The Accountable Care Workforce in North Carolina

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What is an Accountable Care Workforce?

What does an ***Accountable*** Care Workforce look like in North Carolina? Nationally? And why does this matter?

Historically, the health workforce consisted of licensed health professionals (i.e., doctors, nurses, dentists, pharmacists, allied health professionals)

- Flexible & Boundary-Spanning Roles
- Diverse in:
  - Discipline
  - Education
  - Demographics

In healthcare, one of the fastest, least expensive ways to reach more people and decrease costs is to address patient **Social Determinants of Health**

- Income
- Education
- Culture
- Neighbor-hood
- Refrigerators
- Etc.

=

of your health

How is Healthcare Addressing Patient Social Determinants of Health?

1) Shifting existing roles to be more flexible
2) Adding new Boundary-Spanning roles
3) Partnering with local communities

Shifting Existing Roles *and* Adding new boundary-spanning roles

Boundary-Spanning Roles

Patient Navigator
Case Manager
Care Manager
Panel Manager
Health Coach

Sometimes these Roles Overlap

Boundary-Spanning Professionals

Nurse
Social Worker
Medical Assistant
Community Health Worker
Pharmacist

An accountable care workforce requires lay health workers who **live**, **breathe**, and **thrive** in their own communities

- **Lay workers are more likely to have**:
  - Diversity in education and demographics
  - Shared language as patients
  - Shared history and experiential knowledge
  - Lived experience to connect with patient
- **Common Roles for lay health workers or non-healthcare professionals include:**
  - care coordinator assistants
  - peer-support specialists
  - members of faith organizations
  - community health workers

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Examples of **Accountable Care Workforce** Partnerships in North Carolina

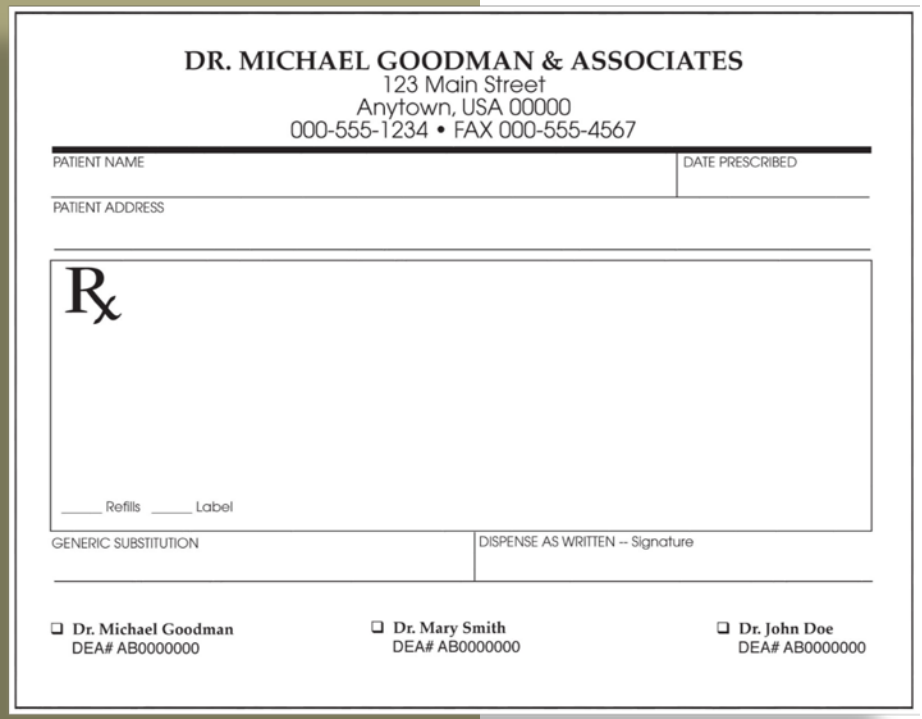
Corner store Initiatives

Diversity in Discipline:

- Communications
- Marketing
- Physical Trainers
- Builders
- Property Managers
- Religious Leaders

Exercise as a Prescription

Partnering with local physical trainers



DR. MICHAEL GOODMAN & ASSOCIATES
123 Main Street
Anytown, USA 00000
000-555-1234 • FAX 000-555-4567

