

Accountable Care Communities in Rural: Laying the Groundwork in Humboldt County, California

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Background

This paper presents a case for the viability of Accountable Care Community (ACC) models in rural communities, including in rural Humboldt County, California. Accountable Care Communities reflect a unified approach to improving the health and reducing the costs of care of an entire community through a purposeful alignment of health care system, social service, and community resources. Informed by a “collective impact” approach,¹ ACCs are built on structured collaborations among many public and private community stakeholders, designed to expand capacity by aligning programs, services, and workforce around a common agenda to effect large-scale social change.^{2,3} Coalitions of stakeholders are stewards of collective resources, applying them toward the community’s most pressing health and social needs while also *sharing the responsibility* to meet those needs. To improve community health, ACCs act upon specific underlying social, behavioral, environmental, and economic determinants that impact the health of a population in addition to specific clinical determinants. Relationships and linkages among community-based organizations, public health and social services, and the local health care system are strengthened in order to leverage collective efforts (the whole is greater than the sum of the parts) in the most effective and efficient way to achieve Triple Aim objectives—better care for individuals, better health for populations, and lower per capita costs.⁴

The hallmark of an ACC model is the many stakeholders and sectors engaged in a collaboration that focuses on the systemic health and social challenges in a community. Successful, on-going collaborations are expected to demonstrate long-term improvement in community-wide health measures and cost reductions through a return on investments made in the upstream determinants of health and in a primary care model that acts as a patient-centered care hub. The model is a clear departure from the current health delivery system paradigm that, as a consequence of incentives from fee-for-service or cost-based payment systems, emphasizes fragmented “sick care” rather than preventive health and wellness efforts that are coordinated across sectors and the health care continua. Current payment systems undermine collaborative, mutually supporting and cooperative behavior among a community’s public and private health and human/social resources. It is well understood that health behaviors, the

¹ Hanleybrown F, Kania J, Kramer M. “Channeling Change: Making Collective Impact Work”. Stanford Social Innovation Review, 2012. <http://partnership2012.com/download/Collective%20Impact%20II.pdf>.

² Profiles of County Innovations in Health Care Delivery: Accountable Care Communities. National Association of Counties. www.naco.org/healthycountiesinitiative.

³ Humboldt County Department of Health and Human Services. Community Health Assessment 2013. Data for planning and policy making.

⁴ Institute for Healthcare Improvement. <http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>.

physical environment, and socio-economic factors drive the health of a population, contributing to roughly 80% of population health outcomes.⁵

Achieving Triple Aim objectives (improving patient experience and the health of populations and reducing the cost of health care) in rural areas is complicated by a number of challenges. In rural places, many of the social, behavioral, environmental, economic, and clinical determinants of health are comparatively worse than metropolitan areas, and health outcomes in rural communities reflect that reality. Mortality from unintentional injuries is higher, as are rates of suicide, smoking and obesity.⁶ Rural persons have a lower likelihood of having employer-provided insurance, and a lower portion of the rural poor are covered by Medicaid benefits. Health status, income, and educational attainment are all lower. Rural patients experience more transportation difficulties in reaching their providers.^{6,7} On the provider side, small population centers and greater geographical distances hinder the development of stable and comprehensive health delivery systems. Far more rural and frontier counties are designated Health Professional Shortage Areas than metropolitan, resulting in persistent challenges for health services access and continuity of care. Because rural areas lack many of the community supports and treatment options for mental health and substance abuse, high-risk behaviors such as drug and/or alcohol abuse among youth, pregnant women, and families often go untreated and result in greater disparities in outcomes for rural populations.⁸ Furthermore, disparate reimbursement among different payers for similar services creates incentives for providers to select patients with better insurance, which can diminish access for rural residents that are covered by public insurance programs. For the rural human services system, at times, even the most basic essential services may not be accessible or may not even exist.⁹ Rural analysts have long argued for a more thoughtful, rural-specific human service delivery framework that takes into consideration other critical factors in addition to the number of people to be served, such as the higher cost of service delivery in rural areas, scarcity of service

⁵ Magnan S, Fisher E, Kindig D, et al. "Achieving Accountability for Health and Health Care". Minnesota Medicine, November 2012.

