-to-day operations of the ACC, including planning, implementation, and improvement efforts.¹⁷ To serve as the backbone, an entity must have sufficient staff and organizational capacity to devote to this work—this organization may or may not be one of the original champions for initiating multi-sector collaboration. In practice, a backbone organization is often a local health department or a health care delivery system, although a nonprofit organization or other human services organization can also fill this role.

Key Functions of the Backbone Organization:

- *Convening partners regularly*
- *Guiding the development of a common vision and strategies*
- *Coordinating an action plan of mutually-reinforcing activities*
- *Building consensus and resolving conflicts*
- *Supporting measurement practices*
- *Increasing awareness of, and public will for, collaboration*

GOVERNING BODY: A governing body or steering committee made up of representatives from key stakeholder organizations and target populations will provide strategic direction to the backbone organization and oversee the initiative’s progress. Additionally, depending on the funding structures of the ACC, this governing body may act as a fiduciary. A fiduciary is tasked with acting in good faith to manage another’s money or other property. This entity may also take on other financial responsibilities, including attracting sustainable funding and determining how and to whom resources should be distributed. The representatives on the governing body must have sufficient leadership authority to make decisions on behalf of their organizations. However, the governing body must ultimately be responsible to the ACC and the community stakeholders it serves—a key principle that can be managed through community engagement and sound governance.



Authentic community engagement is more than informing community members about what representatives of health care organizations, local government, human services organizations, and other agencies are going to do for them. Instead, these organizations must work with the community, establish trust, and share power so that community-members have a sense of self-determination.

AUTHENTIC COMMUNITY ENGAGEMENT: Community stakeholders are involved in the work of an ACC in two ways.¹⁸ First, organizations whose work impacts the health and overall well-being of the community participate directly, doing much of the legwork of an ACC by participating in meetings, workgroups, and implementation activities. They may confront a change in the way they do their work in this new collaborative model. Leadership of the ACC and within these organizations must promote a culture of collaboration. Staff representing these entities must be engaged and supported by their organizational leaders. Second, an ACC must also engage the larger community—the people who are meant to be served by the activities of the ACC. The long-term impact of an ACC will depend on partners' ability to accurately identify and address the needs of the community and the level of support from the community for the strategies proposed to address those needs.

Community support can only be developed through equitable partnerships with community members. ACC partners must engage formal and informal community leaders in the governing body. They should also give community representatives an equal role in decision-making processes, implementation, and evaluation. Authentic community engagement is more than informing community members about what representatives of health care organizations, local government, human services organizations, and other agencies are going to do for them. Instead, these organizations must work with the community, establish trust, and share power so that community-members have a sense of self-determination.

Successful Community Engagement:

- Collaborative Cottage Grove's Community-Centered Health project in Greensboro, North Carolina, unites community members, the Greensboro Housing Coalition, and the Guilford County Department of Health and Human Services around efforts to align housing and health goals. Partners have developed strong mechanisms for community engagement including community member-guided data collection and monthly meetings that give residents an active role. Residents are compensated with a small stipend, a meal, and child care. Community members form teams co-led by a resident and a supporting staff member from one of the partner agencies and design projects that will be implemented with BUILD Health Challenge grant funding. These strategies, combined with ongoing efforts to maintain visibility and create trust with community members, have made this initiative successful in forming community ties.
- The Cleveland County Partnering for Community Prosperity collaboration began with the combination of a vision from community leaders and efforts by County Commissioners. Their work includes addressing access to education and training, access to transportation, school readiness, and access to safe and affordable housing. Community members are engaged in this work in multiple roles, including a Community Advisory Committee, Community Work Group, and a Community Quarterback.

GOVERNANCE: The governance systems that are put in place will establish the foundation for multi-sector partners to work together effectively. Governance refers to the agreed-upon processes and rules that guide the decision-making, resource-sharing, and overall functions of the ACC. Partners must have a strong understanding of each of their roles and responsibilities within the collaborative structure. The group must put mechanisms in place to enforce these obligations. Therefore, partners should develop written agreements and/or memoranda of understanding (MOUs) to define:

- The shared goals, structure, and rules of the ACC; and
- The commitments of each individual organization.

The formality and specificity of these agreements will vary among communities and may evolve over time depending on the legal and financial implications of an ACC's activities.¹⁹ For example, most partnerships begin as loose collaborations with non-binding agreements in place. As activities require increased sharing of resources like staff and funding, ACCs may formalize those agreements.²⁰ Additional governance would need to be in place to ensure data privacy and security if partners work toward cross-system sharing, aggregation, and analysis of data.²¹ Legal considerations and specific forms of these more formal partnerships are discussed on **Page 36**.

Lessons from California's Accountable Communities for Health Initiative

A sound governance structure requires:

- *Effective decision-making*
- *Accountability to the community*
- *Representation of stakeholders' interests*
- *Proper fiscal and social responsibilities*
- *Control over funding and staff*

Community Engagement Resource:

Community Engagement Toolkit by Collective Impact Forum

Governance Resource:

The Strategic Backbone Toolkit by the Spark Policy Institute

Things to Consider:

- **Process fatigue – Partners should take care in developing governance agreements that ensure individual organizations are not disproportionately burdened with the work.**
 - *The governing body membership should be large and diverse enough to spread responsibilities among organizations to avoid burnout.*
 - *This is particularly important for smaller, rural, or low-resource communities where the significant effort of system change may consistently fall on the same people.*
- **Growth in sophistication - Putting processes in place and assigning responsibilities are key to managing activities across numerous organizations and agreements will become more sophisticated as collaboration develops over time.**
 - *Establishing strict governance structures too soon in the process may make new partners hesitant to join the conversation.*
- **Transparency – Transparent communication among the governing body, backbone organization, and community stakeholders is critical to building trusting relationships.**
 - *This is especially important as it relates to decisions made around the allocation of funding.*
- **Relationships – The importance of strong and positive relationships among the community and partners in an ACC cannot be overemphasized.**

FINANCING

Community partnerships will need start-up funding as they are developing and planning for interventions and activities. Communities begin in different places in terms of funding; perhaps a local nonprofit has received a grant to coordinate a collaborative response to a community health issue, a hospital is looking to transform its approach to community benefit spending, or each organization represented has agreed to begin by focusing their work on shared outcomes and better coordination. Regardless of their source, funds will need to support both backbone administrative functions and the intervention/programmatic work of the collaborative. Government or philanthropic grants are often the source of start-up funds; however, this funding usually requires partnerships and goals to already be established, requiring some level of pre-work.²¹ In-kind contributions of staff time can be key to these early stages of partnership development.

Obtaining funding from health systems and payers (i.e. insurers) in a fee-for-service health care landscape may require upfront conversations about incentives for each party. Including strategies to address short-term goals that show specific cost-savings and standards that providers and payers are already held accountable for, like reductions in emergency department visits among high-risk populations, can help facilitate provider participation.¹⁹ Many payers are investing in efforts to address the underlying drivers of health as a means to reduce costs; however, there are constraints, particularly related to payment models, that complicate these investments. North Carolina's upcoming pilot programs as part of Medicaid transformation, as well as continuing efforts to move to value-based payment among private insurers, may help increase support for ACCs.

Ultimately, communities should aim to blend multiple sources of income, such as hospital community benefit dollars, local government budget allocations, social-impact bonds, and/or wellness funds (more information and resources on these funding mechanisms can be found on [Page 39](#)). These approaches ensure that more entities in the community have a stake in an ACC's success. While sustainable funding is a long-term goal of an ACC, there are steps partners can take in the development stages to appeal to investors for the future. Specifically, partners should develop a pitch to make the case for an ACC. This pitch would highlight the goals, strategies, and measures of success of the ACC; the resources and partners that are currently invested; and the possible benefits of the ACC for stakeholders and potential investors. In addition to this pitch, communities should develop a brand for the ACC. A communications strategy with a recognizable logo will increase public knowledge of the ACC, enable partners to express their participation, and grow the initiative's funding potential.

Things to Consider:

An ACC's financing will inform how it should be structured. Partners should consider possible funding sources while selecting an organization through which dollars may flow to the backbone organization, governing body, and other partners. While any type of organization may serve as the backbone organization, a nonprofit organization is best positioned to receive and administer funding for the ACC due to its ability to receive funding from numerous sources.¹⁸

LEGAL CONSIDERATIONS

As with other aspects of ACC development, legal implications will change and may become more complicated as the partnership formalizes over time. Legal structures for ACCs are described on [Page 36](#), but there are important considerations communities should keep in mind in development stages.

POTENTIAL LIABILITY: Governmental, nonprofit, and for-profit entities all bring their own legal requirements in terms of activities they are able to engage in, funds they can receive, and whose interests they represent. These differences are important to consider as partners are developing agreements to ensure that one organization's activities do not become the liability of another, or that activities taken on by the ACC do not threaten a nonprofit's tax-exempt status.

CONFLICTS OF INTEREST: Given that an ACC involves many entities working in the same community, interests of certain stakeholders may overlap across organizations. Partners should develop a conflict of interest policy and a mechanism for accountability to ensure that decisions are made transparently and in the best interest of the community.

