Health systems, are focusing attention on the role that social determinants of health (SDOH) can and should play in health care delivery. This is especially true among accountable care organizations (ACOs) and Medicaid ACOs in particular. In crafting SDOH strategies, senior leadership teams may face an organizational tension in aiming to cede control over dollars, data and patient experience to community-based organizations (CBOs) while also maintaining financial accountability for health outcomes. We review the history of neighborhood health centers (NHCs) in order to foreshadow the types of critiques ACOs are likely to face in working with CBOs. We conclude by suggesting a several strategies by which ACOs may lessen accountability concerns, including raising the issue with regulators, using low-risk dollars to fund joint-work, working through an intermediary, providing technical assistance and viewing the relationship as a partnership rather than contract.

The history of neighborhood health centers (NHCs) in the US, which were pioneers in their commitment to SDOH, may provide some insight on the risks associated with ceding control of key resources. In 1964, the federal government began funding neighborhood health centers (NHCs) as a means to promote social progress in low-income neighborhoods across the United States (Sardell, 1988). The Office of Economic Opportunity provided block grants – notable for their flexibility – to NHC leadership to both treat illness and address underlying conditions. Led by physicians, these NHCs earned a reputation for impacting social needs of poor communities through the creation of food cooperatives, educational programming, latrines, and sewage systems as well as civic mobilization.

NHCs ceded the most obvious degree of control in governance and hiring strategies. Architects of the War on Poverty tied NHC funding to each centers’ ability to demonstrate the community’s maximum feasible participation in managing each center. Drs. Jack Geiger and Count Gibson, who founded one of the most well-known NHCs in Mound Bayou, Mississippi, wove this principle throughout their work: Mound Bayou hired a full-time community organizer – John Hatch – and cultivated a majority local resident governing board, even though much of the surrounding community was illiterate. Employees were recruited locally whenever possible, as NHC leadership recognized jobs as meaningful investments in people's health. Employees also maintained...
a significant voice in determining future direction of each center. With these governance structures, Geiger, Gibson, and Hatch found that organizational decisions moved slowly and the medical staff’s bio-medical concerns could no longer dominate the center’s agenda. Nevertheless, relinquishing some control proved effective in building a community-wide movement aimed at not only improving health but also the economic opportunities and general living conditions available to residents.

This history of NHCs also offers insight into the political risks associated with health care institutions’ ceding control to pursue SDOH activities. In many communities in which NHCs were established, private physicians argued that the NHCs’ broad scope of services would distract providers from the delivery of high-quality, traditional medical care. Critics appealed to the federal government, arguing that funds should be allocated to health care facilities with more straightforward goals and timelines. Still others voiced concern that centers’ emphasis on maximum feasible representation was turning NHCs into political outfits furthering the goals of the black power and other social movements. Such concerns were emblematic of a larger critique of the War on Poverty programs, wherein political elites worried that experts’ willingness to cede control over anti-poverty programs to local communities would result in a large-scale uprising against the government.

Published last year, Thomas Ward Jr’s book, Out in the Rural, further documents the extent to which NHCs were viewed as a political threat to the government establishment (Ward Jr, 2016).

The NHC story can, and perhaps should, be seen as a cautionary tale to today’s ACOs. While NHCs like the one at Mound Bayou were primarily ceding control to community members, ACOs face an analogous set of issues in considering partnerships with CBOs. CBOs’ reputation for being overburdened, underfunded, and under-regulated exacerbates this tension. In both the NHC and ACO cases, a key question emerges: will politicians, payers and regulators accept the involvement of new parties in the process of building healthy communities?

In the case of the 1960s health centers, the answer was ultimately: No. By the early 1970s, the NHC critics who worried too much control had been ceded won out in both the state and federal arena. The Nixon administration converted NHCs from block grant funding to Medicaid fee-for-service, effectively eliminating the ability of NHCs to administer SDOH programs. The Department of Health, Education, and Welfare was given jurisdiction over the NHCs in 1967 and ultimately limited their services to people living below the poverty line. Today’s federally-qualified health centers still require patients to fill some board seats, but their role is, in many cases, pro forma. In short, modern NHCs maintain few of the radical aspects that defined the original model.

Today’s Medicaid ACOs face a new opportunity to develop ambitious SDOH strategies by working with people and organizations beyond the boundaries of the medical establishment. Many ACO leaders perceive the tension between ceding control to partners and maintaining financial accountability as a central tension in their work. The need to maintain accountability drives health care organizations’ interest in building their own SDOH capabilities as opposed to partnering with community organizations whose expertise lies in social service delivery. Where partnerships with other organizations are pursued, it is only natural for health managers to want to exert substantial control - prescribing roles, measures, and payments in advance. These approaches may be understandable given health care’s high regulatory burden, but they are also likely to constrict creativity and discourage partners and community members from openly sharing essential perspectives. Without trusted engagement from these parties, ACOs risk relying on logic that has led to high spending and poor outcomes and diminishing the impact upstream interventions can have.

Senior ACO leaders, and those based at Medicaid ACOs in particular, may consider a series of concrete steps to actively manage this core tension. First, senior leaders should acknowledge this tension explicitly to allow active conversation on whether, and when, the organization is failing to embody both sides of the tension. This is likely to cause discomfort within health care organizations. That discomfort should be named and relayed to regulators and funders, who may need to alter the approach to evaluating the success of health care organizations in order to facilitate effective-long term relationships between health care institutions and the communities that support them. Second, to eschew the most strenuous accountability standards, leadership may experiment with funding CBO relationships using lower-risk pots of funding such as community benefit spending, Designation of Need (DoN) dollars, or grant monies. Third, to improve CBOs’ understanding and responsiveness to health care’s accountability standards, health care institutions may wish to either offer or lobby government for technical assistance to be provided to potential partners. This technical assistance may include education on topics ranging from negotiations and contracting to more specific areas of health care quality metrics, HIPAA compliance, and reporting standards. Fourth, to encourage candid conversation between CBOs and ACOs about challenges that arise, leadership may be well-served conceiving of and describing their relationship with CBOs as partnerships rather than contracts. In bi-directional partnerships, both good and bad news can be shared – whereas in contracts, vendors may down-play bad news for fear of jeopardizing future renewals. The instinct to bury bad news will only exacerbate accountability concerns among health care institutions. Fifth, to diminish the risks associated with ceding control, ACOs may consider brokering their relationship with CBOs via an integrator, an organization such as Health Leads, a local place-based foundation, or other neutral party. These intermediaries may be able to understand and respond to health care’s accountability concerns more immediately than CBOs.

The advent of value-based financing has made the work of the CBO sector more relevant and essential to health system revenues. And yet, CBOs have historically been funded and monitored by overseers outside of the health care system. This leaves open the question of how an ACO, or any health system attempting to deliver on the promise of accountability, should responsibly engage. We have provided some preliminary suggestions of where this process may begin but hope to see a broader discussion of this tension within health policy circles in the months and years to come.

Conflict of interest statement

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