⁶ National Rural Health Association. "What's Different About Rural Health Care?" <http://www.ruralhealthweb.org/go/left/about-rural-health>.

⁷ Barker A, Londeree J, McBride T, Kemper L, Mueller K. (2013). "The Uninsured: An Analysis by Income and Geography." (Research Policy Brief). Iowa City, IA: RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Brief No. 2013

⁸ Rural Assistance Center. <http://www.raconline.org/topics/substance-abuse>.

⁹ RUPRI Rural Human Services Panel. Rethinking Rural Human Service Delivery in Challenging Times: The Case for Service Integration..2010. http://www.rupri.org/areas-of-work/poverty-human-services-policy/ServiceIntegration_Feb2010.pdf.

providers, and the need for innovative approaches to gaining efficiencies that are quite different from what works in cities with high concentration of population.¹⁰

In sum, delivering a comprehensive, coordinated set of health and human services that matches the spectrum of a rural community's health and social needs, and in places that are resource-constrained, requires innovative and thoughtful deliberation about how the *entire* system of health and human services should be configured and investments allocated to best address population health challenges. The Accountable Care Community is a model that takes a whole community view, and evidence from early implementers of ACC models (Summit County, Ohio and San Diego County, California) suggest they can be highly impactful in their efforts to produce changes in population health outcomes.¹¹

Innovation

ACCs advance the Accountable Care Organization (ACO) delivery model by moving beyond a defined "ACO population" (e.g., Medicare or Medicaid) to the entire population of a community, which may be defined by geography or other meaningful boundaries. An ACO might focus on care delivery for a specific population with a single payer, such as state Medicaid enrollees, providing an array of integrated health and social services (e.g., medical, dental, mental, behavioral, transportation, self-management education, care coordination, home health, skilled nursing) that through contractual arrangements are coordinated and which are expected to meet certain quality and performance metrics. Financing mechanisms for this type of service delivery might include fee-for-service plus per member per month payments that are tied to cost containment and performance goals, or global budgets/bundled payments tied to bonuses for meeting performance targets. The ACOs are accountable for measuring, tracking, and meeting performance standards on their specific population's health status, care experience, and outcomes.

Alternatively, an ACC model targets all members of a community, which means financing mechanisms require involvement from all payers; in return, all stakeholders share responsibility and are held accountable to meeting community-wide performance and cost containment goals. Financing an ACC model relies on pooling funding streams from a variety of sources—public and private payers (which could adopt accountable payment systems in service contracts similar to ACO payment designs), membership fees or contributions, county health and human

¹⁰ Ibid.

¹¹ Profiles of County Innovations in Health Care Delivery: Accountable Care Communities. National Association of Counties. www.naco.org/healthycountiesinitiative.

services funds, foundations, non-profit hospital community benefit funds, shared savings, community development financing¹²—so that investments and resources can be flexibly leveraged by the ACC entity in the most impactful way. ACC models lend themselves to communities that care about improving the health of *everyone* in their community, across lifespans and the upstream determinants of health, by linking community prevention and wellness efforts with appropriate and timely health care and human services delivery. Appendix A highlights how two communities are using an ACC-like approach to community population health improvement.

Approach

Because the actual organization and delivery of health and human services takes place at a local level, the formation of an ACC model is dependent on the involvement, action, and commitment of key representatives from community stakeholders, including hospitals and clinicians, county health and human services, long-term services and support providers, health plans, and organizations that provide community-based support services. Pulling from conceptual models of ACCs and Accountable Communities for Health (ACH),^{13,14} there are several key design elements that an ACC should be able to demonstrate: 1) Collaboration and partnership for effective local governance; 2) Structure and process to support the ACC; 3) Leadership and support; 4) Defined geography and geographic reach; and 5) Targeted programmatic efforts. In addition, identifying sources of funding to *establish* an ACC and sources of financing to *sustain* the ACC is critical. Each ACC design component and funding/financing arrangements are discussed further:

1. **Collaboration and partnership for effective local governance** describes the formation of a functional multi-stakeholder group that directly links health system leaders (private and public) to other community stakeholders who have influence on the social determinants of health. The goal of this group is to coalesce around a common vision of community health, identify stewardship priorities, and develop an action and investment agenda around shared goals and measures to address community health

¹² Fisher E, Corrigan J. “Accountable Health Communities: Getting There From Here”. November 2014. JAMA, 312(20):2093-2094.

¹³ Ibid.

¹⁴ California State Innovation Model Testing Grant Proposal. Accountable Communities for Health Initiative. Stakeholder Webinar. California Health and Human Services Agency, September 26, 2014. http://www.chhs.ca.gov/PRI/_CalSIM%20Accountable%20Communities%20for%20Health%20Webinar%20slides.pdf

challenges and improvement. Communities with a history of successful collaboration among key organizations and experience in implementing community and environmental change strategies are well-suited to transitioning to an ACC model of care delivery.

- 2. Structure and process to support the ACC** includes a health information technology or exchange system that allows data sharing among stakeholders, the identification of a “backbone” organization that supports and facilitates the activities of an ACC, agreement about the location and structure of funding and financing arrangements, consensus around a community health needs assessment, presence of a medical home on which to build an integrated and coordinated care network around, and agreed-upon objectives relating to the Triple Aim.

The backbone organization plays an especially important role in the ACC because it guides the development of a common vision, set of goals, and strategies to pursue ACC objectives. It facilitates the development of agreements among partners, coordinates and supports implementation of aligned activities, identifies data needs/shared measurement practices/data sharing mechanisms, and performs administrative functions such as budget management, support-building, data collection and evaluation, and mobilizing funding through the agreed-upon ACC financing mechanism (e.g., Wellness Trust).

- 3. Leadership and support** from strong champions who exemplify a collaborative leadership style is important to obtain support from local government bodies, civic leaders, and political leaders. Active engagement of leaders from health systems and clinics, county health and human services, health plans, and community-based organizations within the local geography signals a commitment to the success of the ACC, as does a commitment of resources from each organization in the ACC.
- 4. Defined geography and geographic reach** puts parameters around the community population that the ACC is going to serve. The geographic reach should be large enough to show a measurable impact and return on investment, but small enough for the ACC members to develop meaningful relationships.
- 5. Targeted programmatic efforts** are the conditions that the ACC will prioritize in their community health improvement activities. For example, it could be cardiovascular disease and the programs that align across domains to address cardiovascular disease

determinants. Domains include Policy and Systems, Environments, Community Resources and Social Services, Community-Clinical linkages, and Clinical Services.

Finally, sources of **funding** (seed investments to establish the ACC) and **financing** (on-going investments to sustain the ACC) must be identified, agreed-upon, and established if the ACC is to take root in a community. ACC members must identify financial sources that will contribute to a common-pool resource to support the actions and infrastructure requirements of the ACC model. Without a stable funding mechanism, efforts are likely to be focused on crisis responses rather than systematic capacity building that benefits a community and its health and human services stakeholders over the long run. Additionally, the ACC will need to determine other sources that provide sustainable, on-going financing to execute long-term investment strategies in population health improvement. Examples of mechanisms that support the establishment of an ACC and which may also contribute to on-going financing are:¹⁵

- **Membership Fees or Contributions** from ACC member organizations designed to provide a basic level of support to establish a backbone entity capable of managing initiatives.
- **Community Benefit Funds** from tax-exempt hospitals are contributed (or loaned) to support the ACC's efforts targeting the community's social, behavioral, and economic determinants of health.
- **Regional Global Payment** from public or private payers that establish population-based global budgets or a portion of **Shared Savings** from ACOs that are allocated to non-health care investments designed to improve population health.
- **Linkages between Health Care and Public Health or Community Partners** are established in many states (e.g., Vermont, New Mexico) that require health care entities (such as ACOs or medical homes) to partner with community-based programs for social services, behavioral health, community health workers, and housing support. These are typically financed by per member per month fees from payers.
- **Health and Wellness Trusts** consist of funds tapped by states and other stakeholders (e.g., local taxes, conversion of hospitals or health plans to for-profit status) to establish

¹⁵ Fisher E, Corrigan J. "Accountable Health Communities: Getting There From Here." November 2014. JAMA, 312(20):2093-2094.

regional or statewide charitable trusts dedicated to support community-based, population health programs.

