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North Carolina Institute of Medicine

PARTNERING TO IMPROVE HEALTH:

*Developing Accountable Care
Communities in North Carolina*



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The North Carolina Institute of Medicine (NCIOM) is a nonpolitical source of analysis and advice on important health issues facing the state. The NCIOM convenes stakeholders and other interested people from across the state to study these complex issues and develop workable solutions to improve health care in North Carolina.

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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. Their leadership and experience were important to the success of the Task Force's work.

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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 after people are already sick. Research on the cost and quality of care, health disparities, and what factors affect individuals' health highlights that access to and use of medical care is only one of many factors that influence health and well-being.¹⁻⁴ 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 (e.g., social and economic factors, health behaviors, physical environment, clinical care, policies, and programs that influence these factors). Because clinical care accounts for only 20 percent of the variation in health outcomes, to improve health and well-being these 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 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.^a ACCs 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.

Fundamentally, ACCs acknowledge that communities have a shared responsibility to ensure the health and well-being of all members of the community.⁶ 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 organizations.⁷ 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.

TASK FORCE PURPOSE

Across the country and state, there is growing recognition of the need to integrate the drivers of health into the conception of health and health care in order to improve health and health equity 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's vision is that communities across the state should convene stakeholders in sectors relevant to health-related social needs 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 organization 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.

Recommendation 1.1:

Promote Accountable Care Communities to improve health of community members.

COLLABORATING FOR BETTER HEALTH

The work of ACCs begins with convening cross-sector partners to assess community health issues and develop strategies to address individual and community needs. Governance, financing structures, and evaluation mechanisms should be discussed and planned out to sustain the ongoing work of the partnership. To address individuals' short-term needs, partners can use a screening and referral process to begin to address issues on the individual level. To address the root causes of community needs for the long-term improvement of population health, the ACC partnership should advocate for the consideration of health and well-being in local policies across all sectors.

Recommendation 2.1:

Promote health and well-being in all policies.

Additionally, it is important to consider the effects of local policies and ACC activities on the health equity of the entire community.

Recommendation 2.2:

Evaluate health equity effects of Accountable Care Community and county-based programs and activities.

In order to address health and well-being in all sectors of policy and to achieve health equity, siloes of local systems and government must be connected. Although many of the organizations that may be involved

^a 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.

in an ACC are recipients of funding that comes through state agencies, collaboration across sectors is difficult in systems that have traditionally been siloed (e.g., health care, housing, transportation, education).

Recommendation 2.3:

Provide guidance on cross-agency collaboration to address drivers of health.

At the local level, leadership to develop an ACC model can come from a variety of sources, from community groups to health care systems. ACCs should involve stakeholders from local government, tribal government and services, public health, health care systems, and the community. If such collaborations do not already exist, local health departments can play a vital role in bringing these interests together.

Recommendation 2.4:

Support local health departments to be leaders in Accountable Care Communities.

As an important stakeholder in cross-sector partnerships, local hospitals and health care systems can contribute their expertise in health care, financial and property resources, and influence on population health of the community. Non-profit hospitals are required to provide community benefits, such as charity care, donations to community groups, and community-building activities (e.g., investments in housing).⁸ The population health effects of these contributions are typically not reported but could assist in understanding how they are currently helping the community and identify potential areas for greater population health improvement.

Recommendation 2.5:

Report results of hospital and health care system community benefits.

One reason sectors have become siloed within the state and working together can be a challenge is that there are inconsistent regional areas for various state programs. This can be a factor in the willingness and ability of some stakeholders to become active partners in an ACC.

Recommendation 2.6:

Align policies for state Department of Health and Human Services regions and understand implications of regionalized programs on Accountable Care Community partner participation.

To take effective action to improve community health, ACC partners must understand the needs of the community. Once the work of assessing the health and needs of a community is complete, the more challenging task of collective decision-making on priorities and interventions begins. Communities around the state will develop ACCs in different ways and gather important lessons learned along the way. Bringing communities together to share these lessons and learn from each other can be a helpful way to disseminate knowledge and develop a sense of camaraderie.

Recommendation 2.7:

Provide technical assistance to Accountable Care Communities.

NORTH CAROLINA OPPORTUNITIES FOR HEALTH

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 healthcare system.”⁹ To do this, NC DHHS has created a statewide framework for healthy opportunities that includes:

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.*^{9,10}

These initiatives will be instrumental in helping to develop or support ACCs throughout the state. Of particular interest to developing ACCs will be the standardized screening questions and NCCARE360 resource platform. The set of nine primary screening questions will cover the domains of food, housing/utilities, transportation, and interpersonal safety and three additional questions will cover the nature of the needs and whether help is wanted.¹¹ The NCCARE360 resource platform is being developed with the goal of developing a tool “to make it easier for providers, insurers and human services organizations to connect people with the community resources they need to be healthy.”¹²

The pilots, referred to as Healthy Opportunities pilots, will allow NC DHHS to test a form of an ACC-style model with a population enrolled in Medicaid and utilize Medicaid funding to pay for health-related social services.

Recommendation 3.1:

Provide technical assistance to Health Opportunities pilots.

Developing public knowledge and support for the range of initiatives will be an important step in ensuring their success.

Recommendation 3.2:

Develop stakeholder support for state Health Opportunities initiatives.

IMPLEMENTING OPPORTUNITIES FOR HEALTH

Taken together, the standardized screening questions and the NCCARE360 resource platform can provide the technical backbone for ACC efforts to screen and refer individuals with health-related social needs. These resources can provide a consistent screening and referral mechanism across the state and save ACCs from spending time and money developing their own.

Recommendation 4.1:

Develop and deploy the standardized screening questions and NCCARE360.

At the same time, protection of personal data and securing informed consent for data usage is important to maintain the trust of individuals using these resources.

Recommendation 4.2:

Ensure individuals are informed about personal data collection and sharing.

The NC DHHS is encouraging all organizations addressing individual health-related social needs across the state to implement the screening questions and NCCARE360 platform to refer individuals who have needs to the resources that can meet those needs. The greater the application of these resources, the greater the potential for positive impact on health throughout the state.

Recommendation 4.3:

Implement screening and referral process across health care payers, providers, human services, and social service entities.

In the event that ACC partners choose to develop their own information technology and data-sharing tools, their work will need to be interoperable with existing and developing state-based data systems.

Recommendation 4.4:

Facilitate data sharing and compatibility.

The work of screening, connecting individuals to community resources, and managing their care/cases can be done by a wide range of professionals including social workers, navigators, care managers, and community health workers. Health care organizations, payers, and other stakeholders will need to consider the roles of community health workers and care managers in addressing health-related social needs as part of overall ACC efforts.

Recommendation 4.5:

Develop, expand, and support the health care workforce to better address health-related social needs and health equity.

Discussions around ACC activities often task human services organizations^b with providing nonclinical resources and services responsive to individuals' health-related social needs. However, the human services sector is not adequately prepared to meet a large increase in demand for their services without additional support. Human services organizations^c face many challenges, including limited funding and resources that limit their ability to partner with health care organizations in ways that will significantly increase demand for services without compensation for services and organizational support.

^b An 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." [HumanServicesEdu.org](https://www.humanservicesedu.org).

^c The Definition of Human Services. <https://www.humanservicesedu.org/definition-human-services.html#context/api/listings/prefilter>

Recommendation 4.6:

Strengthen the human services sector.

EVALUATION AND PROCESS IMPROVEMENT

Evaluation of process and outcomes is an important step in understanding the effect ACC efforts have on the community and health-related metrics. Measuring where an ACC is in the process of addressing community issues and how well programs are working to address needs is vital to knowing what steps should be taken to improve those programs, and thus improve the intended outcomes. Just as evaluations of community-level ACC activities are important to understand their effectiveness, the NC DHHS and their partners should incorporate an evaluation of statewide efforts to address health-related social needs. The wording of the standardized screening questions is currently being piloted and the various approaches to conducting the screening (i.e., telephone versus in-person interview and electronic or paper completion) should be reviewed to provide guidance for optimal methods.

Recommendation 5.1:

Evaluate methods for screening for health-related social needs.

An evaluation of the data gathered using the standardized screening questions can help to inform community-based efforts, such as ACCs, to address health-related social needs. State-produced public reports of these analyses can help to identify areas in the most need and areas that are making progress in addressing community needs.

Recommendation 5.2:

Evaluate data gathered through the standardized screening process.

NCCARE360 partners will be gathering a wealth of information on community needs throughout the state through the NCCARE360 resource platform. This data can inform the quality improvement process for the platform and can inform communities on the volume and types of referrals that are being made for service needs. As the platform is used to identify needs and link people to resources, communities can learn where resource gaps or limitations exist.

Recommendation 5.3:

Evaluate data gathered through NCCARE360.

FUNDING AND FINANCING MODELS

At the core of the work of an ACC is the shift from a system that buys medical care to one that buys health. To do this, new financial incentives are needed to re-align the health care system away from volume to value.¹³ The short-term and long-term funding challenges for ACCs are different. In the short-term, ACCs may need funding to

form and for partners to begin working together. In the long-term, data on services delivered, costs, improvements in health, and cost savings/avoidance should provide means to develop financial models to support the provision of services that address health-related social needs within the realm of health.

Funding for planning and development is needed when ACCs form and begin to explore how partners can better coordinate their work to improve health outcomes. ACC partnership development can be a time-consuming process involving health care organizations, human services organizations, partners, community members, and other stakeholders.

Recommendation 6.1:

Support initial development of local Accountable Care Communities.

Once an ACC has formed and developed a plan for how partners will work together and what work they will do, the ACC must identify funding for implementation. There are two main areas that need funding in this stage: systems and services. ACC work typically involves developing and implementing new systems to screen, refer, provide navigation assistance, track receipt of services and outcomes data, and pay for services. Organizations must also hire and/or train staff and redesign their workflows to incorporate new activities and technologies.

Recommendation 6.2:

Funding for local Accountable Care Community implementation.

The Medicaid Healthy Opportunities pilots are designed to allow more substantial investments in non-clinical health related services with the explicit goal of learning how to finance 'health' interventions and incorporate them into value-based payments. To facilitate this learning, the pilot program incorporates both rapid-cycle evaluation and summative evaluation. This type of data collection and evaluation is critical to developing sustainable funding models for investments in non-clinical health services.

Recommendation 6.3:

Support implementation of Medicaid Health Opportunities pilots.

ACCs will need to capitalize on the savings created by the health improvements resulting from services provided by human services organizations in order to develop sustainable funding models. If ACC efforts create improved health outcomes as well as savings (health care dollars saved or avoided) greater than or equal to costs (dollars spent to provide services), then payers, employers, or health care providers in value-based arrangements are benefitting by avoiding costs they otherwise would have borne. Data collection and analysis is critical to developing sustainable funding models for investments in non-clinical health services.

Recommendation 6.4:

Analyze data to determine costs and benefits of health-related social services.

Along with payer investments and compensation for services, communities can look to a variety of other funding options for long-term ACC sustainability, including local tax revenue and health care system investment. Developing sustainable funding strategies for services to meet people's health-related social needs will be heavily influenced in North Carolina by the Medicaid Healthy Opportunities pilots. ACCs outside of the pilots will need support and assistance to develop sustainable funding.

Recommendation 6.5:

Develop sustainable Accountable Care Community funding.

Developing sustainable ACCs throughout North Carolina will be a complex effort. If done effectively, these models for collective action could go a long way to address the health-related social needs of community members and improve population health into the future.

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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, and social services 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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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.

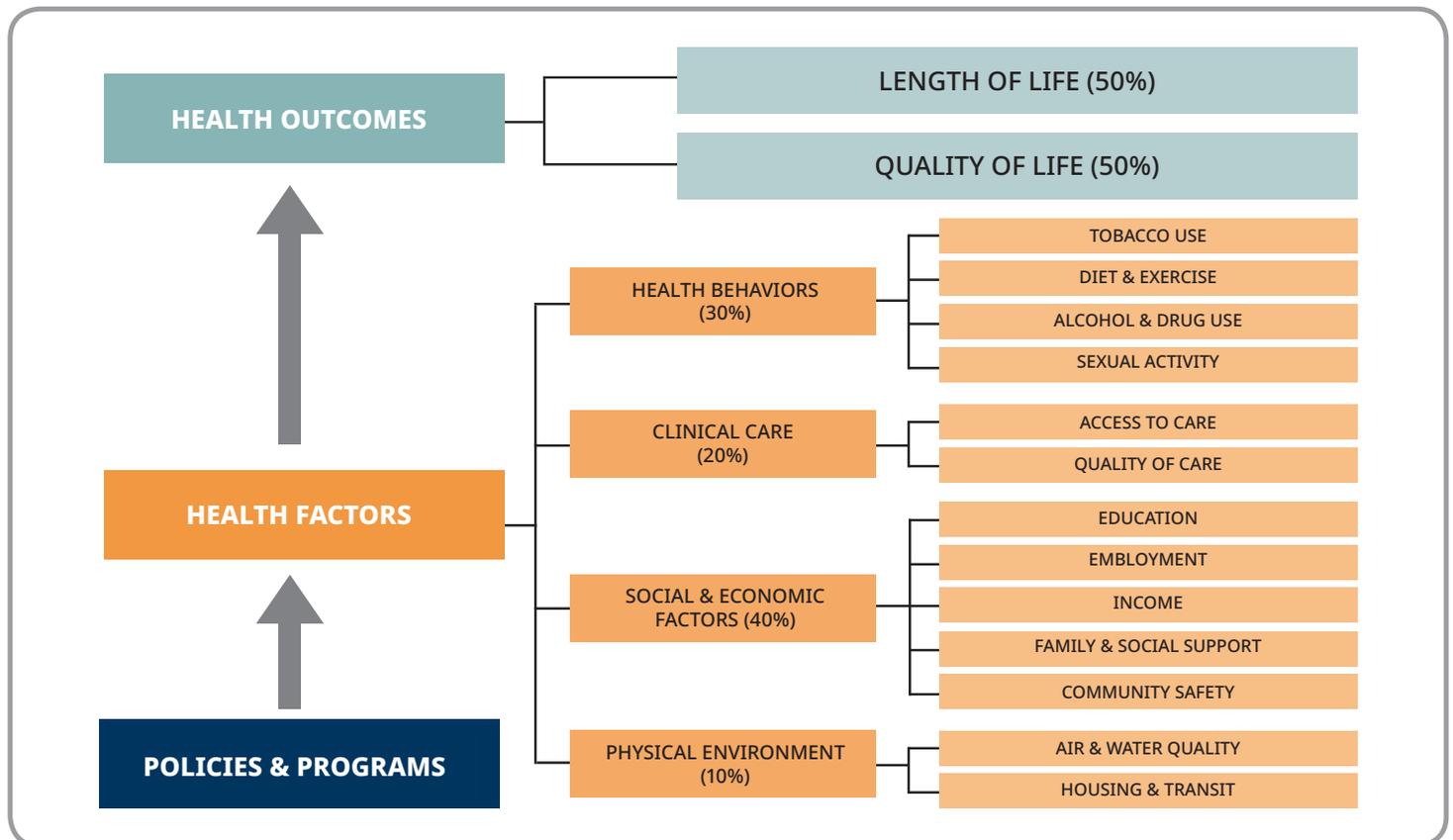
KEEPING PEOPLE HEALTHY REQUIRES ENSURING THAT THEY HAVE OPPORTUNITIES TO BE HEALTHY WHERE THEY LIVE, LEARN, WORK, AND AGE.

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.

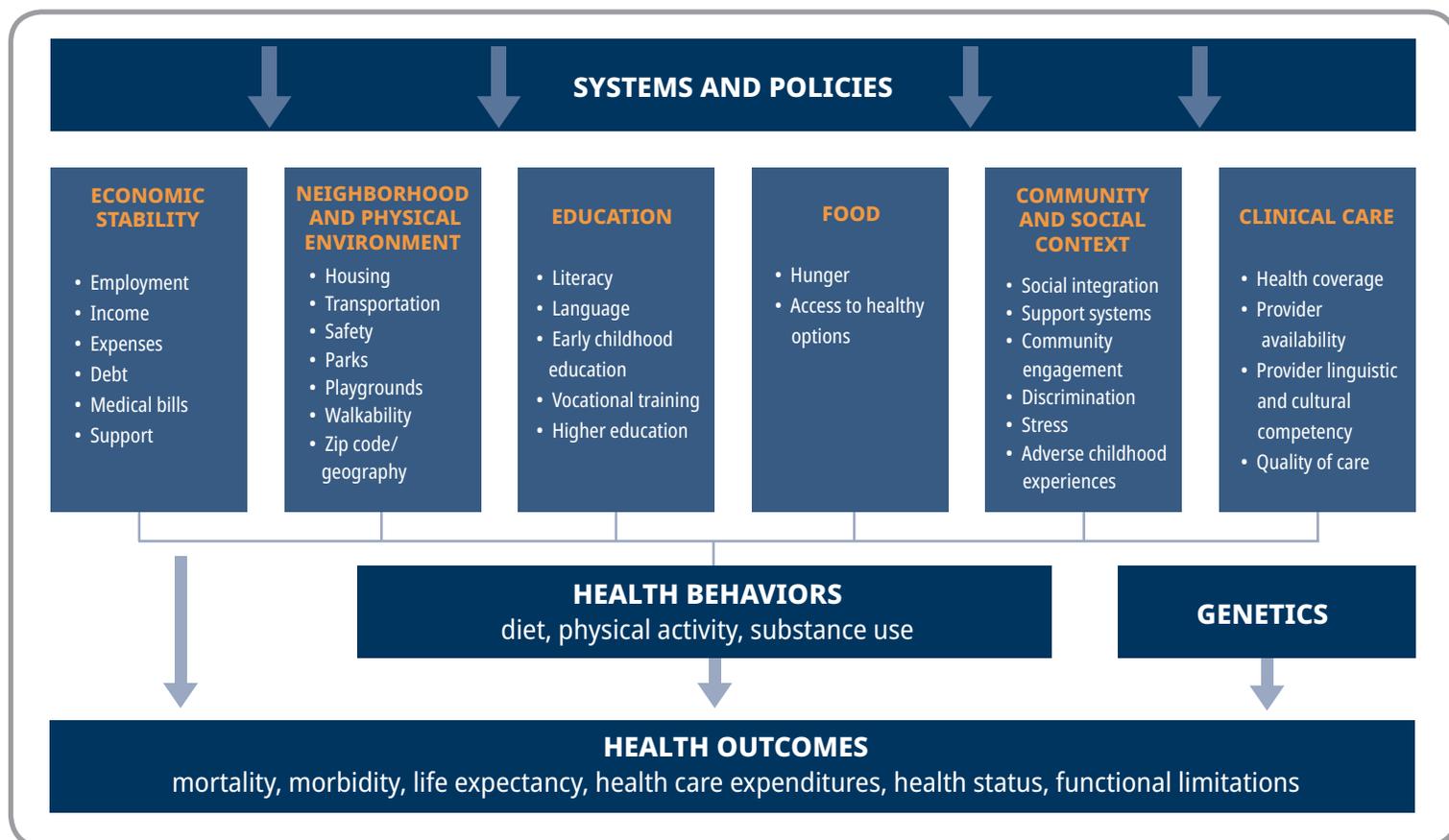
Many of the drivers of health have both independent and interactive effects. For example, people with higher incomes have more opportunities to live in safe and healthy homes near high-achieving schools. People with higher incomes generally have more opportunities

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

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.

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 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.

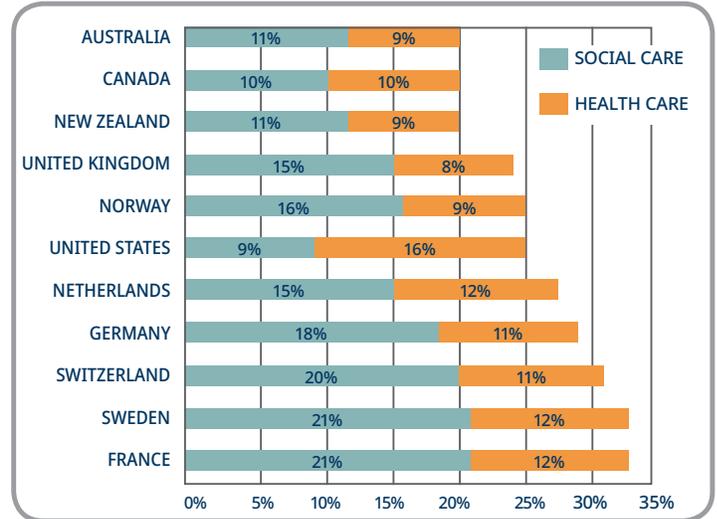
Higher Costs Driving Innovation

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

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.

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 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.

Work of Accountable Care Communities

In an ACC, multiple cross-sector stakeholders join to address health from a community perspective by forming a coalition that shares responsibility for addressing the drivers of health for a defined population within value-based care models. These stakeholders include, but are not limited to: community members, local health authorities, health care providers, insurance companies, employers, human services organizations, philanthropies, and representatives from sectors in the community that may have a role to play in affecting health and well-being needs [e.g., education, housing agencies, food pantries, legal aid, faith communities, social justice organizations, organizations with youth and family-based missions, law enforcement and corrections, parks and recreation, Area Agencies on Aging, advocacy organizations, domestic violence shelters, and homeless shelters].

To accomplish their goals, ACCs typically have the following core features:

- 1. Assessment of Community Health:** *analysis of community health issues to determine ACC priorities (i.e., what health issues and health-related social needs are most urgent in the community; which populations are at 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 recommend 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); 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 (identify 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.*

For more detailed information on these core features and resources for ACC development, please refer to *Partnering to Improve Health: A Guide to Starting an Accountable Care Community* (www.nciom.org/nc-health-data/guide-to-accountable-care-communities). It can be challenging to develop partnerships across various interests, come to consensus on community needs, and agree on a path forward. It may be helpful for communities to engage expert facilitators to facilitate these developmental discussions. In North Carolina, experienced facilitators can be found across the state, including Healthy Places by Design, the North Carolina Center for Health & Wellness, Resourceful Communities, and Rural Forward North Carolina, an initiative of the Foundation for Health Leadership & Innovation.

