Research has shown that 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. However, traditional health care is not designed to address the social, behavioral, and economic factors (eg, housing, transportation, access to healthy food, education, and health behaviors) that impact health outcomes. Accountable care communities are showing that it is possible to design systems that are successful at both addressing social and economic factors and improving population health.

In today's debates about health care, the question most often revolves around insurance—individuals' access to it, how comprehensive it is, and what the conditions are for acquiring it. What gets left out of the debates is that health insurance, and the access it grants individuals to affordable health care services, is only a piece of the greater puzzle of health and wellness. If clinical care accounts for only 20% of variation in health outcomes, there are other factors that must demand our attention if our goal is to actually improve health and well-being [1].

At the heart of accountable care communities (ACCs) is the idea that in order to improve population health, health care delivery systems need to be better aligned with other sectors, including public health, social services, education, business, and other community-based organizations. In an ACC, multiple cross-sector stakeholders join together to address health from a community perspective, by forming a coalition that shares responsibility for addressing multiple determinants of health, including social and environmental factors. By not only looking at health care services, but also considering investments in health across other sectors, ACCs can organize and engage partners to improve health outcomes and reduce cost. ACCs work to leverage the contributions of all members by strengthening links between existing programs and services, and coordinating resources and efforts. ACCs bring together traditional health care, with its focus on preventing and treating illness, with non-traditional partners, whose focus is on creating the conditions necessary for good health [2].

As detailed by Plescia and Dulin, ACCs are relatively new on the health care landscape [3]; however, there are examples of communities and states that have implemented ACCs. By looking at the experiences of these communities and states, we can highlight some of the opportunities and challenges of ACCs. Colorado, Minnesota, and Oregon are all implementing ACC models for their Medicaid populations. While the models are not the same, each illustrates the potential ACCs have to transform the delivery of health care.

Colorado launched its Accountable Care Collaborative in 2011 to improve the health of Medicaid members by “taking wellness and non-medical needs into consideration, and helping members overcome obstacles that have little to do with health care but everything to do with overall health” [4]. The basis of the collaborative’s work is Regional Care Collaborative Organizations that develop networks of providers, manage and coordinate member care, connect members with non-medical services, and report various metrics on their populations, much like Community Care of North Carolina. Primary care medical providers, a statewide data and analytics contractor, and payment reform all support the work of the ACC. Colorado uses 3 key performance measures, and has seen improvements in all 3: reduced emergency room visits, increases in well-child visits, and increases in postpartum care visits [4]. In 2015, the costs avoided by the Colorado ACC ($121 million) exceeded the administrative costs of the ACC ($84 million), resulting in a net savings of $37 million. The Colorado ACC is using alternative payment arrangements and shared savings to support and improve integration and coordination between provider networks and community partners [4].

The Minnesota Accountable Health Model, launched with a Center for Medicare and Medicaid Innovation grant in 2013, expands the state’s patient-centered, team-based care model through “service delivery and payment models that support integration of medical care, behavioral health,
long-term care and community prevention services.” As part of their Accountable Health Model, Minnesota is piloting the adoption of 3 emerging provider types—community health workers, community paramedics, and dental therapists—within their team-based coordinated care model [5]. Additionally, Minnesota has established 15 Accountable Communities for Health (ACHs) that are testing new strategies for improving the health and well-being of community members. The ACHs in Minnesota have helped meet the needs of members in a range of areas outside of traditional health care delivery including housing, transportation, physical activity, nutrition, and education [6-9]. Many of the Minnesota ACHs are using health coordinators (under a variety of titles and placements) whose job is primarily to identify barriers to members’ health and then address these barriers, often by being liaisons to non-health care community services.

Oregon implemented a Medicaid accountable care model in 2012. Oregon’s 115 Medicaid waiver allows Oregon’s coordinated care organizations (CCOs) “to use Medicaid dollars for non-medical services that result in better health at lower costs” [10]. CCOs are regional entities that are responsible for managing a global budget and coordinating physical, mental, behavioral, and dental services for Medicaid. Oregon’s CCO governance boards include health systems and health plans, but also a significant number of community representatives, county government representatives, and consumers [10]. Oregon’s CCO model is limited to personal health services; however, there are strong incentives to coordinate with social service agencies and invest in public health programs [11]. Under global budgets, CCOs can invest in services that may be more effective at addressing social determinants of health than personal health services typically are [12]. Under these flexible services, CCOs are providing housing supports and services such as transitional housing and home improvements, employment support, education and training, and support groups [13]. Oregon’s transition to the CCO model
brought about a 7% reduction in expenditures, due in part to reductions in inpatient utilization, avoidable emergency room visits, and improvements in appropriate care [11].

What Can We Learn from Early Medicaid ACCs?

ACCs present an innovative model for addressing upstream determinants of health. Early adopters of ACC models have shown that partnering social service, public health, and health care providers can reduce health care utilization while improving outcomes. For communities, there is significant interest in having more say in how health care dollars are used [11]. For health care delivery systems and providers that 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 costs savings. Often these opportunities for costs 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.

Improving health outcomes in the community is a goal that many organizations can support. However, agreement about the more specific details can be challenging for communities [14]. ACCs need to develop a shared vision and establish a leadership structure, prioritize health outcomes, agree on financing, develop and implement strategies for integrating/coordinating services, share data, and develop a plan for performance measurement, among other challenges [11]. Many successful examples of ACCs in states and communities across the country have originated out of state or local government, and have dealt exclusively, at least at first, with Medicaid populations.

Despite the challenges, ACCs have the opportunity to transform the health care landscape in North Carolina and across the country. Reaching the goal of improved population health requires stepping outside of the bounds of traditional health care and approaching and addressing patients’ social needs with the same intention as their health care needs. ACCs provide a systemic approach to how disparate systems and organizations can work together to improve the health and well-being of their communities. NCMJ

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Acknowledgments

Potential conflicts of interest. B.Y. has no relevant conflicts of interest.

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