North Carolina Institute of Medicine
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Task Force on
Accountable Care Communities

TASK FORCE ON ACCOUNTABLE CARE COMMUNITIES

MEETING SUMMARY

August 2, 2018

10:00 am – 3:00 pm

North Carolina Institute of Medicine

630 Davis Drive

Morrisville, NC 27560

Attendees:

- *Co-Chairs:* Reuben Blackwell, Ron Paulus (via phone)
- *Steering Committee:* Jason Baisden, Chris Collins, Shelisa Howard-Martinez, Allison Owen, Melanie Phelps, Jeff Spade
- *Task Force Members*: Will Broughton, Tristan Bruner, Barbara Morales Burke, Brett Byerly, Bob Feikema, Robby Hall, Nicole Johnson, Dee Jones, Jai Kumar, Nicolle Miller, Abbey Piner, Sharon Nelson, Brendan Riley, Maggie Sauer, Kim Schwartz, Pam Silberman, Tish Singletary, Anne Thomas, Betsey Tilson, Sheree Vodicka, Mary Warren, Ciara Zachary; *Via phone*: Shauna Guthrie, Ann Meletzke, Linda Shaw

Introductions:

Steering Committee member Jeff Spade opened the meeting and asked Task Force members to introduce themselves. Steering committee members, Task Force members, staff, and guests introduced themselves, including their position and the organization they represent. Adam Zolotor provided a brief overview of the agenda and the goals for the meeting before introducing the first speaker.

Improving Community Health Outcomes with Results Based Accountability and Collective Impact
Deitre Epps, Results Based Accountability and Equity Consultant

Ms. Epps began her presentation by describing a case study of school readiness in Maryland, which showed the benefit of choosing one result and one indicator for all partner organizations to work toward with their own strategies. Thus, the key to Results Based Accountability (RBA) is building a culture of results and establishing the common understanding that this work is not only one organization's role, but that multiple organizations can align contributions to make a larger impact. Turn the Curve thinking is an RBA concept that involves consideration of how a community or population is doing in a certain area of health, thinking about what the story behind the statistics is, what partners have a role to play in changing the trend (or "turning the curve"), what would work to turn the curve, and what the action plan is to do that work. When considering what programs would work to turn the

curve, consider specificity, leverage, values, and reach. Another important aspect of RBA is language discipline, meaning that all parties agree on what the words they are using mean. For example, terms around measurement include performance measure and indicator. It is important to understand the difference between accountability for populations vs. performance. Population accountability starts with identifying the desired result and what measures will determine the success of that result, while performance accountability involves identification of measures that serve as activity-specific results. There are three important questions to ask in the RBA process: 1) How much did we do?; 2) How well did we do it?; and 3) Is anyone better off?

Questions/Discussion:
Question: How can we incorporate equity while using this framework?
Answer: You could look at representation in the collaborative. For the question of people being better off, you could ask for the percentage of people in the community who agree that the priorities that were chosen are the right ones.

Question: Data can be challenge for a lot of communities; what about programs that serve a small number of people that when they are collecting data it may not be meaningful?
Answer: Even small programs have performance measures. But for population measures for smaller communities, partnering with other to collect data can be useful.

Question: Was there specific funding for capacity building for organizations for the examples you gave?
Answer:

Epps presentation here.

Developing an Accountable Care Community with a Health Equity Lens
Ciara Zachary, Health Program Director, NC Child and Leslie deRosset, Program Manager, Improving Community Outcomes for Maternal and Child Health, Division of Public Health, North Carolina Department of Health and Human Services

Ms. Zachary started the presentation with a description of health equity and health disparities and the difference between equity and equality, and noted that rising tides may lift all boats, but that does not close gaps in outcomes. Ms. deRosset introduced the Health Equity Impact Assessment (HEIA), which was developed with the collaboration of NC Child, NC Department of Public Health Women's and Children's Section, the NC Office of Minority Health and Health Disparities, and the NC March of Dimes. The HEIA tool was developed to evaluate the impact of public policies, programs, and administrative practices on health inequities in North Carolina. The tool provides a structured process to guide the development, implementation, and evaluation of policies and programs to reduce disparities. Various settings are appropriate for the HEIA to be used, including: State and local policy leaders/advocates – to examine implications of legislative proposals or proactively design more equitable policies; State and local public health agencies – to evaluate how equitable current initiatives are or develop new initiatives to ensure equitable outcomes; and community-based organization – to review agency practices and

policies as well as leverage the HEIA process for collective impact. Other states, such as Washington and Wisconsin, have developed and used similar tools. The HEIA process involves pre-work (determining the policy or program, identifying implementation team members and their roles; self-assessment and preparing your implementation team; and preparing your data profile), followed by four steps: 1) Describing the current policy or program, 2) Analyzing and interpreting the data, 3) Identifying modifications, and 4) Developing a monitoring plan. The HEIA can be an important tool for ACCs to use in developing their work and can be used to help think about who might be missing from the table.