ACC Policy Advocacy: Health in All Policies

While much of the work of the Task Force was focused on how ACCs can implement effective individual-level interventions to address health-related social needs in their communities, ACCs should also take a public policy approach to address the causes of those needs. ACCs can work to integrate health and well-being into all areas of policymaking at the local and regional level by including representatives from local and tribal government sectors outside of health care, such as transportation, housing, and law enforcement. To encourage the consideration of how health is impacted by policies across sectors, the Task Force recommends:

RECOMMENDATION 2.1: PROMOTE HEALTH AND WELL-BEING IN ALL POLICIES

a) State and local health promotion, advocacy, systems change, and policy-oriented organizations, such as the North Carolina Healthcare Association, North Carolina Medical Society and other health professional associations, North Carolina Community Health Center Association, Care Share Health Alliance, the Foundation for Health Leadership & Innovation (including their Jim Bernstein Community Health Leadership Fellowship, Health ENC, NC Rural Health Leadership Alliance, and Rural Forward NC

initiatives), and the North Carolina Center for Health and Wellness should support:

- i) Strategies to encourage local health officials to engage in community development and planning in a diversity of sectors (e.g., transportation, housing, infrastructure) in order to integrate a health and well-being perspective in all areas of local policy development.
 - ii) The capacity of local government, in conjunction with local health departments, to use tools to evaluate the integration of health and well-being into all aspects of local policy development and/or readiness for Accountable Care Community development.
- b)** The University of North Carolina School of Government, in partnership with experts in health, health infrastructure of communities, health-related social needs, and health equity should:
- i) Incorporate training on the concepts of health and well-being in all policies, health equity, and the purpose and role of Accountable Care Communities into their training programs.
 - ii) Develop an inventory of examples of community government or agency policies outside the area of health care that were developed with an intentional focus, study, or discussion of how such policies would influence the health of the community.

ACCs Advancing Health Equity

As ACCs advocate for the consideration of health in all community policies, they should also consider and promote awareness for how policies affect health equity for all community members. One tool to evaluate the health equity of policies and programs is the Health Equity Impact Assessment, developed by NC Child, the Division of Public Health Women’s Health Branch, and the Office of Minority Health and Health Disparities. The assessment “provides a structured process to guide the development, implementation and evaluation of policies and programs in order to promote health equity and ultimately reduce disparities.”³¹ The Health Equity Impact Assessment process should include: experts who understand the research, policy, and practice behind the issue(s) to be assessed; people working on the ground to carry out the day-to-day work of a policy or program; consumers impacted by the policy or program; people who represent groups heavily impacted by the policy or program; people with influence to create change in the policy or program; community leaders; and professional advocates for the group or community impacted. Steps of the assessment include:

- *Describing the problem that a policy or program intends to address, intended groups it will serve, and outcomes it should achieve;*
- *Compiling and analyzing data on a problem across key demographic categories;*
- *Evaluating root causes or factors that may explain inequities in outcomes and which root causes the policy or program addresses;*
- *Determining impacts and unintended consequences of a policy or program;*

- *Identifying changes to promote health equity in a program or policy; and*
- *Monitoring impacts of changes made to a program or policy.*³²

As of this writing, the North Carolina Health Equity Impact Assessment is being tested with the North Carolina Department of Public Health’s Sickle Cell Request for Applications process and with the five lead health departments in the Improving Community Outcomes for Maternal and Child Health Initiative.³¹ Similar tools have been used around the country, including in the cities of Madison, Wisconsin and Seattle, Washington, as well as the Washington State Department of Health, to evaluate funding processes and hiring practices, among other purposes. As ACCs consider the health equity effects of their work and activities, they also can encourage local government agencies to complete assessments of their programs. Because of the importance of considering how policies and programs affect all people in a community, the Task Force recommends:

RECOMMENDATION 2.2: EVALUATE HEALTH EQUITY EFFECTS OF ACCOUNTABLE CARE COMMUNITIES AND COUNTY-BASED PROGRAMS AND ACTIVITIES

- a)** The North Carolina Office of Minority Health and Health Disparities should continue work to validate the Health Equity Impact Assessment for use in non-health sectors and publicize its use for a wide range of stakeholders.
- b)** Local Accountable Care Community models should evaluate the effects of Accountable Care Community-related programs and activities on the health equity of the community they serve.
- c)** County departments in all sectors (e.g., health, housing, transportation, etc.) should evaluate the health equity of programs and include community members and human services organizations in the process of completing the assessment.

Facilitating Collaboration

In order to address health and well-being in all sectors of policy and to achieve health equity, siloes of local systems and government must be connected. Collaboration across sectors is difficult in systems that have traditionally been siloed (e.g., health care, housing, transportation, education). Additionally, many of those who could be involved in ACCs are recipients of funding that comes through state agencies. These entities may not have a history of partnering or combining funding, however they are all stakeholders in the budgetary effects of health and health-related social needs. Often when different agencies try to work together, they are stymied by a lack of common methods, language, and outcomes, as well as strict financial restraints on how they can use funding. There is a need for leadership to develop an expectation that agencies work together.

Another factor essential to effective collaboration across sectors is common language or terminology when discussing problems, goals, methods, and outcomes. For example, in the education sector, differences in outcomes are labeled the “achievement gap,” while in public health they are referred to as “health disparities.” Professionals across sectors may have different understandings of terms like “result,” “indicator,” and “performance measure.”³³ Sharing common terms and definitions is essential to communication among partners to make a clear path for progress toward achieving goals.

With these considerations for building effective collaboration across sectors, the Task Force recommends:

RECOMMENDATION 2.3: PROVIDE GUIDANCE ON CROSS-AGENCY COLLABORATION TO ADDRESS DRIVERS OF HEALTH

a) Agency leaders and representatives from the North Carolina Departments of Health and Human Services, Commerce, Public Safety, Public Instruction, and Transportation, Hometown Strong, legislative leaders, and community representatives should convene to address barriers to collaboration at the state and local level. This leadership group should develop:

- i)** A vision, guidelines, and funding recommendations for how various state and local agencies could work together to address drivers of health and health equity in order to improve community health and well-being and enhance workforce development and economic prosperity.
- ii)** Templates of contracts with local agencies that reflect the priority of working across various community-based social service agencies that address health-related social needs and health equity.

b) Accountable Care Community partnerships should work to develop common language, common definition of terms, and common metrics to promote effective collaboration across sectors.

At the local level, leadership to develop an ACC model can come from a variety of sources, from community groups to health care systems. With the importance of involving stakeholders from local government, public health, health care systems, and the community, local health departments play a vital role in bringing these interests together, and in some cases may be the natural leader for ACC development. Additionally, local health departments are required to complete a Community Health Assessment every four years “to identify factors that affect the health of a population and determine the availability of resources within the county to adequately address these factors.”³⁴ This effort already involves collaboration of many of the stakeholders that should be partners in an ACC. Results help a community understand its strengths, health concerns, emerging health issues, and resources that are needed to address those concerns, all of which can be used to inform ACC efforts.³⁴ Once the Community Health Assessment is completed, a Community Health Action Plan is developed to address health issues that are community priorities. Because of the important role local health departments already play in

convening stakeholders for the Community Health Assessment process and the role they can potentially play in building an ACC model, the Task Force recommends:

RECOMMENDATION 2.4: SUPPORT LOCAL HEALTH DEPARTMENTS TO BE LEADERS IN ACCOUNTABLE CARE COMMUNITIES

a) The Division of Public Health, in partnership with the North Carolina Association of Local Health Directors and the North Carolina Institute for Public Health, should:

- i)** Train state, regional, and local public health leadership/staff on how to lead multi-sector partnerships and strategies to address drivers of health and health equity.
- ii)** Require local health departments to participate in community coalitions working to address drivers of health and health equity
- iii)** Encourage local health departments to, as needed, convene and facilitate community coalitions working to address drivers of health and health equity.
- iv)** Require local health departments, in collaboration with hospitals and health care systems serving the community, to include at least one driver of health priority in their Community Health Action Plan.

b) Local health departments should help to align the work of Accountable Care Communities with the community and county engagement strategies of Medicaid Prepaid Health Plans and other payers in their communities in order to save the time and resources of human services organizations and other community groups that partner in this process.

c) Philanthropies should provide funding support to local health departments that take on convening and facilitation roles as Accountable Care Communities are developing.

Hospital and Health Care System Role in ACCs and Population Health

Like many of the stakeholders important to an ACC, local hospitals and health care systems are traditionally siloed in cross-sector partnerships. Despite this arrangement, they can play a significant role as partners in ACCs by contributing their expertise in health care, financial and property resources, and influence on population health of the community. Non-profit hospitals can play a role in providing important community health data to a partnership. In order to retain their tax-exempt status, non-profit hospitals are required to complete a Community Health Needs Assessment every three years and provide charitable community benefits. Similar to the Community Health Assessment completed by local health departments, the Community Health Needs Assessment can be used by an ACC to understand community needs and inform its work.

To retain non-profit status, hospitals are required by the Internal Revenue Service to provide and report community benefits, which can include charity and subsidized care, participation in programs like Medicaid, health professions education, health services research, activities to improve community health, cash or in-kind donations to community

groups, and community building activities (e.g., investments in housing).³⁵ North Carolina state law requires reporting of community benefits as a condition of tax-free bond financing.³⁶ Community benefits are most commonly allocated to charity or other patient care, with one study of tax-exempt private hospitals finding 85.0 percent of community benefit expenditures going to these categories.³⁷ Of the remainder, 5.3 percent went to community health improvement and 2.7 percent to cash or in-kind contributions to community groups. ACCs could benefit from a broader allocation of community benefit dollars to these areas of funding that could support the development of ACC activities and/or the services provided to meet health-related social needs of individuals in the community. There are no reporting requirements for how community benefit dollars impact the health of the community. To assist communities in understanding the community benefits provided by hospitals and health care systems and to guide hospitals and health care systems toward identifying health-related social needs of the community, the Task Force recommends:

**RECOMMENDATION 2.5:
REPORT RESULTS OF HOSPITAL AND HEALTH CARE SYSTEM
COMMUNITY BENEFITS**

The North Carolina Hospital Foundation^f should collect information on the population health effects of the community benefit activities of non-profit hospitals and health care systems.

Standardizing Regions in North Carolina

One reason sectors have become siloed within the state and working together can be a challenge is that there are inconsistent regional areas for various state programs. For example, counties are grouped into 10 regions for local health departments, nine regions for Area Health Education Centers, and four service regions for Local Management Entity – Managed Care Organizations. Additionally, the state is transforming Medicaid to managed care (described in Chapter 3), and state law requires the designation of six Medicaid regions in North Carolina. For these reasons, the Task Force recommends:

**RECOMMENDATION 2.6:
ALIGN POLICIES FOR STATE DHHS REGIONS AND UNDERSTAND
IMPLICATIONS OF REGIONALIZED PROGRAMS ON ACC PARTNER
PARTICIPATION**

- a)** The North Carolina Department of Health and Human Services should review existing Department of Health and Human Services-supported regionalized programs and services and develop a plan to help mitigate the influence of the various regions on the investment decisions of Prepaid Health Plans and philanthropies.
- b)** Local community coalitions seeking to develop an Accountable Care Community should be aware of and understand the regional implications and competing regional concerns of Accountable Care Community partners whose work crosses boundaries of more than one Accountable Care Community.

**TO TAKE EFFECTIVE ACTION TO IMPROVE
COMMUNITY HEALTH, ACC PARTNERS
MUST UNDERSTAND THE NEEDS OF THE
COMMUNITY.**

**STRUCTURED DECISION-MAKING AND
ACTION PLAN DEVELOPMENT FOR ACCS**

To take effective action to improve community health, ACC partners must understand the needs of the community. A comprehensive assessment of community health and well-being will not only provide an overall picture of health in the community, it also will uncover the specific challenges among certain portions of the population. This evaluation can lead to more effective interventions, directed funding, and advocacy for policy change. Once the work of an ACC begins, evaluation of process, outcomes, and return on investment is critical for process improvement, re-investment, and strategic planning. Outcome evaluations within an ACC model that show positive improvements in health and return on investment can play a vital role in developing a sustainable funding strategy.

**Understanding Community Health Status:
Implementing and Aligning Community Health
Assessments**

Useful tools for understanding the health needs of a community include the Community Health Assessment (described earlier in this chapter), completed by local health departments, and the Community Health Needs Assessment, completed by nonprofit hospitals. These assessments have become more collaborative over time, and many counties are creating a single assessment cycle for both assessments, with hospitals and health departments building multi-sector teams of representatives from human services organizations and other entities to increase the assessments' reach into communities. In North Carolina, there are currently two networks coordinating their Community Health Assessment and Community Health Needs Assessment processes: WNC Health Network, a network of hospitals, public health agencies, and regional partners across 16 counties in the western part of the state³⁸ and Health ENC, an initiative of the Foundation for Health Leadership & Innovation and collaboration of health departments and hospitals across 33 counties in the eastern part of the state³⁹. These partnerships encourage direct cooperation and coordination between health care systems and local health departments.

With public health and hospital leaders as partners of an ACC, the local Community Health Assessment/Community Health Needs Assessment may naturally serve as the health assessment for an ACC initiative. In this case, an ACC can leverage the existing infrastructure for data collection and analysis and can add new depth to both quantitative and

^f The North Carolina Hospital Foundation is the non-profit affiliate of the North Carolina Healthcare Association.

qualitative data 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 Community Health Assessment and Community Health Action Plan can still be a key source of data for the ACC. Improvement strategies of the health departments or hospitals should be important considerations for any priorities that may emerge for an ACC.

As ACCs use the local Community Health Assessment to inform their work, they should evaluate how well health-related social needs have been integrated into the assessment and Community Health Action Plan. **RECOMMENDATION 2.4** calls on the NC Division of Public Health to require local health departments to collect health-related social needs data and to include at least one health-related social need as a priority in their Community Health Assessment. A study of the health priorities in Community Health Assessments between 2010 and 2015 found that only 17 of North Carolina's 100 counties prioritized a health-related social need.⁴⁰ ACCs can both encourage the collection of this information for the Community Health Assessment process and find information from other sources to inform the development of ACC work.

Moving from Assessment to Action

For an ACC, once the work of assessing the health and needs of a community is complete, the more challenging task of collective decision-making on priorities and interventions begins. Improving health outcomes and, thus, reducing health care spending in the community is a goal that many organizations can support. However, agreement about the more specific details of how to work together towards this common goal can be challenging. ACCs can be assisted in this process by using a structured format for decision-making, such as Results Based Accountability™. Currently in use throughout the country, including multiple community collaboration efforts in North Carolina, such as WNC Health Network, Results Based Accountability™ uses a structured approach by starting with the outcomes a community wants to achieve and working backward to understand the best methods to achieve those goals.

Collaborative Learning and Sharing

Communities around the state will develop ACCs in different ways and gather important lessons learned along the way. Bringing communities together to share these lessons and learn from each other can be a helpful way to disseminate knowledge and develop a sense of camaraderie. Learning collaboratives provide a mechanism for this sharing. Learning collaboratives are groups of peers that meet virtually and/or in person and participate in peer-to-peer and/or expert-to-peer discussions about a topic.⁴¹ These collaboratives could be used to provide education related to topics important to ACC development, and to create opportunities for community leaders to share examples of work they have done and ask questions about what others have experienced.

To help ACCs with the work of developing a shared vision and prioritizing health outcomes, as well as other challenges described in this chapter, the

COMMUNITIES AROUND THE STATE WILL DEVELOP ACCS IN DIFFERENT WAYS

Task Force recommends:

RECOMMENDATION 2.7: PROVIDE TECHNICAL ASSISTANCE TO ACCOUNTABLE CARE COMMUNITIES

a) The North Carolina Center for Health and Wellness, North Carolina Healthcare Association, the Foundation for Health Leadership & Innovation (including their Health ENC and Rural Forward NC initiatives), North Carolina Area Health Education Centers, WNC Health Network, state universities and community colleges, the North Carolina Division of Public Health, the North Carolina Medical Society and other health professional associations, state and local Chambers of Commerce, and state and local Councils of Government should:

- i)** Host or support training on a structured format for decision-making (e.g., Results Based Accountability™ or similar models), for organizations and local government agencies interested in using these methods in their Accountable Care Community development process, or
- ii)** Facilitate conversations with Accountable Care Community partner organizations around alignment of goals and sustainability of work.

b) The North Carolina Medical Society and the North Carolina Healthcare Association, with representation from the Foundation for Health Leadership & Innovation (including their NC Rural Health Leadership Alliance initiative), Care Share Health Alliance, North Carolina Area Health Education Centers, and other partners, should convene learning collaboratives for health care systems, communities, businesses, payers (including private insurers, Medicaid, and Prepaid Health Plans), and providers to support the development and implementation of Accountable Care Communities. These learning collaboratives should include discussions of evidence-based interventions and continuous quality improvement, as well as topics such as:

- i)** Coalition development,
- ii)** Shared goal setting,
- iii)** Backbone organization/team support,
- iv)** Health equity,
- v)** Methods for implementation, data sharing, outcomes/evaluation,
- vi)** Legal considerations, technology needs, financing, organizational/administrative needs, and
- vii)** Developing and financing sustainable payment models.

States are heavily involved in the health and well-being of their residents. Financially, the biggest state investment in health is the provision, in partnership with the federal government, of health care coverage to residents enrolled in Medicaid and Children’s Health Insurance Programs. States also provide many other health services including insurance for state employees, family members, and retirees; services and supports for populations with special health needs and some uninsured patients; oversight of insurers, health service providers, and health care facilities; and the provision of services and programs to promote health and well-being and protect communities from communicable diseases, epidemics, and contaminated food and water. As the largest payer of health care coverage in North Carolina, the state has a vested interest in keeping residents healthy. Additionally, a healthy population is needed to keep and attract businesses, which is critical to the economic well-being of the state.

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 healthcare system.”⁴² To do this, NC DHHS has created a statewide framework for healthy opportunities⁹ that includes:

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.*^{42,43}

Realizing the overall vision of NC DHHS to create healthy opportunities will require health care payers and providers, human services organizations, and other stakeholders 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.

Assessing Health-Related Social Needs

Successfully addressing health-related social needs and maximizing opportunities to be healthy will require a system where unmet needs are identified and a process is in place to meet those needs. The first

CREAT[ING] HEALTHY OPPORTUNITIES WILL REQUIRE HEALTH CARE PAYERS AND PROVIDERS, HUMAN SERVICES ORGANIZATIONS, AND OTHER STAKEHOLDERS TO WORK TOGETHER IN NEW WAYS

step in such a system typically requires systematic screening to identify unmet needs. The Institute of Medicine⁴⁴ and the American Academy of Pediatrics⁴⁵ have policy statements supporting the use of screening for health-related social needs. Many health care and social service organizations have incorporated screening into their work, particularly for health behavior issues like tobacco, alcohol, and substance use, physical activity, and diet, as well as behavioral/mental health and social isolation/support.⁴⁶

Screening for health-related social needs is not as common in clinical settings; however, some health care providers have begun to incorporate these issues into their screening process. For example, clinical partners of Health Leads, including Johns Hopkins Bayview Medical Center in Baltimore, Maryland, Rainbow Babies & Children’s Hospital in Cleveland, Ohio, and Bellevue Hospital Center in New York, New York have incorporated the Health Leads Screening Tool into patient care.⁴⁷ The tool covers domains like food insecurity, housing instability, exposure to violence, and utility needs.⁴⁶ The Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) was developed for use in community health centers. Included in PRAPARE’s core measures are housing status/stability, education, employment, income, transportation, social integration/support, and stress.⁴⁸ PRAPARE is already in use in several community health centers across the state to help connect patients with identified needs to appropriate resources.

One of the approaches the NC DHHS is taking to incorporate and address the effects of health-related social needs in all patients’ care is the development of a set of standardized screening questions. This set of questions, developed by a group of stakeholders representing public health, health care, and sectors related to health-related social needs, incorporates tested and standardized items from existing screening tools (e.g., PRAPARE, Health Leads, and items standardized for use in multiple tools). At this writing, the set of questions is in draft form and is

SUCCESSFULLY ADDRESSING HEALTH-RELATED SOCIAL NEEDS AND MAXIMIZING OPPORTUNITIES TO BE HEALTHY WILL REQUIRE A SYSTEM WHERE UNMET NEEDS ARE IDENTIFIED AND A PROCESS IS IN PLACE TO MEET THOSE NEEDS.

⁹ More information about NC DHHS Healthy Opportunities is available online at <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities>.

undergoing field testing at 21 clinical sites.⁴⁹ The proposed screening tool contains nine questions (see **Figure 5**) across four of the state’s priority domains: food, housing/utilities, transportation, and interpersonal safety. There also are three optional questions about the nature of the needs and whether help is wanted to address those needs.⁵⁰ Asking about preferences for help is an important way to make the screening process more person-centered and to avoid assumptions about what that individual wants or needs.⁵¹ One study found that as few as 15 percent of people with one or more health-related social needs actually wanted help to address that need.⁵²

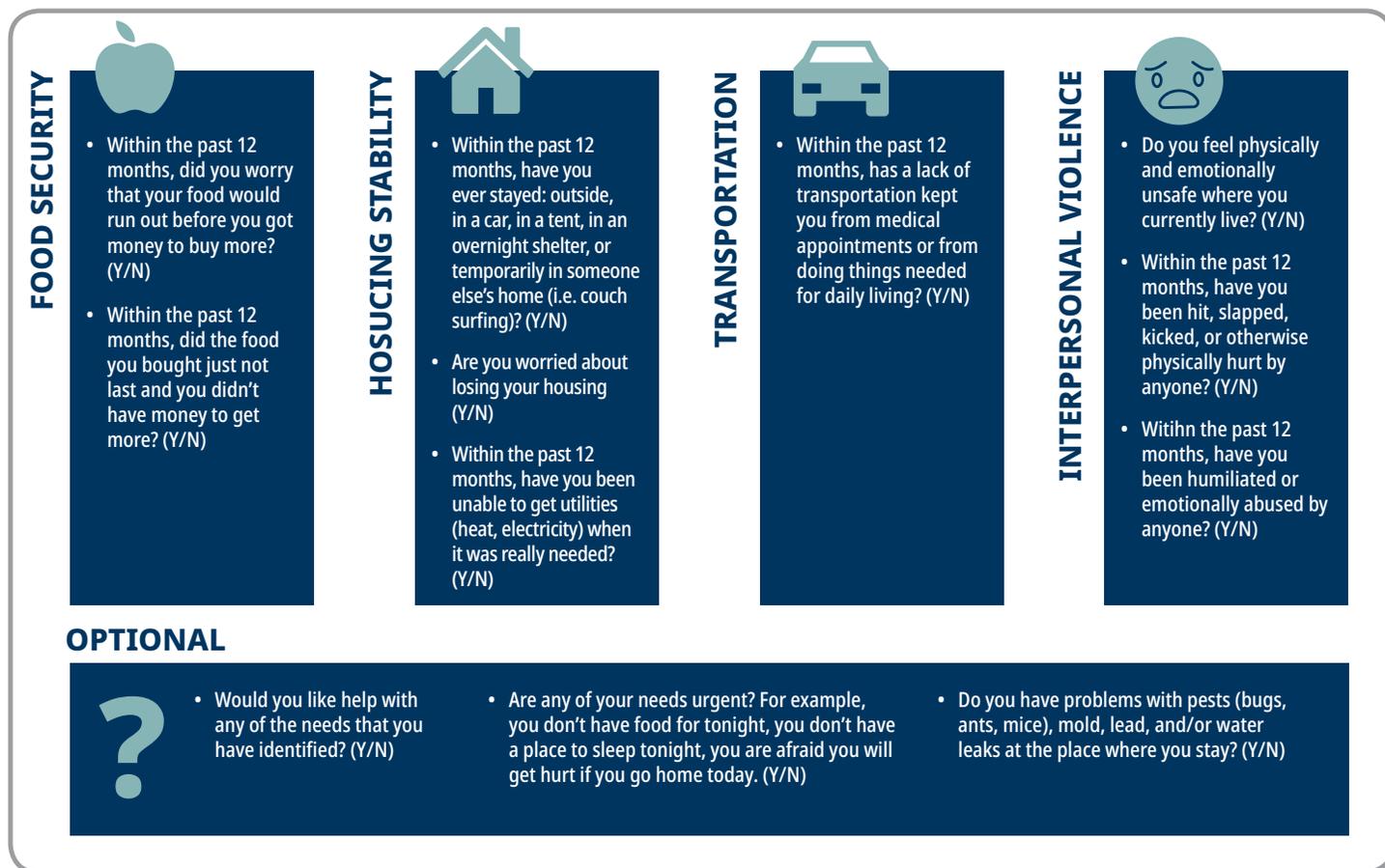
The NC DHHS also has developed a list of optional screening domains and questions covering community safety, housing quality, health care/medicine, mental health/substance use, family/social supports, child care, emotional wellness/stress, education, health literacy/communication/language/culture, employment, income, immigration, legal/correctional, and secondary assessments of housing needs and intimate partner violence.⁵³ These serve as optional items for individual providers or organizations to include in their screening protocols based on the

populations they serve. NC DHHS intends for health care providers, payers, and human services organizations across the state to incorporate the standardized screening questions into their work with patients and community members.

