ACCOUNTABLE CARE COMMUNITIES:
Partnerships to Improve Community Health and Well-Being

In the United States, keeping people healthy has long been a priority for individuals, communities, employers, and policymakers. The prevailing method of doing this has been through the provision of medical care, primarily when people are already sick. Who gets access to health care, how they access it, who provides it, how it is paid for, and what it costs have been an ongoing subject of debate and political discourse. What has not been questioned in this country, until recently, is whether medical care is the best way to keep people healthy. Research on the cost and quality of care, health disparities, and what factors affect individuals' health highlight that access to and use of medical care is only one of many factors that influence health and well-being.[1–4]

Efforts to improve health have typically focused on the health care system as the driver of health outcomes. However, individuals' health outcomes often have more to do with the conditions in which they live, learn, work, and age than the medical care they receive or their personal genetic predisposition for disease. These conditions, or drivers of health, include social and economic factors, health behaviors, the physical environment, and the policies and programs that influence these factors.

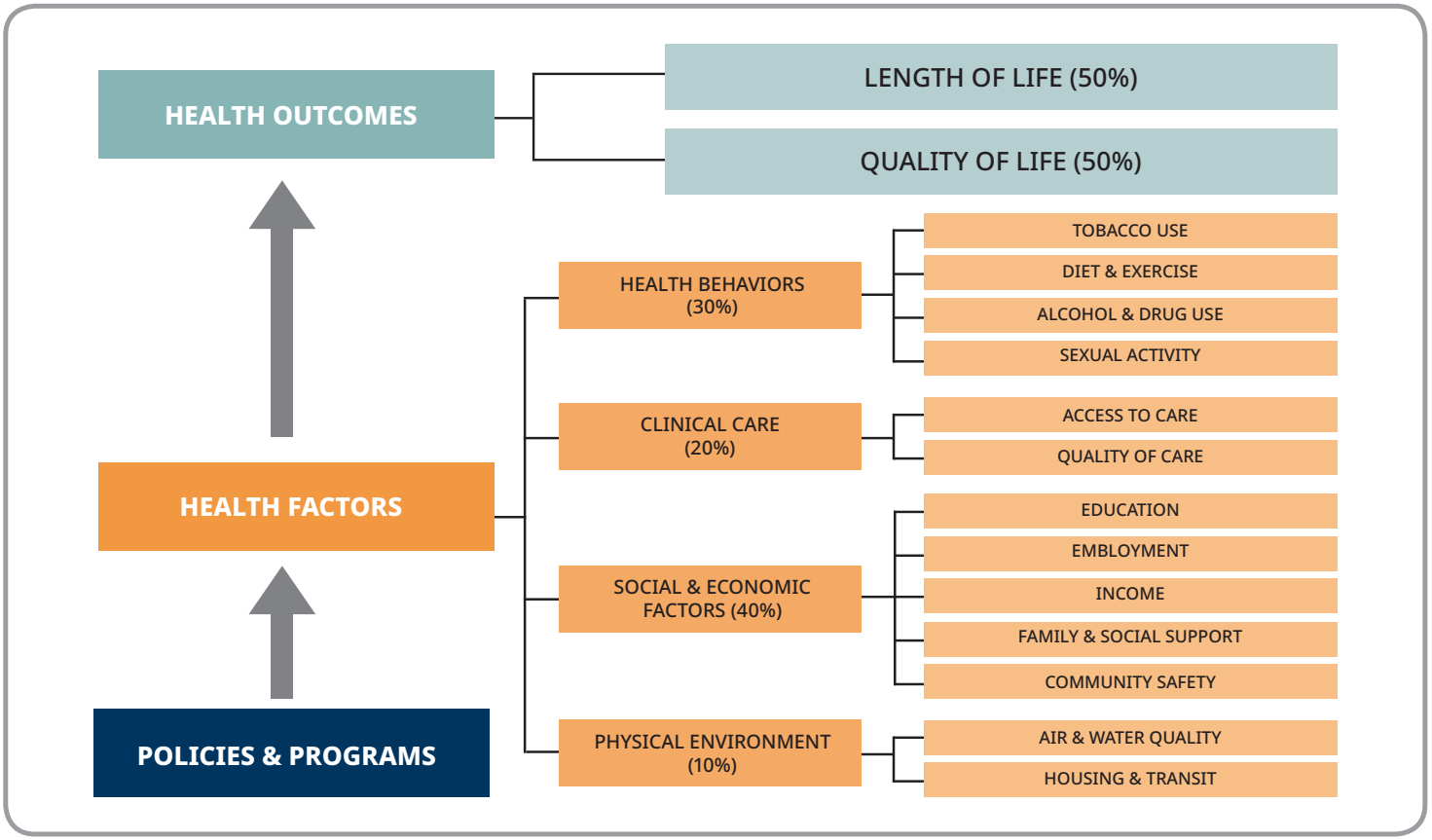
KEEPING PEOPLE HEALTHY REQUIRES ENSURING THAT THEY HAVE OPPORTUNITIES TO BE HEALTHY WHERE THEY LIVE, LEARN, WORK, AND AGE.

