NACo HEALTHY COUNTIES
An initiative of the National Association of Counties

NACo National Association of Counties

Profiles of County Innovations in Health Care Delivery:

Accountable Care Communities

This publication is a part of a series, Profiles of County Innovations in Health Care Delivery, which outlines various health care delivery models being used by some counties to improve health while reducing health care costs. For additional information, please visit www.naco.org/healthycountiesinitiative.

About NACo

The National Association of Counties (NACo) assists America's counties in pursuing excellence in public service by advancing sound public policies, promoting peer learning and accountability, fostering intergovernmental and public-private collaboration, and providing value-added services to save counties and taxpayers money. Founded in 1935, NACo provides the elected and appointed leaders from the nation's 3,069 counties with the knowledge, skills and tools necessary to advance fiscally responsible, quality-driven and results-oriented policies and services to build healthy, vibrant, safe and fiscally resilient counties. For more information about NACo, visit www.naco.org.

About the Healthy Counties Initiative

Launched in 2011, the Healthy Counties Initiative enhances public-private partnerships in local health delivery, individual and community health and assists counties to effectively implement federal health reform. The Initiative is guided by an Advisory Board comprised of county officials who are health leaders at NACo and corporate partners. The Advisory Board assists NACo in identifying priorities and activities and provides input and expertise on program implementation. For more information about the Initiative, visit www.naco.org/healthycountiesinitiative.

Acknowledgements

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To request copies of this brief or information about the Healthy Counties Initiative, please contact:

Emmanuelle St. Jean
Program Manager
County Solutions and Innovations Department
National Association of Counties
estjean@naco.org | 202.942-4267

Background

With 1 out of 2 Americans living with a chronic condition such as cancer, diabetes, respiratory conditions and heart disease,[1] significant increases in health care expenditures and rising economic pressures, the public and private sectors are seeking new and bold approaches for improving health while mitigating costs. Federal, state and local governments are key stakeholders in the provision of health services and financing of these local systems. For example, as employers, counties provide coverage to their employees and their dependents and poor health outcomes affect productivity and county budgets. As the local safety net, counties weave an array of services and financing mechanisms to deliver individual and population-based services including indigent care, behavioral health, maternal-child home visiting programs, immunization, screening treatment for infectious diseases (such as tuberculosis and sexually transmitted infections), communicable disease surveillance, food and water inspections, nutrition counseling, injury prevention, violence prevention, tobacco prevention and obesity prevention.

Using funding from the federal and state governments, county tax revenue and reimbursement from clinical services, counties spend $69.7 billion to provide these services.[2, 3] In recent years, the financial crisis has impacted the ability of many counties to provide comprehensive health services while their fiscal capacity was reduced.[4] At the same time, however, the need for health services grew as more people began relying upon counties for services. This has led counties to explore innovative approaches for providing high quality services and programs that are effective and efficient while continuing to improve individual and community health.

Realizing the collective impact counties and the private sector can bring to initiating necessary changes; counties have formed partnerships with the private sector to achieve their vision of a healthy county. One of the approaches currently being explored is Accountable Care Communities (ACCs). This concept furthers the focus on collaboration and attempts to break down silos to create a coordinated and integrated approach.

An ACC impacts population health by integrating public health and health care delivery. A multisector partnership is a critical component of ACCs because it emphasizes the shared responsibility for the health of an entire community. These partners assist in creating and sustaining a change in population-level health outcomes.

The ACC Approach and the County Experience to Date

ACCs expand the capacity of the public and private sectors by aligning their programs, services and workforce to address the community's needs. ACCs are a promising model because they mobilize the entire community to address one specific goal or multiple goals such as obesity, education, safe streets and/or economic vitality. The involvement of all facets of the community – from economic development to schools to safety-net hospitals – through partnerships also stresses the shared responsibility of all partners.

ACCs are in the early phases of adoption; therefore limited analysis and research are currently available. However, Summit County, Ohio, home to the first ACC in the nation, has experienced significant changes in the lives of some of its county residents. Of note, a reduction in the average cost per month for providing services to diabetics and increased reports of exercise and weight loss for individuals living with diabetes. Summit County's preliminary results also emphasize the importance of using partnerships to improve health. As part of its initiative to connect public lands with public health, members of the ACC identified an underserved neighborhood with no public transportation access to Cuyahoga Valley National Park, which is partially located in Summit County. Working with the Akron Metropolitan Transportation System, the ACC was able to establish a new bus line and connect members of the underserved community to the park.

San Diego County's ACC is part of a multi-year plan, Live Well San Diego, to promote a healthy, safe and thriving region. One objective of the San Diego ACC is to reduce obesity rates among children. The county has experienced reduced rates of overweight/obese children through its partnerships with schools, farms, businesses and other organizations. Examining outcomes of San Diego and Summit Counties' efforts may spur innovation of the ACC model. It will also emphasize the critical role partnerships play in achieving the broadest and best health outcomes for an entire population.