Referring Individuals for Help Meeting Needs

Once individuals have been screened for health-related social needs, a plan should be in place for helping them find resources to meet those needs. Coordination of referrals for resource needs can span the spectrum from printing out a list of community resources to full case management that includes numerous check-ins on the status of a referral and documentation when a connection to resources has been completed. Many resource referral mechanisms and technologies have been developed to meet these needs, from Aunt Bertha, a customizable web-based platform, to 2-1-1, a call center that uses live call specialists to help connect individuals with resources. This coordination has led to a wide variety of approaches across stakeholders serving people with health-related social needs, even within the same community.

Figure 5. State Standardized Screening Questions



Source: NC DHHS. Updated Standardized Screening Questions for Health-Related Resource Needs. July 9, 2018. <https://files.nc.gov/ncdhhs/Updated-Standardized-Screening-Questions-7-9-18.pdf>

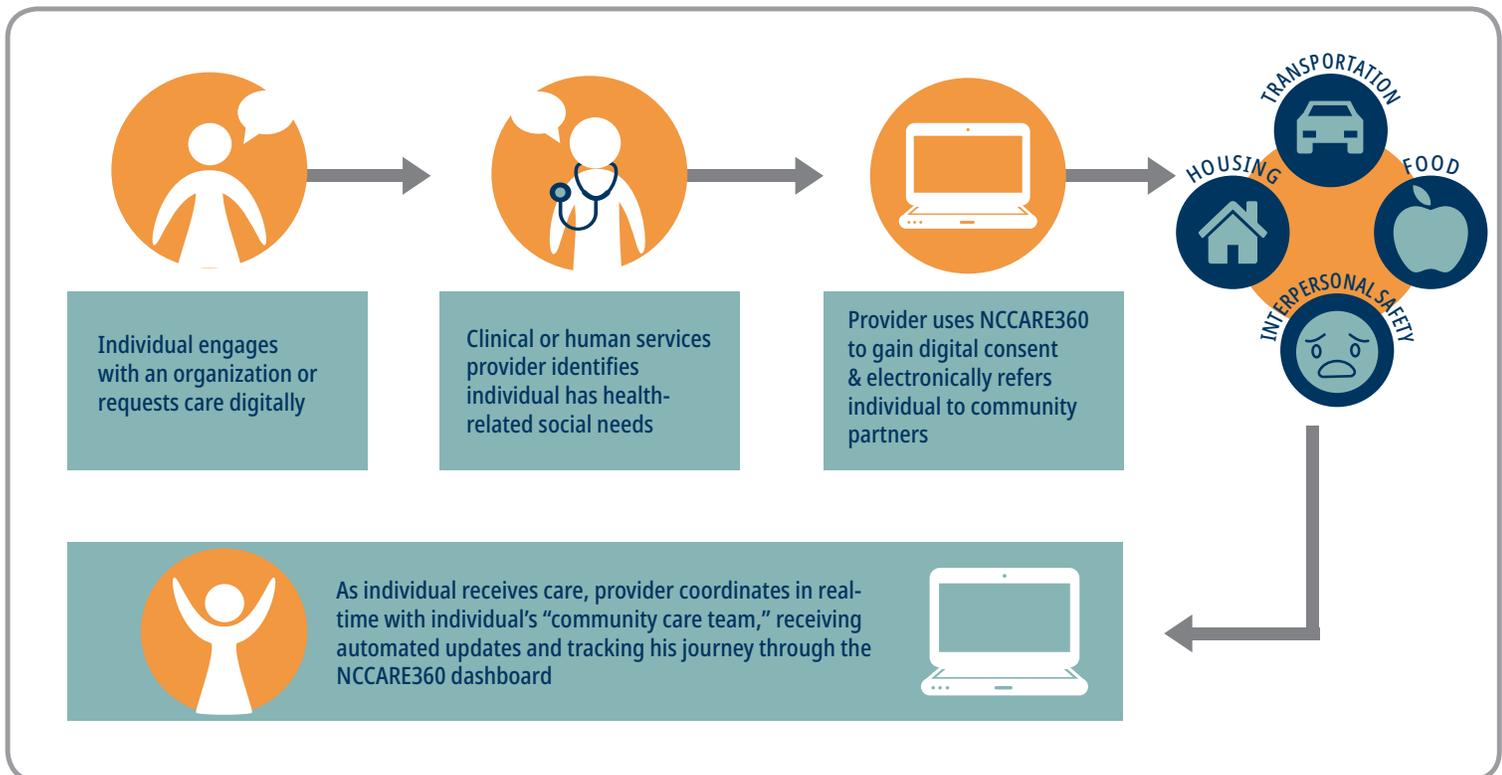
To address this issue, NC DHHS is supporting the development and implementation of the NC Resource Platform called NCCARE360. NC DHHS entered into a public-private partnership with the Foundation for Health Leadership & Innovation to develop and implement NCCARE360. The organizations selected to develop the platform are United Way of NC/ NC 2-1-1, Expound, and Unite Us. Together, the Foundation for Health Leadership & Innovation, NC DHHS, and the developers make up the NCCARE360 partners. The goal is to develop a tool “to make it easier for providers, insurers and human services organizations to connect people with the community resources they need to be healthy.”⁵⁴ NCCARE360 will be available and subsidized for all communities in North Carolina for at least the first five years. It is intended to initially serve as a web-based portal to connect all types of organizations from large health care systems and insurers to human services organizations and individual human service providers. As implementation progresses, it is anticipated that interfaces will be made with other information technology platforms (e.g., electronic health records, human services software, NC HealthConnex). The platform will integrate NC DHHS’ standardized screening questions, a statewide robust resource directory, and a referral and outcome tracking platform. While the full resource directory will be accessible to all users from the beginning, in its first phase, the focus areas for onboarding resources to the referral and outcome platform of NCCARE360 will be the NC DHHS priority domains of food security, housing stability, transportation, and interpersonal safety. More resources will be onboarded onto the referral and outcome platform as implementation proceeds.

NCCARE360 WILL MAKE IT EASIER FOR PROVIDERS, INSURERS AND HUMAN SERVICES ORGANIZATIONS TO CONNECT PEOPLE WITH THE COMMUNITY RESOURCES THEY NEED TO BE HEALTHY.

With the goal of a coordinated, no-wrong-door-style approach, individuals and organizations will be able to access information about community resources. Individuals can even start the referral process on their own. The platform can help organizations engaging clients to address health-related social needs communicate with one another and may help consolidate coordination efforts. Referrals through the platform will require consent by the individual being served and can be made using a variety of methods (e.g., pen and paper, voice recording, text message).⁵⁵ The NC 2-1-1 call center will enhance its current services in coordination with the platform to provide text and chat capabilities and employ navigators to assist individuals seeking services. **Figure 6** shows the process of accessing services using the platform when an organization identifies an individual’s need(s).

NCCARE360 WILL FACILITATE THE SCREENING AND REFERRAL PROCESS AND DATA TRACKING NECESSARY FOR HIGH-FUNCTIONING ACCS

Figure 6. Process of accessing resources using NCCARE360



Mapping Health-Related Social Needs in Communities

NC DHHS recognizes the need to provide more information to help communities around the state understand the health-related social needs of their citizens. With this in mind, a web-based mapping tool called North Carolina Social Determinants of Health by Regions has been created and is supported by the State Center for Health Statistics.⁵⁶

This tool maps drivers of health, including economic factors, housing and transportation, social and neighborhood resources, and an index measuring overall health-related social needs of communities. **Figures 7a and 7b** show how this tool can depict health-related social need variations from one neighborhood or community to another.

Figure 7a. Overview statistics for NC Local Health Department Regions (e.g., age, gender, race)

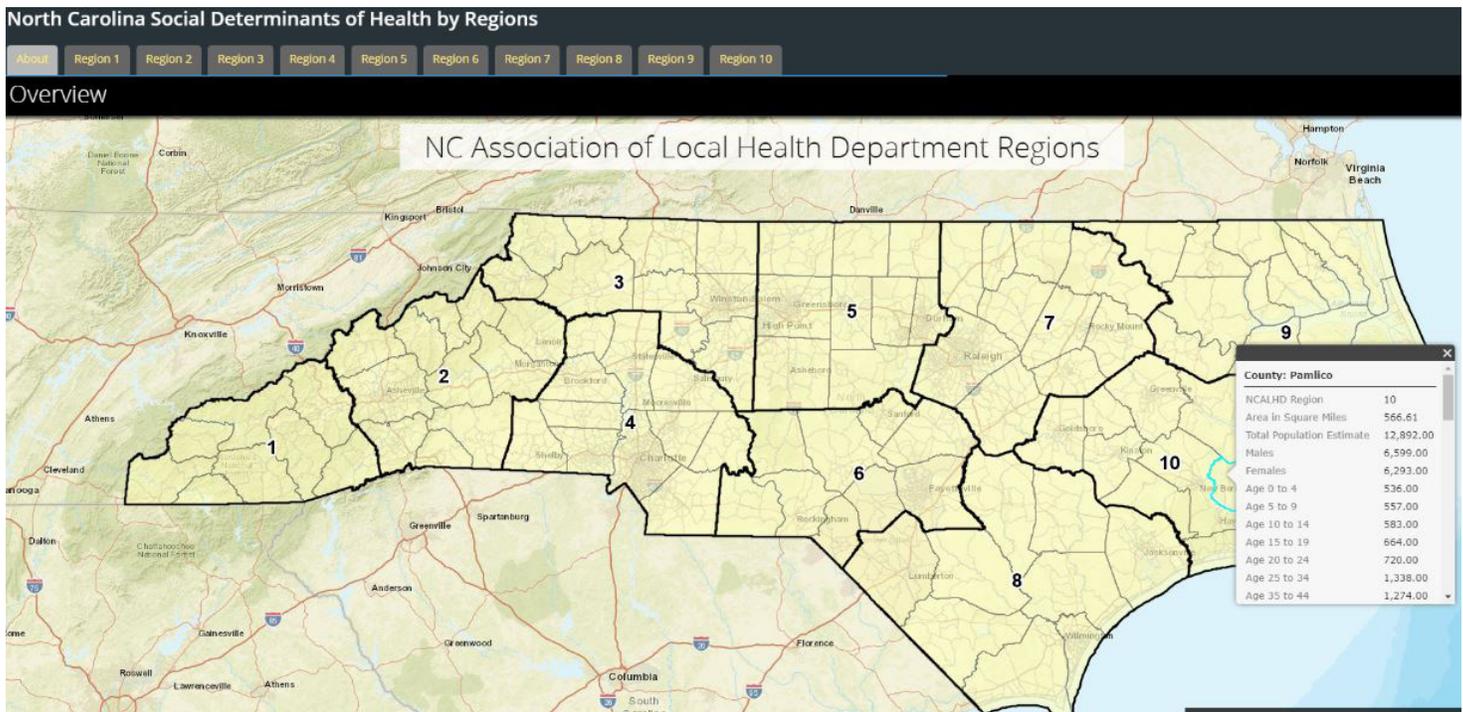
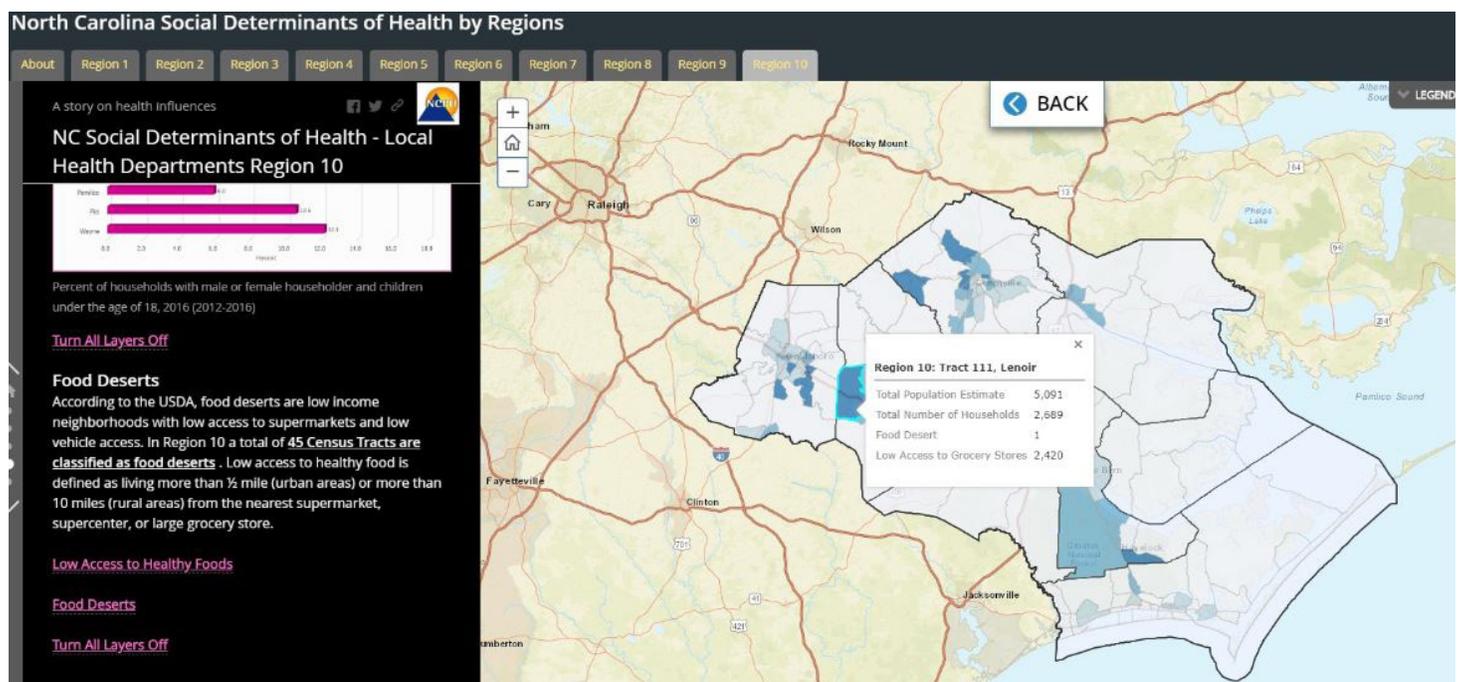


Figure 7b. Specific Social Determinant Data at Census Tract Level (e.g., food insecurity)



Community Health Worker Initiative

Since 2015, NC DHHS has been investigating the status of the community health workforce in the state through the Community Health Worker Initiative. The contributions of community health workers (described in further detail in Chapter 4) can be a great asset when attempting to address individuals' health-related social needs. Starting with identification and description of existing community health worker programs and a survey of workers, the Initiative conducted workgroups, a summit, and listening sessions to develop recommendations for improving and supporting the infrastructure for the profession. In May 2018, the Initiative's final report⁵⁷ was published outlining the three primary recommendations:

1. **Defined roles and responsibilities regardless of the setting a community health worker operates in,**
2. **Core competencies that community health workers should have and curriculum integral to their professional education, and**
3. **Certification requirements and processes to help standardize training and increase professional credibility.**

In order to guide the process for accomplishing these goals, the Initiative recommended the creation of a North Carolina Community Health Worker Certification and Accreditation Board.

Medicaid Transformation

In 2015, the North Carolina General Assembly passed legislation^h to transform the state Medicaid and NC Health Choice programs. The goals of Medicaid transformation were to “(1) Ensure budget predictability through shared risk and accountability. (2) Ensure balanced quality, patient satisfaction, and financial measures. (3) Ensure efficient and cost-effective administrative systems and structures. (4) Ensure a sustainable delivery system.” To meet these goals, the NC DHHS submitted a Section 1115 Medicaid Demonstration waiver to the federal Centers for Medicare & Medicaid Services to request permission to shift Medicaid from a “fee-for-service” system to a “managed care” delivery system. A goal of the state's overall Healthy Opportunities vision is to develop innovative approaches to foster “strategic interventions and investments in...food, housing, transportation, and interpersonal safety...[that] will provide short and long-term cost savings and make our health care system more efficient.”⁵⁸ Strategies to do this have been incorporated into the state's 1115 Medicaid Waiver. The Centers for Medicare & Medicaid Services approved the waiver on October 24, 2018.

Under Medicaid transformation, NC DHHS will remain responsible for the Medicaid and NC Health Choice programs but will contract with Prepaid Health Plans to provide managed care services to most individuals enrolled in Medicaid. Prepaid Health Plans will be required to screen all

HEALTHY OPPORTUNITIES PILOTS, WILL ALLOW NC DHHS TO TEST A FORM OF AN ACC-STYLE MODEL WITH A POPULATION ENROLLED IN MEDICAID AND UTILIZE MEDICAID FUNDING TO PAY FOR HEALTH-RELATED SOCIAL SERVICES.

enrollees using the state's standardized screening questions and use NCCARE360 to connect those with needs to resources.⁵⁹ Results will be shared with primary care providers. Prepaid Health Plans will receive per member per month payments that will support the implementation of screening, referral, navigation assistance (in the form of care management for some populations), and follow-up. Plans will be required to track data needed to assess whether interventions to address health-related social needs create positive health outcomes and/or reduce costs.

Healthy Opportunities Pilots

North Carolina's 1115 Medicaid Waiver also includes public-private pilots designed to allow more substantial investments in non-clinical health-related services with the explicit goal of learning how to finance 'health' interventions and incorporate them into value-based payments.^{60,61} These pilots, referred to as Healthy Opportunities Pilots, will allow NC DHHS to test a form of an ACC-style model with a population enrolled in Medicaid and utilize Medicaid funding to pay for health-related social services. The primary difference from other ACC models is that an ACC typically incorporates a broader network of payers, local government, and organizations that address non-clinical social needs outside of the state's priority domains (i.e., food, housing, transportation, and interpersonal safety).

These pilots will be conducted in two to four “regions” of the state. Funding for each pilot will come from both public and private (e.g., philanthropic) sources. For the purposes of the pilots, a region is defined as at least two contiguous counties that cover both rural and urban areas. Pilot regions will not have to encompass the entirety of any of the six planned Medicaid regions⁶² and any one pilot region cannot cross a Medicaid regional boundary. The pilots will involve partnerships and payments to provide medical and non-medical care to address health-related social needs through evidence-based interventions (e.g., housing transition or tenancy sustaining services, targeted meal delivery services, transportation to health-related and social services, and home visiting programs and parent support). The pilots will focus on certain high-risk, high-needs individuals who meet both health risk and social risk factor criteria.⁶¹

^h SL 2015-245 and SL 2016-121

Pilot funding will cover both capacity-building activities and service provision. Areas participating in the pilots must meet the following objectives:

- *“Increase integration among health and social services entities.*
- *Improve health care service utilization and/or health care costs for target population.*
- *Improve health outcomes for target population.*
- *OPTIONAL: Improve general well-being and reduce non-health care costs for target population.”⁶⁰*

Organizational participants in the Healthy Opportunities pilots will include prepaid health plans, health care providers, behavioral health agencies or providers, public agencies (e.g., local health department or department of social services), and community partners (e.g., philanthropies or human services organizations). Prepaid Health Plans will serve several roles in the pilots, including:

1. *Identifying beneficiaries eligible for the pilots through the care management process,*
2. *Assessing beneficiaries for health-related social needs and connecting them to pilot services,*
3. *Managing funds allocated for providing pilot services to enrolled beneficiaries, and*
4. *Collecting and submitting data to assist with rapid-cycle evaluation of the pilots.⁶³*

A Lead Pilot Entity for each pilot will serve as an NC DHHS contact and coordinator of pilot partners, finances, and required reports.⁶¹ Lead Pilot Entities will be responsible for:

1. *Developing a network of human services organizations (i.e., organizations that will provide pilot services), including training and management of pilot activities,*
2. *Convening pilot stakeholders, including Prepaid Health Plans, human services organizations, and health care providers,*
3. *Managing payments from Prepaid Health Plans and making payments to human services organizations that provide pilot services,*
4. *Providing technical assistance to human services organizations and*
5. *Collecting and submitting data to assist with rapid-cycle evaluation of the pilots.⁶³*

Finally, human services organizations involved in the pilots will have several responsibilities:

1. *Contracting with the Lead Pilot Entity; only organizations that have a contract can provide pilot-related services,*
2. *Participating in educational and training activities related to the pilots and convenings of pilot stakeholders,*
3. *Delivering services to pilot enrollees,*
4. *Tracking and billing for services provided to pilot enrollees and*
5. *Collecting and submitting data to assist with rapid-cycle evaluation of the pilots.⁶³*

NC DHHS has released a Request for Information and will release a Request for Proposals in mid-2019. Lead Pilot Entities will be selected toward the end of 2019 and have a year of implementation planning before service delivery begins in late 2020.⁶³ The pilots will last five years. Over the course of the pilot, payments to Prepaid Health Plans and Lead Pilot Entities for pilot services will increasingly be linked to operational ability, enrollees' health outcomes and healthcare costs through various value-based payment arrangements, including incentives, withholds, and shared savings.¹

To ensure the success of the Healthy Opportunities pilots, the Task Force recommends:

RECOMMENDATION 3.1: PROVIDE TECHNICAL ASSISTANCE TO HEALTHY OPPORTUNITIES PILOTS

The North Carolina Department of Health and Human Services, in collaboration with other relevant state agencies such as the Departments of Transportation, Public Instruction, and Commerce, the Housing Finance Agency, and North Carolina philanthropies should provide or support technical assistance for participants in the Medicaid Healthy Opportunities pilots in order to build capacity for cross-sectoral collaborations to improve health including:

- a) Network development,
- b) Health equity,
- c) Methods for implementation, data sharing, outcomes/evaluation,
- d) Technology needs,
- e) Legal considerations, financing, organizational/administrative needs, and
- f) Developing and financing sustainable payment models.