Traditional health care is designed only to provide (and pay for) clinical care, not to address the other drivers of health that affect health outcomes. However, because clinical care and genetics each account for only 20 percent of the variation in health outcomes, to improve health and well-being the other drivers must be addressed.[5] Keeping people healthy requires ensuring that they have opportunities to be healthy where they live, learn, work, and age.

Drivers of Health

Drivers of health, also called determinants of health or social determinants of health, are the many factors that come together to affect health outcomes. Research shows that non-clinical drivers of health account for approximately 80 percent of health outcomes (**Figure 1**), both directly and by influencing health behaviors.[6-8]

Figure 1. Drivers of Health that Affect Health Outcomes



1. *Source: County Health Rankings model. 2014. http://www.countyhealthrankings.org/what-is-health*

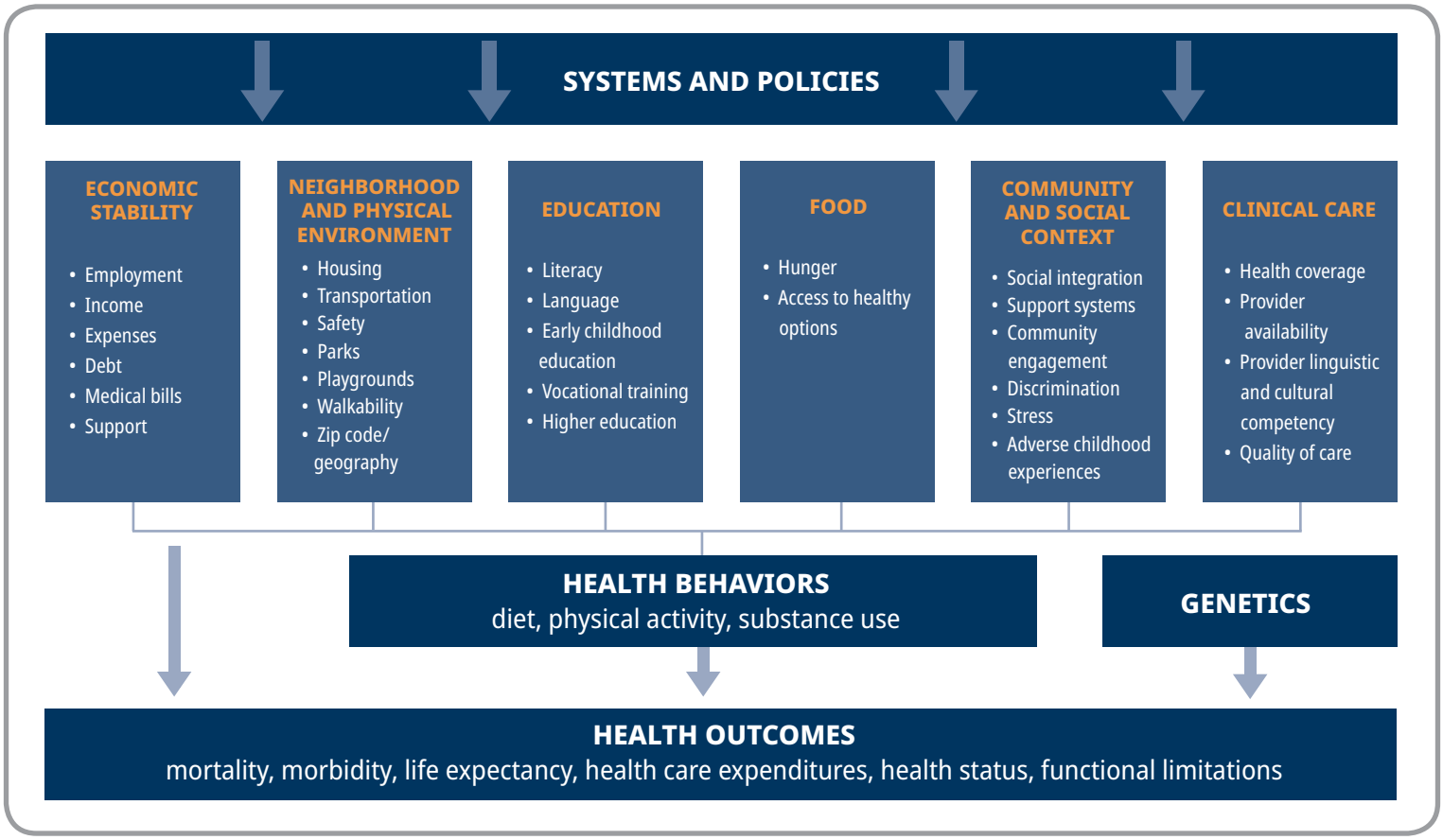
Figure 2 shows further detail of some specific drivers of health and examples of each (i.e., economic stability, neighborhood and physical environment, education, food, community and social context, and the health care system) that are affected by systems and policies and the issues related to each area. These factors combine to affect health outcomes (e.g., morbidity, mortality, life expectancy), as well as the types of health behaviors individuals engage in, which also influence health outcomes. A discussion of several of these factors and related health outcomes is available in Appendix C. People with higher incomes or personal wealth, more years of education, and who live in a healthy and safe environment have, on average, longer life expectancies and better overall health outcomes. Conversely, those with fewer years of education, lower incomes, less accumulated wealth, or who are living in poorer neighborhoods or substandard housing conditions have worse health outcomes.