INVOLVE (AND HIRE) LEGAL COUNSEL

EARLY: Once stakeholders are around the table and have a plan for partnership, legal counsel should be involved in developing governance agreements and planning for the future.²⁰ However, partners should hire lawyers outside of any in-house counsel one of the participating organizations might have, as in-house lawyers are ultimately responsible for protecting the interests of that organization.²¹



ASSESSING COMMUNITY NEEDS

WHY CONDUCT AN ASSESSMENT?: Before taking action to improve community health, partners must have a deep understanding of the needs of the community. A comprehensive assessment of community health and well-being will provide an overall picture of health in the community and help uncover specific challenges of certain subpopulations. This will help partners to select or design more effective interventions, direct funds appropriately, and advocate for policy change.

UTILIZING AND ALIGNING COMMUNITY HEALTH ASSESSMENTS & COMMUNITY HEALTH NEEDS

ASSESSMENTS: Accountable Care Communities (ACCs) provide communities with the opportunity to align with their counties' Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs). CHAs are completed by local health departments. CHNAs are completed by nonprofit hospitals as a requirement under the Affordable Care Act. Once the CHA is completed, a Community Health Action Plan is developed to address health issues that are community priorities.

These assessments have become more collaborative over time. Many counties are creating a single assessment cycle for both the CHA and CHNA. Some hospitals and health departments are building multi-sector teams with representatives from human services organizations and other entities to increase the assessments' reach into their communities. In this way, counties can:

- Leverage resources of both the health department and hospital or health care system,
- Avoid duplicating efforts in data collection and analysis, and
- Create complementary strategies to address both health care and public health improvement goals.

ACCs must be plugged into this existing assessment process. This will look different in practice depending on the community. Since public health and hospitals are natural partners of an ACC, the local CHA/CHNA may serve as the health assessment for the ACC initiative. In this case, an ACC can leverage the existing infrastructure for data collection and analysis.²² An ACC can also help to add new depth to both the quantitative and qualitative data collected for the CHA/CHNA by bringing new sectors and community partners into the assessment efforts.

If the ACC is organizing between assessment cycles or if the ACC is focusing on a different geographic area, the existing CHA and Community Health Action Plan will still be a key source of data for the ACC, and improvement strategies of the health departments or hospitals should be important considerations for any priorities that may emerge for the ACC.

Things to Consider:

An ACC's goal is to develop cross-sector partnerships to share responsibility and funding to address multiple drivers of health. While public health departments are increasingly collecting data on drivers of health (e.g., economic security, housing, education, transportation) and selecting drivers of health as priorities in the CHA, counties across the state are in different places in terms of their mobilization. In fact, only 17 of North Carolina's 100 counties prioritized a driver of health in assessments conducted between 2010 and 2015.²² ACCs can lend support for local health departments to focus on drivers of health and create the conditions necessary for good health. However, if the local CHA has not focused on drivers of health in the past, an ACC may need to develop a plan to collect social, behavioral, and economic data.

GETTING STARTED: Assessing community health and well-being will require analysis of data from a variety of sources. Before pulling data together, partners must reaffirm the geographic target of the ACC initiative. The definition of the geographic area of the community to be served should be discussed when initial ACC partners are coming to the table. This geographic service area is a key consideration when determining data needs for the assessment process. The size of the geographic area will determine the scope of the data needed. If there is a large geographical area, qualitative data collection efforts may be more intensive. The assessment process may present new opportunities to partner with other organizations on data collection and analysis.

In addition to collecting data in specific geographic areas, partners will also want to ensure that they can obtain disaggregated data—data that is split into various subgroups—based on agreed-upon demographic indicators. Disaggregating data is central to understanding and illustrating health disparities.

These may include:

- *Age*
- *Race and/or ethnicity*
- *Household income*
- *Educational attainment*
- *Insurance status*
- *Primary language*
- *Disability status*
- *Veteran status*
- *Gender identity*
- *Sexual orientation*

Quantitative Data:

Information that can be measured and written in a numeric form. Can be gathered from sources like medical records, census, or enrollment statistics.

Qualitative Data:

Information that is descriptive, providing characteristics. Can be gathered through methods like interviews or survey commentary.

It may not always be possible to obtain disaggregated data for all of the categories above. However, it is important to examine the demographic makeup of the community served by the ACC and consider ways to collect information about topics that may not be included in census or other survey data. In these cases, it may be useful to develop or leverage relationships with organizations that serve those particular populations. These organizational partners can help to plan or host focus groups or share other agency-specific data.

Things to Consider:

Community needs can vary greatly by ZIP code. Whether an ACC is intending to serve a region, a county, or a city, partners must be able to compile some of the health and well-being assessment data from the census tract or sub-county level.

Partners must be prepared to use a variety of data collection methods:

- **Secondary data from state and national sources:** Secondary data are data that have already been collected by another entity, such as census data. This type of data is typically publicly available.
- **Agency-specific/program data:** Partners may be willing and able to share de-identified data about the use of services or other information they collect from clients.
- **Primary qualitative data:** This includes information about residents' opinions, values, and perceptions of their health and the barriers they may face. Partners should use a variety of methods to engage community members and hear their perspectives. This type of data can be collected through interviews, community surveys (both online and in person), focus groups, listening sessions, and/or town meetings.

CREATING A DATA STRATEGY: To plan for a productive data collection process, an ACC’s governing body, backbone organization, and other appropriate partners should develop a data strategy. The backbone organization should oversee the overall process and coordinate the efforts of the partners charged with different pieces of data collection. Partners may discuss:

- **Data collection goals:** What questions about community health are partners trying to answer? A top data goal should be to determine the social, behavioral, and economic needs of the community, but partners may have additional topics of interest. Determining what will be measured is the first step.
- **Existing data:** Examine data that are already available, whether for the local CHA or CHNA or published by partner agencies. Take note of common measures that are used across data sources.
- **New data needs:** What data still need to be collected to help partners identify priorities? Might data be available from another source? Or are the data qualitative in nature and should be gathered through community input?
- **Data collection process:**
 - *Who will collect the new data?* Which partners will be responsible for gathering secondary data? Which partners will be responsible for collecting qualitative data in the community?
 - *How will the data be collected?*
 - **Secondary data:** These data will most likely come from national and state databases. See data resource suggestions on **Page 22**.
 - **Local agency data:** What data from local programs or agencies can partners share? Can health care providers share aggregated data from electronic medical records?
 - **Qualitative data:** What methods (e.g., surveys, focus groups, listening sessions) will partners use to collect data on the experiences and opinions of the community? What community engagement techniques will partners employ to ensure they receive enough participation? How will partners obtain information from non-English-speaking residents?
- **New partners:** Are there new partners that need to be engaged in the data collection process?
- **Publication:** How will knowledge gained from the assessment be shared with the community?
- **Updating the data:** How often will the data be updated to track progress?

Partners should also consider the resource needs for data collection and analysis:

- Staff time
- Expertise and/or training in quantitative and qualitative data collection and analysis, including survey design
- Resources for qualitative data collection (space to hold town hall meetings or focus groups; compensation for participants and facilitators)
- Resources for report development and distribution—particularly as it relates to the use of visuals and making information accessible to the general public

TABLE 1. DATA RESOURCES FOR DRIVERS OF HEALTH

NORTH CAROLINA STATE CENTER FOR HEALTH STATISTICS	Contains a vast array of state, regional, and county-level data on demographics and health outcomes
NC SOCIAL DETERMINANTS OF HEALTH MAP	Maps numerous drivers of health at the census tract level
NORTH CAROLINA COUNTY HEALTH DATA	Interactive maps providing health data at the county level, also county health profiles
NC DEPARTMENT OF PUBLIC INSTRUCTION	A wide variety of education-related data including graduation rates, school and student performance, school safety, and school discipline
SMALL AREA INCOME AND POVERTY ESTIMATES	Annual estimates of poverty and income for all U.S. states and counties
AMERICAN FACTFINDER	Includes data from the census, the American Community Survey, the American Housing Survey, the Economic Census, and the Population Estimates Program
COUNTY HEALTH RANKINGS	A snapshot of health and well-being in every U.S. county
LOCAL AREA UNEMPLOYMENT STATISTICS	Monthly and annual employment, unemployment, and labor force data at the state, county, and metropolitan area level
SMALL AREA HEALTH INSURANCE ESTIMATES	County-level estimates of health insurance coverage
BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM	State and regional-level data on health behaviors
FOOD ENVIRONMENT ATLAS	Maps data on factors that influence food choices and diet quality

Resource:

