



## Task Force on Accountable Care Communities

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Population Health Collaborative

## NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

*NCGS §90-470*



# ACC Task Force

- Co-Chairs: Secretary Mandy Cohen, Mr. Reuben Blackwell, Dr. Ron Paulus, Mayor Miles Atkins
- Funded by The Duke Endowment and Kate B. Reynolds Charitable Trust
- 12 meetings through 2018.
- Task force: 53 members, broad constituencies: health, health care, faith, transit, housing, food, faith, wellness

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# Public Health 3.0

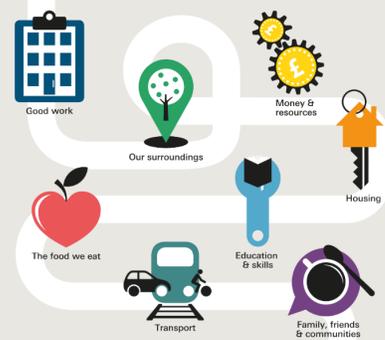
## US DHHS Public Health 3.0

Model in which **leaders serve as Chief Health Strategists, partnering across multiple sectors and leveraging data and resources to address social, environmental, and economic conditions that affect health and health equity.**<sup>4</sup>

### What makes us healthy?

AS LITTLE AS **10%** of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:



But the picture isn't the same for everyone.

## Health Begins Where We Live, Learn, Work and Play

**National Association of  
County Health Officials  
Putting Public Health 3.0 into  
Action, Recommendation 2**

### **Cultivate Cross-Sector Partnerships**

- Engage with public and private community partners to diversify resources and foster collective action



## Cross-sector Partnerships to Address Barriers to Health

Accountable Care Community model:

- bring 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



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# Accountable Care Communities



*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.*



# Examples of Accountable Care Communities



*DC PACT (Positive Accountable Community Transformation) is a coalition effort of community providers, including social service non-profits, faith institutions, behavioral health providers, hospitals, and community health centers, in partnership with multiple District government agencies including the Department of Health Care Finance, Department of Human Services, Department of Behavioral Health, and Department of Disability Services.*

- DC Primary Care Association serves as the Collective Impact "backbone" organization, guided by an Advisory Council.
- DC PACT seeks to identify and address social challenges that create health disparities by linking safety net provider organizations in the District.



# Examples of Accountable Care Communities



CHA unified diverse organizations—from the local hospital system to county parks and recreation programs, school districts, and the Faith Community Health Ministry—to deliver environmental health services, clinical services, and community education to people who are considered to be at risk for developing preventable health conditions.

- working in the domains of healthy behaviors and built environment to decrease both the percentage of adults who consume fewer than 5 servings of fruits and vegetables per day, and who report no exercise
- working to increase the number of healthy corner stores, farmers markets accepting SNAP/EBT (Supplemental Nutrition Assistance Program/Electronic benefit transfer) benefits, facilities with joint use agreements, and physicians providing exercise prescriptions and referrals to local physical activity locations

# Any community can form an ACC

- Existing groups that do similar work could choose to expand their mission to incorporate the goals of an ACC
  - Roanoke Valley Community Health Initiative, joint effort of area businesses, child and family agencies, and community-based organizations dedicated to addressing healthy eating habits and physical activity opportunities in the community that will have a lasting impact on health outcomes
- Local health departments are natural leaders
  - Cabarrus Health Alliance
  - US DHHS: local health department leaders should be Chief Health Strategists, partnering across multiple sectors
- Community organizations could spearhead
  - United Way, OIC, Housing Coalition, Ashe County Sharing Center
- Health Systems
  - Carolinas HealthCare System, Novant Health, and the Mecklenburg County Health Department decided to collaborate and focus on the public health priority areas within Mecklenburg County, also partnering with community organizations, such as the YMCA of Greater Charlotte, Project 658, and the Renaissance West Community Initiative