PATIENT NAME | DATE PRESCRIBED

PATIENT ADDRESS

Rx

_____ Refills _____ Label

GENERIC SUBSTITUTION | DISPENSE AS WRITTEN -- Signature

❑ Dr. Michael Goodman
DEA# AB0000000

❑ Dr. Mary Smith
DEA# AB0000000

❑ Dr. John Doe
DEA# AB0000000

Greensboro Housing Coalition

Builders and Property Managers

CONETOE
FAMILY LIFE CENTER

- Growing Food & Combatting the Food Desert
- Develop farming skills
- Develop business & financial planning skills
- Develop Community Engagement & Responsibility
- Reduced chronic disease, necessary medications & hospital readmissions

How can we promote **sustainability** between health care and local agencies?

Shared Mission and Culture

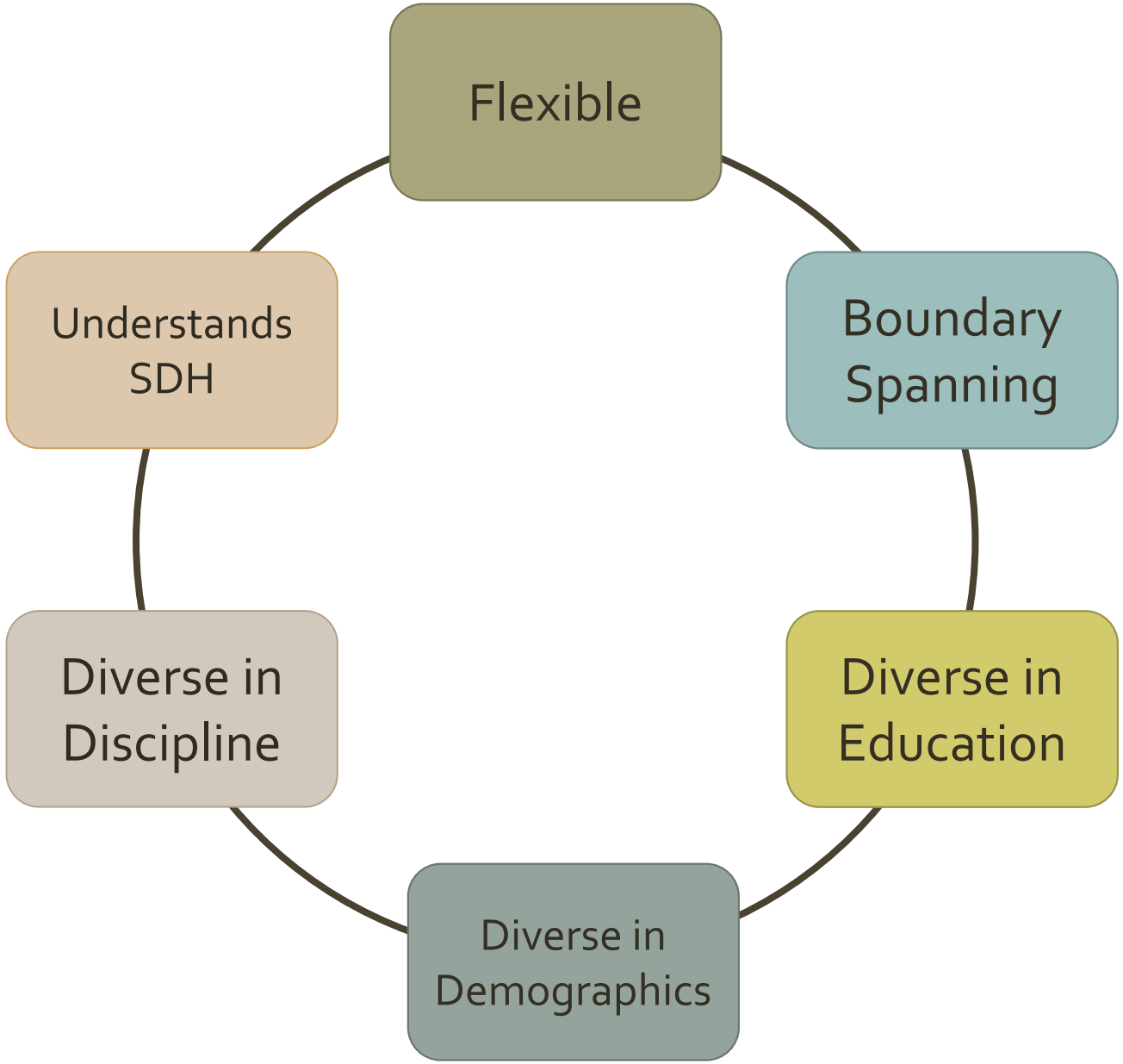
An Interprofessional Workforce

Administrative and Governance Structures

Sustainable Models of Payment

Emphasis on Prevention and SDH

What **DOES** an accountable care workforce look like?



What **DOES** an accountable care workforce look like?

Thank you!

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INVITED COMMENTARY

The Accountable Care Workforce:
Bridging the Health Divide in North Carolina

Erica L. Richman, Brianna M. Lombardi, Lisa de Saxe Zerden

Accountable care communities form as health care entities partner with communities to more fully address population health. This partnership requires an adaptable, boundary spanning, and diverse workforce, as well as flexible regulatory and governing structures that adapt to changing payment models, task shifting, and new roles in health care.

In North Carolina and across the country, the health care system is aspiring to meet the Institute for Healthcare Improvement's Triple Aim [1] of being accountable for better patient experiences, improving population health, and decreasing costs by expanding beyond traditional health care settings and moving deeper into the community [1, 2]. Increasingly, health care entities are partnering with community agencies and social service organizations to break down silos of care and more fully address population health. As these rapidly emerging partnerships become established, they are referred to as accountable care communities (ACCs). ACCs are similar to the accountable health community model developed by the Centers for Medicare & Medicaid Services [3], but ACCs are not bound by the same legal, regulatory, or evaluation requirements and funding structures [2]. This multisector effort to improve health at the community level presents several workforce-related challenges. Collaboration in health care settings requires a flexible, boundary spanning workforce that not only accommodates diversity in the workers' discipline, education, and demographic characteristics, but is also committed to disease prevention strategies [4]. Furthermore, a fundamental step toward improving health through community collaboration is to address the social determinants of health (SDHs), which include social policies and environmental factors as well as the economic and community conditions that impact health outcomes [5].