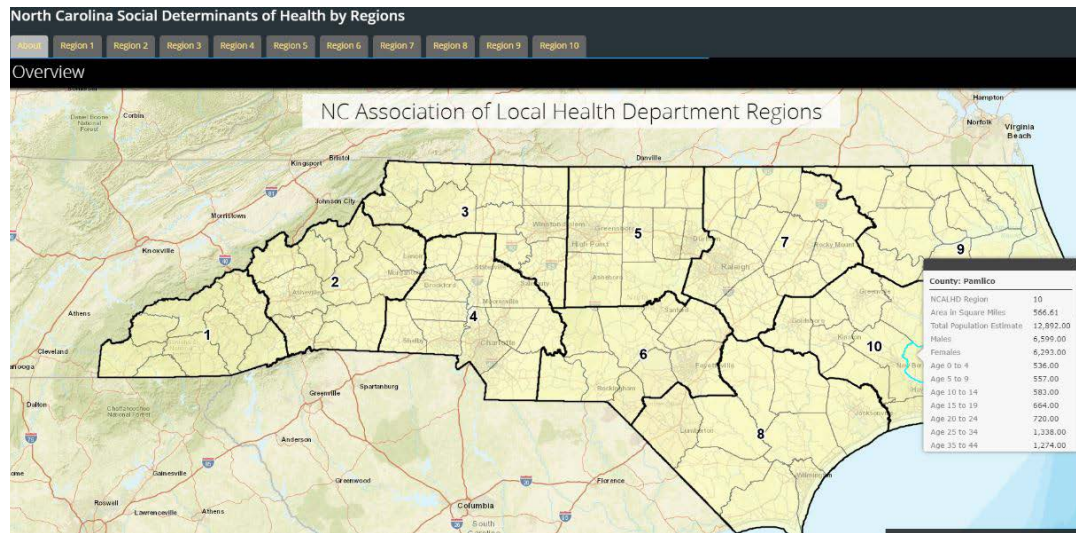
The Association for Community Health Improvement has a [Community Health Assessment Toolkit](#) designed to help hospitals with conducting the Community Health Needs Assessment. It includes useful guidelines for data collection, particularly regarding qualitative data collection methods.

IDENTIFYING COMMUNITY DRIVERS OF HEALTH NEEDS

Collecting information to measure drivers of health should be the primary goal of all data collection efforts for an ACC. The data should help illustrate the root causes of chronic health conditions that health initiatives traditionally focus on. The data resources on the [previous page](#) provide a useful place to start collecting statistics for these purposes.

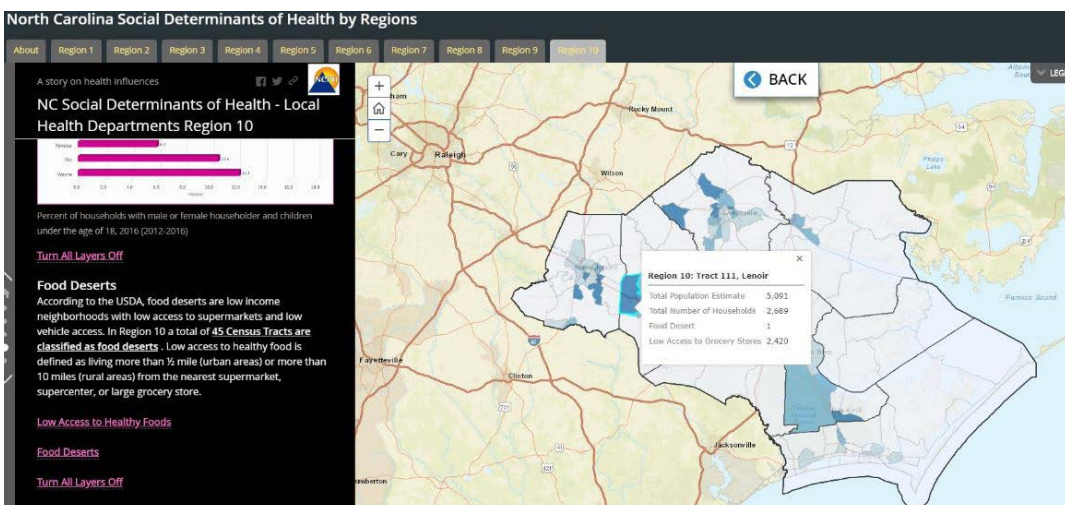
Many of the forces that impact health are difficult to quantify or have varying levels of importance in different communities. Therefore, it is vital for an ACC to emphasize the input of the community on what they see as the greatest strengths and challenges for the community's well-being. Statistics can identify the presence of social, behavioral, and economic barriers, but community members can bring that information to life, demonstrating the real impact it has on their health.

Overview statistics for NC Local Health Department Regions (e.g., age, gender, race)



Additionally, mapping these indicators can help identify areas within a community that face greater systemic barriers to health. A key resource is North Carolina Department of Health and Human Services' [Social Determinants of Health \(SDOH\) map tool](#) (see graphics on this page). This tool maps drivers of health, including economic factors, housing and transportation, and social and neighborhood resources.

Specific Social Determinant Data at Census Tract Level (e.g., food insecurity)



Local resources can also be utilized for these purposes. By partnering with a local academic institution or city and county partners, an ACC can use geographic information system (GIS) maps to overlay health and driver of health data to identify areas that require more targeted health improvement efforts.

GATHERING DATA ON DRIVERS OF HEALTH: ACCs can use community-focused data collection methods to collect information on health-related social needs of the community. These data collection methods include surveys, qualitative interviews, focus groups, concept mapping, and photovoice projects, which are detailed in Table 2, below.

TABLE 2. QUALITATIVE DATA COLLECTION METHODS TO IDENTIFY HEALTH-RELATED SOCIAL NEEDS

METHOD	DEFINITION	GUIDE/RESOURCE
Surveys	Gather opinions or experiences using a set of questions for everyone surveyed; can utilize survey instruments that have already been developed, like those made publicly available by the Centers for Disease Control and Prevention (CDC) , or create your own based on information you would like to gather.	Community Tool Box: Conducting Surveys Resources Guide for Community Survey Projects
Interviews or Focus Groups	Facilitated discussions with individuals representing particular groups of interest; facilitators use interview guides with a pre-set number of questions and probes to gather in-depth information.	FHI360 Qualitative Research Methods: A Data Collector’s Field Guide
Concept Mapping	Uses six steps to collect qualitative data from community participants; six steps include preparation (selecting participants and focus), group brainstorming to generate statements, structuring statements through a sorting process to create clusters, representation of the statements/clusters using a map, interpretation of the maps, and utilization of the maps.	An Introduction to Concept Mapping as a Participatory Public Health Research Method
Photovoice	Photovoice is a way of conducting a community assessment through still photographs or video; may be done by members of the community or by outsiders; images collected are used to generate dialogue among community members or community agencies about the conditions in the community.	Toolkit for a Photovoice Project

Source: Ramirez, L., Baker, E., & Metzler, M. (2008). *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*. Atlanta. Retrieved from <https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/sdoh-workbook.pdf>

SELECTING PRIORITIES

Once sufficient data has been collected through the assessment process, an Accountable Care Community (ACC) can move to planning for action. Partners must prioritize the issues or goals they want to address. While an ACC aims for comprehensive reforms, the plans to drive these reforms must be actionable, particularly as the partnerships are building capacity and working to develop sustainable funding.

There is no one set of criteria for prioritizing competing health issues. Key considerations for prioritizing action may include:

- **LEVEL OF NEED:** Quantitative and qualitative data will help illustrate the magnitude and severity of the issue in the community. Partners might consider how the community is faring compared to the surrounding geographic area or the state average or may consider there to be a high level of need if the problem was brought up by a majority of community members.
- **COMMUNITY CAPACITY:** Community capacity includes human capital, financial capital, and organizational infrastructure. Partners should consider the availability of resources to address community needs. If there has traditionally been a lack of capacity for the community to address a particular issue, whether as a result of leadership, insufficient staff, or targeted funding, there may be an opportunity for joint efforts to take on this problem. Or, a problem may be deemed intractable for the time being and may be revisited later.
- **POLITICAL WILL:** If political will is lacking around a specific issue in the community, it may not be the best issue to focus on. This can be particularly true for newer partnerships. However, this may be an issue that merits targeted advocacy or communications efforts. Building civic engagement around the issue can grow the political will to tackle it in the future.
- **PUBLIC WILL:** During primary data collection, community members should be asked what issues they think are most important in the community. Community members will be more likely to support efforts to address issues that have been identified with community involvement.
- **EQUITY:** Considerations of health equity should be infused in the prioritization process. This can be done by analyzing disaggregated data, emphasizing the perspective of the most vulnerable communities, and building in legitimate processes for community participation and feedback. An ACC must be intentional about designing programmatic, policy, systems, and environmental change activities to address health disparities.
- **EXISTING EFFORTS:** Considering the other health initiatives that are already going on in the community provides the opportunity to reduce duplication of efforts and take advantage of existing energy and social networks to spread information and get others involved

Resources:

The NC Department of Health and Human Services, in partnership with NC Child, has developed the [North Carolina Health Equity Impact Assessment](#), a tool designed “to guide the development, implementation, and evaluation of policies, programs, and initiatives in order to reduce disparities and promote health equity.” This tool encourages partners to dig into disaggregated data and consider possible positive and negative impacts on different populations.