# Any community can form an ACC

## Potential Partners at the Table

- **Traditional health care**
  - Local health departments
  - Health care systems and providers
  - Safety net providers
  - ACOs
- **Community-based partners**
  - City and county government (Transportation, Parks and Rec, city council)
  - Local Education Agencies
  - Food banks, Area Agencies on Aging, Partnerships for Children,
- **Those who purchase and pay for health care**
  - Insurers (private insurance, Medicaid Prepaid Health Plans)
  - Employers (including county and city governments)
  - ACOs
  - LME/MCOs

## Start where you are

- Ideally have all three buckets represented, BUT
- Every ACC will not start with all the necessary partners
- Any coalition can get ACC work started



# Core Features of Accountable Care Communities

- **Assessment of Community Health:** analysis of community health issues to determine priorities
- **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.
- **Screening Tool:** a questionnaire to screen for health-related social needs.
- **Referral Process:** protocols to refer clients for services that can help meet their needs.
- **Navigation Services:** assistance for clients who have trouble accessing community services.
- **Tracking System:** ability to capture information about whether needs were met.
- **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 to determine what programs and services work and have positive return on investment.
- **Financing:** analysis of return on investment can be used to develop financial models to support service delivery of both clinical and non-clinical services.
- **Governance:** collaborative organizations in an ACC should have a shared governance structure that affords shared decision-making, shared risk, and shared reward.



## Chapter 2 – Collaborating for Better Health

- **Rec 2.2 – Evaluate Health Equity Effects of ACCs and County-Based Programs and Activities**
  - NC Office of Minority Health and Health Disparities, ACCs, County departments
- **Rec 2.3 – Provide Guidance on Cross-Agency Collaboration to Address Drivers of Health**
  - Office of the Governor, ACCs
- **Rec 2.4 – Support Local Health Departments to be Leaders in ACCs**
  - DPH, Association of LHDs, NCIPH
- **Rec 2.5 – Report Results of Hospital and Health Care System Community Benefits**
  - NCHA Foundation
- **Rec 2.6 – Align Policies for State DHHS Regions and Understand Implications of Regionalized Programs on ACC Partner Participation**
  - DHHS
- **Rec 2.7 – Provide TA to ACCs and convene learning collaborative**

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## Chapter 3 – NC Opportunities for Health

- **Rec 3.1 – Provide TA to Healthy Opportunities Pilots**
  - NC DHHS, with other state agencies and philanthropies, should provide or support TA for pilot participants to build capacity for cross-sector collaboration
- **Rec 3.2 – Develop Support for State Healthy Opportunities Initiatives**
  - NC DHHS, with partners, should educate enrollment brokers, payers, health care systems, providers, and human services orgs about the NC DHHS approach to health-related social needs, standardized screening questions, and NCCARE360

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## Chapter 4 – Implementing Opportunities for Health

- **Rec 4.1 – Develop and Deploy the Standardized Screening Questions and NCCARE360**
- **Rec 4.2 – Ensure Individuals are Informed about Personal Data Collection and Sharing**
- **Rec 4.3 – Implement Screening and Referral Process Across Health Care Payers, Providers, Human Services, and Social Services Entities**
- **Rec 4.4 – Facilitate Data Sharing and Compatibility**
- **Rec 4.5 – Develop, Expand, and Support the Health Care Workforce to Better Address Health-Related Social Needs and Health Equity**
  - DHHS, NC AHEC, Community College System and others
- **Rec 4.6 – Strengthen the Human Services Sector**
  - Philanthropy and DHHS

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## Chapter 5 – Evaluation and Process Improvement

- **Rec 5.1 – Evaluate Methods for Screening for Health-Related Social Needs**
  - DHHS
- **Rec 5.2 – Evaluate Data Gathered Through the Standardized Screening Process**
  - DIT and DHHS
- **Rec 5.3 – Evaluate Data Gathered Through NCCARE360**
  - NCCARE360 partners

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## Chapter 6 – Funding and Financing Models