ⁱ More information about the Healthy Opportunities Pilots is available in the Healthy Opportunities Pilots Fact Sheet at <https://files.nc.gov/ncdhhs/SDOH-HealthyOpptys-FactSheet-FINAL-20181114.pdf>.”

Ensuring Cross-Sector Understanding and Support for NC DHHS Vision

NC DHHS efforts to ensure opportunities for health for everyone in North Carolina span a wide range of activities and involve stakeholders across a variety of sectors. To provide shared understanding of the NC DHHS vision for healthy opportunities for all North Carolina residents, the Task Force recommends:

RECOMMENDATION 3.2: DEVELOP STAKEHOLDER SUPPORT FOR STATE HEALTHY OPPORTUNITIES INITIATIVES

- a) The North Carolina Department of Health and Human Services, with other partners, should educate enrollment brokers, payers, health care systems, providers, and human services organizations about the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360.
- b) State health and social service membership organizations should:
 - i) Ensure there are in-person and virtual training opportunities for health and human service professionals about the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360.
 - ii) Partner with the North Carolina Department of Health and Human Services and North Carolina Area Health Education Centers to develop practice supports and implementation plans related to the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360 for health care systems and providers.

Resources for Accountable Care Communities

Much of the work of an Accountable Care Community (ACC) relies on effective communication among partners, as well as strong data collection and analytics capabilities. Information technology (IT) infrastructure is key to achieving both aims. When implementing a screening and referral system, IT systems can help streamline the screening process, connect people to needed resources, collect data on the outcomes of the referral process, and allow partners to communicate about individuals receiving services. Taken together, the state standardized screening questions and NCCARE360 (see Chapter 3 for descriptions) can provide the technical backbone for these important ACC efforts.^j The time, effort, and expense required for local ACCs to review the variety of existing screening and referral tools and agree on a path forward can be saved by using these state-developed resources. These resources also have the added benefit of providing systems that facilitate communication and coordination between health care and human services organizations. Because of the important role these resources play in assessing and addressing health-related social needs and the potential unified, statewide approach they provide, the Task Force recommends:

RECOMMENDATION 4.1: DEVELOP AND DEPLOY THE STANDARDIZED SCREENING QUESTIONS AND NCCARE360

- a) The North Carolina Department of Health and Human Services should finalize and publish the standardized screening questions, as planned.
- b) NCCARE360 partners, in developing and deploying NCCARE360, should:
 - i) Seek input from members of the community, human services organizations, and health care providers (including care managers) on the direction, alignment, and implementation of NCCARE360, as well as the curation of resources available on the Platform.
 - ii) Implement plans to ensure the platform:
 1. Integrates the standardized screening questions.
 2. Is available for use by health care and social service providers, individuals, and others who may screen and refer for health-related social needs.
 3. Updates human services organization information and public benefit eligibility with up-to-date information to ensure the platform is current and usable for providers and patients.
 4. Allows human services organizations to submit or update information about their services and capacity to serve clients.
 - iii) Implement their minimum data security qualifications for organizations interested in sharing individuals' data related to health-related social needs.

MUCH OF THE WORK OF AN ACCOUNTABLE CARE COMMUNITY (ACC) RELIES ON EFFECTIVE COMMUNICATION AMONG PARTNERS, AS WELL AS STRONG DATA COLLECTION AND ANALYTICS CAPABILITIES.

- iv) Provide education, in-person training, and technical assistance to human services organizations around NCCARE360's purpose, implementation, and on-boarding.
- v) Develop an Advisory Council to provide a voice to stakeholders in the development and deployment of NCCARE360.
- vi) Develop outreach plans and training materials for marketing and education on the purpose and features of the platform and should seek input from human services organizations, users, health care providers, and other stakeholders on these plans and materials.

Screening for health-related social needs is a sensitive matter that should involve considerations of trust and privacy. To have a successful screening process, individuals being screened need to trust that their information is safe and will be shared in a limited way to improve their health or access to services. Screening should be non-judgmental, performed by trained staff, offered in private settings, and enhance access to services. National standards for privacy of patient data are detailed in the Health Insurance Portability and Accountability (HIPAA) Act of 1996. HIPAA covered entities (i.e., health plans, clearinghouses, and certain health care providers) must follow strict privacy rules with patient information.

NCCARE360 has embedded plain-language informed consent into the platform and consent is required for information exchange within the platform. Payers, health care providers, and human services organizations will also need to consider what additions may need to be made to their regular informed consent procedures to account for new screening and resource referral efforts. To ensure that individuals screened for health-related social needs understand the purpose of the screening and how their information may be shared, the Task Force recommends:

RECOMMENDATION 4.2: ENSURE INDIVIDUALS ARE INFORMED ABOUT PERSONAL DATA COLLECTION AND SHARING

- a) Prepaid Health Plans, private insurers, the State Health Plan, health care providers, and human services organizations should ensure that guidelines around informed consent are followed before sharing client information collected through the standardized screening questions or NCCARE360. This includes informed consent in plain language that describes how the information will be used, how it may be shared, and with whom it may be shared with (e.g., Prepaid Health Plans, providers, human services organizations).

^j NCCARE360, NC Resource Platform is one part of NC DHHS' infrastructure for creating "Healthy Opportunities" for all North Carolinians. See Chapter 3 for more information.

b) The North Carolina Department of Health and Human Services should require Prepaid Health Plans to use plain-language informed consent prior to sharing information collected by the standardized screening questions with a non-Health Insurance Portability and Accountability Act (HIPAA) covered entity (if not completing screening through NCCARE360).

c) Private insurers, the State Health Plan, health care providers, and human services organizations should use plain-language informed consent prior to sharing information collected by the standardized screening questions, if one of the entities is not a Health Insurance Portability and Accountability Act (HIPAA) covered entity (if not completing screening through NCCARE360).

The greater the adoption of the standardized screening questions and NCCARE360 among health care providers and systems, human services organizations, ACCs, and other stakeholders, the more streamlined efforts will be to address health-related social needs. By providing a subsidized system, the organizations involved, including NC DHHS, expect NCCARE360 to become a shared utility that is used by all of these stakeholders. Consistent approaches to screening and referral throughout the state will make it easier for providers and clients who live and work across communities to navigate systems to address health-related social needs. Therefore, the Task Force recommends:

**RECOMMENDATION 4.3:
IMPLEMENT SCREENING AND REFERRAL PROCESS ACROSS HEALTH CARE PAYERS, PROVIDERS, HUMAN SERVICES, AND SOCIAL SERVICE ENTITIES**

a) To ensure people are both screened and connected to appropriate community resources and to maximize efficiencies across the state, all Accountable Care Community partners should:

- i)** Use the standardized screening questions and NCCARE360.
- ii)** Review the optional domain items identified by the North Carolina Department of Health and Human Services and determine what items are appropriate to include with the core measures of the North Carolina standardized screening questions for populations in their community.

b) To facilitate the use of the standardized screening questions and NCCARE360, the North Carolina Department of Health and Human Services should:

- i)** Require screening of enrollees in Prepaid Health Plans, as stated in the Request for Proposals for Prepaid Health Plan Services.⁶⁴
- ii)** Require Prepaid Health Plans to share results of the standardized screening questions with Advanced Medical Homes for individuals receiving care management through those practices, as stated in the Request for Proposals for Prepaid Health Plan Services.
- iii)** Encourage use of the screening questions by:
 1. All individuals applying for public benefits.
 2. All enrollees in traditional Medicaid.
 3. All individuals enrolled in Advanced Medical Home practices.

NCCARE360 WILL BE A SHARED UTILITY THAT IS USED BY ALL STAKEHOLDERS.

iv) Support NCCARE360 developers as they work with providers and community agencies to develop and adopt protocols and work flows for using the Platform to address the needs of, and ensure follow-up with, individuals whose screening results indicate they could benefit from additional resources.

c) Medicaid insurers, private insurers, the State Health Plan, the NC Navigator Consortium, health care systems, independent providers, local health departments, safety net providers, and human services organizations should use the standardized screening questions to identify unmet resource needs and use NCCARE360 to refer and navigate individuals whose screening results indicate they could benefit from additional resources to appropriate community resources.

In the event that ACC partners choose to develop their own IT and data-sharing tools, their work will need to be interoperable with the state-based data systems that exist and those that are being developed. Minimum requirements to do so should incorporate standard document exchange methods, such as Health Level 7 interfaces or Fast Healthcare Interoperability Resources web services⁶⁵, and comply with all state and federal privacy laws. IT systems also will need to comply with state and federal privacy laws. It is likely that NCCARE360 will serve the data-sharing and collection needs of ACC partners and will remove the need for independent IT system development. To ensure that any IT infrastructure independently developed by ACC models is compatible with the state-based data systems, the Task Force recommends:

**RECOMMENDATION 4.4:
FACILITATE DATA SHARING AND COMPATIBILITY**

Any data systems developed to support an Accountable Care Community model should incorporate standard document exchange methods, such as Health Level 7 (HL7) interfaces or Fast Healthcare Interoperability Resources (FHIR) web services and be compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state and federal privacy laws.

Developing a Workforce to Meet the Needs of ACCs

The work of screening, connecting individuals to community resources, and managing their care/cases can be done by a wide range of staff including social workers, navigators, care managers, and community health workers. Staffing decisions will vary across organizations involved in an ACC. An important component of the work of an ACC is to assess which organizations are already screening and referring for health-related social needs and which need to develop this capacity. Some human services organizations and health care providers may already be screening for needs; however, approaches 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 these tasks, keeping in mind the organization's culture and potential workflow.

CARE MANAGER

A 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, monitoring patient status, and training on patient self-management.

-Assisted Living Comparison Experts, UNC-Chapel Hill, <http://alce.unc.edu/blog/care-managers-what-do-they-do-and-how-can-i-find-one-2>

COMMUNITY HEALTH WORKER

"A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery." Other terms for this role include community health liaison, lay health advisor, and promotora.

-American Public Health Association, <https://www.apha.org/apha-communities/member-sections/community-health-workers>

Health care systems, community health centers, and insurers may already work with community health workers and care managers in some capacity. These professions can play an integral role in addressing the health-related social needs of patients. Community health workers commonly come from the same communities they serve and share similar ethnicity, life experiences, socioeconomic status, and language. Their personal background can often gain them trust with the community and the individuals they serve, making them effective interprofessional care team members, particularly when addressing health-related social needs. Research shows that community health workers are effective at helping people address health-related social needs,⁶⁶ reducing urgent care and inpatient utilization^{67,68}, improving health outcomes⁶⁸, and in many cases producing cost savings.⁶⁸

COMMUNITY HEALTH WORKERS AND CARE MANAGERS CAN PLAY AN INTEGRAL ROLE IN ADDRESSING THE HEALTH-RELATED SOCIAL NEEDS OF PATIENTS.

Care managers also help patients navigate the many medical and non-medical issues they have, helping to improve patient outcomes. Like community health workers, care management programs have been shown to improve primary care quality and outcomes⁶⁹, decrease emergency room and inpatient care⁷⁰, and decrease patient costs.⁷⁰ With the growth of value-based payment arrangements, health care providers and insurers have incentives to use the skills of these professionals to address individuals' health-related social needs. Organizations employing these professionals are essential partners in ensuring there is an adequate workforce to address the needs of patients and also play a role in ensuring that these professionals' expertise is maximized.

Currently there is a reliance on grants and contracts of three years or less to fund community health worker positions.⁷¹ This arrangement leaves these workers and programs open to unpredictable funding conditions and potential job loss. An expansion of payment mechanisms to support the work of community health workers could provide more job stability and lead to greater use of these effective professionals. Unlike community health workers, payment for care management has been more incorporated into health care. Private payers are beginning to pay for care management services either through direct payment or by paying for outcomes that care managers can help to improve.⁷² Even before the transition to managed care, North Carolina has used care management for the individuals enrolled in Medicaid through Community Care of North Carolina. Community Care of North Carolina provides care management services for people enrolled in Medicaid by working in hospitals and medical practices. Services are paid for as part of the per member, per month payment from the state. After Medicaid transformation, Prepaid Health Plans will receive capitated payments to serve people enrolled in Medicaid and provide care management services through the Prepaid Health Plans or through advanced medical home practices (Tier 3 and 4) that will take on care management responsibilities⁷³

Health care organizations, payers, and other stakeholders will need to consider the roles of community health workers and care managers in addressing health-related social needs as part of overall ACC efforts. First, to ensure an adequate workforce supply into the future, a pipeline of students is needed from a young age through high school, community college, and university levels with an interest in entering these professions. Next, adequate payment is needed to retain these professionals once they join the workforce. Further, community health workers should be recognized for their contributions as interprofessional care team members. Establishing these roles with the professional status they deserve and recognizing their contributions to the interprofessional care team can build trust and develop a basis for effective team communication. Additionally, professionals serving in these roles

COMMUNITY HEALTH WORKERS AND CARE MANAGERS SHOULD BE ENCOURAGED AND INCENTIVIZED TO OBTAIN AVAILABLE CREDENTIALING AND CERTIFICATION.

should have the same access to patient health records or electronic documentation as other team members to maximize their effectiveness, particularly if they will be instrumental in the implementation of a screening and referral protocol for health-related social needs. Finally, to continue to build on their experience and knowledge, these professionals should have access to continuing education on health-related social needs. Community health workers and care managers should be encouraged and incentivized to obtain available credentialing and certification to strengthen their skills and perceptions of their professional status as interprofessional care team members. Among the recommendations of a recent report from the North Carolina Community Health Worker Initiative (described in Chapter 3), the need for development of a certification process for community health workers in North Carolina is highlighted.⁵⁷ This would help to standardize community health worker training and improve credibility with other interprofessional care team members.⁵⁷ Other recommendations in the report define community health worker roles and responsibilities, core competencies, and curriculum.

To support the workforce needs of ACCs, increase interprofessional understanding of health-related social needs, and provide payment for health care workers addressing these needs, the Task Force recommends:

RECOMMENDATION 4.5: **DEVELOP, EXPAND, AND SUPPORT THE HEALTH CARE WORKFORCE TO BETTER ADDRESS HEALTH-RELATED SOCIAL NEEDS AND HEALTH EQUITY**

- a) The North Carolina Area Health Education Centers and health professional associations should help raise awareness and create opportunities to educate current health care professionals on the effect that health-related social needs have on health, how interprofessional health care team members can help to assess the needs of individuals, and how to support Accountable Care Community models.
- b) The North Carolina Community College System, colleges and universities, North Carolina Area Health Education Centers, health care training programs, health care systems, and providers across the state should:
 - i) When possible, collaborate to develop interprofessional team-based care and training for all members of health care teams to understand the impact of health-related social needs on health, how health care team members can help to assess the needs of individuals, and how to work as a team to support Accountable Care Community models.

- ii) Develop a pipeline for high school students interested in health care fields, including community health work and nursing or social work care management, in order to expand the workforce capacity for Accountable Care Community needs.

- iii) Study and implement effective methods to improve the diversity of the health care workforce to reflect the diversity of the communities being served.

- c) The North Carolina Department of Health and Human Services, the North Carolina Community College System, colleges and universities, North Carolina Area Health Education Centers, and, once developed and in place, the North Carolina Community Health Worker Certification and Accreditation Board, should support the implementation of the findings of the North Carolina Community Health Worker Initiative.

- d) Health care organizations using care management services, as well as providers of care management services, should educate staff on the association of health-related social needs with health outcomes and how care managers can help in the assessment and referral process.

- e) Payers and health care providers should:

- i) Continue to develop new payment and delivery models that support the work of community health workers, health coaches, care managers, care coordinators, and other emerging roles.

- ii) Ensure that care management services are provided to people who have high unmet health-related social needs, but who do not currently have high medical costs.

Addressing Needs of the Human Services Sector to Meet ACC Goals

Discussions around ACC activities often task human services organizations^k with providing nonclinical resources and services responsive to individuals' health-related social needs. This discussion often assumes that human services organizations are prepared to respond to an increase in referrals once ACC partners begin to evaluate individual needs, and that providing payment for services rendered will be sufficient to cover associated costs.

However, the human services sector is not adequately prepared to be a viable partner with healthcare organizations in a value-based system. The sector has been underfunded and under-organized for decades,

THE HUMAN SERVICES SECTOR IS NOT ADEQUATELY PREPARED TO BE A VIABLE PARTNER WITH HEALTHCARE ORGANIZATIONS IN A VALUE-BASED SYSTEM. INVESTMENTS IN THE CAPACITY OF HUMAN SERVICES ORGANIZATIONS ARE NEEDED.

^k An 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.” HumanServicesEdu.org. *The Definition of Human Services*. <https://www.humanservicesedu.org/definition-human-services.html#context/api/listings/prefilter>

UNLESS RESOURCE, STRUCTURAL, AND SYSTEMIC ISSUES ARE ADDRESSED, HUMAN SERVICES ORGANIZATIONS WILL NOT BE ABLE TO PARTICIPATE AS FULL PARTNERS IN ADDRESSING POPULATION HEALTH NO MATTER HOW MANY REFERRALS THEY RECEIVE AND FOR WHICH THEY ARE COMPENSATED.

comprised of organizations that largely operate independently of one other. As such, a human services “system” does not exist. Furthermore, there are no local or statewide associations in North Carolina that represent and advocate for the interests of this sector. As a result, relationships with government, philanthropy, and health care providers tend to be transactional at best.

The status of the sector is well-documented in the recent report by the Alliance for Strong Families and Communities, *A National Imperative: Joining Forces to Strengthen Human Services in America*. Against the backdrop of an increasing need for human services — driven by income inequality, lagging student achievement, an aging population, and the challenge of the opioid epidemic — the financial stability of the human services sector is deeply threatened. According to the study’s findings, too many human services organizations operate under persistent deficits, have few or no financial reserves, and lack access to capital to invest in technology and modern data sharing tools.⁷⁴ Addressing these complex and interrelated challenges requires a comprehensive response by nonprofits, government, and the philanthropic community.

In order to deliver better outcomes, investments in the human services sector are needed to develop its capacity for innovation, including improved data sharing and analysis, better deployment of technological strategies, adoption of best practices, and sharing knowledge of effective solutions. This also means adopting more robust financing and financial risk management capabilities and developing strategic partnerships to broaden reach and deepen results. Unless resource, structural, and systemic issues are addressed, human services organizations will not be able to participate as full partners in addressing population health no matter how many referrals they receive and for which they are compensated. As such, some leaders in this sector are advancing innovative solutions, such as arrangements like shared service organizations that can help consolidate some of the administrative work among human services organizations¹ in a community.

The human services sector will need to become better informed and be re-formed for human services organizations to participate as full partners in an ACC-style model in a collaborative (rather than instrumental) manner. This will enable human services organizations to take cooperative

action based upon mutual deliberation and transparency, grounded in respect for and acceptance of the critical role that each sector brings to the process. The capacity of human services organizations to participate in ACC models must be bolstered by strengthening administrative, human resource, and technological functions. At the same time, the funding and regulatory environment that undermines the sector’s stability needs to be addressed.

To begin the process of understanding the challenging issues that human services organizations are facing and to develop a path forward, the Task Force recommends:

RECOMMENDATION 4.6: STRENGTHEN THE HUMAN SERVICES SECTOR

- a) Philanthropies should promote the convening of an intersectoral work group, including leaders from state and local government, health care (i.e., providers, insurers, Prepaid Health Plans), community members, philanthropy, and the human services sector, to:
 - i) Determine strategies human services organizations can use to increase their capacity to track outcomes; share information across programs, organizations, and government divisions and departments throughout the state; and use outcomes as evidence of effectiveness for funding purposes. This should include a review of how NCCARE360 can be used to achieve these goals and how the intersectoral work group can promote the adoption of the Platform by human services organizations.
 - ii) Promote and incentivize human services organizations and stakeholders (e.g., Prepaid Health Plans and health care providers) to invest in experimentation, innovation, and information technology infrastructure that foster cost-effective models of service delivery in order to achieve integrated health systems.
 - iii) Encourage payment models that promote partnership and collaboration between health care and human services organizations.
 - iv) Explore and generate a plan of action for how health care funding streams can be used to support services to address health-related social needs delivered by human services organizations.
 - v) Identify, or develop plans to form, an entity that can provide consultation to enable human services organizations to improve financial management, contracting processes, and coordination/ collaboration within the human services sector. This entity should help human services organizations understand Medicare, Medicaid, and private insurance payment opportunities as part of a financial services portfolio.
 - vi) Determine how to increase the sector’s capacity to attract, retain, and provide opportunities for advancement for a diverse workforce.

¹ Shared services organizations or administrative services organizations are a concept that is somewhat commonplace in large organizations in the private sector. They can take on finance, accounting, IT, data analytics, contracts, human resources, real estate and other administrative activities. Shifting the time and resources for these tasks could allow human services organizations to focus more on program delivery.

b) The North Carolina Department of Health and Human Services should review state reporting and administrative requirements for human services organizations receiving state funding to:

i) Reform public agency contracting processes and grantmaking to:

1. Provide full and timely payment for services rendered, and
2. Fund administrative overhead at a minimum of 10 percent or the agency's federal- or state-approved indirect cost rate agreement, whichever is the most beneficial to the human services organization.

ii) Examine how reporting requirements may be streamlined and facilitated with use of NCCARE360.

iii) Minimize outdated, duplicative, conflicting, or overlapping state regulations within its control that impede efficient and effective service delivery.

Evaluation of process and outcomes is an important step in understanding the effect ACC efforts have on the community and the intended health-related metrics. Measuring where an ACC is in the process of addressing community issues and how well programs are working to address needs is vital to knowing what steps should be taken to improve those programs, and thus improve the intended outcomes. Information about the impact that partnerships and programming have on the community's health also can help secure funding opportunities for the short- and long-term financial security of the partnership.