Many of the drivers of health have both independent and interactive effects. For example, people with higher incomes have more opportunities to live in safe and healthy homes near high-achieving schools. People with higher incomes generally have more opportunities to purchase healthy foods and more time for physical activity. Health insurance and health care also become more accessible with more monetary resources. Conversely, people who live in poverty are more likely to live in substandard housing or in unsafe communities. Their communities may lack grocery stores that sell fresh fruits and vegetables, or they may lack access to outdoor recreational facilities where they can exercise.

EXAMPLES: SOCIAL NEEDS AFFECTING HEALTH

- 44 percent of asthma cases in children are related to home-based exposures (Lanphear et al., 2001)
- Food insecurity significantly affects adult Type 2 diabetes mellitus outcomes (Smalls et al., 2015 & Selgiman et al., 2012)
- Living in a neighborhood with economic disadvantages increases risk of coronary heart disease risk of coronary heart disease (Roux et al., 2001)

Figure 2. 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/

Health behaviors—actions that are either beneficial or detrimental to one's health—are reflective of the effects that the drivers of health can have on individual opportunities to make healthy choices. So, those who lack access to grocery stores that sell fresh fruits and vegetables may not be able to prepare healthy meals and those who do not have outdoor recreational facilities where they can exercise may have low physical activity. Consequently, individuals living within these circumstances tend to have higher rates of obesity, diabetes, and heart disease.[9] Drivers of health can either limit or facilitate opportunities to engage in healthy activities and behaviors.

