Accountable Care – accountable to whom and for what?

MLPB Blog Post
by Samantha Morton

March 2, 2018

Accountable care – *accountable to whom and for what? Health workforces in Massachusetts and across the nation enter a* new normal *with SDOH in the job description.* As Medicaid ACOs (accountable care organizations) stood up in Massachusetts yesterday and operate in many states across the country, social determinants of health (SDOH) represent a critical frontier of care delivery innovation, workforce quality and satisfaction, cost reduction potential, and health equity progress. Recent developments show promise:

- **Housing** is now accepted as a "foundational" social determinant of health, with analogies to housing as a "prescription" and "vaccine" being increasingly mainstream. This will support sound priority-setting by **health and human services organizations and workforces**, and likely will accelerate population-level improvements in housing stability through system and policy change levers informed by large data sets.
- **Social risk factors** – like housing and neighborhood conditions – are making their way into innovative **risk adjustment formulas** that drive health financing. This "new math" accounting for SDOH could make it easier for the workforce to sustainably supply more of the services that people actually need to get and stay healthy.

Yet leadership has much work to do:

- Population management is not the same as health equity advancement. Only when systems are incentivized to look beyond the highest-of-high utilization members can **meaningful progress on health equity** be achieved. An innovative framework for data collection on health disparities in pediatrics is now available to organizations and communities who are pursuing a life course approach to health and wellness.
- The **"screen + refer" paradigm** driving nascent SDOH care implementation is problematic for many reasons, including the *Bridge to Nowhere* challenge. And the focus on systematically outsourcing SDOH solutions ignores the fact that plenty of SDOH interventions must happen within the four walls of the health clinic or hospital.
- Health and human services workforces need a blueprint for the central roles they will play in **social health integration**. Their work comes with great responsibility and some risk – risk that vulnerable individuals, families, and communities will be (further) alienated from health services; risk that workforce members who are not adequately supported will burn out; risk that employers will churn talented staff and fail to meet performance targets; and risk that the health and human services sector simply will not meet the quality and cost imperatives that inspired delivery system transformation in the first place. It's early days, but exciting new strategies are emerging with demonstrated impact.

Through a blog series for workforce leaders in 2018, MLPB will dive deeper on each of these topics. In the meantime, we are grateful to the organizations with whom we are collaborating in this new landscape – one that promises to better meet the needs of individuals, families and communities through more integrated, human-centered systems and services.