- **Social investing** involves investors who agree to support community-based prevention or social service programs (e.g., asthma management) in return for explicit commitments that a share of the health care savings are returned to the investors.
- **Community Development Financing** from financial institutions who satisfy federal requirements to provide capital to underserved geographical areas by funding projects that address social determinants of health (e.g., Mercy Housing).

ACCs in Rural Areas

Rural Considerations

As touched upon in the previous section, rural populations differ from urban along a key set of socio-demographic and economic characteristics. Rural persons are older, and many rural areas have seen considerable increases in community diversity due to a growing number of residents born outside of the U.S.^{16,17} Income in rural America has lagged incomes in urban America for decades, and poverty rates are higher.¹⁸ Unemployment among rural adults is higher than metropolitan areas.¹⁹ While overall uninsured rates between urban and rural areas are converging,²⁰ there are growing disparities among rural and urban uninsured due to state variation in Medicaid expansion. Of all uninsured persons, those in rural areas are disproportionately likely to live in states that are not expanding Medicaid.²¹ Adding to the challenges of a more disadvantaged population, access to and delivery of health care in rural places is more limited than urban places because of persistent health care shortages (particularly primary care, the backbone of rural health delivery), an inability for health systems to achieve scale efficiencies in health care delivery because of low volume, and in many places,

¹⁶ Data taken from American Community Survey 2010 estimates.

¹⁷ Heflin C, Miller K. The Geography of Need: Identifying Human Service Needs in Rural America. June 2011. Rural Policy Research Institute. http://rupri.org/Forms/HeflinMiller_GeogNeed_June2011.pdf

¹⁸ Data taken from American Community Survey, 2006-2010 estimates.

¹⁹ Miller K, Weber B. Persistent Poverty Dynamics: Understanding Poverty Trends of 50 Years. July 2014. Rural Policy Research Institute. http://www.rupri.org/Forms/Poverty_MillerWeber_July2014.pdf

²⁰ Karpman M. (2015) *QuickTake: Thirty-Six Percent Drop in Uninsurance Rate for Adults in Rural Areas Narrows Rural-Urban Coverage Gap*. Urban Institute. February 4. <http://hrms.urban.org/quicktakes/Thirty-Six-Percent-Drop-in-Uninsurance-Rate.html>

²¹ Newkirk V, Damico A. *The Affordable Care Act and Insurance Coverage in Rural Areas*. Issue Brief, May 29, 2014. Kaiser Family Foundation. <http://kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/>

geographical isolation of a rural community. Low compensation, professional isolation, limited time off, and scarcity of jobs for spouses are just some of the reasons given for difficulty in recruitment and retention of rural primary care providers.²²

Public payers, the predominant financier of health care services in rural areas, have reimbursed providers (e.g., rural health clinics, Medicare Dependent Hospitals, and Critical Access Hospitals) in rural places differently than those in metropolitan areas for decades in order to enable access to care for those without insurance as well as to make up shortfalls in the cost of delivering health services to small population areas. Reimbursement has been tied to, or indexed by, costs rather than prospective payment, to assure payment adequate to sustain essential services. However, the payment systems allow for little to no room for any margin that might finance other health-related but non-medical community health initiatives. As a result, the siloed nature of health care delivery is more fragmented and less coordinated in rural places. Were there sources of financing that foster greater integration and coordination among clinical settings as well as between clinical and non-clinical providers across the health and human services spectrum, many of the more costly and inefficient services use could be reduced while investments could be made in non-clinical health determinants that have a longer term payback to the community.