System and Policy Effects on Drivers of Health

Federal, state, and local systems and policies shape the conditions in which individuals live, work, learn, and age.[10,11] Public policies are those policies, and the systems and programs they create, that result from government action. Our lives are shaped by public policies. 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, air and water quality, and laws around health insurance access and coverage.

POLICY IMPACTS ON DRIVERS OF HEALTH

- Regulations around clean air and water affect the air we breathe.
- Zoning policies determine where homes are constructed.
- Transportation policies affect access to resources in the community including employment, grocery stores, and health care facilities.

Often public policies are not included as a driver of health; however, public policies create the context within which the drivers of health exist. As such, public policy provides an avenue for intervening in the drivers of health. This approach involves trying to affect government action in an effort to change systems and policies to improve drivers of health in communities. For example, to address lack of transportation among those with chronic health conditions (whose health is best supported with regular visits to health professionals), the work of local organizations that offer transportation assistance may be coordinated. Additionally, local public transportation could be improved to better meet the needs of these individuals. In many cases, working to influence local or state public policies may be the most effective way to meet the needs of the community on a large scale.

HEALTH INEQUITIES EXIST WHEN PEOPLE ARE NOT ABLE TO ATTAIN OPTIMAL HEALTH BECAUSE OF UNJUST, UNNECESSARY, AND AVOIDABLE CIRCUMSTANCES, WHICH THEN RESULT IN HEALTH DISPARITIES IN A COMMUNITY.

FEDERAL, STATE, AND LOCAL SYSTEMS AND POLICIES SHAPE THE CONDITIONS IN WHICH INDIVIDUALS LIVE, WORK, LEARN, AND AGE.

Health Equity

When considering how policies in all sectors affect health, it is important to also consider how those policies impact the equity in opportunities for health. Health equity is the opportunity for all people to attain the highest level of personal health regardless of demographic characteristics.[12] Health inequities exist when people are not able to attain optimal health because of unjust, unnecessary, and avoidable circumstances, which then result in health disparities in a community. Health disparities are differences in health status and outcomes between groups based on characteristics like race, ethnicity, gender, and income.[13] The presence of health disparities in a community is largely the result of the policies that created the systems that subsequently led, directly or indirectly, to the unmet health-related social needs of the community.

In North Carolina, health inequity results in disparities across many measures of health outcomes. For example, compared to infant death rates (per 1,000 births) of 5.4 for Whites, the rate is 13.0 for African Americans and 9.0 for American Indians. Mortality rates (per 100,000) for many chronic diseases are higher for African Americans than Whites (diabetes: 44.0 vs. 18.8; kidney disease: 31.0 vs. 13.4; HIV: 7.5 vs. 0.8; all cancer: 190.7 vs. 165.0).[14] Inequities can also be viewed across geographic areas in the state, especially when factoring in the racial/ethnic makeup and other demographics of those areas. For instance, people born in Robeson County have the lowest life expectancy at 73.5 years (74.8 years for White, 72.6 years for African American), while those in Chatham County have the highest at 81.2 years (82.3 years for White, 77.9 years for African American).[15] Within-county data further illustrate the differences in health outcomes by community, even within relatively close distances: in Raleigh, life expectancy varies from 88 years in northwest Raleigh (where the population is between .8 percent and 11.4 percent African American, depending on census tract) to 76 years in southeast Raleigh (where the population is 52.0 to 82.8 percent African American, depending on census tract, and has higher rates of poverty, lack of health insurance, lack of access to a vehicle, low access to healthy foods, and more people spending 30 percent or more of their income on rent).[16,17]

[a] *Typically, reimbursable services are treatments and procedures rather than preventive measures, counselling, health coaching and non-clinical health-related services.*

