FUNDERS FORUM on Accountable Health

Building Equity and Community Accountability into Pandemic Response and Recovery:

A Proposal to Create Response and Resilience Accountability Councils

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Preface and Acknowledgements

The Funders Forum on Accountable Health is a project of the Department of Health Policy and Management at the George Washington University Milken Institute School of Public Health. The Forum is a common table for the growing number of public and philanthropic funders supporting accountable communities for health initiatives to share ideas, experiences, and expertise. It is a shared venue for funders to explore potential collaborations and consider how to assess the impact of these investments over time.

The following foundations support the Forum's work: Blue Shield of California Foundation, Episcopal Health Foundation, RCHN Community Health Foundation, Robert Wood Johnson Foundation, The California Endowment, The Commonwealth Fund, The Kresge Foundation, W.K. Kellogg Foundation, and The Blue Cross and Blue Shield of North Carolina Foundation.

This paper reflects input from a wide variety of funders, experts, and practitioners who participated in a series of virtual convenings during the month of June 2020. We are deeply grateful for their input and hope this reflects their creative thinking.

Executive Summary

If we are to address the twin challenges of rebuilding our nation's communities to be more resilient to pandemics while also addressing the underlying institutional racism that has driven so much of the inequity associated with COVID-19, we must fundamentally alter decision making at the local level that empowers communities to address the root causes of the problems that have made the United States, and in particular communities of color, more vulnerable to the impact of the pandemic than any other developed nation.

This paper proposes a two-part program that would build an infrastructure of Response and Resilience Accountability Councils throughout the nation to ensure that communities that are hardest hit by the pandemic and also have experienced historical racial and economic injustice will receive funding to support the priorities they most value to build resiliency and health in their respective communities. Councils will bring together partners across sectors that will advance trust and create alignment among them. The Councils would also be empowered to ensure that funds devoted to pandemic recovery (and possibly future response) efforts are distributed in an equitable fashion through this accountability mechanism.

Universal program: *A National Network of Response and Resilience Accountability Councils.* Federal recovery dollars going to states would be conditioned on creating Response and Resilience Accountability Councils at the regional or county level as a vehicle for planning and resource allocation. The first task of the Councils would be to develop community recovery plans that would provide direction for new resources from the federal government and could provide guidance for how other funds in the community could be aligned with this plan. The Councils should also be charged with adopting or developing an equity framework for the community's decision making to assure all efforts drive toward remedying the inequities in the community. States would be encouraged to use existing entities such as ACHs or create new ones as needed. Technical assistance and other support may be needed in communities that have historically experienced underinvestment and may not have pre-existing entities. This would begin the process of building or institutionalizing cross-sector relationships and empowering a wider range of decision makers in deciding how to increase equity and community well-being.

Pilot program: Testing Councils as Vehicles for Systemic Change
The universal program would primarily focus on new money coming into the community. But one of the fundamental challenges we face is the misalignment of health, social and public safety resources in communities – as much as the total level of investment in communities. In a pilot program, Councils would have authority to braid and blend into a virtual budget federal, state, and local health and human services funds. The program would fund a backbone organization that would not just set a table and conduct planning and facilitated community-based resource allocation decisions within the confines of existing programs, but would have the power (through waivers from the various federal and state programs) to realign programs and dollars based on community-determined need.

Both elements of this initiative would require some fundamental changes in how the government and communities do business. However, they are achievable and build on existing assets in many communities across the nation. But the times require such fundamental changes if we are

serious about learning the lessons of the COVID-19 pandemic and beginning to unwind the decades of policies embedding systemic racism that have resulted in widely disparate outcomes in health and well-being. It is our hope that this paper starts a discussion that results in a major new investment in restructuring how we make decisions about community health.