What is Health Equity? And What Difference Does a Definition Make?, a report by the Robert Wood Johnson Foundation and the University of California San Francisco, includes a lot of information about health equity and a list of additional resources.

PROCESSES FOR PRIORITIZING ACTION

Selecting priorities should be both data- and community-driven. Partners can learn from the prioritization processes utilized by health departments and hospitals for their own health assessments. These typically include bringing community leaders together, presenting data collected through the assessment process, and coming to consensus based on established criteria.

Just as there is no one set criteria to select priorities, communities can tailor prioritization methods to fit their needs. A structured process that combines data and community input can help narrow a long list of complex issues into something more actionable.

EXAMPLES OF PRIORITIZATION METHODS²³:

Multi-voting Technique	Useful for narrowing a long list of problems by using multiple rounds of voting to build consensus
Strategy Grids	Organizes strategies into quadrants based on levels of need and feasibility to identify strategies with the most impact—helpful for partnerships looking to achieve maximum impact with few resources
Nominal Group Technique	Typically used as a brainstorming technique to develop a list of ideas that can be narrowed down using a multi-voting process; ideas are brainstormed, discussed, and then ranked individually
The Hanlon Method	Rank health priorities with scores calculated from ratings of specific criteria and feasibility factors
Prioritization Matrix	Rate priorities against defined criteria that are weighted based on each criterion's level of importance in the community; results in a numerical priority score

Note: Step-by-step instructions for these methods can be found in this [guide](#) from the National Association of City and County Health Officials.

Many communities in North Carolina are using Results-Based Accountability™ (RBA) to guide the transition from assessment to prioritization to action. RBA is a process that starts with the goal in mind and works backward to determine strategies to achieve that goal. Through the RBA process, partners establish common measures of the quantity and quality of outputs and the effects of those outputs on community members' well-being. RBA can be a useful decision-making method, as it requires partners to consider how data will be operationalized, adopt common measures, and continuously communicate to make an impact.

Resources:

- Learn more about RBA with the [Implementation Guide for Results-Based Accountability](#).
- RBA is only one example of a planning and evaluation model. Partners may find other models to be useful depending on the goals of the partnership. Chapter 2 of the *Community Tool Box* from the Center for Community Health and Development contains information about several models, including:
 - MAPP: Mobilizing Partners for Action through Planning and Partnerships
 - CHIP: Community Health Improvement Process
 - The County Health Rankings & Roadmaps Take Action Cycle

Things to Consider:

As priorities are being selected, an ACC should reevaluate if new partners need to be brought on board. For example, if housing emerges as a significant issue from the community assessment process, an ACC must ensure that there is representation from the housing sector that can make an impact in the area. Reassessing the need to engage new membership in an ACC should be a constant pulse check throughout planning, implementation, and evaluation.

ACTION PLANS

As partners move toward implementation, an action plan will create structure and accountability among the partners. Action plans outline the goals and specific strategies that will be used to achieve those goals. The action plan should include a realistic timeline as well as the agency(ies) responsible for leading the various strategies. Keep in mind that the activities of the ACC will become increasingly integrated as the partnership matures. In the early stages, partners may focus more on coordinating and aligning efforts of the individual organizations. In the long term, an ACC may have a goal to develop a portfolio of strategies that is owned and funded jointly across organizations. Creating this action plan of mutually reinforcing activities helps organizations that are spread across sectors see how their work interrelates with that of other partners.

Strategies included in the action plan will span a range of activities to create the conditions necessary for good health both in the community and for individuals. These strategies will probably combine both programmatic and systems-level components, including:

- Clinical: changes within health systems to increase the focus on prevention
- Social services and community resources: programs, based in local government, schools, workplaces, or human services organizations to address socioeconomic and/or lifestyle factors that are barriers to health
- Clinical-community linkages: strategies to connect health care in clinical settings to social services and community resources such as referral mechanisms, collocating services, or health care system support for policy, systems, and environmental changes
- Policy, systems, and environment: strategies to address both the physical and social environment to make health accessible for all.

Once priorities and an action plan with mutually reinforcing activities have been established, the backbone organization should take the lead role in maintaining the action plan as the ACC moves into implementation phases.

QUICK REFERENCE

CONSIDERATIONS FOR ACCOUNTABLE CARE COMMUNITY DEVELOPMENT

INTRODUCTION TO ACC SYSTEM STRUCTURES

The work of different Accountable Care Communities (ACCs) will vary greatly. The experiences of existing ACCs show that successfully addressing drivers of health requires systems that allow for the coordination and funding of activities. These systems must address assessment, referral, workforce, technology, and legal needs. ACCs will also need to develop plans for evaluation and financial sustainability.

One of the most consistent activities of ACCs and ACC-style models is the screening of individuals for health-related social needs (e.g., unsafe homes, lack of transportation or healthy foods, exposure to violence) and referral to resources to meet those needs. Referral systems exist in many forms and the most effective ones involve a communication and tracking mechanism. Tracking of referrals allows the organizations involved to know the status of referrals and when follow-up with the individual being served may be helpful.

SCREENING

Choosing a Standard Tool: Screening for health-related social needs can happen in many settings including human services organizations, health care, social services, and insurers. ACC partners should assess whether any partners are currently using a screening tool for these needs. If screening is already occurring, ACC partners should review the screening tool(s) being used, discuss the needs of all partners, and determine a common screening tool so there is consistency across partners.

If screening tools are not being used, ACCs should select a tool that has already been developed and tested for accuracy in evaluating needs in multiple domains. The North Carolina Department of Health and Human Services (NC DHHS) has developed a set of standardized screening questions that are intended to be used in various settings across the state. The screening questions are designed for use by any organization but will be mandated for use by Prepaid Health Plans serving many people enrolled in Medicaid. NC DHHS is encouraging adoption of the screening questions in combination with the new web-based NCCARE360 resource platform.

See the side panel on this page for information about the standardized screening questions developed for North Carolina, as well as other tools that have been developed and tested for accuracy.

SCREENING

NC DHHS Standardized Screening Questions

- Primary screener includes 4 domains: food, housing/utilities, transportation, and interpersonal safety
- Optional items gather greater detail on housing needs and intimate partner violence
- Supplemental questions can be added to evaluate: community safety, housing quality, health care/medicine, mental health/substance use, family and social supports, child care, emotional wellness, education, health literacy, employment, income, immigration, and legal/correctional issues.

Health Leads

- An organization that consults with communities and health care organizations to develop screening and referral processes
- Licensed screening tool domains: food insecurity, housing instability, utility needs, financial resource strain, transportation, and exposure to violence
- Optional domains: childcare, education, employment, health behaviors, social isolation/supports, and behavioral/mental health

Things to Consider:

Adoption of the North Carolina standardized screening questions in an ACC's process of screening for health-related social needs will promote consistency with other activities going on throughout the state.

Developing a Screening Process: As important as the screening tool is for evaluating needs, an efficient process for using it is a vital aspect of successful screening implementation. Considerations when developing the process for screening include:

- **Staff** – social workers, community health workers, medical assistants, home visitors, volunteers, navigators
- **Timing** – when during the visit or care management process the screening occurs; make efforts to avoid interfering with regular patient or client care
- **Population** – think big, but start small; consider groups that you can identify as having the highest likelihood for need
- **Repetitive questions** – avoid duplicating information already collected, which can lead to patient frustration and wasted time

SCREENING

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)

- Developed by national group of stakeholders for use in community health centers
- Currently used in several community health centers across North Carolina
- Website includes implementation information
- Screening tool domains: housing stability, education, employment, food, utilities, clothing, transportation, social integration/support, stress
- Optional measures: incarceration, refugee status, safety, domestic violence

REFERRAL

If any health-related social needs are identified for an individual, the next step is to ask if that person wants help. Do not assume that everyone with needs will want help meeting those needs. Integrate consent to referral into the screening process. Once consent is granted, the individual should be linked to community resources that will help meet those needs. A variety of positions within the health care team or human services organization can then help in the referral process: care managers, social workers, nurses, community health workers, and/or volunteers.

ACC partners should use the same referral system to identify resources within the community. Ideally, an electronic referral can be made directly to organizations that can help meet needs for an individual.

NCCARE360 Resource Platform: A web-based resource platform called NCCARE360 is being developed and implemented for statewide use. It is a tool “to make it easier for providers, insurers and community-based organizations to connect people with the community resources they need to be healthy.”²⁴ NCCARE360 will be available and subsidized for all communities in North Carolina for at least the first five years. It will provide a web-based portal to connect all types of organizations to assist with referrals to meet health-related social needs. The platform will integrate the NC DHHS standardized screening questions, a community resource identification and referral system, automated updates, and tracking of referral status.

The goal of the NCCARE360 resource platform is a coordinated, no-wrong-door style system. Individuals will be able to access information about community resources and even start the referral process on their own. Organizations engaging clients or patients in addressing needs will be assisted in communicating with other organizations and will be able to consolidate efforts using one platform. All referrals through the platform will require consent, which can be given via a variety of methods, including pen and paper, voice recording, touch screen, e-mail, or text message. The NC 2-1-1 call center will enhance 2-1-1’s current services in coordination with the platform to provide text and chat capabilities and employ Navigators to assist individuals seeking services.