Why Pilot an ACC in a Rural Community?

Because of factors that make rural areas different from urban and broad payment reform initiatives driven by public and private payers, rural communities are at a crossroad for pursuing transformational change in health care delivery. Faced with limited resources, a shift in payment from fee-for-service and cost-based systems to value-based payment systems, and a population with social needs that transcend what clinical systems alone can address, rural communities must consider new strategies to meet population health goals. ACC models are an important opportunity for rural areas in their transition toward high performance health systems because *by design* they require an examination of the balance and configuration of a community's essential health services by those providing them; they require greater integration within and across service sectors; and they focus attention of key stakeholders on population health. Rural areas can be rich in the very resources necessary for successful ACCs. They tend to be smaller systems, sometimes closed systems, in which community members know each other and have multiple relationships.²³ In addition, smaller systems can often move and adapt more quickly than larger ones. Their very interconnectedness is an asset, particularly since

²² Doescher MP, Skillman SM, Rosenblatt RA. The Crisis in Rural Primary Care. Policy Brief. April 2009. WWAMI Rural Health Research Center. www.ruralhealth/research.org.

²³ Snow, LK. (2001). *The Organization of Hope: A Workbook for Rural Asset-Based Community Development*. Asset-Based Community Development Institute, Northwestern University. www.abcdinstitute.org/docs/kelloggabcd.pdf

interdependence is apparent. Novel delivery arrangements like ACCs that depend upon shared governance arrangements to achieve collective impact on specific, measurable community goals have strong chances for success in places where members know one another and who have an aligned interest in moving beyond crisis management toward strategies that improve the long-term health of a community.

Why Humboldt County?

Humboldt County is uniquely positioned to pilot a rural ACC model demonstration because it already has in place or has achieved outcomes in line with the key design elements of an ACC described above. Humboldt County has substantial experience in bringing community leaders and stakeholders together to address desperate social challenges and service delivery inefficiencies. Over the early 1990s to early 2000s, the Department of Health and Human Services in Humboldt County underwent a transformation in how health and human services were organized and delivered from a program-driven, multi-agency system to an integrated community partner system. This process began after the community came to understand and acknowledge that the essential human service delivery system was taxed beyond capacity and services were becoming increasingly inadequate. The Humboldt Area Foundation and a community-wide needs assessment were key drivers of this transformation. Philanthropy provided training expertise, strong facilitators and a safe environment for diverse community members. The community needs assessment increased community engagement by providing a broad needs assessment that included both the public health and human service agencies and community. This transformation took several years to accomplish and is still maintained through continued collaboration, resource and information sharing.²⁴

Through this community input on needs and priorities, and with help from both the state legislature and a supportive county Board of Supervisors that allowed health and human services funding streams to be aggregated and service delivery to be integrated at the county DHHS level, health and human services were reorganized into a comprehensive and flexible *client-centered* service delivery model rather than the programmatic approach that had resulted in inefficient, siloed service delivery. For example, one of the strengths of Humboldt County's delivery system is the network of almost 20 Family Resource Centers located across the vast geography of the county, supported by both health and education sectors (St. Joseph Health-Humboldt community benefit funds and the school system, respectively). The decentralized Family Resource Centers are community sites for a number of activities that

²⁴ Humboldt County, California: A Promising Model for Rural Human Services Integration and Transformation. February, 2012. RUPRI Rural Human Services Panel.

promote healthy people and healthy communities, including parent education, food and clothing, social services, local health and behavioral health and community meetings. These centers provide a variety of cross-sector services driven by the needs of the community in an approachable manner. Community-focused resources, by *design*, encourage involvement by all community members in the task of community health and well-being.²⁵ These Family Resource Centers are an established, trusted community support network that could be the community hubs for ACC activities.