- **Rec 6.1/6.2/6.5 – Support Initial (transition/sustainability) Development of Local ACCs**
  - Philanthropy with support from PHPs, Medicaid, other payers, health systems, local businesses, local government.
- **Rec 6.3 – Support Medicaid Healthy Opportunities Pilots**
  - DHHS, NCGA, Philanthropy
- **Rec 6.4 – Analyze Data to Determine Costs and Benefits of Health-Related Social Services**
  - DIT, DHHS, PHPs

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## How Accountable Care Communities Fit into North Carolina's Evolving Health Care System



NC Department of Health and Human Services

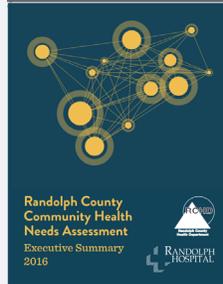
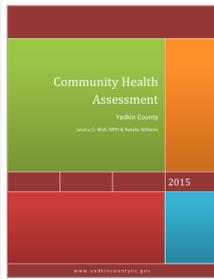
### The Opportunity for Whole Person Health

NC DHHS has developed a framework for providing “Healthy Opportunities” to all North Carolinians that will build much of the infrastructure needed for accountable care communities

# Assessment of Community Health

## Community Health Assessments

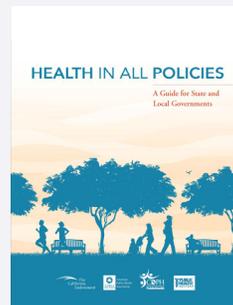
- Conducted every 3-4 years by local health departments (LHD)
- Required as part of accreditation for LHD
- Have been conducted in North Carolina for more than 40 years
- Assessment and improvement planning process



# Education and Advocacy

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.

- Health in All Policies
  - Promote health, equity, and sustainability
  - Support intersectoral collaboration
  - Benefit multiple partners
  - Engage stakeholders
  - Create structural or process change



# Screening Tool

NC DHHS  
Standardize  
Screening Tool

### Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
<b>Food</b>		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
<b>Housing/ Utilities</b>		
3. Within the past 12 months, have you ever stayed outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
<b>Transportation</b>		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
<b>Interpersonal Safety</b>		
7. Do you feel physically and emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
<b>Optional: Immediate Need</b>		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

Medicaid Prepaid Health Plans will be required to use

NC DHHS encouraging statewide adoption



# Referral Process



NCCARE360 is the first statewide coordinated network that includes a robust data repository of shared resources and connects healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

### NCCARE360 Partners:



## Navigation Services

Assistance for clients who have trouble accessing community services

- Within Medicaid Prepaid Health Plans
  - Prepaid Health Plans will receive per member per month payments that will support the implementation of screening, referral, navigation assistance
- Many health systems and larger health care provider practices, as well as human service organizations, have care managers who may be able to meet some of the need for navigation services.



## Tracking, Outcomes, Financing and Governance: Non-Medicaid

- Tracking, outcome measurement, financing and governance will vary greatly across ACC models
  - Hope that NC Health Connex will be able to fill the tracking and outcomes piece of this work to some degree.



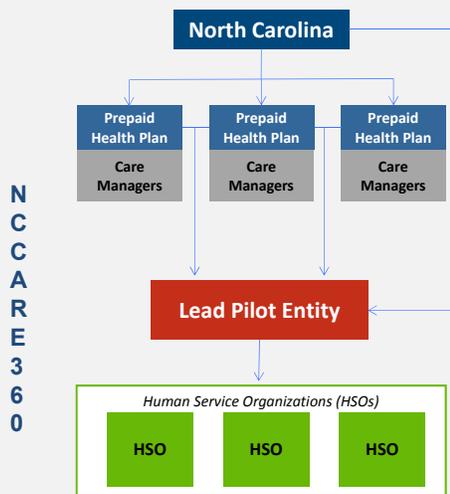
# Tracking, Outcomes, Financing and Governance: Medicaid