Closing the Loop on Referrals: There is a large spectrum of referral follow-up protocols. In less coordinated systems, individuals may be provided a list of available resources. Systems with more coordination or navigation may incorporate multiple points of follow-up. Currently, many organizations that conduct screenings provide a referral to needed services but do not follow-up or “close the loop” on referrals. Closing the loop refers to the practice of ensuring that an individual referred for a service has received that service or, if not, is connected to another service provider who can meet the individual’s needs.

Closing the loop helps to:

- Ensure individuals were able to contact the agency or organization they were referred to
- Find alternative resources if the referral was unsuccessful
- Gather data on resources that are most helpful
- Evaluate the parts of the referral process that can be improved for better individual outcomes



The NCCARE360 resource platform will include a referral feedback system that will make “closing the loop” an imbedded part of the system.

If your ACC partnership chooses not to use the State Resource Platform as their referral system, there are considerations that factor into the level of follow-up your ACC model will provide. These include:

- **Staff capacity for navigating referrals** – Are there enough team members at a health care organization to meet follow-up needs?
- **Tracking capabilities** – Does the referral system or database you plan to use allow you to track referral outcomes?
- **Organizational capacity to receive referrals – Are human services organizations connected to the same system to enter referral updates from their end? If not, do they have databases that allow them to report outcomes?**
- **Evaluation needs** – What level of detail are you interested in to show outcomes for your program (e.g., referrals made, individuals receiving services, individuals denied services)?

Connecting People to Human Services Organizations and Social Services

Human services organizations and social service agencies will be the most common referral targets for addressing the environmental, social, and economic needs identified through screening. These may include food pantries, the local Department of Social Services, and crisis or homeless shelters, just to name a few. Carefully consider the processes developed around referrals and follow-up to maximize success in connecting people to services. The easier it is for someone to find the help they need and make the connection with that service, the more likely they are to have their needs met.

Helpful Resources:

North Carolina’s Standardized Screening Questions: <https://files.nc.gov/ncdhhs/Updated-Standardized-Screening-Questions-7-9-18.pdf>

Health Leads Screening Toolkit: <https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/>

The Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE): <http://www.nachc.org/research-and-data/prapare/>

Center for Health Care Strategies, Inc. – Screening for Social Determinants of Health in Populations with Complex Needs:

Implementation Considerations: <https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/>

WORKFORCE

The work of screening and connecting patients to community resources can be done by a wide range of staff including social workers, navigators, care managers, and community health workers. Accountable Care Communities (ACCs) will need to assess which organizations are already screening and referring for needs and which need to develop this capacity. Some human services organizations and health care providers may already be screening for needs, however a systematic approach and staff capacity for doing so varies greatly. ACC partners will need to evaluate workflow and determine if this work can be done by existing staff or if new staff will be needed. If new staff is needed, organizations should determine the type of professional best suited for completing the screening process. Organizational culture and workflow are major factors in these considerations.

Health care systems and insurers may already be working with care managers and community health workers in some capacity. These organizations are essential partners in ensuring that 1) there is adequate workforce to address the needs and 2) the value of these professionals' expertise is maximized. Considerations related to these professionals include:

ENSURING ADEQUATE WORKFORCE AND IMPROVING RETENTION

- Develop pipeline with local high schools, community colleges, and universities
- Pay as members of care team
- Recognize contributions as care team member
- Develop trust and communication between team members

MAXIMIZING POTENTIAL

- Provide access to electronic health record or documentation
- Implement screening tool/questions
- Develop protocols for resource referral and follow-up
- Encourage and incentivize continuing education courses on health-related social needs and obtaining credentialing/certification

Helpful Resources:

North Carolina's Care Management Strategy Under Managed Care (North Carolina Department of Health and Human Services) - https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability - <https://publichealth.nc.gov/chronicdiseaseandinjury/doc/DHHS-CWH-Report-Web-052118.pdf>

TERMS TO KNOW

Care Manager

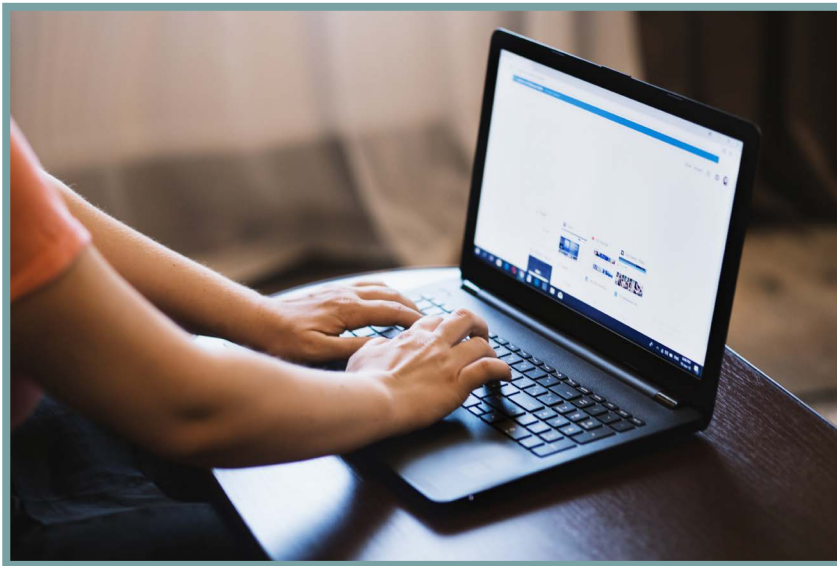
Specially trained professional who works with individuals and families. Their roles can include completing assessments of health status and health-related social needs, creating care plans, organizing appointments and care, and monitoring patient status.

Community Health Worker

A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served (APHA). They serve as a link with health and social services and participate in community outreach, education, informal counseling, and advocacy. Other terms for this role include community health liaison, lay health advisor, and promotora.

IT INFRASTRUCTURE

The purpose of information technology (IT) in Accountable Care Community (ACC) models is to allow for communication amongst partners about programs and services provided to community members. The communication chain should ideally begin with any partner within the ACC that is serving an individual with needs. IT systems that link health care settings and human services organizations make the referral process easier for staff in both organizations. Time and resources are saved by streamlining the communication process, decreasing the need for multiple phone calls and efforts to track referral status. Clients and patients also benefit from a more streamlined process when their information is stored in a database or electronic system.



Important Note: The new NCCARE360 web-based resource platform will fill many of the IT needs of ACCs. The platform should be seriously considered before looking into the development of a new IT infrastructure for ACC purposes.

EXISTING RESOURCE REFERRAL SYSTEMS

NCCARE360 Resource Platform:

- Subsidized for all communities in North Carolina for at least the first five years
- Screening embedded
- Referral status updates by all parties
- Integrates NC 2-1-1, an existing referral database

Health Leads Reach:

- Customizable platform
- Screening embedded
- Referral status updates by client and referral source

Aunt Bertha:

- Customizable platform
- Referral status updates by all parties

Healthify:

- Referral status updates by referral source and referred organization

NowPow:

- Referral status updates by referral source and referred organization

Data Privacy and Security

The Health Insurance Portability and Accountability Act (**HIPAA**) is a federal law that ensures individuals' rights to their private health information and sets standard requirements for anyone handling private health information.

Learn more at www.hhs.gov/hipaa.

THINGS TO KNOW

Thinking of developing an IT infrastructure for your community collaboration?

Keys to success:

- Determine how you can utilize state systems, like the NCCARE360 resource platform
- Build trusting relationships between partners
- Choose a lead or champion agency
- Keep all partners engaged in the process
- If designing a unique system, ensure a simple user interface
- Integrate data that is already collected
- Balance the amount of data collected from clients with the preservation of client interaction
- Provide partners incentives for participation

Challenges:

- Changing referral methods is difficult
- Avoiding duplicative data entry is very important
- Partner organizations may have varying capabilities and access to technology
- Closing the loop on referrals

NCCARE360 Resource Platform: As described in the Referral section on **Page 30**, the North Carolina Department of Health and Human Services, the Foundation for Health Leadership & Innovation, United Way of NC/NC 2-1-1, Expound, and Unite Us have partnered to develop the NCCARE360 web-based resource platform. NCCARE360 will help health care providers, insurers, and human services organizations in the state connect people with resources to address identified needs. NCCARE360 will initially focus on connecting to needs related to housing, transportation, food, interpersonal violence, and employment. Features of the platform will include:

- Standardized screening questions for health-related social needs,
- Database with resources by geographic area and need,
- Call center,
- Referral tracking capabilities,
- Communication and referral between organizations, and
- Electronic health record integration.

The goal is to provide one resource referral platform that can be used by organizations across the state to streamline efforts to address health-related social needs. Implementation of the platform began in January 2019 and will be fully statewide by the end of 2020.

Other IT Tools and Systems: If it is determined that the NCCARE360 resource platform will not meet the IT needs of an ACC, consider other existing resource referral systems presented in the sidebar on the previous page. Developing an IT system unique to your community collaboration can be a challenging undertaking that requires large time and financial investments. See the “Things to Know” box on this page for key points to consider.