1 Wu SY, Green A. Projection of chronic illness prevalence and cost inflation. Santa Monica, CA: RAND Health; 2000. Available at: http://www.cdc.gov/chronicdisease/overview/index.htm

2 National Association of County and City Health Officials. 2013 National profile of local health departments. 2013. Available at: http://naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdf

3 Mays GP and Smith SA. Geographic variation in public health spending: correlates and consequences. Health Services Research. 2009; 44(5): 1796-1817. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2758407/

4 National Association of County and City Health Officials. 2013 National profile of local health departments. 2013. Available at: http://naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdf

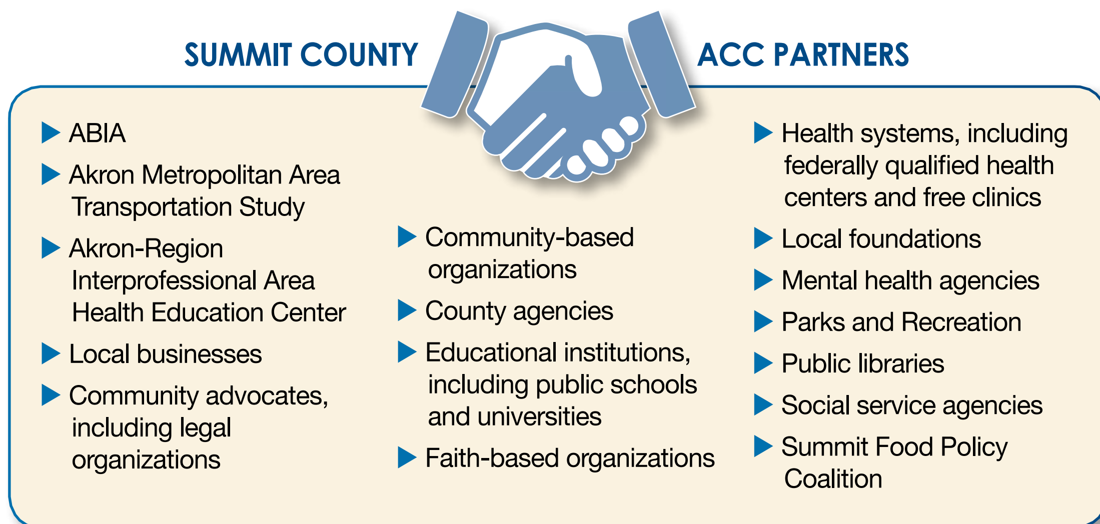
County Snapshot

Summit County, Ohio

Population (2010 Census): 541,781

Overview

In response to the rising rates of diabetes, high levels of physical inactivity and poor eating habits of residents, the Austen BioInnovation Institute in Akron (ABIA), a local nonprofit organization convened local champions to create a new health culture through an ACC. As a result, Summit County Public Health's Care Coordination: Community Response Model was created in April 2012. This model addresses health disparities caused by limited resources and access to care by linking residents to services. Trained outreach specialists and public health nurses work closely with residents of Summit County to assure access to services such as health care, housing, transportation, medications and dental and vision services. Through Care Coordination, four projects: (1) Access to Care, (2) Adult Protective Services, (3) Certified Application Counseling and (4) the Million Hearts Campaign have been developed to efficiently and effectively address the needs of vulnerable populations in the community.



Impacts

ACCESS TO CARE (ATC)

ATC is a volunteer network of 300 primary and specialty care physicians that provide care at no cost to participants. Care coordinators assess eligibility for this program and serve as patient advocates and connect clients to care. This program began in 2008 through a federal grant and has since been transitioned to Care Coordination as a way to provide more coordinated services.

The mean cost per ATC client with diabetes is $113.30 per month, while the estimated costs for those that have remained in the program for four or more years has decreased markedly to $68.01 per month, a 40 percent reduction. Likewise, the mean cost per ATC client with hypertension has also declined for those that have remained enrolled in the program. During their first year of enrollment, hypertensive clients were provided services that averaged $136.41 per month, while the estimated costs for those that remained in the program for four or more years decreased by 53 percent to $64.31 per month.

ADULT PROTECTIVE SERVICES (APS)

The overall results of the federal fiscal year 2013 evaluation of Summit County APS program are very favorable based on data outlined in an evaluation report. Each of the key components of the evaluation, such as the 2013 Provider Satisfaction Survey, the 2013 Quarterly Chart Audits and the 2013 Direct Observations of APS/Care Coordination Teams, yielded favorable results for patient improvement and workforce efficiency and effectiveness.