Introduction

The COVID-19 pandemic continues to pose a tremendous challenge to our health care, public health, and social services systems, and has exposed community-wide vulnerabilities that relate to race and class. For example, the pandemic has highlighted our health system's insufficient attention to equity and the social determinants of health that drive higher rates of population-level chronic disease, resulting in higher rates of serious disease and death from COVID-19 in certain populations. As our nation's policymakers face the dual challenge of continued response to a virulent pandemic and plan for recovery and rebuilding in a post-pandemic period, it will be critical to assure a focus on the root causes of the poor outcomes we are seeing. This paper proposes a new approach that addresses the immediate needs of responding to and recovering from the pandemic, but that also lays the foundation for addressing the broader inequities that lead to poor health outcomes over the long term. Equity must be central to any response and resiliency effort, and communities themselves must be at the center of any equitable response. Therefore, we propose establishing a community-based decision-making structure, *Response and Resilience Accountability Councils*, through which communities serve as the vehicle for allocating federal resources, ensuring accountability for a comprehensive approach to improving community health.

Background

The tragedy of the COVID-19 pandemic has laid bare the disparities in health outcomes related to race and class in the United States. While various factors place many individuals at greater risk for poor outcomes, the pandemic has struck communities of color most severely – with these communities becoming seriously ill and dying at a disproportionately higher rate than other groups. Indeed, some analyses, even after controlling for chronic disease or high- risk occupations and living conditions, have found that race alone is a predictor of worse outcomes.[1]

The ongoing response to COVID-19 is taking place during a simultaneous (and quite related) response to police killings across the country as expressed in the Black Lives Matter movement. Both the pandemic *and* police violence are underscoring the structural racism in American society. The confluence of these issues provides an opportunity to think more broadly about root causes – and to build a response that focuses on a broad vision for *community health* that encompasses community safety from violence and racism.

[1] S. Begley, To understand who's dying of Covid-19, look to social factors like race more than preexisting diseases, Statnews.com, June 15, 2020, and "The Fullest Look Yet at the Racial Inequity of Coronavirus," *New York Times*, July 5, 2020.

Indeed, the policy discussions with regard to police brutality and public safety have a parallel in health. Chronic underinvestment in social services and mental and behavioral health programs combined with overinvestment in policing have created an environment where police departments and the larger criminal justice system are inappropriately tasked to perform services they are not trained or equipped to handle, in historically marginalized communities that are already disproportionately affected by police hostility and violence.[2] Many communities are now rethinking their budgetary allocations – and potentially reallocating funding from police departments and other government agencies (or expanding investments) in social services, housing, and mental and behavioral health services – to address the root causes of crime, advance public safety, and reduce over-policing and police brutality. The same conversation has begun within the health community: as we recognize what drives community health, we should be increasing investments in the social services (from housing to job training and education) that drive poor health outcomes, rather than expecting the health care system to take on this role and/or deal with the medical consequences of this underinvestment. **The Response and Resilience Accountability Councils concept provides a pathway for these types of conversations and decision making.**

This paper emerges from work by the Funders Forum on Accountable Health as we looked across the country and saw that Accountable Communities for Health (ACHs)[3] are playing an important role in the response to the pandemic.[4] An ACH is a multi-sector partnership across health care, public health, social services, and the community collaborating to address the health and social needs of individuals and communities. Accountable *care* holds providers responsible for managing clinical conditions of a *patient population*; accountable *health* holds multiple sectors responsible for the health of a *community* often with a central focus on advancing equity.

Through a series of convenings, we consulted with a wide range of policy experts, health leaders, funders, and practitioners familiar with the ACH model to develop this concept. The paper is

[2] American Public Health Association (APHA). Addressing Law Enforcement Violence is a Public Health Issue. November 13, 2018.

[3] The Funders Forum has identified more than 100 ACHs across the nation. They are also referred to as "accountable care communities," "coordinated care organizations," and "accountable health communities." ACH initiatives have been developed and implemented with both public and private funding support. One example of a privately funded ACH initiative is the *California Accountable Communities for Health Initiative (CACHI)*, which is supported by California health foundations. On the public side, the Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare and Medicaid Services (CMS) has invested nearly $150 million in the *Accountable Health Communities* model, which is being implemented in 29 sites across 22 states.