Humboldt County can replicate the concept of the client-centered services delivery model in the health sector through medical homes that provide essential *patient-centered* primary care integrated with behavioral, mental, dental, specialist, and social services. In addition to links with other medical providers, medical homes have linkages to community-based resources such as community health workers and family resource centers, and other organizations that provide non-medical services (for example self-care education, nutritionists, care coordination, transportation, housing, insurance enrollment, and additional social services supports) to extend the reach and influence of preventive care and wellness into the community where people live.

Indeed, health care organizations in Humboldt County have already implemented a number of health care quality improvement programs under the *Aligning Forces for Quality (AF4Q)* grant that have laid the foundation for medical homes and an ACC delivery model more broadly. Initiated in 2008, Aligning Forces Humboldt (the name given to the local AF4Q alliance which is composed of a partnership between the Humboldt Independent Practice Association, St. Joseph Hospital-Eureka, and the California Center for Rural Policy), has served as a collaborative effort in improving the quality of healthcare on the North Coast. Funded by the Robert Wood Johnson Foundation, the AF4Q initiative was one impetus for Humboldt County partners to engage those who give care, pay for care, and receive care around the common goal of creating better quality and patient-centered systems of healthcare delivery in the community. Throughout the course of this 7 year effort (the grant concludes in April 2015), Aligning Forces Humboldt (AFH) partners have spearheaded a series of projects that promote better integration and collaboration among the broader healthcare community. These include: the Super Utilizer nurse-led case management program for high emergency department utilizers (lead by the Humboldt Independent Practice Association), the Care Transitions Program (lead by St. Joseph Health System), robust implementation of the Chronic Disease Self-Management Program (led by CCRP), and community-wide primary care improvement collaboratives (led by the Humboldt Independent Practice Association).

²⁵ St. Joseph Health. Community Resource Centers. <http://www.stjosepheureka.org/For-Community/Community-Resource-Centers.aspx>.

Independent of the AF4Q initiative, other organizations have made strides in delivering high quality care. One example of this is Open Door Community Health Centers that are dedicated to delivering high value and integrated medical, dental, behavioral health, and health services (case management and social services assistance) to patients. Open Door's interdisciplinary team of professionals in behavioral health, case management, Health Connections Coaches, promotores, and Member Services integrate with the medical care team to support patient-centered, patient-driven care. Staff address patients' social determinants of health in a multitude of ways. Case managers are integrated on-site with primary care teams and assist patients with goal setting and alleviating access to care barriers. In collaboration with the St. Joseph-Humboldt County hospital system, Health Connections Coaches (2 coaches and 1 program RN) provide intensive case management to a smaller panel of emergency room "super utilizers" to assist them in utilizing their medical home for improved health outcomes. Promotores for Open Door's Latino Health Promotion Project work with the Latino community to provide culturally and linguistically relevant health education and support.

The Member Services staff at Open Door provide care coordination services for Open Door patients and community members in accessing programs for which they may be eligible, in addition to providing support in navigating the health care delivery system in Humboldt County. Patients and community members may be referred to Member Services by their Open Door care team, by community partner agencies, or self-referral. Member Services Specialists assist patients in addressing their needs by advocating on their behalf in the process of applying for social support programs, working as liaison with outside partners, and making referrals for access to resources for wellness. Member Services staff also manage Open Door's CalFresh (California's branding of the "Supplemental Nutrition Assistance Program") Outreach and Education program and manage the clinics network of Health and Wellness Community Gardens. In sum, essential health care delivery elements, like the medical home model networked with other health care providers and community-based resources, are already in place in Humboldt County and provide a fundamental piece of the rural ACC model.

The largest hospital system in the county, the St. Joseph Health System – Humboldt County, has a long history of recognizing that the circumstances and conditions of their community contribute to the health of their patients. Well before the Affordable Care Act requirements, St. Joseph Hospital has been conducting community needs assessments, and most importantly for the foundation of an ACC, has included both health and human service needs in their assessment. As a result of these assessments, the hospital system created the Care for the Poor community benefit program. The program funds Family Resource Centers, as mentioned above, as a means to proactively address community needs and provide wellness outreach.