It is important to understand the planned or expected results of the programs an ACC engages in to develop outcome measures and evaluation mechanisms that are relevant. 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 were 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 program effectiveness and show funders the positive results of the work. Indeed, intended outcomes and evaluation should be part of the initial planning process for all ACC work, rather than a later step in the process. With outcomes and evaluation in mind, programs can be built to more effectively target key issues and plan to measure for successes and lessons learned.

Recommendation 2.7.a from Chapter 2 of this report details technical assistance that can be useful for the initial development of an ACC and is also relevant to evaluation planning and process improvement. This recommendation calls on groups across the state to support training on a structured decision-making process, such as Results Based Accountability™. This type of decision-making framework is useful in determining plans for action, as well as process and outcome measures. Additionally, Recommendation 2.7.b. calls on groups across the state to convene learning collaboratives. Again, while these collaborative efforts would discuss ACC development topics, they would also share outcomes and evaluation techniques, along with lessons learned.

Evaluations of State-Led Efforts to Address Health-Related Social Needs

Just as evaluations of community-level ACC activities are important to understand their effectiveness, the North Carolina Department of Health and Human Services (NC DHHS), and their partners should incorporate an evaluation of statewide efforts to address health-related social needs.

The standardized screening questions for health-related social needs are being piloted (as of this writing) using an in-person process in a clinical setting with the intention of evaluating the wording of the screening questions. Revisions may be made to the questions depending on the

EVALUATION OF PROCESS AND OUTCOMES IS AN IMPORTANT STEP IN UNDERSTANDING THE EFFECT ACC EFFORTS HAVE ON THE COMMUNITY AND THE INTENDED HEALTH-RELATED METRICS.

findings of the pilot tests. Even with valid screening questions, the method and location for completing the assessment plays an important role in the likelihood of an individual completing the assessment and providing honest answers. NC DHHS, Prepaid Health Plans, and providers must consider the pros and cons of various approaches, such as telephone versus in-person interview, electronic or paper completion, as well as individual literacy levels.^{75,76} Additionally, organizations administering the screening questions could benefit from guidance on the best methods for educating individuals about the purpose of the screening. This “priming” process could help to increase the response rate to the screening process by helping individuals understand why the questions are being asked (i.e., the association of health-related social needs to health outcomes) and how they may benefit from responding (i.e., potential referral to services that can meet needs).

Additionally, there should be considerations of the burden of completing the assessment, both on staff and the individual providing responses. A balance needs to be struck between assessing for needs often enough to capture changes in need and linking individuals to resources and over-screening that could lead to screening fatigue for both the individual and staff. Evaluations of these factors could consider whether a pre-screening question would reduce the potential for screening fatigue. A pre-screening question could ask about changes to health-related social needs like access to food, housing, personal safety, or transportation and trigger the standard screening questions if answered affirmatively. Stakeholders, such as Prepaid Health Plans, health care providers, and human services organizations, could benefit from an evaluation and guidance on the standards for completing the screening in a manner that is least invasive, yet most effective. In order to provide consistent guidance on effective screening processes, the Task Force recommends:

RECOMMENDATION 5.1: EVALUATE METHODS FOR SCREENING FOR HEALTH-RELATED SOCIAL NEEDS

The North Carolina Department of Health and Human Services should provide guidance on optimal frequency, modality, and location for screening individuals for health-related social needs. This guidance should balance concerns about under- or over-screening with the need to gather timely information and engage services to address beneficiary needs. The guidance should also consider and describe best practices for preparing or “priming” individuals for the screening process to help produce the highest rates of screening acceptance and completion as possible. This guidance should:

- a) Be published and disseminated to Prepaid Health Plans and other payers, health care providers, human services organizations, educational institutions with health workforce training programs, and other stakeholders through NC DHHS website(s) and other forms of communication (e.g., presentations, training materials).
- b) Inform future standards and requirements for Prepaid Health Plans related to screening for health-related social needs.
- c) Consider the utility of a pre-screening question to identify individuals who should be screened or re-screened, with the intention of reducing burden to individuals being screened and those assisting with screening processes.

With the variety of providers and organizations that will be implementing the standardized screening questions for health-related social needs, a central repository for this information could enhance the care individuals receive from other providers and organizations. A natural location for this data to be stored is NC HealthConnex, North Carolina's Health Information Exchange. NC HealthConnex is administered by the North Carolina Health Information Exchange Authority, which was established by the General Assembly in 2015 and is housed in the North Carolina Department of Information Technology's Government Data Analytics Center.⁷⁷ The purpose of the system is to "connect health care providers to safely and securely share health information through a trusted network to improve health care quality and outcomes for North Carolinians."⁷⁸ Data elements available in NC HealthConnex currently include allergies, encounters, medications, problems, procedures, and results. The law mandated that all hospitals, doctors, and mid-level practitioners providing Medicaid or state-funded services and that had technology capabilities should have been connected by June 1, 2018, followed by all other providers of Medicaid or state-funded services that did not have technology capabilities by June 1, 2019. Adding the information gathered through the standardized screening questions to NC HealthConnex would allow the variety of providers that an individual sees to access important information about their health-related social needs.

In addition to hospitals and health care providers, Prepaid Health Plans will amass a wealth of information on the health-related social needs of the beneficiaries enrolled in their plan through required screening for health-related social needs using the standardized screening questions. This information will be used for internal care management purposes and can inform the investments Prepaid Health Plans make in the communities they serve. The data also can help to inform community-based efforts, such as ACCs, to address health-related social needs, and should therefore be collected and analyzed by the state. State-produced public reports of these analyses can help to identify areas in the most need and areas that are making progress in addressing community needs.

To encourage the evaluation of statewide efforts to assess health-related social needs in North Carolina and the dissemination of information learned through those evaluations, the Task Force recommends:

ACCS CAN SERVE AN IMPORTANT ROLE IN IDENTIFYING GAPS BASED ON INDIVIDUAL NEEDS AND MAKING THE CASE FOR EXPANDED ACCESS TO SERVICES.

RECOMMENDATION 5.2: **EVALUATE DATA GATHERED THROUGH THE STANDARDIZED SCREENING PROCESS**

- a) The Department of Information Technology should explore how NC HealthConnex could be used to collect, aggregate, and share data from the standardized screening question responses collected by Prepaid Health Plans, NCCARE360, and other providers and organizations using the standardized screening questions to screen individuals for health-related social needs.
- b) The North Carolina Department of Health and Human Services should:
 - i) Require Prepaid Health Plans to submit quarterly raw data files with standardized screening question results. Data should include gender, race/ethnicity, age, and geography of screened individuals.
 - ii) Maintain a Memorandum of Understanding with the Foundation for Health Leadership & Innovation for use of all data collected through NCCARE360.
 - iii) Release aggregate data reports annually on its website. Information should be disaggregated by gender, race/ethnicity, age, and geography to the smallest degree possible for evaluation and planning. These reports should identify areas where resources are needed in communities.
 - iv) Work with academic and research partners to use identified data for evaluation.

NCCARE360 partners will be gathering a wealth of information on community needs throughout the state through NCCARE360. This data can inform the quality improvement process for the Platform and also should be analyzed to inform communities on the volume and types of referrals that are being made for service needs. As the platform is used to identify needs and link people to resources, communities can learn where resource gaps or limitations exist. ACCs can serve an important role in identifying gaps based on individual needs and making the case for expanded access to services.

NCCARE360 will use a referral feedback loop so that all parties involved know the status of an individual's referral for resources. This includes whether the individual's needs have been met, if the referred organization does not have capacity to meet needs, or if an individual has not made contact with the organization to which they were referred. With a large variety of stakeholders using NCCARE360 it is possible that an individual could be introduced into the system via more than one organization. In those cases, it will be important to know whether the system is recognizing duplications of individuals being linked to services or if there

are duplicative referrals of one individual to the same organization. Evaluating this information can help NCCARE360 partners continue to improve the platform and cut down on potentially confusing and duplicative efforts across multiple organizations.

The overall user experience with NCCARE360 also should be reviewed. Users can be broadly defined as organizations making referrals, organizations receiving referrals, and the individuals being referred. For each of these parties, the experience using the platform and interacting with the other parties in the process should be considered and will determine user engagement and the success of the platform. For organizations making referrals, they may be asked whether the platform has streamlined their referral process (if they had been making referrals previously), whether the platform has allowed them to add referrals to their care, how well resources available on the platform match the needs of their patients/clients, and how accurate the referral feedback loop has been in their experience. For organizations receiving referrals, they may be asked whether they have been able to clearly communicate with the referral source, what issues they have had coordinating with the individual referred, whether they have had any issues with the referral feedback loop, whether they have seen an increase in referrals and have sufficient capacity to meet that increase, and what the cost of implementing the platform into their work and serving new clients has been. Finally, for individuals being served through the platform, they may be asked if the service has been person-centered (i.e., do they feel like part of the decision-making process), how it has been to navigate the referrals made on their behalf, if they have had trouble communicating with either the referral source or organizations to which they were referred, whether their privacy has been respected, and whether they have been denied services to which they were referred.

To encourage the evaluation of statewide efforts to address health-related social needs and the dissemination of information learned through those evaluations and to ensure the utility and user experience of NCCARE360 is maximized, the Task Force recommends:

RECOMMENDATION 5.3: EVALUATE DATA GATHERED THROUGH NCCARE360

- a) The Foundation for Health Leadership & Innovation should:
 - i) Require regular reports from NCCARE360 developers including:
 1. Reports specified in the Resource Platform vendor Request for Proposals.
 2. The density of service providers connected to the platform in each of the North Carolina Department of Health and Human Services priority areas (i.e., transportation, housing, food, and interpersonal violence) and in relation to the service needs of a community, as identified with standardized screening questions response data.
 3. The volume of referrals, whether the referral loop was closed, and percent of referrals declined by the agency receiving referral, with data aggregated by agency individual was referred to.

4. Referral outcomes (i.e., referral completion or “fill” rate) for an individual referred for services, the referral source, and the organization receiving referrals, in order to evaluate and improve the referral process.

- ii) Publish annual reports analyzing the above measures. Data should be provided at the smallest geographic gradation possible (e.g., county, zip code, or neighborhood) to be used by ACCs and individual entities for planning and evaluation. These reports should be published on the Foundation for Health Leadership & Innovation website.

- b) NCCARE360 developers should develop a method to assess:

- i) The quality of the experience of referrals
 - ii) Frequency of duplicated referrals and, if high, mechanisms for decreasing referral duplication.
 - iii) The cost to human services organizations of meeting needs of those referred using the Platform.

See also: Recommendation 6.4 Analyze Data to Determine Costs and Benefits of Health-Related Social Services.

At the core of the work of an Accountable Care Community (ACC) is the shift from a system that buys medical care to one that buys health. To do this, new financial incentives are needed to re-align the health care system away from volume to value.²⁴ While this is beginning to happen, as discussed in Chapter 1, changing an industry that accounts for 18 percent of the United States Gross Domestic Product and more than \$3.3 trillion in spending is challenging.²⁰ While many within the health care industry agree that addressing non-clinical drivers of health is critical to achieving improved population health and lowering costs, doing so requires a significant shift in the identity of the health care industry and its funding. For this reason, the most daunting and critical challenge in implementing ACC models is developing sustainable financing strategies for community-based services that support improved health outcomes.

ACCs attempt to bridge the critical gap between clinical care and community services in the current health care delivery system. ACCs aim to develop systems whereby health care payers “purchase” social services as a means to improve wellness and reduce overall costs. Most examples of successful implementation of ACCs that have incorporated payment have been driven by either government-funded health programs (Medicaid and Medicare), insurance companies, or large health care systems. Therefore, there are no clear financing models for community-based, multi-payer, multi-health care system ACC efforts to follow.

AT THE CORE OF THE WORK OF AN ACCOUNTABLE CARE COMMUNITY (ACC) IS THE SHIFT FROM A SYSTEM THAT BUYS MEDICAL CARE TO ONE THAT BUYS HEALTH.

ACC models have been shown to produce both cost savings and cost avoidance.^{79,80,m} Cost saving measures are those that reduce current spending (two- to five-year time horizon), which can be seen in financial statements when comparing year-over-year spending. Much of the short-term work of ACCs aims to achieve and document cost savings. Many ACC efforts aim to reduce avoidable acute care because doing so produces cost savings. For example, ensuring individuals with asthma have clean, mold- and bug-free housing can produce cost savings by reducing emergency room visits immediately. When year-to-year costs for individuals with asthma are reviewed, evidence of cost savings can be seen. In the long term, ACCs ultimately aim to achieve cost avoidance. Cost avoidance measures are those that, when implemented, prevent future health conditions from occurring. Savings from cost avoidance measures cannot be seen in short-term budget statements. Many efforts to address drivers of health, such as education, employment, and neighborhood safety, are prevention efforts which aim to achieve cost avoidance. While ACCs focus on health care savings, the work of human services organizations has been shown to produce savings in areas such as corrections, public safety, and public benefits.⁷⁴ For this reason, developing sustainable financing for

THE MOST DAUNTING AND CRITICAL CHALLENGE IN IMPLEMENTING ACC MODELS IS DEVELOPING SUSTAINABLE FINANCING STRATEGIES FOR COMMUNITY-BASED SERVICES THAT SUPPORT IMPROVED HEALTH OUTCOMES.

non-clinical drivers of health care services will require an examination of where savings accrue. Successful ACCs will include stakeholders in sectors outside of health care who may benefit from long-term cost avoidance because of ACC efforts. Since these stakeholders stand to benefit in the long term from ACC efforts, they should be engaged as potential sources of funding.

As discussed in Chapter 1, many of the services to address people’s social, behavioral, economic, and environmental health needs are not currently well-funded in communities. Yet, increasingly these services are crucial to reigning in health care costs. The formation of ACCs provides a bridge for communication and partnership among health care organizations (i.e., payers and health care providers), public health, local and tribal government, and human services organizations. Together, community members can assess how to best work together to better align and coordinate social services and health care. ACCs must then develop systems to facilitate communication and coordination between human services organizations and health care organizations and capture data about service provision, costs, and savings. Sustainable payment systems must be developed to financially support organizations that effectively improve health outcomes and/or lower costs at levels that meet the needs of the community.

Funding Needs Vary Based on Stage of Development

The short-term and long-term funding challenges for ACCs are different. In the short-term, ACCs may need funding to form and for partners to begin working together (described in more detail below). Because ACC models are most likely to succeed within value-based purchasing health care models, which are just beginning to be implemented, human services organization activities will need a source of funding in the short-term to increase capacity, evaluation, and partnership. In the long-term, data on services delivered, costs, improvements in health, and cost savings/avoidance should provide means to develop financial models to support the provision of services to address health-related social needs within the realm of health.

THE FORMATION OF ACCS PROVIDES A BRIDGE FOR COMMUNICATION AND PARTNERSHIP AMONG HEALTH CARE ORGANIZATIONS, PUBLIC HEALTH, LOCAL AND TRIBAL GOVERNMENT, AND HUMAN SERVICES ORGANIZATIONS.

^m Throughout this chapter, the term savings will refer to both cost savings and cost avoidance.

IN THE SHORT-TERM, ACCS MAY NEED FUNDING TO FORM AND FOR PARTNERS TO BEGIN WORKING TOGETHER

ACC Start-Up Funding

Funding for planning and development is needed when ACCs form and begin to explore how partners can better coordinate their work to improve health outcomes. ACC partnership development can be a time-consuming process involving health care organizations, human services organizations, partners, community members, and other stakeholders. The process of developing a shared vocabulary, agenda, alignment of activities, and plan for action may require the assistance of outside groups to facilitate discussion. Legal counsel is necessary for groups that would like to have shared governance and/or benefits. Additionally, partners may require assistance with technologies to develop communication and data capacities for ACC work. These activities can be costly and may require outside financial support. The most likely sources of funding for these activities are state and local philanthropies, local and tribal government, and partners within the ACC who have the resources to support the work. Given the impact ACCs can have on the health and well-being of their communities, local businesses could be valuable partners in funding and supporting ACCs.

Ultimately, communities should aim to blend multiple sources of funding, such as hospital community benefit dollars (explained in Chapter 2), local and tribal government budget allocations, social-impact bonds, and/or wellness funds (more information and resources on these funding mechanisms can be found in *Partnering to Improve Health: A Guide to Starting an Accountable Care Community* (www.nciom.org/nc-health-data/guide-to-accountable-care-communities)). 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, such as developing a case statement including the potential benefits, to appeal to investors for the future. To help ACCs with funding for the initial stages of partnership development, the Task Force recommends:

IN THE LONG-TERM, DATA ON SERVICES DELIVERED, COSTS, IMPROVEMENTS IN HEALTH, AND COST SAVINGS/AVOIDANCE SHOULD PROVIDE MEANS TO DEVELOP FINANCIAL MODELS TO SUPPORT THE PROVISION OF SERVICES TO ADDRESS HEALTH-RELATED SOCIAL NEEDS WITHIN THE REALM OF HEALTH

Recommendation 6.1:
Support Initial Development of Local Accountable Care Communities

- a) Philanthropies should:
 - i) Provide support for capacity development in communities to help local leaders interested in creating an Accountable Care Community.
 - ii) Provide grant funding to support the development of local Accountable Care Communities. When possible, philanthropies should coordinate portfolios of work with other philanthropies and streamline reporting requirements.
 - iii) Require local Accountable Care Communities to develop a lead entity, plans for funding and sustainability, outcomes measures, and an evaluation plan.
- b) Prepaid Health Plans, Medicaid, and other payers should develop strategies to financially support local Accountable Care Community efforts and provide subject-area expertise as partners in community coalitions.
- c) Health care systems should direct community benefit dollars toward a greater mix of investments that impact the drivers of health. These investments may include community partnerships, such as development of an Accountable Care Community model; infrastructure building, such as the NCCARE3060 resource platform; or direct investment in addressing health-related social needs of the community related to housing, food, transportation, interpersonal safety, or other needs. Community benefit investments should be aligned with the Community Health Assessment, Community Health Needs Assessment, and Community Health Action Plan.
- d) Local businesses should direct funds to support Accountable Care Community efforts and/or donate subject-area expertise as partners in community coalitions.

See also Recommendations 2.4 Support Local Health Departments to be Leaders in Accountable Care Communities and 2.7 Provide Technical Assistance to Accountable Care Communities.

Funding for Implementation Activities of ACCs

Once an ACC has formed and developed a plan for how partners will work together and what work they will do, the ACC must identify funding for implementation. There are two main areas that need funding in this stage: systems and services. ACC work typically involves developing and implementing new systems to screen, refer, provide navigation assistance, track receipt of services and outcomes data, and pay for services. Organizations must also hire and/or train staff and redesign their workflows to incorporate new activities and technologies. Developing and implementing new systems requires financial support and technical assistance (as discussed in Recommendation 2.7 - Provide Technical Assistance to Accountable Care Communities). ACCs must also identify funding for the provision of services.

North Carolina is in a unique position with the development of NCCARE360 (described in Chapter 3), which will provide the technical backbone for the efforts of ACCs in North Carolina to link people to needed services.ⁿ NCCARE360 solves many of the challenges ACCs face as they consider systems that facilitate communication and coordination between health care organizations and human services organizations. The Platform will provide a solution to bridge the technology gap and coordination challenges among different types of providers. NCCARE360 also will facilitate the screening and referral process and data tracking necessary for high-functioning ACCs. The platform is funded through the NCCARE360 public-private partnership and will be subsidized for organizations for at least the first five years. By providing a subsidized system, the organizations involved, including the North Carolina Department of Health and Human Services (NC DHHS), hope NCCARE360 will become a shared utility that is used by health care organizations, human services organizations, payers, and individuals across the state. NCCARE360 partners also are expected to on-board human services and health care organizations, including training for how to use the platform and workflow integration.

To utilize NCCARE360, organizations may need additional computers, IT support, and staff time to interface with the platform. Within Medicaid transformation, Prepaid Health Plans will receive per member per month payments that will support the implementation of screening, referral, navigation assistance (in the form of care management for some populations), and follow-up. Prepaid Health Plans will be required to use NCCARE360 and track various data needed to assess which interventions create positive outcomes and/or reduce costs. Other payers and health care providers are being encouraged to use the Platform as well. Providers may or may not be reimbursed for screening, referral, and navigation services according to the policies of individual payers. There is currently no payment system for services rendered by human services organizations through NCCARE360.^o

Under an ACC model, one objective is to increase the use of human services organizations to meet health-related social needs (e.g., food, housing, transportation). As discussed in Chapter 4, increases in referrals to human services organizations may place burdens on these organizations that they may not be able to meet without additional resources. Human services organizations are typically funded by a combination of sources, which may include individual donations, corporate contributions, foundation grants, government grants and contracts, tax revenue, investment interests, and fees for services. While larger human services organizations (e.g., county Department of Social Services, Housing Authority) may have relatively dependable budgets, smaller human services organizations (e.g., local food banks, domestic violence shelters) often operate with little or no financial reserves, lack access to capital, and often run operating deficits.⁷⁴ Many human services organizations do not have the resources needed to significantly increase their operations without additional funding.

During the implementation phase of ACC development, 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. Other sources of funding for human services organizations within an ACC are health care systems and payers (i.e., insurers). Obtaining funding for services provided by human services organizations in a fee-for-service health care landscape may require upfront conversations about incentives for each party. Provider participation can be encouraged by including strategies to address short-term goals that show specific cost-savings and standards that both providers and payers are already held accountable for, like reductions in emergency department visits among high-risk populations.⁸¹ Many providers and 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 Healthy Opportunities pilot programs (described in Chapter 3) 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.

As ACCs begin working to address unmet health-related social needs, new models of payment will need to be developed and tested. Therefore, the Task Force recommends:

Recommendation 6.2: **Funding for Local Accountable Care Community Implementation**

- a) Prepaid Health Plans, Medicaid, other payers, and health care providers should develop and test payment models for coverage of social services to improve wellness and reduce overall costs in alignment with the Community Health Assessment, Community Health Needs Assessment, and Community Health Action Plan in the communities they serve and/or provide payment for services rendered by Accountable Care Communities and their partners.
- b) Philanthropies should provide bridge financing to Accountable Care Communities transitioning from startup funding to payment structures that can support human services organizations providing services for those with health-related social needs.
- c) Local governments should consider using local tax revenues to support Accountable Care Community activities.

See also Recommendations 2.3 Provide Guidance on Cross-Agency Collaboration to Address Drivers of Health, 2.7 Provide Technical Assistance to Accountable Care Communities, and 6.5 Develop Sustainable Accountable Care Community Funding.