[4] As part of the convenings held in June 2020, we heard from multiple ACHs about their role in the COVID-19 response. Having pre-existing relationships with multiple sectors and having the infrastructure from which to build a community's response, have allowed ACHs to rapidly and nimbly respond to the pandemic-related needs of their communities. See also *California Accountable Communities for Health Respond Mightily to the COVID-19 Pandemic*, June 2020 found at cachi.org.

premised on the view that the essential elements of an ACH—strong relationships and trust across organizations and sectors, authentic community engagement, shared vision and commitment to collaborative decision-making approaches, and a focus on health equity throughout all ACH activities—provide the foundation for marshalling and aligning community resources to more effectively respond to the pandemic and the vast needs of residents. Ultimately, ACHs operate from the belief that improving population health requires doing business differently at the community level. It is critical that these elements be central to the recovery and rebuilding process that will follow the pandemic.

The notion of multisector partnerships and community engagement in responding to public health crises or challenges is not a new concept; it simply has not been applied in a comprehensive, structured, and consistent way as envisioned here. Whether in the federal Ryan White Program, which funds HIV-related care and social services that are directed by metropolitan area planning councils,[5] or the more recent Center for Medicare and Medicaid Innovation's Accountable Health Communities or Integrated Care for Kids (InCK) models,[6] there is strong precedent for federal investment in strengthening multisector partnerships and decision making at the local level. These efforts are not only initiated by the health care sector. The US Department of Health and Human Services' Administration for Community Living is promoting greater integration of social and health services, with a particular focus on the needs of older adults and people with disabilities.[7] Indeed, health outcomes have been shown to improve in localities with strong multisector partnerships.[8]

This approach is also consistent with standards set in the disaster recovery community. A focus on building community-wide resilience and empowerment as the goal of recovery was a central theme in a 2015 Institute of Medicine (now National Academy of Medicine) consensus study, "Healthy, Resilient, and Sustainable Communities After Disasters: Strategies, Opportunities, and Planning for Recovery." The Committee noted that disasters, such as floods, fires, as well as disease outbreaks provide "opportunities for transformation to advance a vision of a healthier and more resilient and sustainable community." Notably, the committee concluded that "Successful recovery and the post-disaster rebuilding of healthier and more resilient and sustainable communities require the coordinated efforts of a broad multidisciplinary group of stakeholders from health and non-health sectors (i.e., a whole-community approach)."

[5] As part of the Ryan White Program, metropolitan areas are required to establish planning councils that oversee (in total) more than a billion dollars that are distributed across the nation each year – starting with needs assessments and ending with allocation of resources to top priorities. The Ryan White councils also have an ongoing oversight role. The council's membership must include a range of stakeholders, with one-third of the seats reserved for consumers of Ryan White services. A similar (and sometimes unified approach) is taken for HIV community prevention planning.

[6] See CMMI's Accountable Health Communities Model and CMMI's Integrated Care for Kids Model.

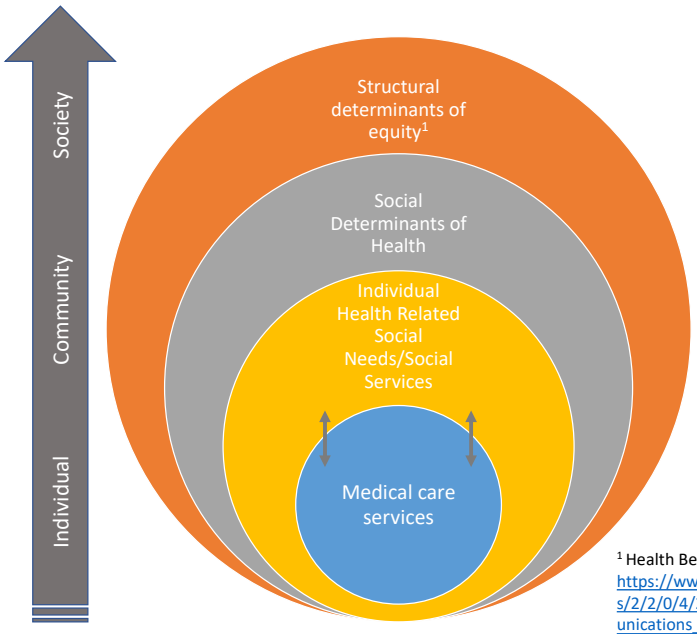
[7] See ACL's Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities.