Community Example:

The McDowell Access to Care & Health (MATCH) system, funded by the Kate B. Reynolds Charitable Trust, was developed to integrate physical and behavioral health care with community resources to address patients' health-related social needs. The MATCH system has a network structure including a lead network agency, partner agencies, participating agencies, and clients. A web-based, privacy-compliant care coordination and electronic health record application called FHASHES is used to support MATCH.

IT Systems, Data Collection, and Evaluation: Capturing data on social needs of patients can be an important aspect of evaluating the work of your community collaboration. Service usage and outcomes data can help determine community needs, where future growth in social services is needed, and where changes to your collaboration's efforts may be needed. When selecting or developing an IT structure for your partnership, be sure to consider the kinds of data you will be able to gather from those efforts.

Helpful Resources:

Accountable Communities for Health Data-Sharing Toolkit – Center for Healthcare Organizational Innovation Research
(<http://choir.berkeley.edu/ach-toolkit/>)

Toolkit for Communities Using Health Data – How to collect, use, protect, and share data responsibly – National Committee on Vital and Health Statistics (<https://www.ncvhs.hhs.gov/wp-content/uploads/2013/12/Toolkit-for-Communities.pdf>)

Data Across Sectors for Health (DASH) - <http://dashconnect.org/>

LEGAL CONSIDERATIONS

There are multiple layers of legal considerations to account for when developing an Accountable Care Community (ACC) model, including partnership development, data collection, and data sharing.

Formalized partnerships: ACC model partnerships will vary on a spectrum of legal formality depending on the needs, priorities, and resources in the community. As partnerships become more formalized, there are three common frameworks to think about:

- 1. Contractual Collaboration** – Can be basic or advanced. Can involve a Memorandum of Understanding (MOU), which is essentially a contract between partners outlining roles and responsibilities. Also can involve shared services agreements. Partners stay independent. May involve some shared resources.
- 2. Joint Venture** – Typically involves agreement between partners to engage in joint activities and share financial gains and losses. Contractual agreement or formation of Limited Liability Company (LLC).
- 3. New Organization** – This could be a nonprofit corporation or unincorporated association or a tax-exempt Limited Liability Company (LLC).

Legal obligations related to assessing for health-related social needs: It is important to consult legal counsel to understand what issues are required to be reported to law enforcement officials (e.g., child abuse, interpersonal violence in the presence of a child). Legal guidelines should be made clear to both staff and clients/patients. This will help avoid confusion that could lead to unnecessary reporting of clients/patients to law enforcement by staff or mistrust and fear by clients/patients. With these considerations in mind, ACC partners should develop a plan for communicating with clients/patients about:

- The purpose of the screening,
- Privacy requirements, and
- Concerns with sharing information.

THINGS TO KNOW

Formalized Partnership Considerations

Contractual Collaboration - Basic

- Flexible
- Informal
- Typically not centrally managed

Contractual Collaboration – Advanced

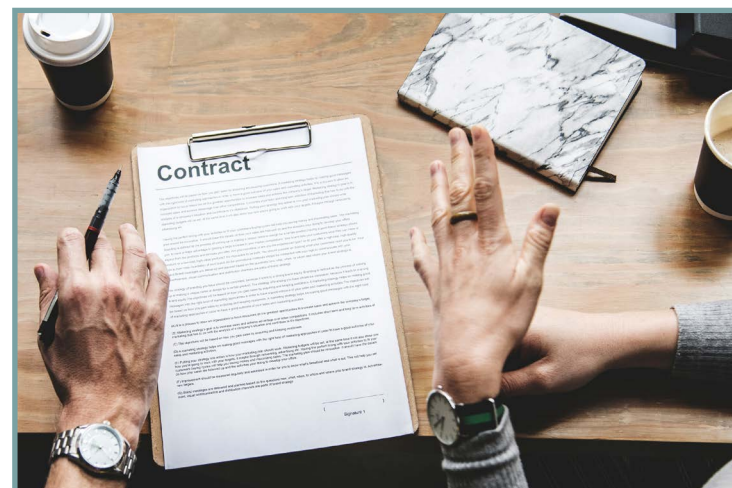
- Typically involves multiple signed agreements
- More coordination of management and resource sharing
- Increased liability

Joint Venture

- Can involve tax-exempt and taxable/for-profit entities
- Impacts on tax status
- Involves governance/ management
- Financial responsibilities

New Organization

- Separate/independent governance
- Tax, financing, and operational changes
- Potential for more liability protection



NOTE: The NCCARE360 resource platform meets the various legal requirements around data privacy and security. Organizations that choose to use NCCARE360 will work with the developing partners, who will determine data access according to federal and state laws. Organizations will have different levels of access according to their roles as will staff of organizations using the platform.

THINGS TO KNOW

- **In-house counsel** (e.g., legal counsel for an organization) is intended to represent the interests of that organization/partner.
- **Outside counsel** (e.g., legal counsel intended to represent a partnership) should be obtained to advise on the needs of a community partnership and avoid conflict of interest.
- **Engage legal counsel... but not too early.** It is important to involve legal counsel in any contracting process involved in developing a community partnership; however, it may save time and money to do so once conversations go beyond vague ideas to more concrete planning.

Sharing Data: If an ACC will be sharing data between organizations, it is very important to understand and account for legal requirements around data privacy and security.

- **Personally Identifiable Information (PII)** – Any data that can be used to identify an individual (e.g., name, birthdate, address, social security number). Privacy safeguards for sharing this type of data are essential to protecting the information and maintaining trust. Consent is needed to share an individual’s personally identifiable information.
- **Protected Health Information (PHI)** – Health information that can be used to identify an individual (e.g., name, birthdate, medical record number). Protected under the Health Insurance Portability and Accountability Act (HIPAA).
- There are no uniform standards for data privacy between different sectors. Different sectors, like health and education, have separate rules to protect individual-level data. This does not preclude collaboration and data sharing; it only means that attention is needed to understand the rules.
- If using or developing a data sharing system, a “partitioned” system that involves different levels of user permission for data access can improve data privacy and security.
- It’s important to secure legal counsel who understands data privacy issues.

Helpful Resources:

Confidentiality Toolkit – Administration for Children & Families. A toolkit to help agencies navigate laws around confidentiality as it relates to data sharing. (https://www.acf.hhs.gov/sites/default/files/assets/acf_confidentiality_toolkit_final_08_12_2014.pdf)

North Carolina Center for Nonprofits – Pro-Bono Legal services – limited service available (<https://www.ncnonprofits.org/pro-bono-help/legal>)

Health Information Data Sharing – The Network for Public Health Law (https://www.networkforphl.org/topics_resources/topics_resources/health_information_and_data_sharing/)

HealthIT.gov Security Risk Assessment (<https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment>)

OUTCOMES-BASED ASSESSMENT & EVALUATION

Evaluation of process and outcomes is an important step in understanding effects of Accountable Care Community (ACC) efforts on community health. This information is vital to knowing what steps should be taken to improve programs and services to better meet community needs, and thus improve the intended health outcomes. Information about the community health outcomes can also help in the process of securing funding opportunities for the short- and long-term financial security of the partnership.

Results Based Accountability

One framework for developing collective impact strategies and performing continuous outcome evaluation is Results Based Accountability™ (RBA). RBA uses data to first investigate a problem, ensure that all relevant stakeholders are involved, form a plan of action, and answer three questions:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

To develop outcomes measures and evaluation mechanisms that are relevant, it is important to have an understanding of the planned or expected effects of programs and services. For example, if an ACC's goal is to decrease the percent of families in the community who are food insecure, baseline measures of food insecurity are required, program activities that are addressing the need should be monitored (e.g., how many families served, their satisfaction with the program, and whether needs were met), and there should be a plan to measure and report changes in these data points. Planning for data collection and continuous monitoring will provide information that can help to improve the program's effectiveness and show funders the positive impacts of the work.

SAMPLE MEASURES FOR ACCOUNTABLE CARE COMMUNITIES

Screening for Health-Related Social Needs

How many people:

- Were screened?
- Screened positive for needs?
- Accepted referral to community resource?
- Received services from community resource?

Community Needs

Percent in community with:

- Access to transportation
- Food deserts
- Unemployment
- Overcrowded households

Process

- Number of staff trained on client/patient needs assessment
- Client/patient satisfaction with referral assistance
- Ease of communication between ACC partners related to client/patient referrals

Helpful Resources:

Results Based Accountability: <https://clearimpact.com/results-based-accountability/>

Mobilizing Partners for Action through Planning and Partnerships: <http://archived.naccho.org/topics/infrastructure/mapp/>

The County Health Rankings & Roadmaps Take Action Cycle: <http://www.countyhealthrankings.org/take-action-improve-health/action-center>

The Centers for Disease Control and Prevention – Developing an Effective Evaluation Plan:

<https://www.cdc.gov/obesity/downloads/cdc-evaluation-workbook-508.pdf>

FINANCING AND SUSTAINABILITY

A significant consideration for Accountable Care Community (ACC) partnerships is financing. This includes questions about how to finance the development of the partnership, ongoing partnership needs, and the services provided. Financing these activities can come in multiple phases, with early work of an ACC funded through grants and other short-term sources. Long-term sustainability will require planning and potentially coordination with partners who benefit financially from the improvements in community health to help support programs.