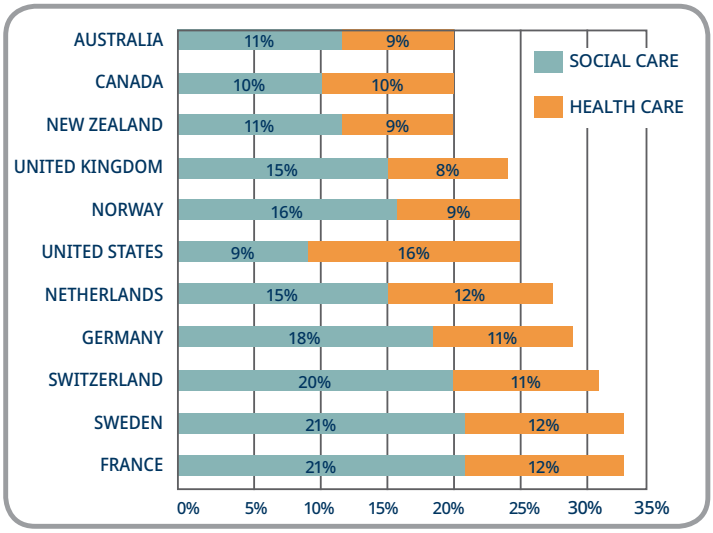
Higher Costs Driving Innovation

Historically, the United States health care system has been organized around a fee-for-service payment structure whereby health care providers are paid for each reimbursable service[a] they provide, regardless of cost or outcome. As a payment system, the fee-for-service model rewards providers for the quantity of reimbursable services (e.g., visits, treatments, procedures) rather than for the health and well-being of their patients (i.e., quality and outcomes). This payment structure has led to the United States spending approximately twice as much as other high-income countries on medical care while having poorer health outcomes (e.g., life expectancy, infant mortality, obesity, rates of chronic disease).[18] This statistic may not be surprising considering the relatively low amount the United States spends on social care to provide services that address health-related social needs, which have a greater bearing on health outcomes than medical services. Compared with 10 other high-income countries, the United States spends the least on social services like food security, retirement and disability benefits, employment programs, and supportive housing, as seen in **Figure 3**.[19]

The rising cost of health care has outpaced inflation in the United States for decades. In 2017, health care spending was 17.9 percent of GDP. This is predicted to grow to 19.7 percent of GDP by 2026.[20] Increasingly, those who pay for health care (i.e., federal and state governments, employers, and taxpayers) have been looking for alternatives that can improve outcomes and reduce costs.

With the steadily rising cost of health care, the United States health care insurance industry is in the midst of reorienting payment toward quality and value for patients.[21] **Figure 4** depicts the calculation of value in terms of cost and quality. Value in this equation is defined as health outcomes achieved per dollar spent.[22,23] Alternative payment models, with varying degrees of accountability and financial risk, are increasingly used to change the incentives of health care systems. In recent years, some insurers have begun to experiment with value-based payment systems that incentivize improved health and wellness to decrease health care use in place of past payment systems that solely incentivized greater usage of health care treatments and services. Value-based payment models provide payment based on patient outcomes and/or expected outcomes given certain data analytics, rather than on the number of services provided. With the large role that value-based payment has in recent legislation such as the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act (MACRA), private insurers are following the lead of Medicare in moving toward performance-based payment models, including value-based purchasing[b], accountable care organizations[c], and bundled payments.[21,d]

Figure 3. Spending on Health and Social Care as Percentage of Gross Domestic Product in Select High-Income Countries



NCIOM adaptation from Bradley, EH, Taylor LA. The American Healthcare paradox: Why Spending More is Getting Us Less. Public Affairs. 2013.