In addition to its role as a driver of healthcare improvement projects across the ambulatory health delivery system, the Humboldt Independent Practice Association (IPA) has historically been an innovation center for numerous practice payment reform initiatives. These have included participation in Pay for Performance programs and being the first in the state to offer a nurse-led care coordination program as part of human resource benefit through Anthem Blue Cross. The plan shared savings based on achievement of quality and cost goals. In addition to having over two decades of experience as a risk-bearing and administrative services organization, the Humboldt IPA has capacity to share and aggregate data through the North Coast Health Information Network (NCHIN), Humboldt County's Health Information Exchange (HIE). The IPA developed NCHIN in 2010 and is now sharing data among a multitude of practices and organizations in Humboldt County. Leading the *Aligning Forces Humboldt* as a "backbone" organization is the California Center for Rural Policy (CCRP) at Humboldt State University. Through this Center, community leaders and volunteers have been encouraged to develop a bottoms – up, community buy-in mentality that allows the capture of many more community assets than if transformation occurred via the expected power channels. In addition to its role as the coordinating agency CCRP for the AF4Q initiative,²⁶ CCRP has provided assessment and evaluation for the Healthy Communities effort in Del Norte County, funded by The California Endowment. These two broad-based initiatives approach community wellness development in a model similar to Accountable Care Communities. Across America, rural counties that are leading in innovation often have the good fortune to have a local University or Community College that plays this backbone role. Continuing to support their capacity is critical to rural community development and encourages these institutions to continue to use their expertise and resources to assist their "home" community.

Finally, Humboldt County is an appropriate rural ACC demonstration site because the challenges it faces are representative of those in many rural counties in the United States, yet its strengths in collaborative leadership, experience in building community connectedness, and its local assets are unique. An assessment by the RUPRI Rural Human Services Panel in 2012 found that Humboldt County exemplified a rural place where key elements of an innovative service integration model were already in place.²⁷ Specifically, the Panel found that Humboldt County has demonstrated and operationalized:

A shared (and public) vision, goals, principles of practice, responsibility, and accountability for success that are well understood, embraced, and verbalized by staff, providers and the community, and are operationalized by publication and dissemination of progress evaluations and by ongoing dynamic community planning.

²⁶ <http://www.aligningforceshumboldt.org/>

²⁷ Humboldt County, California: A Promising Model for Rural Human Services Integration and Transformation. February, 2012. RUPRI Rural Human Services Panel. www.rupri.org.

A culture of service with a focus on the whole person/family which focuses more resources on prevention.

Integrated funding streams and shared resources that advance the operation of client-centered comprehensive service delivery.

Reorganization of centralized and decentralized functions, with administrative infrastructure integrated and co-located (centralized) but services delivery in the outlying communities where people live, such as the Family Resource Center sites (decentralized).

Community driven transformation through continual step-by-step engagement and partnerships over time that builds trust and mutual commitment.

Quality leadership and appropriate leadership for each stage of transformation especially in service integration efforts where leadership must develop the critical technical skills for blending and managing funding streams, with a clear orientation of organizing resources not by services but by target population, and translating the redesign into programming.

Appendix A: Case Studies of ACC-type Approaches to Community and Population Health Improvement

There are two communities that exemplify an ACC conceptual approach to improving community and population health. Their organizational and financing approaches are highlighted here to inform how ACC development might be pursued.

Hennepin County, MN

In **Hennepin County, Minnesota** four partners affiliated or owned by the Hennepin County government created the Hennepin Health ACO.²⁸ The four partners in the new business consist of medical providers (Hennepin County Medical Center, NorthPoint Health and Wellness Center, and county public health clinics), the county social services and public health provider (Hennepin County Human Services and Public Health Department), and Metropolitan Health Plan, a nonprofit county-run, state-certified health maintenance organization serving Medicare and Medicaid enrollees. Their target population is newly enrolled Medicaid beneficiaries under the Minnesota state expansion. As a business, all partners share full financial risk, believing that in working together under global capitation care delivery would be more coordinated and comprehensive.