CERTIFIED APPLICATION COUNSELING

During the first open enrollment period (October 1-March 31, 2014) during the establishment of the Affordable Care Act (ACA), Summit County Public Health (SCPH) made more than 5,000 assists. The assists included enrollment activities, outreach events, speaking engagements and one-on-one appointments. SCPH continues to assist individuals who are Medicaid eligible on an ongoing basis.

MILLION HEARTS CAMPAIGN

The Million Hearts Campaign began in August of 2013 and is currently being evaluated. Its goals are to, by June 30, 2014, improve hypertension control rates by 20 percent among (1) patients already in the system but not yet diagnosed with hypertension and (2) patients diagnosed with hypertension that is uncontrolled. The Campaign is focusing on male patients at 12 participating Summit County practices.

Lessons Learned

- **The collaboration must remain flexible in the process and open to new ideas.** The needs of a community are fluid and often change quickly. The community must be able to respond to changes and support new initiatives, as many are time-limited like the implementation of the ACA and the need to enroll individuals in the Health Insurance Marketplace.
- **All partners bring strength to the collaboration.** In an ACC, all partners are welcomed and needed to assist residents with a variety of necessary services. ACCs may include nontraditional partnerships and this may result in a learning curve as each partner learns what another partner may contribute. This understanding should lead to strong working relationships among partners and the community.

Next Steps

As all partnerships develop and evolve, change is inherent in the process. Summit County's ACC will be developing a medical collaborative with formal agreements with all partners and developing new funding strategies to address identified needs. Additionally, the collective impact of the ACC on the community will be measured and an evaluation determining the return on investment and the savings to be reinvested in other programs for community benefit will be created.

Resources

- The Austen BioInnovation Institute in Akron http://www.abiakron.org
- Summit 2020: A Quality of Life Project www.healthysummit.org

County Snapshot

San Diego County, California

Population (2010 Census): 3,140,069

Overview

Live Well San Diego is a 10-year plan to make San Diegans healthy, safe and thriving. The region's key goal to improving its service delivery system is an ACC. Increases in chronic disease rates and health care costs prompted the county to take action, adopting a comprehensive plan for population health and safety that began with the Building Better Health agenda in 2010, and was followed by the Living Safely agenda in 2012, which addresses the need for safe and resilient residents and communities. The current Thriving agenda will address quality of life issues. Championed by the Board of Supervisors, county staff supports this collective effort, as do its 44 recognized partners—cities, school districts, businesses and faith- and community-based organizations—each committed to a shared vision for healthy, safe and thriving communities.

Impact(s)

IMPROVING QUALITY AND EFFICIENCY OF CLINICAL CARE

- San Diego County established successful collaborations with all major regional health care systems and designed an Emergency Medical Services Hub, a technology that makes pre-hospital records and electrocardiograms available in real-time to improve clinical care of patients, lowers resource utilization at hospitals and decreases wait times for pre-hospital providers.
- San Diego Health Connect, a local health information exchange with participating hospitals and clinics, was developed as an automated interface to make immunization information available to participating providers. This reduced duplicative immunizations, improved patient management, decreased documentation efforts of schools and improved population immunization assessments.
- Be There San Diego, a collaborative of local medical groups, health plans, Naval Medical Center San Diego, community clinics, the local medical society and the local health department had a shared vision to make San Diego the nation's first heart attack and stroke-free zone. The collaboration established regional standards of care and treatment protocols and designed technology-supported tools to assist physicians in managing the health of their whole practice population and help patients manage their own health outcomes.
- The San Diego Care Transitions Partnership (SDCTP), a collaboration between the County and four large health systems, Palomar Health, Scripps Health, Sharp HealthCare and the UC San Diego Health System that together include 13 hospitals, is providing comprehensive hospital and community-based care transition support to medically and socially complex patients. The program is successfully reducing the 30 day all-cause readmission rate and Medicare costs by delivering patient-centered interventions, including coaching by transition nurses, medication support by pharmacists, and short-term, intense, post-discharge care coordination by social workers, targeting almost 21,000 high risk fee-for-service Medicare patients per year.

ENGAGING THE COMMUNITY IN IMPROVING POLICIES, SYSTEMS, ENVIRONMENTS AND HEALTHY BEHAVIORS

- As part of the process for obtaining public health accreditation, five sub-regional Live Well San Diego Leadership Teams — comprised of leaders from all sectors and active community residents — were established to conduct community health assessments, develop community health improvement plans and take action to improve the health and safety of their geographic regions, covering a 4,200-square mile area and all San Diegan residents.
- Obesity was reduced by 3.2 percent over a 2-year period in an elementary school district with 29,000 students. This was achieved by establishing baseline measurements of body mass index and by designing and implementing a wellness policy that increased physical activity, improved eating habits and reduced intake of sugary drinks and snacks.
- The locally developed Resident Leadership Academy curriculum provided over 80 members of the community with training and tools to constructively advocate for change in their neighborhoods and communities, including meeting with local planning groups and elected officials, addressing elected bodies in public meetings and participating on citizen advisory boards to influence policy and improve the built environment essential for healthier communities.
- Through Love Your Heart, a one-day event held annually since 2011, San Diego County and its partners, including health care providers, libraries, the fire community, universities, city government, non-profits and the business community, provide free blood pressure screenings to the public with the goal of encouraging San Diegans to "know their numbers" and take charge of their own heart health. The 2014 event took place on February 14—Valentine's Day—and involved dozens of partners at hundreds of sites who performed over 17,700 blood pressure screenings.

