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.

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

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.*

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

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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