- Under Medicaid Transformation, NC DHHS will track:
  - Health and health-related service receipt
  - Costs
  - Standardized screening tool data
  - Measure outcomes
- Within the Healthy Opportunities pilots, will also:
  - Experiment with new payment models
  - Develop a governance structure at the local level



## Healthy Opportunities Regional Pilots

### Sample Regional Pilot



### Pilot Overview

- Authorization to spend up to \$650 million in 2-4 regions
- Test and scale to a population level evidence-based interventions designed to improve health and reduce costs more intensely addressing food insecurity, housing quality and instability, transportation insecurity, interpersonal violence and toxic stress
- For eligible Medicaid beneficiaries (health and social risk)
- Key pilot entities include:
  - North Carolina DHHS
  - Prepaid Health Plans (PHPs)
  - Care Managers (predominantly located at Tier 3 AMHs and LHDs)
  - Lead Pilot Entities
  - Human Service Organizations (HSOs)
- NCCARE360 part of the infrastructure

# Overview of Approved Pilot Services

North Carolina's 1115 waiver specifies services that can be covered by the Pilot. Pilots will not be required to offer all approved services.



**Housing**

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)
- Short-term post hospitalization housing



**Food**

- Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery



**Transportation**

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
  - Public transit
  - Taxis, in areas with limited public transit infrastructure



**Interpersonal Violence**

- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

# ACC Core Features Supported by NC DHHS

- ✓ Assessment of Community Health
- ☐ Education and Advocacy
- ✓ Screening Tool
- ✓ Referral Process
- ✓ Navigation Services
- ✓ Tracking System
- ✓ Outcomes Data and Analysis
- ✓ Financing
- ☐ Governance



## Community Health Assessments

**Health Screening**

We believe everyone should have the opportunity to reach... Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

Question	Yes	No
1. Within the past 12 months, did you worry that your food would run out before you did? (e.g., you didn't have money to get more?)		
2. Within the past 12 months, did the food you brought get moldy and/or spoiled?		
3. Within the past 12 months, have you ever stayed outside, in a car, in a tent, or in an emergency shelter, or temporarily in someone else's home (e.g., a couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
6. Within the past 12 months, has lack of transportation kept you from attending an appointment or from doing things needed for daily living? (e.g., shopping, work, school)		
7. Do you feel physically and emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
<b>Optional: unanswerable item</b>		
10. Are you or your loved one(s) ever? For example, you don't have food to bring home, you don't have a place to sleep tonight, you are afraid you will get hurt or killed? (Please circle)		
11. Would you like help with any of the needs that you have identified?		



**Medicaid Managed Care core program element: Care Management**

**HIE and Medicaid Transformation Evaluation**

**Medicaid Managed Care-Regional Pilots**



## ACCs: A Guide to Getting Started

[www.nciom.org/nc-health-data/guide-to-accountable-care-communities/](http://www.nciom.org/nc-health-data/guide-to-accountable-care-communities/)

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### PARTNERING TO IMPROVE HEALTH: A GUIDE TO STARTING AN ACCOUNTABLE CARE COMMUNITY

**COMING SOON!**

Partnering to Improve Health: A Guide to Starting an Accountable Care Community provides information for those thinking about developing an Accountable Care Community model for community partnership to address the drivers of health.

**COMING SOON**

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, and who delivers and pays for care. What often gets left out is that health care is only a piece 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 and economic factors that affect health include safe families, communities, and housing, and access to healthy food, education, and transportation, among others. These factors are called *drivers of health* (also called social determinants of health). They directly affect health.

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## ACCs: A Guide to Getting Started

- What is an ACC: core features and examples
- Building partnerships and engaging community
- Structure and governance
- Financing and sustainability
- Quick reference:
  - Screening
  - Referral
  - Workforce
  - IT infrastructure
  - Legal considerations
  - Assessment and evaluation
- Lots of helpful resources!



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## For more information

- Websites: [www.nciom.org](http://www.nciom.org)  
[www.ncmedicaljournal.com](http://www.ncmedicaljournal.com)
- Key contacts:
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