Questions/Discussion:

Question: What about addressing institutional racism and implicit bias and the fact that we can't really move the needle without addressing those things?
Answer: We do encourage participants to take racial equity trainings through REI and utilize other tools like the implicit bias assessment. It does have to be about changing the larger system. One of the most valuable aspects of this structure has been bringing people together to have difficult conversations, because if we can't name the cause of the disparities we can't move forward.

Question: Have you started to see results in terms of changes in the data?
Answer: It's still too early but one of the things that has come out of breastfeeding in Union/Mecklenburg is seeing the lack of involvement of men and doing focus groups with men. Aligning data collection process among partners working on LARCs.

Question: Any information you could share about incorporating HEIA into RBA?
Answer: Results of HIEA could be included under values as a way to judge is this a strategy we want to move forward with?

Zachary/deRosset presentation here.

Panel: Considerations for Developing and Implementing an ACC Model in Rural Settings
Reuben Blackwell, President & CEO, Opportunities Industrialization Center, Inc.; Robby Hall, Director of Social Services, Richmond County Human Services; Lisa Macon Harrison, Health Director, Granville-Vance Public Health

The panelists were asked questions about their experiences working in collaborative efforts in rural areas. First, they discussed unique needs for rural communities, describing the need as great and the resources low, with data difficult to come by. Populations are more dispersed than urban areas. With many needs, and few people filling roles, there are issues with burnout and lack of innovation with all the same people always at the table. Sometimes, state-level requirements can pull resource away from important issues.

Regarding strengths and weaknesses in rural communities addressing health equity, the people who fill multiple roles can often see the gaps in services and needs more clearly. Sometimes, discussions of equity may not be seen as a good thing by the people who hold power and resources. Reframing the

discussion can be helpful. There are strengths in the trusted relationships in smaller communities, and liabilities in the embedded culture that grows from those relationships.

Specific to ACCs, rural communities have the benefits of trusted relationships. Panelists provided examples of health-related community partnerships that exist in their communities.

Questions/Discussion:

Question: Thinking about anyone in this room presenting in a rural community about ACCs—where are we going to run into issues in terms of a practical issue?
Answer: Scarce resources can make it difficult to collaborate because so many entities are already competing for funding.

Question: What is the degree of overlap in partners among those coalitions and then second question is people usually become attached to their niche issue, do you think it will be harder to get people to the table if those come under one umbrella?
Answer: Aligning across coalitions could make for efficiencies, but having these coalitions is often tied to some other requirement or funding stream. There is significant overlap in partners.

Integrating the Needs of the Aging Population and People with Disabilities into ACC Development and Implementation
Mary Warren, Director, Triangle J Area Agency on Aging

Ms. Warren provided a background on the role of Area Agencies on Aging (AAAs), which serve as regional planners for the needs of older adults, adults living with disabilities, and family caregivers; share information and provide service and benefit navigation; develop programs and resources; advocate for the protection of rights for older adults and adults with disabilities; and provide fiscal administration and quality improvement for funded services. There are many commonalities between the needs of older adults and adults with disabilities, although there will be some differences. Ms. Warren provided an overview of statistics for the gaining population in North Carolina, with 37% having a disability, 81% having at least one chronic disease, high suicide rates for white males, and 21% are food insecure. Systems serving older adults are often siloed, community resources often have limited organizational capacity, difficult intake processes, may not be culturally appropriate, have gaps in coverage areas, and may have waiting lists. Environmental concerns include lack of accessibility, gentrification and displacement, lack or poor condition of sidewalks, and narrow store aisles.

Some solutions to these issues are found in age-friendly communities. AARP targets 8 domains for making a community age-friendly: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community support and health services. There is a need for better referral mechanisms for services and more focus on the convergence of aging and disability. Aging-related considerations for ACCs include: services and solutions should be both important FOR and important TO

individuals, support for family caregivers should be a part of the SDOH conversation, and opportunities should be created for input from older adults, family caregivers, and those aging with disabilities.

Questions/Discussion:
Question: Have you all developed a process for engaging caregivers?
Answer: It's hard because it is hard to find them. We work with some local organizations which helps. When we work with caregiver groups the challenges they share revolve around finding specialists, inefficiencies at the appointments, interpreter needs, materials not getting to the right people.

Question: AAAs have a lot of resources to connect people to services, what are big opportunities/challenges in connecting older adults?
Answer: An obvious issue is that there is not enough to go around. We are seeing more specialization for people who can work individually to find the right solutions. A lot of the referrals we are able to make are one-size-fits-all solutions that we are giving to people. The systems only allow a certain amount of flexibility.

Warren presentation here.

Development and Discussion of Recommendations
Facilitators: Brieanne Lyda-McDonald, Berkeley Yorkery, Adam Zolotor

All meeting attendees reviewed and discussed previously-developed recommendations and provided comments and edits.

Wrap-Up and Next Steps
Brieanne Lyda-McDonald, Project Director, NCIOM

Ms. Lyda-McDonald gave a brief presentation on the upcoming meeting dates and topics we will cover.

Lyda-McDonald presentation here.