Currently many of the services to address people's social, behavioral, economic, and environmental health needs are not well funded in communities. In order to improve health outcomes, partners in ACCs must develop sustainable methods of funding these services at levels that can meet the needs of the community. If proven effective, payment systems need to be developed that ensure funding for the organizations providing those services.

Short-term funding for ACC efforts: ACC partnership development can be a time-consuming process involving many meetings of partners, community members, and other stakeholders. The process of developing a shared vocabulary, agenda, and plan for action may require the assistance of outside groups to facilitate discussion. Legal counsel (discussed on [Page 36](#)) is necessary for groups that would like to have shared governance and/or benefits. Partners may require IT assistance to develop communication and data capacities for ACC work. All of these activities, and more, can be costly and require financial support.

In the beginning, philanthropic organizations and state programs may be available to support these short-term development efforts. Public revenues may also be a possibility through taxes, assessments, public fees, or tax credits. The sidebar on this page briefly describes some financing structures described in a highly useful resource produced by ReThink Health: A Typology of Potential Financing Structures for Population Health.

Long-term sustainability: As ACC activities advance, it is important to thoughtfully measure outcomes so that a return on investment (ROI) can be calculated and used to support movement to sustainable long-term financing. For long-term sustainability of ACC efforts, ROI should be used to negotiate with local government, business, health care systems, and insurance providers for payment for services.

SAMPLE OF FINANCING STRUCTURES

Where can Regions Find the Money Needed for Population Health Initiatives?

Seed Funding:

- Grants – short-term funding for specific initiatives

Sustainable Financing:

- Health Care Payment Model – value-based payments from health care payers or providers
- Reinvestment – savings accrued in health care or government services applied to other investments
- Anchor Institutions – important community institutions invest in community needs
- Public Revenues – funds raised through taxes, assessments, etc.
- Public Appropriations – reallocation of dollars based on health impacts

Helpful Resources:

ReThink Health: Beyond the Grant – A Sustainable Financing Workbook: <https://www.rethinkhealth.org/financingworkbook/>

JSI Research & training Institute: Accountable communities for Health: strategies for financial sustainability.
http://cachi.org/uploads/resources/JSI-Sustainability_Final_2015_05.pdf

Spark Policy Institute: Tools for Sustaining Funding for Local Programs. <http://tools.sparkpolicy.com/introduction/>

Spark Policy Institute: Blending and Braiding Toolkit <http://tools.sparkpolicy.com/overview-blending-braiding/>

Center for Community Health and Development at the University of Kansas: The Community Tool Box, Applying for Grants Toolkit <https://ctb.ku.edu/en/applying-for-grants>

RESOURCES

HEALTH EQUITY

North Carolina Health Equity Impact Assessment - The NC Department of Health and Human Services, in partnership with NC Child, developed this tool, which is designed “to guide the development, implementation, and evaluation of policies, programs, and initiatives in order to reduce disparities and promote health equity.” <http://www.ncchild.org/wp-content/uploads/2017/08/HEIA-Toolkit-Final.09.21.17.pdf>

What is Health Equity? And What Difference Does a Definition Make? - A report by the Robert Wood Johnson Foundation and the University of California San Francisco with information about health equity and a list of additional resources. <https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html>

National Collaborative for Health Equity - An organization promoting health equity through “action, leadership, inclusion, and collaboration.” Their mission is “to promote health equity by harnessing evidence, developing leaders, and catalyzing partnerships across the many different sectors that share responsibility for creating a more equitable and just society.” <http://www.nationalcollaborative.org/>

HEALTH IN ALL POLICIES

Health in All Policies: A Guide for State and Local Government (Public Health Institute) - <http://www.phi.org/resources/?resource=hiapguide>

Health in All Policies Resource center (Centers for Disease Control and Prevention) - “The Resource Center was created to house practical and engaging [Health in All Policies] tools and resources to achieve better health for individuals, families, and communities.” <https://www.cdc.gov/policy/hiap/resources/>

ISSUE FRAMING

A New Way to Talk About the Social Determinants of Health (Robert Wood Johnson Foundation) - <https://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023>

GENERAL

Community Tool Box (Center for Community Health and Development, University of Kansas) – “Offers thousands of pages of Tips and tools for taking action in communities.” <https://ctb.ku.edu/en>

Guidebook on Local Planning for Healthy Communities (North Carolina Department of Commerce) - http://www.ecu.edu/cs-dhs/chsrd/upload/0815_Guidebook_on_Local_Planning_for_Health_Communities.pdf

DEVELOPING PARTNERSHIPS/COLLABORATIONS

Communities Joined in Action - “A private, non-profit membership organization of nearly 150 community health collaboratives – each of our members being committed to improving health, improving access, and eliminating disparities in their communities.” <https://www.cjaonline.net/>

Stewarding Regional Health Transformation: A Guide for Changemakers (ReThink Health) – <https://www.rethinkhealth.org/tools/stewardship-guide/>

RESOURCES

Full online guide: https://www.rethinkhealth.org/wp-content/uploads/2015/11/Stewardship_Guide_Final-11-19-15.pdf

Pathway Self-Diagnostic Tool: Where are you on the Pathway? -

<https://www.rethinkhealth.org/resources/stewardship-field-guide-pathway-diagnostic-tool/>

Partnership Assessment Tool for Health (Nonprofit Finance Fund) - “The objective of the tool is to help partnering organizations work together more effectively and maximize their impact.”

<https://nff.org/fundamental/partnership-assessment-tool-health>

Cutting Through the Complexity: A Roadmap for Effective Collaboration (Stanford Social Innovation Review) - https://ssir.org/articles/entry/cutting_through_the_complexity_a_roadmap_for_effective_collaboration?utm_source=BHPN+Website+Newsletter+List&utm_campaign=318b34adbe-EMAIL_CAMPAIGN_2018_03_30&utm_medium=email&utm_term=0_c39fafc581-318b34adbe-355659301

Blog Series: Resident Engagement (ReThink Health)

Exploring Resident Engagement for Health System Transformation -

<https://www.rethinkhealth.org/the-rethinkers-blog/exploring-resident-engagement-for-health-system-transformation/>

Keep Three Approaches in Balance for Successful Resident Engagement -

<https://www.rethinkhealth.org/the-rethinkers-blog/keep-three-approaches-in-balance-for-successful-resident-engagement/>

The Importance of Residents’ Sense of Belonging, Trust, and Power -

<https://www.rethinkhealth.org/the-rethinkers-blog/the-importance-of-residents-sense-of-belonging-trust-and-power/>

When Designing Resident Engagement Practices, Local Context Matters -

<https://www.rethinkhealth.org/the-rethinkers-blog/when-designing-resident-engagement-practices-local-context-matters/>

Resident Engagement Practices Typology -

https://www.rethinkhealth.org/wp-content/uploads/2018/02/RTH-ResidentTypologyOutcome_2152018.pdf

FACILITATING COMMUNITY COLLABORATION

Care Share Health Alliance - <https://www.caresharehealth.org/>

Healthy Places By Design - <https://healthyplacesbydesign.org/>

Rural Forward - <https://foundationhli.org/programs/rural-forward-north-carolina/>

Community Engagement Toolkit by Collective Impact Forum -

<https://collectiveimpactforum.org/sites/default/files/Community%20Engagement%20Toolkit.pdf>

Population Health Improvement Partners - <https://improvepartners.org/>

RESOURCES

COMMUNITY NEEDS ASSESSMENT

Opportunity 360 (Enterprise Community Partners) – Opportunity360 helps improve people’s lives by offering a 360-degree view of any neighborhood. Enter an address to instantly see where a neighborhood ranks on key measures of opportunity, including affordable housing, education, access to jobs, transportation and health food, safe, green spaces for kids to play – even the quality of the air you breathe.” <https://www.enterprisecommunity.org/opportunity360>

Community Health Assessment Toolkit (The Association for Community Health Improvement) - Designed to help hospitals with conducting their Community Health Needs Assessment. Includes useful guidelines for data collection, particularly regarding qualitative data collection methods.