[8] G. Mays, et al., Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks, *Health Affairs*, November 2016.

Advancing Equity as the Central Frame

While the concepts in this paper build from these prior programs and recommendations, we are taking this a step further. Most of the efforts in the past have focused on coordination among programs and addressing individual health-related social needs – and at times community-level social determinants of health. We believe each of these is important, but that ultimately, we must also take an equity frame that should not be conflated with social determinants of health (especially when addressed often in the context of individual social needs). Instead, we must address the broader structural and systems-level drivers of inequities to truly get at the root causes.

WHO defines social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems." WHO defines equity as the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. 'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."



Structural Determinants of Equity: The "causes of the causes". The climate, socioeconomic and political context and structural mechanisms and policies that shape social hierarchy and equity. Racism is a structural determinant of equity, for example.

Social Determinants of Health: The underlying social economic and physical conditions that cause poor health. Lack of access to affordable healthy food for a community is a SDOH, for example.

Individual Health-Related Social Needs: Individual needs, outside of the medical care system, that contribute to poor health.

[1] Health Begins. https://www.healthbegins.org/uploads/2/2/0/4/22040328/upstream_communications_toolkit_-_may_2019.pdf

The proposed Response and Resilience Accountability Councils are designed to address two issues: 1) Power and programs need to be realigned to advance equity in communities and 2) the biggest drivers of health fall outside the health care delivery system. And, although we may come to this discussion starting with a health perspective, the fact that equity and social determinants often fall outside the sphere of the health care delivery system compels those from the health care sector to come to the table with humility about how to solve these problems; we

must collectively recognize the imbalance associated with the level of public and private investment in health care relative to the social determinants of health that we know drive poor health outcomes. We must be willing to share power and resources to achieve greater equity.

Consistent with this recognition of a power and investment imbalance, we must measure success differently, if we are truly committed to advancing equity and addressing social determinants. This framework requires a new set of success metrics that go beyond the traditional measures of health that tend to be restricted to the health care sphere with narrow definitions focused on immediate outcomes and cost. Part of building healthier communities requires outcome measures that look beyond personal and even population-level health outcomes – potentially measuring such outcomes as greater community resilience, overall equity (and reduced inequities in the health system), and community empowerment. Such metrics would ultimately result in healthier communities but may also take longer to achieve. It will be critical to have short-term goals and metrics that provide "early wins" that inspire continued efforts, but funders and policy makers must recognize the long-term nature of this effort and, particularly in the health arena, must move beyond a financial return-on-investment model and embrace a "social return on investment" approach. This will require a major shift in current government programs and philanthropic investments and their evaluation.

Translating Past Experience into Response and Resilience Accountability Councils

Our assumptions in developing this proposal to establish Response and Resilience Accountability Councils across the nation are:

- Given the nature of the COVID-19 pandemic, the nation will simultaneously be responding to the pandemic, while also planning for and/or beginning to recover or rebuild. Regardless of the stage of the pandemic in a state or region, the multisector engagement described here will be essential to success in responding to COVID-19 and addressing equity.
- Response and recovery/rebuilding must be localized, given the diverse nature of health systems across the country, and will be more effective when inclusive of local context, racial equity and community conditions. Definitions of "local" will vary. In some instances, leadership may be at the neighborhood level, in others it will be at the county or regional level. But ultimately interventions and programming must be localized.
- New federal funds for recovery and rebuilding are likely to flow through state elected officials (and health departments) who in turn will provide funding to local government entities at the city, county, or regional level. It is possible that there will be a diverse set of funding streams ranging from health care and public health to social services, public safety and criminal justice, and economic development. Aligning these investments in support of a common vision and strategies will be critical.
- There will be a tension between new funds for recovery from the federal government and a very constrained fiscal environment at the state and local level. Keeping a focus on building resilient communities within this tension will be challenging but critical.
- There will be high levels of concern regarding accountability for how the money is spent. Accountability is more than the element of preventing fraud and abuse; it must also mean

accountability to affected communities for creating health and resilience, and empowering for actual decision making by community leaders.