ⁿ The NCCARE360 resource platform is one part of the NC DHHS infrastructure for creating "Healthy Opportunities" for all North Carolinians. See Chapter 3 for more information.

^o Except for within the Medicaid Healthy Opportunities pilot programs (see Chapter 3).

State Efforts to Develop Sustainable Payment Models for Unmet Health-Related Social Needs

Transforming Medicaid^p is part of the state’s “Healthy Opportunities”^q work. One goal of Healthy Opportunities is to develop innovative approaches to foster “strategic interventions and investments in...food, housing, transportation, and interpersonal safety...[that] will provide short and long-term cost savings and make our health care system more efficient.”⁵⁸ Strategies to do this have been incorporated into the state’s 1115 Medicaid Waiver.

Under Medicaid transformation, NC DHHS will remain responsible for the Medicaid and NC Health Choice programs but will contract with Prepaid Health Plans to provide managed care services to most individuals enrolled in Medicaid. Prepaid Health Plans will be required to screen all enrollees using the state’s standardized screening questions when they enroll (and at least annually for those determined to be high-risk) and use NCCARE360 to connect those with needs to resources that meet their needs and track outcomes.⁵⁹ The Prepaid Health Plan contracts also will incentivize Prepaid Health Plan contributions to health-related resources in each region in which they operate. For example, Prepaid Health Plans that contribute 0.1 percent of capitation payments to health-related resources will be given preference in beneficiary plan assignment.

The public-private regional pilots^r, called Healthy Opportunities pilots, that are part of North Carolina’s 1115 Medicaid Waiver are designed to allow more substantial investments in non-clinical health related services with the explicit goal of learning how to finance ‘health’ interventions and incorporate them into value-based payments. Within the pilots, Medicaid Prepaid Health Plans will be able to pay for select services to meet beneficiary needs in the four categories (i.e., housing, transportation, food insecurity, and interpersonal safety) using Medicaid dollars. Over the course of the five-year pilots, payments for pilot services will increasingly be linked to operational ability, enrollees’ health outcomes, and health care costs through various value-based payment arrangements, including incentives, withholds, and shared savings.

The pilot model will not work without better integration across health and social service organizations. To facilitate better integration, each pilot area will have a Lead Pilot Entity that will develop, manage, and oversee a network of human services organizations and social service agencies providing services; assist care managers with connecting beneficiaries to services; collect data for evaluation; and facilitate payments to organizations providing services. For the pilots, the Lead Pilot Entities will function similarly to a backbone organization for an ACC. The main difference is that an ACC incorporates a broader network of payers, local government, and organizations that address health-related social needs outside of food, housing, transportation, and interpersonal safety.

THE HEALTHY OPPORTUNITY PILOTS WILL ALLOW MORE SUBSTANTIAL INVESTMENTS IN NON-CLINICAL HEALTH RELATED SERVICES WITH THE EXPLICIT GOAL OF LEARNING HOW TO FINANCE ‘HEALTH’ INTERVENTIONS AND INCORPORATE THEM INTO VALUE-BASED PAYMENTS.

The Healthy Opportunities pilots are designed to test how to finance and scale non-clinical interventions across multiple domains to the full population enrolled in Medicaid with the goal of applying what is learned in the pilots statewide. To facilitate this learning, the pilot program incorporates both rapid-cycle evaluation and summative evaluation. This type of data collection and evaluation is critical to developing sustainable funding models for investments in non-clinical health services. While NC DHHS is focused on populations enrolled in Medicaid, the lessons learned will be applicable to all payers. Therefore, the Task Force recommends:

Recommendation 6.3: **Support Implementation of Medicaid Healthy Opportunities Pilots**

- a) As part of the Healthy Opportunities pilots, the North Carolina Department of Health and Human Services should implement its plans as stated in the Prepaid Health Plan Request for Proposal and public documents to:
 - i) Require the Lead Pilot Entities to facilitate an Accountable Care Community by convening key local stakeholders (e.g., payers, health care providers, local government agencies, and human services organizations).
 - ii) Require Prepaid Health Plans to participate in the Lead Pilot Entity-led Accountable Care Communities.
 - iii) Develop requirements for how Prepaid Health Plans should partner with the pilots to address health-related social needs, as well as mechanisms for accountability.
 - iv) Develop funding streams for human services organizations participating in the pilots, in partnership with Prepaid Health Plans and other payers, including all potential federal funding streams.
 - v) Complete rigorous rapid-cycle and summative evaluations to identify successful components of the pilots, cost savings, and lessons learned.
 - vi) Develop a plan for how to sustain or improve upon pilot activities and implement successful components for Medicaid services across the state based on lessons learned from the five years in pilot communities.
- b) Philanthropies should align efforts to support the Medicaid Healthy Opportunities pilots by:

^p See Chapter 3 for more information

^q See Chapter 3 for more information

^r See Chapter 3 for more information

- i) Coordinating with the North Carolina Department of Health and Human Services to provide funding for services to address drivers of health that cannot be paid for using Medicaid funds.
 - ii) Streamlining reporting requirements if multiple philanthropies provide pilot funding.
 - iii) Supporting capacity building for Lead Pilot Entities participating in the pilots (e.g., leadership development).
 - iv) Providing bridge financing, if needed, to support communities that transition from the Healthy Opportunities pilot model concept to one with financial return on investment.
- c) The North Carolina General Assembly should approve the North Carolina Department of Health and Human Services' full spending authority under the 1115 Waiver for Medicaid transformation. The Healthy Opportunities Pilots, with the approved rapid cycle assessments and summative evaluation, will be important to ensure accountability for investments, learn which interventions are most and least effective, and inform other Accountable Care Communities efforts.

Sustained Funding for ACCs

To develop sustainable funding models, ACCs will need to capitalize on the savings created by the health improvements resulting from services provided by human services organizations. If the ACC model creates improved health outcomes as well as savings (health care dollars saved or avoided) greater than or equal to costs (dollars spent to provide services), then payers, employers, or health care providers in value-based arrangements are benefitting by avoiding costs they otherwise would have borne. To create sustainable funding, financial arrangements need to move money from those profiting from or benefitting from services provided by human services organizations to the human services organizations providing the services.

Return on Investment

Establishing long-term financing strategies for services provided by human services organizations using health care dollars is predicated on determining the return on investment of different services. In general, return on investment examines the gains or losses on an investment based on the outcomes it generated. However, return on investment calculations can vary widely depending on the time frame used to measure benefits, as well as the range of benefits and beneficiaries included. Human services organizations often calculate their return on investment by measuring the cost of the service versus the cost savings/avoidance and/or taxpayer gains realized by the service provided.⁸² In an ACC, the return on investment focuses more specifically on the cost savings from avoided medical events/diagnoses within a certain time period.⁸³ If the benefits outweigh the costs, and can be demonstrated, there exists a financial justification to pay for services.⁵

TO DEVELOP SUSTAINABLE FUNDING MODELS, ACCS WILL NEED TO CAPITALIZE ON THE SAVINGS CREATED BY THE HEALTH IMPROVEMENTS RESULTING FROM SERVICES PROVIDED BY HUMAN SERVICES ORGANIZATIONS.

Accountable Care Organizations and health insurers are limited in what services they cover by what the purchasers of individual health insurance plans (e.g., individuals, employers, or state/federal government) are willing to cover. Expanding benefits that are provided to plan enrollees increases certain 'health care' costs. In many instances there are savings in downstream costs, but not always to the same insurer or even within the health care domain. Although some health-related social services will produce positive return on investment for health in a timely manner, many more will have benefits that occur in the future or outside health budgets. This is why ACC efforts often begin by focusing on patients who use a higher-than-average number of medical services. Meeting the health-related social needs of these individuals often can reduce their medical costs much faster than those of the general population. Because many benefits from health-related social services occur outside the budget horizon of health care payers and accrue to those outside of health care, ACCs need to incorporate a wide range of partners. Local and tribal governments, education, public safety, and others who may reap the benefits all need to be at the table. Funding for many services, particularly preventive services, may only make sense when all of those benefitting pool funds. For long-term sustainability of ACC efforts, return on investment should be used to negotiate with local and tribal government, education businesses, health care systems, and insurance providers to pay for services.

Developing mechanisms to fund interventions that address the drivers of health and health equity will require evidence that such efforts are cost effective. Calculating return on investment requires data. Data on the health and social needs of those receiving services, services provided, cost of services, cost savings/avoidance for health and other budgets are held by payers, providers, NCCARE360 partners, and in other data sets controlled by the North Carolina Department of Information Technology. Data collection and analysis is critical to developing sustainable funding models for investments in non-clinical health services. In North Carolina, no entity outside of state government has the ability to collect and aggregate this data. Therefore, the Task Force recommends:

TO CREATE SUSTAINABLE FUNDING, FINANCIAL ARRANGEMENTS NEED TO MOVE MONEY FROM THOSE PROFITING FROM OR BENEFITTING FROM SERVICES PROVIDED BY HUMAN SERVICES ORGANIZATIONS TO THE HUMAN SERVICES ORGANIZATIONS PROVIDING THE SERVICES.

⁵ The focus of ACCs is on health savings, but ACC models have shown savings in other areas (e.g., education, corrections) and such partnerships should be explored.

ALTHOUGH SOME HEALTH-RELATED SOCIAL SERVICES WILL PRODUCE POSITIVE RETURN ON INVESTMENT FOR HEALTH IN A TIMELY MANNER, MANY MORE WILL HAVE BENEFITS THAT OCCUR IN THE FUTURE OR OUTSIDE HEALTH BUDGETS.

Recommendation 6.4

Analyze Data to Determine Costs and Benefits of Health-Related Social Services

- a) The Department of Information Technology should work with payers and NCCARE360 developers to ensure that data from existing state health and social service data systems can be integrated with data from the standardized screening questions and NCCARE360 to allow for analysis of the costs and benefits of addressing health-related social needs within the Medicaid program.
- b) The North Carolina Department of Health and Human Services should:
 - i) Publicize the results of analysis done using this data and advocate for Prepaid Health Plans to adopt interventions that are proven to have positive financial returns on investment.
 - ii) Work with other funders of health-related social needs interventions to ensure they can access the data needed to evaluate the work of Accountable Care Communities and efforts to address health-related social needs.
 - iii) Conduct a rigorous cost/benefit analysis of interventions to address health-related social needs used in the Medicaid Healthy Opportunities pilots.
- c) Prepaid Health Plans, Medicaid, and other payers should evaluate the return on investment for individuals covered by the Prepaid Health Plans/payers who receive services from Accountable Care Community interventions and disseminate their findings publicly to encourage greater understanding and adoption of services to meet health-related social needs.

Developing Long-Term Funding Strategies

In our current system, looking to payers to implement such changes makes sense on the surface. As the purveyors of health insurance plans, they seemingly have the power to control what is covered and the incentives to pay for services provided by human services organizations that can create savings in what they spend on health care. However, there are several reasons that health insurance companies alone cannot drive the move to purchasing health and well-being alone. As previously stated, health insurance companies are restricted in their spending to what is covered by the plans that have been purchased. In North Carolina, 31 percent of residents receive health insurance through state and federal

government (i.e., Medicaid, Medicare, and Tricare); 47 percent receive health insurance through their employer (including self-funded plans); 12 percent purchase individual plans; and 9 percent are uninsured.⁸⁴

As described in Chapter 1, the federal government is actually driving much of the move to value-based care, but still has strict rules that insurers must follow around what can and cannot be paid for under Medicare and Medicaid. While there may be room for innovation under some employer-purchased plans, approximately 60 percent of those plans are completely or partially self-funded, which means the companies pay for health care services for their workers, even if using a health insurance company as the administrator of the plan. Therefore, the insurance company has limited ability to innovate with these plans.⁸⁵ For the remaining insurance plans, incentives related to timing and policyholders' movement between insurers dampen insurance companies' willingness to pay for services provided by human services organizations. Under a one-year budgeting time frame, any direct payments for services or payment arrangements with health care providers must produce cost savings within the year, which is challenging. Additionally, constraints related to pricing and insurer requirements for financial returns (in light of federal requirements for minimum levels of spending on medical costs^u) undermine the financial business case for insurers. Nonetheless, insurance companies have the opportunity to provide leadership on improving health insurance affordability and on health care transformation, through their willingness to experiment (including with payment models) and invest for potential long-term returns.

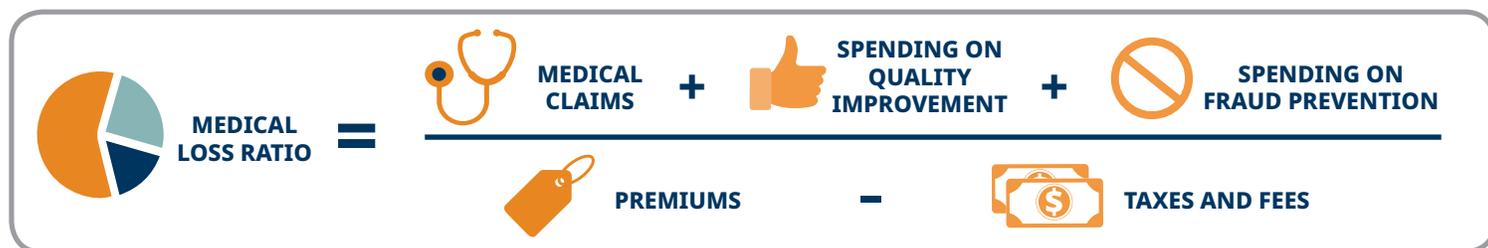
The Prepaid Health Plans that will manage care under Medicaid transformation can play a role in paying for services to meet health-related social needs for individuals enrolled in their plans. These plans will be required to use a percentage of the premiums they receive to pay for medical care and other health-related services. This is known as a medical loss ratio and is calculated as the proportion of premiums (less taxes and fees) that go to medical claims, quality improvement, and fraud prevention (see **Figure 8**).⁸⁶ NC DHHS will require an 88 percent medical loss ratio, meaning that plans will need to spend at least 88 percent of Medicaid premiums on medical services and quality improvement expenses. The federal government has not explicitly defined what qualifies as quality improvement, although generally these expenditures should be allocated to services that have been shown to reduce medical spending. NC DHHS has provided additional guidance in the Request for Proposals for Prepaid Health Plans. This guidance states that quality improvement expenditures may be included in the numerator of the

FUNDING FOR MANY SERVICES, PARTICULARLY PREVENTIVE SERVICES, MAY ONLY MAKE SENSE WHEN ALL OF THOSE BENEFITTING POOL FUNDS

^t The Affordable Care Act requirement for medical loss ratio for individual and small group (80 percent) and large group (85 percent), with rebate, includes medical claims plus narrowly-defined quality assurance activities measured annually and evaluated on 3-year rolling average to determine whether it was met and, if not, amount of rebates required to go back to policy holder.

^u 42 C.F.R. § 438.8.

Figure 8. Calculation of Medical Loss Ratio



NCIOM adaptation of Exhibit 4 from Bachrach, D, Guyer, J, Meier, S, Meerschaert, J, Brandel, S. *Enabling Sustainable Investments in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 31, 2018. <https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review>.*

INSURANCE COMPANIES HAVE THE OPPORTUNITY TO PROVIDE LEADERSHIP ON IMPROVING HEALTH INSURANCE AFFORDABILITY AND ON HEALTH CARE TRANSFORMATION, THROUGH THEIR WILLINGNESS TO EXPERIMENT (INCLUDING WITH PAYMENT MODELS) AND INVEST FOR POTENTIAL LONG-TERM RETURNS.

medical loss ratio calculation if they “reflect meaningful engagement with local communities” and “are spent directly on improving outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation or other essential services.”⁵⁹

Prepaid Health Plans will have incentives to pay for interventions and services that meet health-related social needs in order improve health outcomes, reduce medical service use, and reduce costs. Conversely, if interventions for health-related social needs are successful in decreasing medical claims, plans may develop concerns about the potential for premium rate reductions. Part of the considerations for setting premium rates is the recent claims experience of the plan, so reduced health care utilization can encourage lower premium rate setting. This can disincentivize Prepaid Health Plans to continue making investments in quality improvement. Therefore, a careful balance must be struck to encourage Prepaid Health Plans to invest in quality improvement, while accounting for the decrease in medical expenses that those investments intend to produce.

Aside from payer investments and compensation for services, communities can look to a variety of other funding options for long-term ACC sustainability, including local tax revenue and health care system investment. Developing sustainable funding strategies for services to meet people’s health-related social needs will be heavily influenced in North Carolina by the Medicaid Healthy Opportunities pilots. However, most communities in the state will not be involved in these pilots. Those ACCs not in the pilots will not have the same level of assistance with developing sustainable financial models. There will be communities all over the state wrestling with how to make the integration of health and

health-related social services sustainable from a funding perspective. ACCs outside of the pilots will need support and assistance to develop sustainable funding. Therefore, the Task Force recommends:

Recommendation 6.5
Develop Sustainable Accountable Care Community Funding

- a) Local Accountable Care Community models, in partnership with local government, should evaluate private, local, state, and federal sources of funding to support Accountable Care Community activities and services to meet health-related social needs (e.g., sales and other local taxes, hospital/health care system reinvestment, Medicare and Medicaid).
- b) Philanthropies should support Accountable Care Community models by:
 - i) Funding technical assistance and identifying organizations that provide technical assistance to help Accountable Care Communities determine the best financing model for their programs and functions. This technical assistance may include:
 1. Developing a funding strategy.
 2. Creating financial sustainability plans to ensure long-term financial stability of the Accountable Care Community model.
 - ii) Building the case and advocating for sustainable funding for Accountable Care Communities across the state using both health and financial outcomes.
- c) Payers should cover interventions that are proven to have positive financial returns on investment, including providing support to human services organizations serving patients’ health-related social needs.
- d) The North Carolina Department of Health and Human Services should:
 - i) Incentivize Prepaid Health Plans to incorporate appropriate payments for services and interventions that have been shown to produce a reliable return on investment. In so doing, considerations should be made for ensuring a rate-setting process that encourages and accounts for these investments.
 - ii) Incorporate effective interventions from the Healthy Opportunities pilots into the statewide Medicaid plan for the next Medicaid waiver application process.

ACCOUNTABLE CARE COMMUNITIES (ACCS) PROVIDE A MODEL FOR DEVELOPING MULTI-SECTOR PARTNERSHIPS TO ADDRESS HEALTH-RELATED SOCIAL NEEDS OF INDIVIDUALS, AS WELL AS THE CAUSES OF THOSE NEEDS AND INEQUITY IN THE COMMUNITY.

Health care spending in the United States continues to rise and our health outcomes often fall short when compared with other high-income countries. This fact, coupled with the growing evidence that health outcomes and overall well-being are determined by much more than medical care and genetic predisposition for disease, has led to a growing movement to address all drivers of health. Beyond medical care, these drivers of health include social and economic factors, the physical environment, and health behaviors. The increased awareness of health-related social needs and their impacts on health outcomes are driving efforts across the country to link health care, social services, and other sectors through partnerships to address the range of community needs affecting health and well-being.

Accountable Care Communities (ACCs) provide a model for developing multi-sector partnerships to address health-related social needs of individuals, as well as the causes of those needs and inequity in the community. These partnerships include representatives from health care, social services, transportation, food systems, public safety/law enforcement, education, housing, and other sectors that play a role in the opportunities people have to live healthy lives. Developing ACC partnerships can be challenging and requires overcoming the siloes these sectors currently exist in.

The initiatives supported by the North Carolina Department of Health and Human Services (see Chapter 3) could reduce several of the barriers to developing ACC partnerships. The standardized screening questions and NCCARE360 resource platform can provide resources that will be consistent across the state and allow ACCs to focus time and funding on other areas of partnership and program development. The Medicaid Healthy Opportunities pilots will provide a laboratory for testing an ACC-style model and financing mechanisms in several communities across the state.

INITIATIVES OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES COULD REDUCE SEVERAL OF THE BARRIERS TO DEVELOPING ACC PARTNERSHIPS

The recommendations of the North Carolina Institute of Medicine Task Force on Accountable Care Communities seek to support the development of local ACC models throughout North Carolina. The recommendations call on state agencies, health care payers and providers, local health departments, philanthropies, health professional and trade organizations, representatives of local and tribal government, and other stakeholders to lay the groundwork and support ACC development, evaluate the outcomes and equity of state and ACC efforts, and find sustainable ways to support the ongoing work of local partnerships.

With the implementation of these recommendations and the development of ACCs across North Carolina, communities can go a long way to addressing the health-related social needs of their residents. In doing so, our state can advance the health, well-being, and economic prosperity of our communities into the future.

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CHAPTER 1: BACKGROUND

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 Accountable Care Community Task Force Community Guide).
- 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.

CHAPTER 2: COLLABORATING FOR BETTER HEALTH

RECOMMENDATION 2.1:

PROMOTE HEALTH AND WELL-BEING IN ALL POLICIES

- a) State and local health promotion, advocacy, systems change, and policy-oriented organizations, such as the North Carolina Healthcare Association, North Carolina Medical Society and other health professional associations, North Carolina Community Health Center Association, Care Share Health Alliance, the Foundation for Health Leadership & Innovation (including their Jim Bernstein Community Health Leadership Fellowship, Health ENC, NC Rural Health Leadership Alliance, and Rural Forward NC initiatives), and the North Carolina Center for Health and Wellness should support:
 - i) Strategies to encourage local health officials to engage in community development and planning in a diversity of sectors (e.g., transportation, housing, infrastructure) in order to integrate a health and well-being perspective in all areas of local policy development.
 - ii) The capacity of local government, in conjunction with local health departments, to use tools to evaluate the integration of health and well-being into all aspects of local policy development and/or readiness for Accountable Care Community development.
- b) The University of North Carolina School of Government's Center for Public Leadership and Governance, in partnership with experts in health, health infrastructure of communities, health-related social needs, and health equity should:
 - i) Incorporate training on the concepts of health and well-being in all policies, health equity, and the purpose and role of Accountable Care Communities into their training programs.
 - ii) Develop an inventory of examples of community government or agency policies outside the area of health care that were developed with an intentional focus, study, or discussion of how such policies would influence the health of the community.

RECOMMENDATION 2.2:

EVALUATE HEALTH EQUITY EFFECTS OF ACCOUNTABLE CARE COMMUNITIES AND COUNTY-BASED PROGRAMS AND ACTIVITIES

- a) The North Carolina Office of Minority Health and Health Disparities should continue work to validate the Health Equity Impact Assessment for use in non-health sectors and publicize its use for a wide range of stakeholders.
- b) Local Accountable Care Community models should evaluate the effects of Accountable Care Community-related programs and activities on the health equity of the community they serve.
- c) County departments in all sectors (e.g., health, housing, transportation, etc.) should evaluate the health equity of programs and include community members and human services organizations in the process of completing the assessment.