Figure 4. Calculating Value in Terms of Cost and Quality

Source: NCIOM adaption of HIMSS Innovation Center. (2016). Solving the healthcare value equation. Retrieved October 29, 2018, from https://www.healthcareitnews.com/sponsored-content/solving-healthcare-value-equation-0

[a] *Typically, reimbursable services are treatments and procedures rather than preventive measures, counselling, health coaching and non-clinical health-related services.*

[b] *"Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers." HealthCare.gov, https://www.healthcare.gov/glossary/value-based-purchasing-vbp/, accessed November 12, 2018*

[c] *"A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings." HealthCare.gov, https://www.healthcare.gov/glossary/accountable-care-organization/, accessed November 12, 2018*

[d] *"A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments." HealthCare.gov, https://www.healthcare.gov/glossary/payment-bundling/, accessed November 12, 2018*

Changing Payment and Health Care Delivery Structures Leading to Community-Focused Interventions

Changing payment and health care delivery models, accompanied by new quality metrics, an increased focus on patient outcomes, and incentives to reduce the cost of care, have resulted in greater attention to how to keep patients well and reduce "excess utilization." Keeping patients well cannot be achieved without addressing non-clinical drivers of health.[24]

In this changing landscape, some purchasers and providers of health care have turned to community focused interventions.[25] While clinicians have always known that patients' health- related social needs affect both their health and their ability to access and take advantage of treatment, there is increasing focus on these results under new payment models.[26] To successfully keep a child with asthma who is living in substandard housing, or an adult with diabetes who cannot afford medication, out of the emergency room, the health care team must look beyond diagnosis and prescription of treatment and consider how to help patients with needs beyond their immediate medical concern. Growing evidence indicates that the success of value-based payments will depend on these efforts to address behavioral, social, economic, and environmental drivers of health that are key to health outcomes and disparities.[27] Although some clinical care purchasers and providers are addressing non-clinical drivers of health on their own, most are looking at how to improve the linkages between clinical care providers and community- based service providers.[28] This approach often requires health professionals to collaborate and coordinate with non-traditional community partners to achieve better health outcomes by addressing root causes of poor health.

The Accountable Care Community Model

Drivers of health outside clinical care are typically addressed at the community level by human services organizations operating in the social services and nonprofit sectors, which are not usually coordinated with clinical care. One strategy that has shown promise in bridging this gap is the Accountable Care Community (ACC) model, a regional multisector partnership that shares responsibility for coordinating and financing efforts to address multiple drivers of health.[e] ACCs address the critical gap between clinical care and community-based services in the current health care delivery system. ACCs do this by bringing together traditional health care with its focus on preventing and treating illness, community-based partners whose focus is on creating the conditions necessary for good health, and those who purchase and pay for health care.

Fundamentally, ACCs acknowledge that communities have a shared responsibility to ensure the health and well-being of all members of the community.[26] ACCs seek to fulfill this shared responsibility through cross-sector collaboration that most often includes community members, businesses, education, the health care delivery system, public health, social services, finance, housing, transportation, and human services

ACCOUNTABLE CARE COMMUNITIES ARE REGIONAL MULTISECTOR PARTNERSHIPS THAT SHARE RESPONSIBILITY FOR COORDINATING AND FINANCING EFFORTS TO ADDRESS MULTIPLE DRIVERS OF HEALTH

organizations.[29] ACCs provide a way for human services organizations addressing food insecurity, interpersonal violence, housing instability, and other health-related social needs to collaborate with the health care sector to achieve better and more equitable health outcomes with potential cost savings. ACCs work to leverage the contributions of all partners by strengthening links between existing programs and services and coordinating resources and efforts. ACCs can improve the health and well-being of communities by developing shared goals, systems, and sustainable funding among partners.

The federal government and others have been testing models that bridge the gap between clinical care and community services. The Centers for Medicare & Medicaid Services' Accountable Health Communities model provides clinical-community collaboration through:

- *"Screening of community dwelling beneficiaries to identify certain unmet health-related social needs;*
- *Referral of community dwelling beneficiaries to increase awareness of community services;*
- *Provision of navigation services to assist high-risk community dwelling beneficiaries with accessing community services; and*
- *Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community dwelling beneficiaries."*[30]

If successful at improving health outcomes and reducing costs, these pilots may lead to greater Medicare and Medicaid reimbursement for non-clinical health services for the larger population of people enrolled in these programs. While the federally-sponsored Accountable Health Communities project envisions models similar to ACCs, the focus of those pilots is exclusively on people enrolled in Medicare and Medicaid. Other examples of existing models similar to ACCs can be found in Appendix D.