Lessons Learned

- **Keep it simple.** From messaging to measurement, "potent simplicity" is the rule. In reaching across political jurisdictions, disciplines, programs and geographic and cultural lines, it is necessary to communicate very clearly and simply the issues, the proposed solutions, the measurements and the opportunities to engage.
- **Keep it local.** In a large, diverse region like San Diego County (which has a population of 3.2 million filled with complex societal dynamics, 18 incorporated cities, 18 tribal organizations and 43 school districts), information, engagement and action must occur at the sub-regional level in order to be effective and sustained. A one-size-fits-all approach to community health improvement does not always work.
- **Keep it real.** The Accountable Care Community requires goal and resource alignment, changing the business culture to be more data-driven and evidence-based and addressing workforce wellness concurrent with population health—"walking the talk." Initially, progress is slow and steady, but it accelerates with time.

Next Steps

Health care providers, social service agencies, businesses and many other industry groups, along with regional leadership from the County, are working together to transform service delivery from a traditional program-centered model to an integrated person-centered model.

Initiatives supporting this transformation include the San Diego Health Connect (Beacon Health Information Exchange), San Diego 2-1-1 and San Diego Community Information Exchange. Another major component is the County Knowledge Integration Program (KIP). To facilitate business process improvements — from data-based decision-making to expansive process re-engineering — the county is establishing pertinent governance and standards and procuring a technology vendor to build an enterprise information exchange that will connect 10 data source systems and enable staff and customers to access their integrated records, make electronic referrals for services, share collaborative case notes and receive alerts and notifications. This model will be initially implemented with a small target populations before increasing to include more individuals.

Resources

To learn more about Live Well San Diego, visit LiveWellSD.org for history, blog posts, resources and best practices, profiles of recognized partners and the Top 10 Live Well San Diego indicators of progress.

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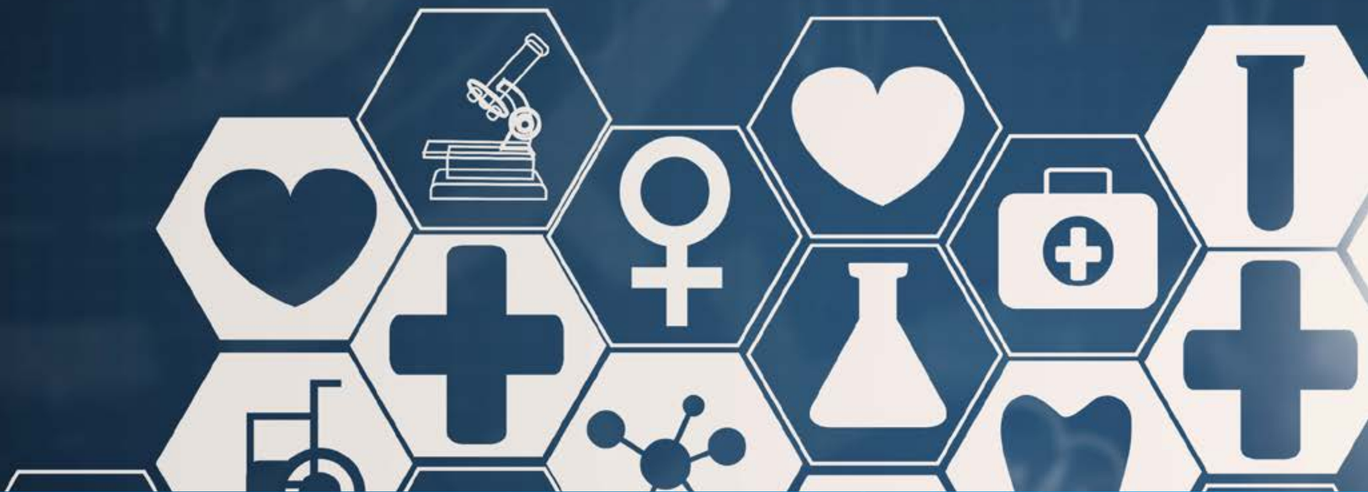

25 MASSACHUSETTS AVENUE, NW
SUITE 500 | WASHINGTON, DC 20001

202.393-6226 | FAX 202.393.2630
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