RECOMMENDATION 2.3: PROVIDE GUIDANCE ON CROSS-AGENCY COLLABORATION TO ADDRESS DRIVERS OF HEALTH

a) Agency leaders and representatives from the North Carolina Departments of Health and Human Services, Commerce, Public Safety, Public Instruction, and Transportation, Hometown Strong, legislative leaders, and community representatives should convene to address barriers to collaboration at the state and local level. This leadership group should develop:

i) A vision, guidelines, and funding recommendations for how various state and local agencies could work together to address drivers of health and health equity in order to improve community health and well-being and enhance workforce development and economic prosperity.

ii) Templates of contracts with local agencies that reflect the priority of working across various community-based social service agencies that address health-related social needs and health equity.

b) Accountable Care Community partnerships should work to develop common language, common definition of terms, and common metrics to promote effective collaboration across sectors.

RECOMMENDATION 2.4: SUPPORT LOCAL HEALTH DEPARTMENTS TO BE LEADERS IN ACCOUNTABLE CARE COMMUNITIES

a) The Division of Public Health, in partnership with the North Carolina Association of Local Health Directors and the North Carolina Institute for Public Health, should:

i) Train state, regional, and local public health leadership/staff on how to lead multi-sector partnerships and strategies to address drivers of health and health equity.

ii) Require local health departments to participate in community coalitions working to address drivers of health and health equity

iii) Encourage local health departments to, as needed, convene and facilitate community coalitions working to address drivers of health and health equity.

iv) Require local health departments, in collaboration with hospitals and health care systems serving the community, to include at least one driver of health priority in their Community Health Action Plan.

b) Local health departments should help to align the work of Accountable Care Communities with the community and county engagement strategies of Medicaid Prepaid Health Plans and other payers in their communities in order to save the time and resources of human services organizations and other community groups that partner in this process.

c) Philanthropies should provide funding support to local health departments that take on convening and facilitation roles as Accountable Care Communities are developing.

RECOMMENDATION 2.5: REPORT RESULTS OF HOSPITAL AND HEALTH CARE SYSTEM COMMUNITY BENEFITS

The North Carolina Hospital Foundation should collect information on the population health effects of the community benefit activities of non-profit hospitals and health care systems.

RECOMMENDATION 2.6: ALIGN POLICIES FOR STATE DHHS REGIONS AND UNDERSTAND IMPLICATIONS OF REGIONALIZED PROGRAMS ON ACC PARTNER PARTICIPATION

a) The North Carolina Department of Health and Human Services should review existing Department of Health and Human Services-supported regionalized programs and services and develop a plan to help mitigate the influence of the various regions on the investment decisions of Prepaid Health Plans and philanthropies.

b) Local community coalitions seeking to develop an Accountable Care Community should be aware of and understand the regional implications and competing regional concerns of Accountable Care Community partners whose work crosses boundaries of more than one Accountable Care Community.

RECOMMENDATION 2.7: PROVIDE TECHNICAL ASSISTANCE TO ACCOUNTABLE CARE COMMUNITIES

a) The North Carolina Center for Health and Wellness, North Carolina Healthcare Association, the Foundation for Health Leadership & Innovation (including their Health ENC and Rural Forward NC initiatives), North Carolina Area Health Education Centers, WNC Health Network, state universities and community colleges, the North Carolina Division of Public Health, the North Carolina Medical Society and other health professional associations, state and local Chambers of Commerce, and state and local Councils of Government should:

i) Host or support training on a structured format for decision-making (e.g., Results Based Accountability™ or similar models), for organizations and local government agencies interested in using these methods in their Accountable Care Community development process, or

ii) Facilitate conversations with Accountable Care Community partner organizations around alignment of goals and sustainability of work.

b) The North Carolina Medical Society and the North Carolina Healthcare Association, with representation from the Foundation for Health Leadership & Innovation (including their NC Rural Health Leadership Alliance initiative), Care Share Health Alliance, North Carolina Area Health Education Centers, and other partners, should convene learning collaboratives for health care systems, communities, businesses, payers (including private insurers, Medicaid, and Prepaid Health Plans), and providers to support the development and implementation of Accountable

Care Communities. These learning collaboratives should include discussions of evidence-based interventions and continuous quality improvement, as well as topics such as:

- i) Coalition development,
- ii) Shared goal setting,
- iii) Backbone organization/team support,
- iv) Health equity,
- v) Methods for implementation, data sharing, outcomes/evaluation,
- vi) Legal considerations, technology needs, financing, organizational/administrative needs, and
- vii) Developing and financing sustainable payment models.

CHAPTER 3 – NORTH CAROLINA OPPORTUNITIES FOR HEALTH

RECOMMENDATION 3.1: PROVIDE TECHNICAL ASSISTANCE TO HEALTHY OPPORTUNITIES PILOTS

The North Carolina Department of Health and Human Services, in collaboration with other relevant state agencies such as the Departments of Transportation, Public Instruction, and Commerce, the Housing Finance Agency, and North Carolina philanthropies should provide or support technical assistance for participants in the Medicaid Healthy Opportunities pilots in order to build capacity for cross-sectoral collaborations to improve health including:

- i) Network development,
- ii) Health equity,
- iii) Methods for implementation, data sharing, outcomes/evaluation,
- iv) Technology needs,
- v) Legal considerations, financing, organizational/administrative needs, and
- vi) Developing and financing sustainable payment models.

RECOMMENDATION 3.2: DEVELOP STAKEHOLDER SUPPORT FOR STATE HEALTHY OPPORTUNITIES INITIATIVES

- a) The North Carolina Department of Health and Human Services, with other partners, should educate enrollment brokers, payers, health care systems, providers, and human services organizations about the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360.
- b) State health and social service membership organizations should:

- i) Ensure there are in-person and virtual training opportunities for health and human service professionals about the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360.
- ii) Partner with the North Carolina Department of Health and Human Services and North Carolina Area Health Education Centers to develop practice supports and implementation plans related to the new North Carolina Department of Health and Human Services approach to health-related social needs, the standardized screening questions, and NCCARE360 for health care systems and providers.

CHAPTER 4 – IMPLEMENTING OPPORTUNITIES FOR HEALTH

RECOMMENDATION 4.1: DEVELOP AND DEPLOY THE STANDARDIZED SCREENING QUESTIONS AND NCCARE360

- a) The North Carolina Department of Health and Human Services should finalize and publish the standardized screening questions, as planned.
- b) NCCARE360 partners, in developing and deploying NCCARE360, should:
 - i) Seek input from members of the community, human services organizations, and health care providers (including care managers) on the direction, alignment, and implementation of NCCARE360, as well as the curation of resources available on the Platform.
 - ii) Implement plans to ensure the platform:
 1. Integrates the standardized screening questions.
 2. Is available for use by health care and social service providers, individuals, and others who may screen and refer for health-related social needs.
 3. Updates human services organization information and public benefit eligibility with up-to-date information to ensure the platform is current and usable for providers and patients.
 4. Allows human services organizations to submit or update information about their services and capacity to serve clients.
 - iii) Implement their minimum data security qualifications for organizations interested in sharing individuals' data related to health-related social needs.
 - iv) Provide education, in-person training, and technical assistance to human services organizations around NCCARE360's purpose, implementation, and on-boarding.
 - v) Develop an Advisory Council to provide a voice to stakeholders in the development and deployment of NCCARE360.

c) NCCARE360 partners, including the North Carolina Department of Health and Human Services, should develop outreach plans and training materials for marketing and education on the purpose and features of the platform and should seek input from human services organizations, users, health care providers, and other stakeholders on these plans and materials.

RECOMMENDATION 4.2:

ENSURE INDIVIDUALS ARE INFORMED ABOUT PERSONAL DATA COLLECTION AND SHARING

a) Prepaid Health Plans, private insurers, the State Health Plan, health care providers, and human services organizations should ensure that guidelines around informed consent are followed before sharing client information collected through the standardized screening questions or NCCARE360. This includes informed consent in plain language that describes how the information will be used, how it may be shared, and with whom it may be shared with (e.g., Prepaid Health Plans, providers, human services organizations).

b) The North Carolina Department of Health and Human Services should require Prepaid Health Plans to use plain-language informed consent prior to sharing information collected by the standardized screening questions with a non-Health Insurance Portability and Accountability Act (HIPAA) covered entity (if not completing screening through NCCARE360).

c) Private insurers, the State Health Plan, health care providers, and human services organizations should use plain-language informed consent prior to sharing information collected by the standardized screening questions, if one of the entities is not a Health Insurance Portability and Accountability Act (HIPAA) covered entity (if not completing screening through NCCARE360).

RECOMMENDATION 4.3:

IMPLEMENT SCREENING AND REFERRAL PROCESS ACROSS HEALTH CARE PAYERS, PROVIDERS, HUMAN SERVICES, AND SOCIAL SERVICE ENTITIES

a) To ensure people are both screened and connected to appropriate community resources and to maximize efficiencies across the state, all Accountable Care Community partners should:

i) Use the standardized screening questions and NCCARE360.

ii) Review the optional domain items identified by the North Carolina Department of Health and Human Services and determine what items are appropriate to include with the core measures of the North Carolina standardized screening questions for populations in their community.

b) To facilitate the use of the standardized screening questions and NCCARE360, the North Carolina Department of Health and Human Services should:

i) Require screening of enrollees in Prepaid Health Plans, as stated in the Request for Proposals for Prepaid Health Plan Services.⁶⁴

ii) Require Prepaid Health Plans to share results of the standardized screening questions with Advanced Medical Homes for individuals receiving care management through those practices, as stated in the Request for Proposals for Prepaid Health Plan Services.

iii) Encourage use of the screening questions by:

1. All individuals applying for public benefits.
2. All enrollees in traditional Medicaid.
3. All individuals enrolled in Advanced Medical Home practices.

iv) Support NCCARE360 partners as they work with providers and community agencies to develop and adopt protocols and work flows for using the Platform to address the needs of, and ensure follow-up with, individuals whose screening results indicate they could benefit from additional resources.

c) Medicaid insurers, private insurers, the State Health Plan, the NC Navigator Consortium, health care systems, independent providers, local health departments, safety net providers, and human services organizations should use the standardized screening questions to identify unmet resource needs and use NCCARE360 to refer and navigate individuals whose screening results indicate they could benefit from additional resources to appropriate community resources.

RECOMMENDATION 4.4:

FACILITATE DATA SHARING AND COMPATIBILITY

Any data systems developed to support an Accountable Care Community model should incorporate standard document exchange methods, such as Health Level 7 (HL7) interfaces or Fast Healthcare Interoperability Resources (FHIR) web services and be compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state and federal privacy laws.

RECOMMENDATION 4.5:

DEVELOP, EXPAND, AND SUPPORT THE HEALTH CARE WORKFORCE TO BETTER ADDRESS HEALTH-RELATED SOCIAL NEEDS AND HEALTH EQUITY

a) The North Carolina Area Health Education Centers and health professional associations should help raise awareness and create opportunities to educate current health care professionals on the effect that health-related social needs have on health, how interprofessional health care team members can help to assess the needs of individuals, and how to support Accountable Care Community models.

b) The North Carolina Community College System, colleges and universities, North Carolina Area Health Education Centers, health care training programs, health care systems, and providers across the state should:

- i)** When possible, collaborate to develop interprofessional team-based care and training for all members of health care teams to understand the impact of health-related social needs on health, how health care team members can help to assess the needs of individuals, and how to work as a team to support Accountable Care Community models.
 - ii)** Develop a pipeline for high school students interested in health care fields, including community health work and nursing or social work care management, in order to expand the workforce capacity for Accountable Care Community needs.
 - iii)** Study and implement effective methods to improve the diversity of the health care workforce to reflect the diversity of the communities being served.
- c)** The North Carolina Department of Health and Human Services, the North Carolina Community College System, colleges and universities, North Carolina Area Health Education Centers, and, once developed and in place, the North Carolina Community Health Worker Certification and Accreditation Board, should support the implementation of the findings of the North Carolina Community Health Worker Initiative.
- d)** Health care organizations using care management services, as well as providers of care management services, should educate staff on the association of health-related social needs with health outcomes and how care managers can help in the assessment and referral process.
- e)** Payers and health care providers should:
- i)** Continue to develop new payment and delivery models that support the work of community health workers, health coaches, care managers, care coordinators, and other emerging roles.
 - ii)** Ensure that care management services are provided to people who have high unmet health-related social needs, but who do not currently have high medical costs.
- ii)** Promote and incentivize human services organizations and stakeholders (e.g., Prepaid Health Plans and health care providers) to invest in experimentation, innovation, and information technology infrastructure that foster cost-effective models of service delivery in order to achieve integrated health systems.
- iii)** Encourage payment models that promote partnership and collaboration between health care and human services organizations.
- iv)** Explore and generate a plan of action for how health care funding streams can be used to support services to address health-related social needs delivered by human services organizations.
- v)** Identify, or develop plans to form, an entity that can provide consultation to enable human services organizations to improve financial management, contracting processes, and coordination/ collaboration within the human services sector. This entity should help human services organizations understand Medicare, Medicaid, and private insurance payment opportunities as part of a financial services portfolio.
- vi)** Determine how to increase the sector’s capacity to attract, retain, and provide opportunities for advancement for a diverse workforce.
- b)** The North Carolina Department of Health and Human Services should review state reporting and administrative requirements for human services organizations receiving state funding to:
- i)** Reform public agency contracting processes and grantmaking to:
 1. Provide full and timely payment for services rendered, and
 2. Fund administrative overhead at a minimum of 10 percent or the agency’s federal- or state-approved indirect cost rate agreement, whichever is the most beneficial to the human services organization.
 - ii)** Examine how reporting requirements may be streamlined and facilitated with use of NCCARE360.
 - iii)** Minimize outdated, duplicative, conflicting, or overlapping state regulations within its control that impede efficient and effective service delivery.

**RECOMMENDATION 4.6:
STRENGTHEN THE HUMAN SERVICES SECTOR**

- a)** Philanthropies should promote the convening of an intersectoral work group, including leaders from state and local government, health care (i.e., providers, insurers, Prepaid Health Plans), community members, philanthropy, and the human services sector, to:
- i)** Determine strategies human services organizations can use to increase their capacity to track outcomes; share information across programs, organizations, and government divisions and departments throughout the state; and use outcomes as evidence of effectiveness for funding purposes. This should include a review of how NCCARE360 can be used to achieve these goals and how the intersectoral work group can promote the adoption of the Platform by human services organizations.

CHAPTER 5 – EVALUATION AND PROCESS IMPROVEMENT

**RECOMMENDATION 5.1:
EVALUATE METHODS FOR SCREENING FOR HEALTH-RELATED SOCIAL NEEDS**

The North Carolina Department of Health and Human Services should provide guidance on optimal frequency, modality, and location for screening individuals for health-related social needs. This guidance should balance concerns about under- or over-screening with the need to gather timely information and engage services to address beneficiary needs. The guidance should also consider and describe best practices for preparing or “priming” individuals for the screening process to help produce the

highest rates of screening acceptance and completion as possible. This guidance should:

- i) Be published and disseminated to Prepaid Health Plans and other payers, health care providers, human services organizations, educational institutions with health workforce training programs, and other stakeholders through NC DHHS website(s) and other forms of communication (e.g., presentations, training materials).
- ii) Inform future standards and requirements for Prepaid Health Plans related to screening for health-related social needs.
- iii) Consider the utility of a pre-screening question to identify individuals who should be screened or re-screened, with the intention of reducing burden to individuals being screened and those assisting with screening processes.

**RECOMMENDATION 5.2:
EVALUATE DATA GATHERED THROUGH THE STANDARDIZED SCREENING PROCESS**

- a) The Department of Information Technology should explore how NC HealthConnex could be used to collect, aggregate, and share data from the standardized screening questions responses collected by Prepaid Health Plans, NCCARE360, and other providers and organizations using the standardized screening questions to screen individuals for health-related social needs.
- b) The North Carolina Department of Health and Human Services should:
 - i) Require Prepaid Health Plans to submit quarterly raw data files with standardized screening questions results. Data should include gender, race/ethnicity, age, and geography of screened individuals.
 - ii) Maintain a Memorandum of Understanding with the Foundation for Health Leadership & Innovation for use of all data collected through NCCARE360.
 - iii) Release aggregate data reports annually on its website. Information should be disaggregated by gender, race/ethnicity, age, and geography to the smallest degree possible for evaluation and planning. These reports should identify areas where resources are needed in communities.
 - iv) Work with academic and research partners to use identified data for evaluation.

**RECOMMENDATION 5.3:
EVALUATE DATA GATHERED THROUGH NCCARE360**

- a) The Foundation for Health Leadership & Innovation should:
 - i) Require regular reports from NCCARE360 partners including:
 1. Reports specified in the Resource Platform vendor Request for Proposals.

- 2. The density of service providers connected to the platform in each of the North Carolina Department of Health and Human Services priority areas (i.e., transportation, housing, food, interpersonal violence, and employment) and in relation to the service needs of a community, as identified with standardized screening questions response data.
- 3. The volume of referrals, whether the referral loop was closed, and percent of referrals declined by the agency receiving referral, with data aggregated by agency individual was referred to.
- 4. Referral outcomes (i.e., referral completion or “fill” rate) for an individual referred for services, the referral source, and the organization receiving referrals, in order to evaluate and improve the referral process.

ii) Publish annual reports analyzing the above measures. Data should be provided at the smallest geographic gradation possible (e.g., county, zip code, or neighborhood) to be used by ACCs and individual entities for planning and evaluation. These reports should be published on the Foundation for Health Leadership & Innovation website.

- b) NCCARE360 partners should develop a method to assess:
 - i) The quality of the experience of referrals
 - ii) Frequency of duplicated referrals and, if high, mechanisms for decreasing referral duplication.
 - iii) The cost to human services organizations of meeting needs of those referred using the Platform.

CHAPTER 6 – FUNDING AND FINANCING MODELS

**Recommendation 6.1:
Support Initial Development of Local Accountable Care Communities**

- a) Philanthropies should:
 - i) Provide support for capacity development in communities to help local leaders interested in creating an Accountable Care Community.
 - ii) Provide grant funding to support the development of local Accountable Care Communities. When possible, philanthropies should coordinate portfolios of work with other philanthropies and streamline reporting requirements.
 - iii) Require local Accountable Care Communities to develop a lead entity, plans for funding and sustainability, outcomes measures, and an evaluation plan.
- b) Prepaid Health Plans, Medicaid, and other payers should develop strategies to financially support local Accountable Care Community efforts and provide subject-area expertise as partners in community coalitions.

- c) Health care systems should direct community benefit dollars toward a greater mix of investments that impact the drivers of health. These investments may include community partnerships, such as development of an Accountable Care Community model; infrastructure building, such as the NCCARE3060 resource platform; or direct investment in addressing health-related social needs of the community related to housing, food, transportation, interpersonal violence, or other needs. Community benefit investments should be aligned with the Community Health Assessment, Community Health Needs Assessment, and Community Health Action Plan.
- d) Local businesses should direct funds to support Accountable Care Community efforts and/or donate subject-area expertise as partners in community coalitions.

Recommendation 6.2:

Funding for Local Accountable Care Community Implementation

- a) Prepaid Health Plans, Medicaid, other payers, and health care providers should develop and test payment models for coverage of social services to improve wellness and reduce overall costs in alignment with the Community Health Assessment, Community Health Needs Assessment, and Community Health Action Plan in the communities they serve and/or provide payment for services rendered by Accountable Care Communities and their partners.
- b) Philanthropies should provide bridge financing to Accountable Care Communities transitioning from startup funding to payment structures that can support human services organizations providing services for those with health-related social needs.
- c) Local governments should consider using local tax revenues to support Accountable Care Community activities.

Recommendation 6.3:

Support Implementation of Medicaid Healthy Opportunities Pilots

- a) As part of the Healthy Opportunities pilots, the North Carolina Department of Health and Human Services should implement its plans as stated in the Prepaid Health Plan Request for Proposal and public documents to:
 - i) Require the Lead Pilot Entities to facilitate an Accountable Care Community by convening key local stakeholders (e.g., payers, health care providers, local government agencies, and human services organizations).
 - ii) Require Prepaid Health Plans to participate in the Lead Pilot Entity-led Accountable Care Communities.
 - iii) Develop requirements for how Prepaid Health Plans should partner with the pilots to address health-related social needs, as well as mechanisms for accountability.
 - iv) Develop funding streams for human services organizations participating in the pilots, in partnership with Prepaid Health Plans and other payers, including all potential federal funding streams.

- v) Complete rigorous rapid-cycle and summative evaluations to identify successful components of the pilots, cost savings, and lessons learned.

- vi) Develop a plan for how to sustain or improve upon pilot activities and implement successful components for Medicaid services across the state based on lessons learned from the five years in pilot communities.

- b) Philanthropies should align efforts to support the Medicaid Healthy Opportunities pilots by:

- i) Coordinating with the North Carolina Department of Health and Human Services to provide funding for services to address drivers of health that cannot be paid for using Medicaid funds.

- ii) Streamlining reporting requirements if multiple philanthropies provide pilot funding.

- iii) Supporting capacity building for Lead Pilot Entities participating in the pilots (e.g., leadership development).

- iv) Providing bridge financing, if needed, to support communities that transition from the Healthy Opportunities pilot model concept to one with financial return on investment.

- c) The North Carolina General Assembly should approve the North Carolina Department of Health and Human Services' full spending authority under the 1115 Waiver for Medicaid transformation. The Healthy Opportunities Pilots, with the approved rapid cycle assessments and summative evaluation, will be important to ensure accountability for investments, learn which interventions are most and least effective, and inform other Accountable Care Communities efforts.

Recommendation 6.4

Analyze Data to Determine Costs and Benefits of Health-Related Social Services

- a) The Department of Information Technology should work with payers and NCCARE360 partners to ensure that data from existing state health and social service data systems can be integrated with data from the standardized screening questions and NCCARE360 to allow for analysis of the costs and benefits of addressing health-related social needs within the Medicaid program.

- b) The North Carolina Department of Health and Human Services should:

- i) Publicize the results of analysis done using this data and advocate for Prepaid Health Plans to adopt interventions that are proven to have positive financial returns on investment.

- ii) Work with other funders of health-related social needs interventions to ensure they can access the data needed to evaluate the work of Accountable Care Communities and efforts to address health-related social needs.

- iii) Conduct a rigorous cost/benefit analysis of interventions to address health-related social needs used in the Medicaid Healthy Opportunities pilots.
- c) Prepaid Health Plans, Medicaid, and other payers should evaluate the return on investment for individuals covered by the Prepaid Health Plans/payers who receive services from Accountable Care Community interventions and disseminate their findings publicly to encourage greater understanding and adoption of services to meet health-related social needs.