An initial investment of \$1.6 million was made to fund new staffing and data infrastructure needs. Because Hennepin Health ACO includes a licensed health plan, it receives a per member per month capitation payment from the state to cover the cost of all Medicaid services for the enrolled population (integrated medical, behavioral, and social services). The medical providers in the partnership are reimbursed through fee-for-service payments from Hennepin Health. Hennepin Health also contracts with other affiliated providers to ensure service needs are met in the geographic area of coverage (including vision, behavioral health, pharmacy, and primary care). Social services are paid for with human service funds from state and county sources when applicable, and supplemented by the ACO's health plan per member per month payments. At year end, a portion of the funds leftover are distributed per a gain-sharing formula to the partners to offset costs associated with operating the model. Other remaining reinvestment funds are used for projects designed to achieve strategic goals.

A critical piece of the ACO care model is an interdisciplinary care coordination team located in primary care clinics. The teams include registered nurse care coordinators, clinical social workers, and community health workers. The care coordination team provides not only clinical care coordination but also coordination with nonclinical services such as housing and vocational

²⁸ Sandberg S, Erikson C, Owen R, et al. "Hennepin Health: A Safety-Net Accountable Care Organization for the Expanded Medicaid Population". November, 2014. *Health Affairs*, 33(11): 1975-1984.

support, since many of the new enrollees have considerable physical, behavioral, and social needs.

Beaverton, Oregon

In 2013 the **City of Beaverton** in **Beaverton, Oregon**, along with several other key participants,²⁹ facilitated the Beaverton Community Health Collaborative (BCHC), a collaboration of public and private entities that share a vision to create a new model of healthcare delivery that integrates services in an innovative and unprecedented way to serve the 260,000 residents of the greater Beaverton area.³⁰ Members signed a Declaration of Cooperation that serves as a roadmap for the BCHC to move forward on goals. The goals are broadly defined as achieving high levels of health for all members of the greater Beaverton community, including the most vulnerable members, having outstanding health outcomes, and lower than average cost per capita for health care expenditures. Each party in the Project Team (who signed the Declaration) has specific stakeholder goals that outline their commitment to the process, why they have participated, and how they may contribute to the actions identified.

Funding sources include a \$1.6 million Community Transformation Grant (CTG) from the Centers for Disease Control and Prevention and a \$12,000 grant from the NW Health Foundation to the City of Beaverton. The CTG grant supports three goals: the creation of new policies and programs that focus on strategic goals (including but not limited to tobacco-free living, active living and healthy eating, increased use of high impact quality clinical preventative services, and social and emotional wellness), the creation of a health element in the City of Beaverton's Comprehensive Plan, and the formation of an organization to sustain the efforts described in the first two strategic goals. The NW Health Foundation grant supports a needs assessment of the health and wellness of the community's population and the work force training requirements for a set of health professionals required for an integrated medical home model facility.

²⁹ Other key participants include Community Action of Washington County, Kaiser Permanente, Lifeworks Northwest, Northwest Health Foundation, Oregon Health Authority, Oregon Health Policy Board, Oregon Housing and Community Services, Oregon Solutions, Pacific University, Portland State University Urban and Public Affairs (Community Health), Providence Health and Services, Virginia Garcia Memorial Health Center, Virginia Garcia Foundation, Vision Action Network, Washington County Health and Human Services Division, Washington County Disability, Aging & Veteran Services Division, Washington County Commission on Children and Families, Women's Healthcare Associates.

³⁰ Declaration of Cooperation. Beaverton Community Health Collaborative (BCHC). February 19, 2013. Sponsored by City of Beaverton, Community Action, LifeWorks NW, Pacific University, Virginia Garcia Memorial Health Center, Washington County Public Health, and Oregon Solutions.

At this time, the BCHC is working on the creation of a governance structure that allows for efficient decision-making among collaborative members. BCHC is also actively pursuing the construction of a new health and wellness facility that supports the integrated, patient-centered healthcare delivery system objectives.