<http://www.healthycommunities.org/Education/toolkit/files/step4-collect-analyze.shtml#.W1jINhKi9Y>

DATA SOURCES FOR COMMUNITY NEEDS ASSESSMENT

North Carolina State Center for Health Statistics - <https://schs.dph.ncdhhs.gov/>

NC Social Determinants of Health Map -

<http://nc.maps.arcgis.com/apps/MapSeries/index.html?appid=def612b7025b44eaa1e0d7af43f4702b>

North Carolina County Health Data - <http://nciom.org/map/>

NC Department of Public Instruction - <http://www.dpi.state.nc.us/data/reports/>

Small Area Income and Poverty Estimates - <https://www.census.gov/programs-surveys/saipe.html>

American FactFinder - <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

County Health Rankings - <http://www.countyhealthrankings.org/>

Local Area Unemployment Statistics - <https://data.bls.gov/map/MapToolServlet?survey=la>

Small Area Health Insurance Estimates - <https://www.census.gov/programs-surveys/sahie.html>

Behavioral Risk Factor Surveillance System - <https://schs.dph.ncdhhs.gov/units/stat/brfss/>

Food Environment Atlas - <https://www.ers.usda.gov/foodatlas/>

QUALITATIVE DATA COLLECTION

Surveys

Community Tool Box: Conducting Surveys (Center for Community Health and Development at the University of Kansas) - <https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-surveys/main>

Resources Guide for Community Survey Projects (Department of Recreation, Sport & Tourism University of Illinois at Urbana-Champaign) - <https://lb.webservices.illinois.edu/files/2011/10/05/35500.pdf>

RESOURCES

Interviews or Focus Groups

Qualitative Research Methods: A Data Collector's Field Guide (Family Health International) -

<https://www.fhi360.org/sites/default/files/media/documents/Qualitative%20Research%20Methods%20-%20A%20Data%20Collector's%20Field%20Guide.pdf>

Concept Mapping

An Introduction to Concept Mapping as a Participatory Public Health Research Method -

<https://www.publichealth.pitt.edu/Portals/0/BCHS/Burke%20concept%20mapping%20introduction.pdf>

Photovoice

Toolkit for a Photovoice Project (United for Prevention in Passaic County, New Jersey) -

<https://www.wpunj.edu/uppc/images/UPinPC+Photovoice+Facilitator+Toolkit+Final.pdf>

OUTCOMES-BASED ASSESSMENT AND EVALUATION MODELS

Results-Based Accountability™

Implementation Guide (Results-Based Accountability™) - <http://raguide.org/>

Clear Impact - <https://clearimpact.com/results-based-accountability/>

Culture of Results (North Carolina Center for Health and Wellness at the University of North Carolina – Asheville) -

<https://ncchw.unca.edu/culture-results>

R.A.C.E. for Equity - <https://www.linkedin.com/in/deitre-epps-716a2330/>

Other

Community Tool Box (Center for Community Health and Development) - Chapter 2 of this tool box contains information about several models for planning and evaluation, including MAPP: Mobilizing Partners for Action through Planning and Partnerships; CHIP: Community Health Improvement Process; and The County Health Rankings & Roadmaps Take Action Cycle <https://ctb.ku.edu/en>

Mobilizing Partners for Action through Planning and Partnerships (National Association of County and City Health Officials) - <http://archived.naccho.org/topics/infrastructure/mapp/>

The County Health Rankings & Roadmaps Take Action Cycle:

<http://www.countyhealthrankings.org/take-action-improve-health/action-center>

Developing an Effective Evaluation Plan (The Centers for Disease Control and Prevention) -

<https://www.cdc.gov/obesity/downloads/cdc-evaluation-workbook-508.pdf>

GENERAL EVALUATION

Accountable Communities for Health: An Evaluation Framework and Users' Guide (Blue Sky Consulting Group)

http://static1.1.sqspcdn.com/static/f/675504/27508434/1490912864837/ACH_Evaluation_Framework_Users_Guide_Final_with_links.pdf?token=9NW3wyNgTIEFiF4Yc%2BBDK9zK3z%2Bk%3D

RESOURCES

What's Your ROI?: A Web-Based Tool to Estimate Economic Returns on Investment for Public Health Agency Projects (Association of State and Territorial Health Officials) - <http://www.astho.org/Programs/Evaluation/>

Instructional Guide - <http://www.astho.org/Evaluation/ASTHO-ROI-Tool-Instructional-Guide/>

HOSPITALS, HEALTH CARE SYSTEMS, AND OTHER HEALTH CARE PROVIDERS

The Value Initiative (American Hospital Association) - Resources, including issue briefs and presentations on hospital involvement in initiatives and partnerships to address determinants of health in their communities www.aha.org/thevalueinitiative

Improving Community Health by Strengthening Community Investment: Roles for Hospitals and Health Systems (Robert Wood Johnson Foundation) - https://iri.hks.harvard.edu/files/iri/files/rwjf_strengthening_community_investment_031517.pdf

Conversations with Hospitals and Health System Executives: How Hospitals and Health Systems Can Move Upstream and Improve Community Health (de Beaumont Foundation and The Build Health Challenge) - <http://buildhealthchallenge.org/resources/conversations-with-hospital-health-system-executives/>

SCREENING FOR HEALTH-RELATED SOCIAL NEEDS

North Carolina's Standardized Screening Questions (Developed by the North Carolina Department for Health and Human Services) - <https://files.nc.gov/ncdhhs/Updated-Standardized-Screening-Questions-7-9-18.pdf>

Health Leads Screening Toolkit: <https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/>

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE): <http://www.nachc.org/research-and-data/prapare/>

Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations (Center for Health Care Strategies, Inc.) - <https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/>

WORKFORCE

North Carolina's Care Management Strategy Under Managed Care (North Carolina Department of Health and Human Services) - https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf

Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability (North Carolina Department of Health and Human Services) - <https://publichealth.nc.gov/chronicdiseaseandinjury/doc/DHHS-CWH-Report-Web-052118.pdf>

INFORMATION TECHNOLOGY AND DATA SHARING

Accountable Communities for Health: Data-Sharing Toolkit (Center for Healthcare Organizational Innovation Research) - "This toolkit is designed to assist communities working to share data across sectors to improve health." <http://choir.berkeley.edu/ach-toolkit/>

RESOURCES

Health Insurance Portability and Accountability Act (United States Department of Health and Human Services) - Information about data privacy and security requirements that are part of federal law www.hhs.gov/hipaa

Toolkit for Communities Using Health Data (National Committee on Vital and Health Statistics, United States Department of Health and Human Services)- How to collect, use, protect, and share data responsibly – National Committee on Vital and Health Statistics

<https://www.ncvhs.hhs.gov/wp-content/uploads/2013/12/Toolkit-for-Communities.pdf>

Data Across Sectors for Health (DASH) - <http://dashconnect.org/>

Confidentiality Toolkit (Administration for Children & Families) - A toolkit to help agencies navigate laws around confidentiality as it relates to data sharing

https://www.acf.hhs.gov/sites/default/files/assets/acf_confidentiality_toolkit_final_08_12_2014.pdf

Health Information Data Sharing (The Network for Public Health Law) -

https://www.networkforphl.org/topics_resources/topics_resources/health_information_and_data_sharing/

Security Risk Assessment (HealthIT.gov) -

<https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment>

GOVERNANCE

The Strategic Backbone Toolkit by the Spark Policy Institute - <http://tools.sparkpolicy.com/?toolkit=backbone>

LEGAL SERVICES AND CONSIDERATIONS

North Carolina Center for Nonprofits – Pro-Bono Legal services, limited service available

<https://www.ncnonprofits.org/pro-bono-help/legal>

The Network for Public Health Law - <https://www.networkforphl.org/>

FINANCING AND SUSTAINABILITY

Beyond the Grant: A Sustainable Financing Workbook (ReThink Health) – “This workbook offers modules with practical, user-friendly tools to answer common financing questions and develop action plans for moving beyond the grant.” <https://www.rethinkhealth.org/financingworkbook/>

Financing Regional Health Transformation: A Primer for Changemakers (ReThink Health) - “This Financing Primer helps regional leaders think through key questions around the investment and financing of long-term, health reform ventures. It focuses on what sustainable financing is, why it is important, the critical elements of a financing plan, and what others around the country have been doing to frame and finance their work.”

<https://www.rethinkhealth.org/tools/financing-primer/>

RESOURCES

Supporting Healthy Communities: How rethinking the funding approach can break down silos and promote health and health equity (Deloitte Insights) -

<https://www2.deloitte.com/insights/us/en/industry/health-care/building-and-funding-healthy-communities.html>

Social Impact Bonds: A Guide for State and Local Governments (Harvard Kennedy School Social Impact Bond Technical Assistance Lab) -

<http://govlab.hks.harvard.edu/files/siblab/files/social-impact-bonds-a-guide-for-state-and-local-governments.pdf>

Clarifying Feasible Procedures for Reinvesting Health Care Cost Savings: Issue Brief (Altarum Institute) -

https://altarum.org/sites/default/files/uploaded-publication-files/CSHS_Reinvesting%20Issue%20Brief_Final.pdf

Accountable Communities for Health: Strategies for Financial Sustainability (JSI Research & Training Institute, Inc.) -

https://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

Tools for Sustaining Funding for Local Programs (Spark Policy Institute) - <http://tools.sparkpolicy.com/introduction/>

Blending and Braiding Toolkit (Spark Policy Institute) - <http://tools.sparkpolicy.com/overview-blending-braiding/>

The Community Tool Box, Applying for Grants Toolkit (Center for Community Health and Development at the University of Kansas) - <https://ctb.ku.edu/en/applying-for-grants>

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