Recommendation 6.5

Develop Sustainable Accountable Care Community Funding

- a) Local Accountable Care Community models, in partnership with local government, should evaluate private, local, state, and federal sources of funding to support Accountable Care Community activities and services to meet health-related social needs (e.g., sales and other local taxes, hospital/health care system reinvestment, Medicare and Medicaid).
- b) Philanthropies should support Accountable Care Community models by:
 - i) Funding technical assistance and identifying organizations that provide technical assistance to help Accountable Care Communities determine the best financing model for their programs and functions. This technical assistance may include:
 1. Developing a funding strategy.
 2. Creating financial sustainability plans to ensure long-term financial stability of the Accountable Care Community model.
 - ii) Building the case and advocating for sustainable funding for Accountable Care Communities across the state using both health and financial outcomes.
- c) Payers should cover interventions that are proven to have positive financial returns on investment, including providing support to human services organizations serving patients' health-related social needs.
- d) The North Carolina Department of Health and Human Services should:
 - i) Incentivize Prepaid Health Plans to incorporate appropriate payments for services and interventions that have been shown to produce a reliable return on investment. In so doing, considerations should be made for ensuring a rate-setting process that encourages and accounts for these investments.
 - ii) Incorporate effective interventions from the Healthy Opportunities pilots into the statewide Medicaid plan for the next Medicaid waiver application process.

RECOMMENDATIONS BY RESPONSIBLE AGENCY/ORGANIZATION – APPENDIX B

RECOMENDATIONS	RESPONSIBLE AGENCY/ORGANIZATION									
	DEPARTMENT OF HEALTH AND HUMAN SERVICES (OVERALL)	DIVISION OF PUBLIC HEALTH	DEPARTMENT OF INFORMATION TECHNOLOGY	NORTH CAROLINA GENERAL ASSEMBLY	LOCAL HEALTH DEPARTMENTS	PREPAID HEALTH PLANS	PHILANTHROPIES	HEALTH PROFESSIONAL AND TRADE ORGANIZATIONS	LOCAL ACC MODELS	OTHER
CHAPTER 1										
Rec. 1.1: Promote Accountable Care Communities to improve health of community members	✓				✓			NCHA, NCMS		NCIOM Task Force Members, NC Chamber of Commerce, civic organizations, local hospital and/or health care system government relations representatives
CHAPTER 2										
Rec. 2.1: Promote health and well-being in all policies								NCHA, NCMS, NCCCHA		Care Share Health Alliance, FHLI, NC Center for Health and Wellness, UNC School of Government
Rec. 2.2: Evaluate health equity effects of Accountable Care Community and county-based programs and activities					✓				✓	County departments in all sectors (e.g., health, housing, transportation, etc.), Office of Minority Health and Health Disparities
Rec. 2.3: Provide guidance on cross-agency collaboration to address drivers of health									✓	NC Departments of Health and Human Services, Commerce, Public Safety, Public Instruction, and Transportation, legislative leaders, Hometown Strong, local and community representatives
Rec. 2.4: Support local health departments to be leaders in Accountable Care Communities		✓			✓			NCALH, NCIPH		
Rec. 2.5: Report results of hospital and health care system community benefits										NCHF
Rec. 2.6: Align policies for state Department of Health and Human Services regions and understand implications of regionalized programs on Accountable Care Community partner participation	✓									✓
Rec. 2.7: Provide technical assistance to Accountable Care Communities		✓						NCHA, NCMS		NC Center for Health and Wellness, FHLI, AHEC, WNC Health Network, Care Share Health Alliance, state universities and community colleges, state and local Chambers of Commerce, state and local Councils of Government

APPENDIX B – RECOMMENDATIONS BY RESPONSIBLE AGENCY/ORGANIZATION

RECOMMENDATIONS	RESPONSIBLE AGENCY/ORGANIZATION									
	DEPARTMENT OF HEALTH AND HUMAN SERVICES (OVERALL)	DIVISION OF PUBLIC HEALTH	DEPARTMENT OF INFORMATION TECHNOLOGY	NORTH CAROLINA GENERAL ASSEMBLY	LOCAL HEALTH DEPARTMENTS	PREPAID HEALTH PLANS	PHILANTHROPIES	HEALTH PROFESSIONAL AND TRADE ORGANIZATIONS	LOCAL ACC MODELS	OTHER
CHAPTER 3										
Rec. 3.1: Provide technical assistance to Healthy Opportunities Pilots	✓						✓			Other state agencies, such as Departments of Transportation, Public Instruction, and Commerce; Housing Finance Agency
Rec. 3.2: Develop stakeholder support for State Health Opportunities initiatives	✓									State health and social service membership orgs.
CHAPTER 4										
Rec. 4.1: Develop and deploy the standardized screening questions and NCCARE360	✓									NCCARE360 partners
Rec. 4.2: Ensure individuals are informed about personal data collection and sharing	✓					✓				Private insurers, State Health Plan, health care providers, human services organizations
Rec. 4.3: Implement screening and referral process across health care payers, human services, and social service entities	✓				✓				✓	Medicaid insurers, private insurers, State Health Plan, NC Navigators Consortium, health care systems, independent providers, safety net providers, human services organizations
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	✓									AHEC, NC Community College System, NC Community Health Worker Certification and Accreditation Board, colleges and universities, health care training programs, health care systems, health care providers, health care organizations using care management services, payers
Rec. 4.6: Strengthen the human services sector	✓						✓			

RECOMMENDATIONS BY RESPONSIBLE AGENCY/ORGANIZATION – APPENDIX B

RECOMENDATIONS	RESPONSIBLE AGENCY/ORGANIZATION									
	DEPARTMENT OF HEALTH AND HUMAN SERVICES (OVERALL)	DIVISION OF PUBLIC HEALTH	DEPARTMENT OF INFORMATION TECHNOLOGY	NORTH CAROLINA GENERAL ASSEMBLY	LOCAL HEALTH DEPARTMENTS	PREPAID HEALTH PLANS	PHILANTHROPIES	HEALTH PROFESSIONAL AND TRADE ORGANIZATIONS	LOCAL ACC MODELS	OTHER
CHAPTER 5										
Rec. 5.1: Evaluate methods for screening for health-related social needs	✓									
Rec. 5.2: Evaluate data gathered through the standardized screening process	✓		✓							
Rec. 5.3: Evaluate data gathered through NCCARE360										FHLI, NCCARE360 partners
CHAPTER 6										
Rec. 6.1: Support initial development of local Accountable Care Communities						✓	✓			Medicaid, other health care payers, health care systems, local businesses
Rec. 6.2: Funding for local Accountable Care Community implementation						✓	✓			Medicaid, other health care payers, health care providers, local governments
Rec. 6.3: Support implementation of Medicaid Health Opportunities pilots	✓			✓			✓			
Rec. 6.4: Analyze data to determine costs and benefits of health-related social services	✓		✓			✓				Medicaid, other health care payers
Rec. 6.5: Develop Sustainable Accountable Care Community funding	✓						✓		✓	Health care payers

FHLI=Foundation for Health Leadership & Innovation; NC AHEC = North Carolina Area Health Education Centers; NCCHCA = North Carolina Community Health Center Association; NCHF = North Carolina Hospital Foundation; NCALHD = North Carolina Association of Local Health Directors; NCHA = North Carolina Healthcare Association; NCIPH = North Carolina Institute for Public Health; NCIOM = North Carolina Institute of Medicine; NCMS = North Carolina Medical Society; UNC = University of North Carolina

The drivers of health, sometimes called the social determinants of health, are the social, economic, and environmental conditions in which people are born, live, work, and age. Although they significantly contribute to the risk of premature death, the drivers of health are often overlooked when it comes to preventive health measures, with most efforts targeted towards medical services.¹ The following is a brief overview of how some drivers of health affect health outcomes.

Poverty

In the United States, individuals and families are considered to live in poverty when their income does not reach a federally-determined threshold to adequately afford minimum necessities such as food, clothing, transportation, and shelter.² According to the United States Department of Health and Human Services, the poverty threshold for an individual is an annual income of \$12,140 or less, and for a family of four, an annual household income of \$25,000 or less.³ Around 12.7 percent of the United States population lives in poverty.⁴ In North Carolina, 14.7 percent of the population lives in poverty, giving the state the thirteenth highest poverty rate in the country.^{5,6} Those who live at or near the federal poverty line are at significant risk of poor health. Evidence shows that individuals who live in poverty have higher rates of HIV and other sexually transmitted infections, chronic disease, obesity, tobacco use, and community violence.^{7,8} Studies have found positive associations between life expectancy and income, with men in the highest income bracket living an average of 87.3 years compared to men in the lowest income bracket living an average of 72.7 years.⁹ Income level is also related to other drivers of health. Individuals who live in poverty also face food insecurity, limited access to transportation, challenges affording health insurance and medical care, and are often unable to live in communities that present opportunities to be healthy because of the cost burden of quality housing options or the lack of affordable housing options in safe areas.^{2,10,11}

Education

Academic achievement and education are strongly correlated with health across the lifespan. In general, those with less education have more chronic health problems and shorter life expectancies. In contrast, people with more years of education are likely to live longer, healthier lives. Further, these health disparities based on years of education are seen in every ethnic group.¹² Adults who have not finished high school are more likely to be in poor or fair health than college graduates. The age-adjusted mortality rate of high school dropouts ages 25-64 is twice as large as the rate of those with some college education. They are also more likely to suffer from the most acute and chronic health conditions, including heart disease, hypertension, stroke, elevated cholesterol, emphysema, diabetes, asthma attacks, and ulcers. College graduates live, on average, five years longer than those who do not complete high school. In addition, people with more education are less likely to report functional limitations and are also less likely to miss work due to disease.¹² Level of education is also positively correlated with health literacy. Health literacy is the capacity to which people can gather, process, and comprehend health information

and services to make health decisions. Individuals with higher levels of education are more likely to have adequate-to-high health literacy than individuals with lower levels of education. Low health literacy is associated with poor health outcomes and exacerbates health disparities.¹³⁻¹⁶ Low health literacy contributes to poor health outcomes because those with low health literacy are less able to understand health information, to engage with health care providers, and to understand how certain health-risk behaviors can be detrimental to their health.¹⁵

Access to Health Care

Accessing quality health care is necessary to promote and maintain good health, to prevent and manage diseases, and to achieve health equity.¹⁷ Although genetics play a strong role in risk factors for chronic conditions like cardiovascular disease, diabetes, and cancer,¹⁸ the quality of care received can mitigate or increase the risk of these diseases. Those who lack access to health care services because of lack of insurance coverage are more likely to have poor health status, be diagnosed with a disease or condition at a late stage, and die prematurely.¹⁷

Within the United States, there are disparities in access to care. People of color, low-income Americans, and those who reside in rural areas are less likely to have insurance coverage, utilize less care, and face numerous barriers to accessing health care.¹⁹⁻²¹ People of color are more likely to forego or delay care and less likely to have a regular source of care or checkups. Individuals with low incomes are frequently unable to afford private insurance and often forego regular care appointments to avoid costs. Americans who reside in rural areas can have limited access to coverage compared to those who reside in urban areas. These barriers and lack of routine preventive care contribute to higher rates of many health conditions in these populations.

Built Environment

Built environment encompasses our homes and neighborhoods, open spaces, streets, and community infrastructure.²² Communities having few or no sidewalks, bicycle lanes, walking paths, parks, or recreational facilities contribute to sedentary lifestyles by not providing ample opportunities for physical activity. With fewer opportunities for physical activity, the risk of obesity, diabetes, cardiovascular disease, and other diseases increases.²²⁻²⁴ A systematic review of 28 interventions that examined the relationship between built environment features and physical activity and/or travel infrastructure found that built environment interventions can have a positive effect on physical activity.²⁵ In addition to physical activity, access to healthy foods, health care, and other services can be limited by the ability of individuals to navigate their neighborhood without a car.

Housing is another component of the built environment that is a major driver of health. Housing can be detrimental to health through two pathways: cost burden of paying for housing and quality of housing. A household is considered cost-burdened if they spend more than 30

percent of their income on housing and severely cost-burdened if they spend more than 50 percent of their income on housing. Cost-burdened households are associated with worse self-reported health and a higher likelihood of postponing health care services. This relationship is particularly strong among severely cost-burdened households and low-income renters.²⁶

Housing quality greatly influences health and factors into acute episodes of illness.²⁷ Overcrowding and poor ventilation in a home can be a breeding ground for pests (mites and roaches), mold, and respiratory viruses.²⁸ Poor housing conditions, such as loose carpets, poor lighting, unsafe stairways, and bathtubs without handles, can also result in falls and hospitalizations, particularly among elderly individuals.^{29,30} The link between chronic diseases, particularly asthma, and housing quality has been studied extensively. Studies have shown that damp, cold, moldy housing can increase the likelihood of developing asthma.^{13–15} Exposure to lead through lead-based paint can cause lead poisoning and can lead to developmental delays and neurological changes in children.³⁵ Early interventions and investments to address these housing quality issues significantly improve health outcomes and yield considerable returns. Under conservative estimates, each dollar invested in lead paint hazard control yields a return between \$17 and \$221 in savings for health care, lost earnings, tax revenue, special education, and direct costs of crime.³⁶ Other housing quality issues that affect health include accessibility for older adults or individuals with disabilities. Hazards such as uneven flooring and stairs can lead to falls or make homes inaccessible. Interventions, such as ramps, grab bars, and single-floor housing units, can make independent living safer and more accessible for these populations.

Transportation

Access to transportation is another important driver of health outcomes. For example, having a driver's license influences the likelihood that an individual will seek health services such as chronic care management and regular checkups.³⁷ Adults who miss health care appointments due to transportation problems are 1.9 times more likely to have arthritis and heart disease, 2.5 times more likely to have diabetes, and 3.3 times more likely to have depression or chronic obstructive pulmonary disease when compared to adults who do not miss health care appointments due to transportation problems.³⁸ This is particularly true for lower-income and under/uninsured people and is further exacerbated for rural residents who often have to travel outside of town for specialty care.³⁹

Children, older adults, individuals with low socio-economic status, and racial and ethnic minority populations are often cited as populations that have difficulty accessing health services due to transportation barriers. One study found that 21 percent of older adults cited transportation problems as a barrier to accessing care.⁴⁰ A study that surveyed more than 600 low-income immigrants in Nassau County, New York found that many participants had to miss or reschedule clinic appointments because of issues related to transportation, such as unreliable rides, issues with

public transportation, and transportation-related costs.⁴¹ Transportation barriers also affect other drivers of health. Poor transportation or lack of access to transportation can cut off access to many food outlets that offer healthy foods, such as supermarkets and farmers' markets.⁴²

Food

When an individual or family does not have access to enough food, they are considered food insecure. Food insecurity is defined as the disruption of food intake or eating patterns because of a lack of money and other resources.⁴³ Being food insecure has many consequences that often result in negative health outcomes, directly and indirectly. Those who are living in food-insecure households are more at risk for diabetes and obesity⁴⁴ and food insecurity can also have adverse effects on child and adolescent mental health. A study conducted within the United States found a positive association between mental disorders and a household's food security status.⁴⁵ Other studies focusing on children and adolescents have found that food insecurity negatively affects a child's academic performance, weight gain, and social skills, which subsequently leads to specific nutritional and non-nutritional consequences for children.³² In the older adult population, those who are malnourished use more health care services, including more and longer hospital admissions.⁴⁶ Malnourishment can result from food insecurity or the inability to properly store or cook foods (e.g., broken or inaccessible appliances or disabled utilities making refrigerators and freezers unusable).

Interpersonal Violence

Interpersonal violence includes intimate partner violence, sexual violence, and childhood sexual and physical abuse.⁴⁷ According to the Centers for Disease Control, 37 percent of women and 31 percent of men in the United States have experienced some form of interpersonal violence. One in 4 children have faced some form of childhood abuse, with more than a 1,000 children dying from physical abuse in 2016.¹⁵ Interpersonal violence victimization is associated with a range of physical, psychological, and social consequences.

Physically, interpersonal violence can result in bruises, broken bones, traumatic brain injury, pain, and other issues.⁴⁸ Victims of violence can also experience cardiovascular, gastrointestinal, endocrine, and immune system health conditions as a result of chronic stress from the trauma of abuse.⁴⁸ While one may only see the physical effects of interpersonal violence, there are also many psychological and social effects. People who are victims and survivors often also experience anxiety, post-traumatic stress disorder, sleep disturbances, and suicidal behaviors.⁴⁸ Numerous health-risk behaviors have been associated with interpersonal violence, including the use and abuse of tobacco, alcohol, and illicit substances, unsafe sexual behaviors, and eating disorders.⁴⁹ Socially, people who are victims and survivors may face restricted access to various social services and may feel isolated from social networks.⁴⁸

People who are victims of sexual violence face other long-term consequences. Major physical health consequences may include unwanted pregnancies, gynecological complications, sexually transmitted infections, cervical cancer, genital injuries, gastrointestinal disorders, and chronic pain. Psychologically, these individuals often suffer from anxiety, shame or guilt, social withdrawal, post-traumatic stress disorder, depression, low self-esteem, and high risk of suicide.⁵⁰

Abuse suffered during childhood, either physical or sexual in nature, has long-term physical and mental health impacts that last throughout the lifespan. Children who experience abuse are at increased risk for several diseases and conditions as an adult, including cardiovascular disease, cancer, obesity, chronic lung disease, and liver disease. These individuals are also at an increased risk for developing depression and other psychiatric disorders before the age of 21.⁵¹

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Below are a few of the current programs and initiatives, through government and non-governmental entities, that in design and purpose are similar to Accountable Care Communities (ACCs). It is important to note that not all are examples of ACCs; some are examples of community coalitions and health systems investing in social needs, and others are delivery and payment models that are addressing health-related social needs.

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 beneficiaries to identify unmet health-related social needs,*
- *Referring these beneficiaries to increase awareness of 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.).¹ 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.”² There are currently 31 organizations participating in these 5-year models that represent rural and urban communities across 23 states.³ An independent evaluation will review the model’s effects on quality of care and spending.²

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.

Washington State: Accountable Communities of Health

Under Washington state Medicaid transformation (Medicaid Section 1115 Waiver approved January 9, 2017)⁴, Accountable Communities of Health (ACHs) are one of the three initiatives in which the state hopes to better the health of the Medicaid population. Throughout the state, nine ACHs were established that align directly with the state’s regional Medicaid service area—ensuring that every part of the state is covered by an ACH.⁵ These regional ACHs are meant to bring together community

organizations and health care providers to work on regional goals (e.g., practice transformation) to solve the unique health problems of those regions.⁵

Washington’s ACHs have built the necessary internal capacity and infrastructure to plan and carry out the work outlined in the demonstration waiver.⁶ The state is currently in Phase 2 of implementation. This phase focuses on continuing to build relationships and shared decision-making with stakeholders on regional interventions.⁶ The Olympic Community of Health (one of the regional ACHs), has developed a multi-sectoral effort to address the opioid epidemic within the region and is currently in the implementation phase.⁷

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 Centers for Medicare and Medicaid Services’ 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.⁸ 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.⁹ 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 payers.¹⁰ As of last year, the information exchange portal had facilitated more than 800,000 services ranging from housing, job training, and food for clients.¹¹

Hennepin Health Accountable Care Organization

The Hennepin Health Medicaid accountable care organization is a partnership between medical providers, the county social services, the county public health provider, and the Metropolitan Health Plan in Hennepin County, Minnesota. Through this partnership, Medicaid contracts with the Minnesota Department of Human Services to provide health care coverage for individuals newly enrolled under Medicaid expansion.¹² All partners share financial risk. Eligible residents can enroll in one of three plans to address medical behavioral health, housing assistance, and social service needs.¹³ Care coordinator teams for each member in each plan help navigate and connect beneficiaries to these services. Services include transportation and housing assistance

and connection to resources that provide fresh food and cell phone assistance, for example. Services for health-related social needs are funded through state and county human services and supplemented by monthly payments the accountable care organization collects for each member. Hennepin receives a per member per month capitation payment for the costs for Medicaid services for its enrolled population. State and county funding sources pay for the social services covered under the plans.¹²

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 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.¹⁴ The Alliance has also worked with food pantries to enhance their ability to provide more food and increase healthy food options.¹⁵ 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' needs.¹⁵

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.¹⁶

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. Boston Medical Center has invested over \$6.5 million over 5 years in community partnerships to support affordable housing initiatives in neighborhoods across the Greater Boston area.¹⁷ Funding will be used to help families

avoid eviction through the support of community-based organizations, develop a food market in a new housing development, and create a housing stabilization program for people with complex medical needs, among other programs.¹⁷ Nearly a quarter of Boston Medical Center's hospital admissions are for patients who are homeless and 1 in 3 families who are seen in the pediatric emergency department is housing insecure, so they have a strong interest in serving these needs for the community.¹⁷

Spectrum Health in West Michigan is another health care system dedicating funds to improving various drivers of health. Spectrum Health dedicates \$6 million every year to their Healthier Communities initiative.¹⁸ This initiative targets vulnerable and under-served populations who may lack access to health care or are at risk for poor health outcomes. The dedicated yearly funding goes towards professional development and education, as well as community health education. Healthier Communities also coordinates with various community-based organizations such as community centers, food clubs, faith-based organizations, farmers' markets, public schools, higher education institutions, YMCAs, and many others, to provide programs—such as Programa Puente, Healthy Homes Coalition of West Michigan, or Community Food Club—that provide services to meet health-related social needs and maximize the impact of this initiative.¹⁹

Mission Health in Western North Carolina also invests heavily in population health and social needs. 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 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.²⁰ Over time, Mission Health has invested over \$76 million in community health improvement programs through services and grants, MOUs, and in-kind contributions to community groups.²⁰

In Baltimore, Maryland, Bon Secours Baltimore Health System is also dedicating resources to addressing health disparities and the drivers of health through the West Baltimore Primary Care Access Collaborative. The Collaborative is a partnership between the health system, the state of Maryland, and 12 other institutions to reduce health disparities in four neighborhoods in West Baltimore. These four neighborhoods have some of the highest disease burden and greatest health-related social needs in Maryland. Through the Collaborative, Bon Secours and its partners look to improve access to health care and to increase the health care workforce in these neighborhoods. Individuals who are high utilizers of health care emergency services are connected with community health workers and primary care providers. Members of the community are being trained to work in the health care field and health care providers are being incentivized through state tax credits to set up practices in the area. In addition, the Collaborative is working to increase screening for hypertension and diabetes among the residents of the targeted areas.²¹

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