The recent movement toward value-based payment models has intensified the recognition that social factors play an influential role in individual and population health outcomes. SDHs such as income, education, beliefs, and neighborhood characteristics can have a profound effect on health [6, 7] and health care costs [8]. Estimates suggest that access and quality of care received in a traditional health care setting account for only 20% of a person's health problems while the remaining 80% is determined by social factors [9]. The integration of medical care, prevention initiatives, and social services has the potential to both improve the health of more people and reduce health care spending by focusing on the social and economic factors affecting health [10, 11].

What is the Ideal Workforce for an ACC?

Prescribing a specific set of professionals to staff ACCs is a complicated and perhaps impossible task. The primary goal of the ACC model is to support health care by addressing the SDHs that exacerbate physical and behavioral health outcomes; however, few communities have identical sets of health care needs, socioeconomic circumstances, or health care workers. In urban North Carolina counties, there tend to be sufficient numbers of health care professionals per capita to care for the local population; but in rural counties, there may not be an adequate supply of providers. According to 2016 data, 3 NC counties do not have a single actively working physician and 32 counties do not have a working psychiatrist [12]. Given rural providers are more isolated from other healthcare workers, it is not unusual for these professionals to perform a wider breadth of care for the patients they serve. Similarly, rural residents are likely to seek care from an alternative, more widely available health care worker when a more traditional professional is not employed nearby [13]. For example, more people may utilize social workers for behavioral health care in cases where psychologists are not available. In places where nurses are scarce, you may see them performing expanded roles like care management on top of their typical duties, and perhaps medical assistants may be working in their stead. In general, a broader definition of the health workforce is needed to include workers from many disciplines—some of which may be unexpected—with diverse backgrounds and varied levels of professional training. This new definition allows for community specific combinations of professionals and lay people to work together in

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