Early adopters of ACC models have shown that bringing partners together across multiple sectors can reduce health care use while improving outcomes. For communities, there is significant interest in having more say in how health care dollars are spent.[29] For health care delivery systems

[e] *These partnerships go by many names including accountable health communities, clinical-community partnerships, community-centered health homes, accountable care collaboratives, accountable health, etc. The Task Force used the term accountable care communities to refer to all such partnerships.*

ACC MODELS HAVE SHOWN THAT BRINGING PARTNERS TOGETHER ACROSS MULTIPLE SECTORS CAN REDUCE HEALTH CARE USE WHILE IMPROVING OUTCOMES.

and providers who historically receive most of the health care dollars, the movement away from fee-for-service payments toward global payments tied to health outcomes demands that they begin to look for opportunities to achieve cost savings. Often these opportunities for cost savings come by creating conditions for people to be healthy in their homes and communities—work typically done by community social service providers and others outside the health care delivery system. Under an ACC model, governments and businesses, as the primary purchasers of health insurance, have the power to demand changes by redefining what they are purchasing—health or health care. Payers can drive change by restructuring payments to pay for outcomes and to cover the types of social services that can improve outcomes. For the business sector, the connection between good health, community well-being, and strong economic growth may not always be obvious. However, making these connections with the availability of a healthy labor force and interest in controlling employer-sponsored health coverage costs could develop and encourage the business sector's support for, and partnership in, ACCs.

Task Force on Accountable Care Communities

The North Carolina Institute of Medicine recognizes the need to integrate the drivers of health into the conception of health and health care in order to improve the health and health equity of the people of North Carolina and control rising costs of care. Across the state, there is growing interest in ACCs as an emerging and promising model for how to more fully address the health and well-being of communities while reducing costs. There are currently no ACCs in North Carolina, although there are health care systems and community groups beginning to engage in activities similar to those of ACCs. With a need for leadership and recommendations on how community agencies and health care providers can partner to share responsibility for the health of communities through collaborative and integrated strategies to promote health, 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 Task Force was co-chaired by Miles Atkins, Mayor of the Town of Mooresville and Director of Corporate Affairs & Government Relations at Iredell Health System; Reuben Blackwell, President & Chief Executive Officer of Opportunities Industrialization Center, Inc. and City Council Member in Rocky Mount, NC; Mandy Cohen, MD, MPH, Secretary for the North Carolina Department of Health and Human Services; and Ronald Paulus, MD, MBA, President & CEO of Mission Health System. They were joined by 56 other Task Force and Steering Committee members, including legislators, state and local agency representatives, service providers, and community representatives. The Task Force met 11 times between January and November 2018. The Task Force made 24 recommendations. The recommendations are summarized in the executive summary and a full list of recommendations is included in Appendix A of this report.

Task Force Vision for North Carolina

ACCs provide a model for how disparate systems and organizations can work together to improve the health and well-being of their communities. ACCs can transform the health care landscape in North Carolina and across the country. ACCs have the potential to demonstrate that it is possible to design systems that are successful at both addressing social and economic factors and improving the health of the community. Reaching the goal of improved community health requires stepping outside the bounds of traditional health care by assessing and addressing individuals' health-related social needs with the same intention as their health care needs. Therefore, the Task Force developed the following vision for the development of ACC models throughout North Carolina:

VISION OF ACCOUNTABLE CARE COMMUNITY TASK FORCE - DEVELOPMENT OF ACCOUNTABLE CARE COMMUNITIES

Communities across the state should convene stakeholders from relevant sectors (including health, human services, transportation, food, housing, aging, local government, tribal government and services, private sector, legal aid, faith communities, and others) to develop and implement Accountable Care Communities to improve health outcomes, strive for health equity, and reduce health care costs by addressing many of the key drivers of health. Across communities, health-related social needs will vary. Each community should develop both short- and long-term goals along with an associated plan and strategy to systematically fill those needs to enable optimal health. In the short-term, human services organizations can help provide services to meet immediate needs, such as food insecurity and interpersonal violence. In the long-term, ACCs can work to address the policies that have created the circumstances for those needs. Existing coalitions or initiatives across the state may be at varying stages of action or movement toward becoming an Accountable Care Community. Where these efforts have not yet begun, existing community partners and meetings should be used as a basis for collaboration to limit additional time and responsibilities on an already full list of existing commitments.

ACCS PROVIDE A MODEL FOR HOW DISPARATE SYSTEMS AND ORGANIZATIONS CAN WORK TOGETHER TO IMPROVE THE HEALTH AND WELL-BEING OF THEIR COMMUNITIES.

These efforts should involve:

- ***Inclusion of the full spectrum of stakeholders within the community.***
- ***Identification of:***
  - ***Specific health priorities for the community to address through the ACC model.***
  - ***A model of shared governance and a backbone organization or lead entity.***
- ***Implementation of evidence-based programs, strategies, and policies to address identified community health priorities and social needs, including a coordinated system of screening, referral, and navigation for services to address unmet health-related social needs.***
- ***Evaluation of the performance of any programs or processes put in place through the ACC's efforts.***
- ***Development of financing mechanisms for sustaining programs and processes developed and put in place by the ACC and supporting organizations that meet health-related social needs.***

In response to this vision and to help promote the concept of ACCs across North Carolina, the Task Force recommends:

RECOMMENDATION 1.1:
PROMOTE ACCOUNTABLE CARE COMMUNITIES TO IMPROVE HEALTH OF COMMUNITY MEMBERS

a) NCIOM Task Force Members should provide education regarding the Accountable Care Communities concept to professional organizations and communities across North Carolina.

i) Representatives of the North Carolina Institute of Medicine Task Force on Accountable Care Communities should provide educational presentations on the Accountable Care Community model to the 16 Councils of Government, Local Management Entity-Managed Care Organizations, the Metro Mayors Coalition, North Carolina Association of County Attorneys, North Carolina Association of County Commissioners, North Carolina Association of County Directors of Social Services, North Carolina Association of Health Plans, North Carolina Association of Local Health Directors, North Carolina Association of Planners, North Carolina Chapter of the American Planning Association, North Carolina City and County Management Association, North Carolina Council of Churches, North Carolina League of Municipalities, North Carolina Navigator Consortium, North Carolina Police Chiefs Association, North Carolina Public Health Association, North Carolina School Boards Association, North Carolina Sheriffs Association, Public Housing Authorities, and the North Carolina and local Chambers of Commerce.

ii) Organizations represented on the Task Force should disseminate the model of Accountable Care Communities to communities around the state by participating in community discussions, giving presentations on the value of Accountable Care Communities to community groups, and advocating for their respective organizations to support such activities.

b) The North Carolina Department of Health and Human Services should encourage communities to form Accountable Care Community-style models by:

i) Promoting resources that advance community understanding (e.g., community presentations by the North Carolina Department of Health and Human Services or North Carolina Institute of Medicine Task Force representatives), and

ii) Providing technical assistance with developing these models (e.g., North Carolina Institute of Medicine's Partnering to Improve Health: A Guide to Starting an Accountable Care Community).

c) The North Carolina Chamber of Commerce, the North Carolina Healthcare Association, the North Carolina Medical Society, civic organizations, local health departments, and local hospital and/or health care system government relations representatives should collaborate to develop business and corporate support, investment, and participation in local ACC activities. To accomplish this, these organizations should help educate the business community on the influence that health-related social needs have on community well-being and the local economy and business.