- There will be strong pressure from those currently benefiting from the flow of government money to continue investments in a siloed fashion that would bake in the current structural inequities. This requires a countervailing force, such as empowered Response and Resilience Accountability Councils, that will push for investments that support a community resilience and well-being frame.
- There will also be a strong effort to define recovery narrowly – with a focus on the existing health care system. A broader vision will be essential if we are to address some of the structural underpinnings of the disparities we have seen in the pandemic.
- Historical lack of investment in public health and social services, coupled with redlining and other manifestations of systemic racism, may make it challenging for many communities to stand up a Council because they lack the foundational infrastructure to do so, and additional time, resources, technical assistance and patience may be necessary. The pandemic provides an opportunity to remedy this underinvestment.

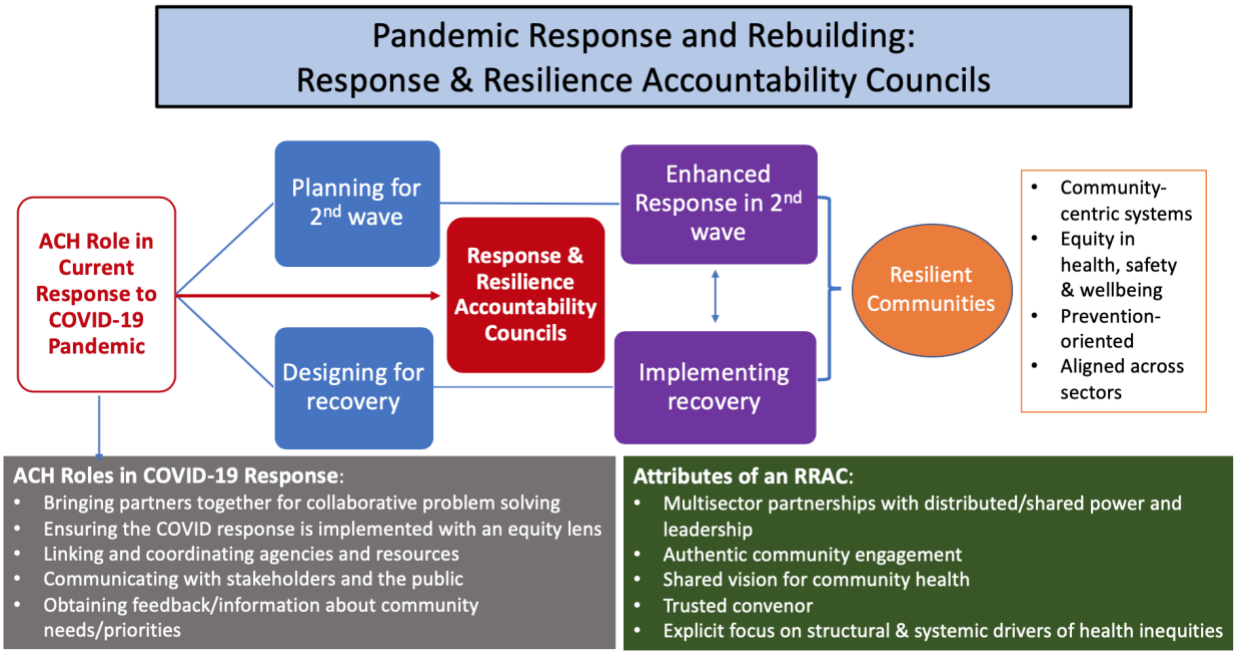
The Response and Resilience Accountability Councils would ideally be mandated by the federal government as the principal funder of recovery, but they could also be mandated at the state level or created by local officials at their own initiative. They can also be catalyzed by investments from private philanthropy.

Ideally, the Councils would be responsible for ensuring recovery design is a collaborative process among all relevant sectors, not driven solely by the health care delivery system, and would use data and community-identified needs to develop recovery/rebuilding plans.

The Councils would be appointed by state or local officials, depending on who is convening the Councils, and could build on existing infrastructures (such as ACHs or Health Equity Zones). Appointments should be made to ensure equitable and diverse representation especially from communities more impacted by COVID-19 and experiencing the greatest health disparities. The Councils would have the following roles, drawing on the experiences of the ACH model:

- Bringing diverse partners together for collaborative problem solving and ensuring the residents and community-based organizations are a majority of the voting participants.
- Developing a shared vision and implementation plan for the community's recovery.
- Making racial equity a conscious goal of the work and ensuring the pandemic response is implemented in an equitable manner.
- Obtaining feedback and information about community needs and priorities. This can build on the already-established requirements for Community Health Needs Assessments performed by non-profit hospitals.
- Aligning and coordinating public agencies and community-based organization resources.
- Prioritizing allocation of resources based on the recovery plan. (This may start with new resources that are recovery-specific; but ultimately a formal global budget approach would be more transformative and would enable more investments in prevention.)
- Overseeing implementation of recovery activities.
- Communicating with stakeholders and the public.

- Providing technical assistance and capacity building for all stakeholders, especially community members and consumers, to be able to participate equitably and effectively in shared decision making and shared resource allocation decisions.
- Engaging relevant government agencies as ex officio members of the Councils with ultimate responsibility for implementation of the Council's recommendations.



Trust Building through Power Sharing

We are in an unusual period in the United States where multiple crises have merged, and the nation is highly aware of cross-cutting legacies related to race, power, and lack of investment in the social safety net that undermine faith in government-led interventions at a time when trust to contain a public health epidemic is desperately needed. Response and Resilience Accountability Councils can lead to three outcomes that build trust. First, Councils will help to ensure that communities that are hardest hit by the pandemic and also have experienced historical racial and economic injustice will receive funding to support the priorities they most value to build resiliency and health in their respective communities. Second, Councils will bring together partners across sectors that will advance trust and create alignment among them. Third, the Councils will ensure that funds devoted to pandemic recovery (and possibly future response) efforts are distributed in an equitable fashion through this accountability mechanism. Establishing a new legacy of trust will be critical to ongoing efforts to improve health and to our ability to successfully address future public health crises.

This is not a simple undertaking and any recovery or rebuilding efforts will face key challenges. These include:

- Accepting community-led definitions of community health and safety as the basis for response and resilience building requires extra flexibility from funders. Funders must be willing to adapt their programs and investments to reflect community-derived priorities.
- Power sharing in decision making and in resource allocation requires a culture shift among stakeholders, policy makers, and programmatic expectations and will need to overcome engrained local political decision-making processes. An important step to changing this dynamic can begin with public and private funders empowering community leaders by directing funds through community-based organizations, especially BIPOC-led organizations, creating a more level playing field with more powerful players in the health system.
- Identifying genuine community leaders and supporting them in their participation. This requires new skill sets and norms for both community/consumer leaders and those who traditionally hold levers of power. This can mean resetting the usual health policy tables and/or bringing health decision making to already-existing community-driven tables.
- Being able to leverage all health and non-health resources in a community related to a broad definition of community health, safety and well-being. To that end, Councils must have a broader definition of accountability beyond individual programmatic goals. This may require:
    - Initially making sure that existing funding streams in a community are coordinated and eliminate duplication of effort.
    - Over time, a functional, if not literal, global budget approach, permitting braiding and blending of various funding streams in a community. This can, over time, extend beyond health programs.
    - Creating accountability expectations and incentives for meeting community-defined goals that apply to the largest centers of financial power. Several starting points might be leveraging federal oversight of the community benefit requirements, state contractual requirements of Medicaid managed care organizations, accreditation standards for managed care organizations, and state or local hospital certificate of needs requirements.

Key First Steps Toward Implementing a Formal Initiative

Despite the challenges identified above, if we are to address the twin challenges of rebuilding our nation's communities to be more resilient to pandemics while also addressing the underlying institutional racism that has driven so much of the inequity associated with COVID-19, we must begin the process of engaging and empowering communities and broadening our support for policies and programs that contribute to better health outcomes. This is a key moment in our nation's history when we have the opportunity to imagine a new vision for community health, safety and well-being. The challenges experienced by low-income communities, especially those that are majority people of color, are the result of decades of disinvestment, especially in the social services sector and in public health and discrimination (e.g., redlining). This is not because we lack resources as a society, it is that we have invested them disproportionately (and without the level of success we should expect) on the health care delivery side. Our health care delivery system now recognizes the important role that social services, such as housing, transportation and food, plays in improving health; however, we are now placing the

responsibility to address those issues on the health care system rather than investing in the social services infrastructure[9].

Therefore, to begin to rectify this imbalance in investment and in power, we recommend taking a two-pronged approach so that we can begin the process of change while learning what is the most effective approach.

Universal program: *A National Network of Response and Resilience Accountability Councils*
Federal recovery dollars going to states would be conditioned on creating Response and Resilience Accountability Councils at the regional or county level as a vehicle for planning and resource allocation. The first task of the Councils would be to develop community recovery plans (possibly building on existing Community Health Needs Assessments and Community Health Improvement Plans) that would provide direction for new resources from the federal government and could provide guidance for how other funds in the community (e.g., hospital community benefit investments) could be aligned with this plan. The Councils should also be charged with adopting or developing an equity framework[10] for the community's decision making to assure all efforts drive toward remedying the inequities in the community. This would include considering the most equitable way of addressing any state and local cuts to health and human services that might result from revenue shortfalls. States would be encouraged to use existing entities such as ACHs or create them as needed. This would begin the process of building or institutionalizing cross-sector relationships and empowering a wider range of decision makers in deciding how to increase equity and community well-being.

Within the universal program, additional funds should be provided to marginalized communities to ensure they can participate in the Councils. The resources may take the form of funding to local non-profits, capacity building, resident engagement, and leadership support. Equity requires a strong community voice, and these supports could be an important step to ensuring it is present in the Councils' work.

Pilot program: Councils as Vehicles for Systemic Change
The universal program would primarily focus on new money coming into the community. But one of the fundamental challenges we face is the misalignment of health, social and safety resources in communities – as much as the total level of investment in communities. In a pilot program, Councils would have authority to braid and blend into a virtual budget federal, state, and local health and human services funds as well as public safety/criminal justice resources – from programs such as Medicaid, Area Agencies on Aging, and housing assistance, to name a few. The program would fund a backbone organization that would not just set a table and conduct planning and facilitated community-based resource allocation decisions within the confines of existing programs, but would have the power (through waivers from the various federal and state programs) to realign programs and dollars based on community-determined need. There could be a higher cost per community given breadth of the pilots compared to the universal program, but such pilots would have the potential to demonstrate the effectiveness of

[9] B. Young and J. McGuire, The Non-profit Human Services Sector: A Brief Primer, November 2018.
[10] Funders Forum on Accountable Health, Developing a Framework To Measure the Health Equity Impact of Accountable Communities For Health, July 2020.

this approach if brought to scale and help to identify the associated capacities and support that would be needed if made national in scope.

Conclusion

Both elements of this initiative would require some fundamental changes in how the government and communities do business. However, they are achievable and build on existing assets in many communities across the nation. But the times require such fundamental changes if we are serious about learning the lessons of the COVID-19 pandemic and beginning to unwind the decades of policies embedding systemic racism that have resulted in widely disparate outcomes in health and well-being. It is our hope that this paper starts a discussion that results in a major new investment in restructuring how we make decisions about community health.