



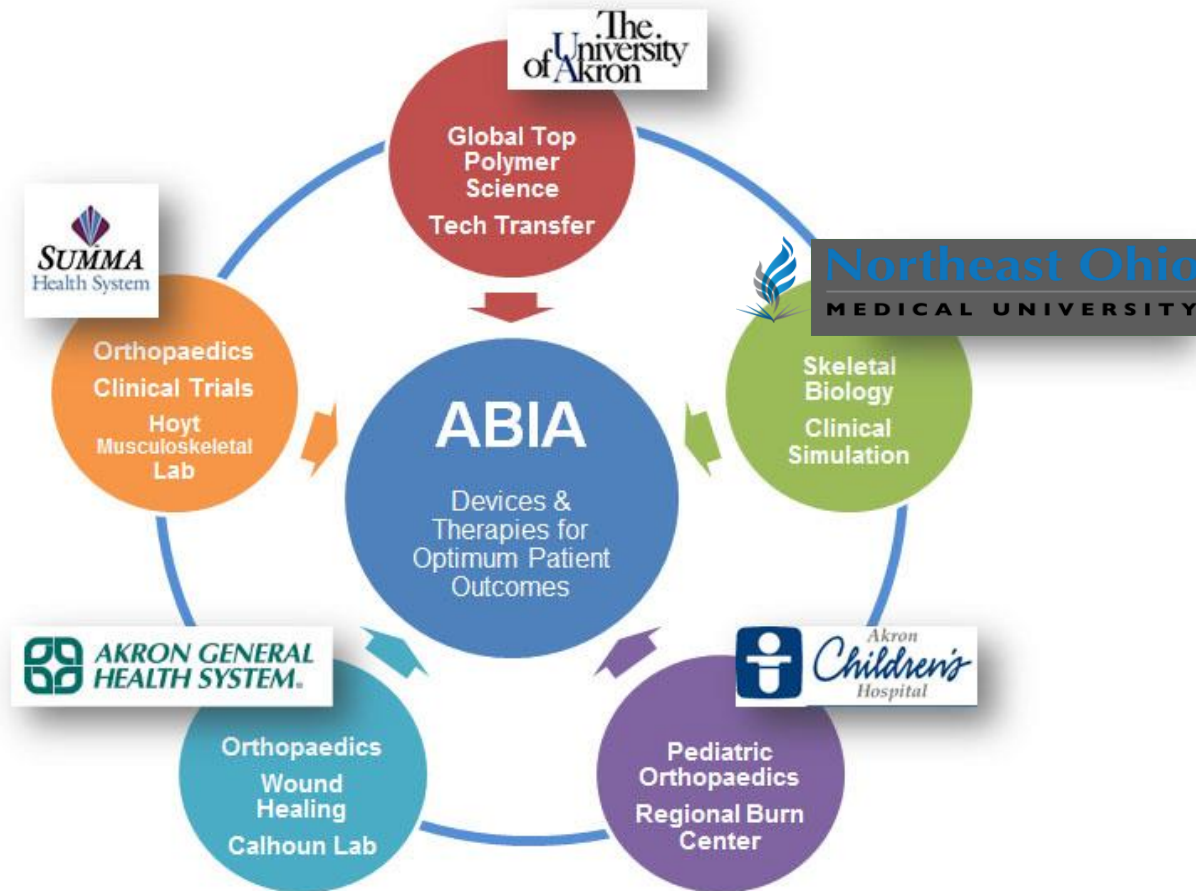
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ABIA: Unique Convergence



John S. and James L. Knight Foundation
Informed, engaged communities.



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Accountable Care Community (ACC)

- **Vision**

To improve the health of the community.

- **Mission**

To design, develop, implement, and serve as a national framework for improving the overall health of an entire community through a collaborative, integrated, multi-institutional approach that emphasizes shared responsibility for the health of the community.

- **Metrics**

The ACC results in job creation, a spin-out business entity, and improved health via higher quality, cost effectiveness and cost saving, and an improved patient experience in health promotion and disease prevention, access to care and services, and health care delivery.

ACC vs. ACO

- ACC is not dependent upon providers adopting Medicare infrastructure
- ACC encompasses medical care systems plus grassroots community stakeholders and community organizations
- ACC focuses on health outcomes of the entire population in a geographic region

Partners, Accountable Care Community



Communities Transforming

To make healthy living easier



ACC Coalition

Collaborative partnerships leverage multi-sector resources to improve community health.

Benefits of partnership:

- Addresses broad range of issues with greater breadth and depth
- Coordinates services and prevents redundant efforts
- Increases public support
- Allows individual organizations to influence community on a larger scale
- Includes diverse perspectives
- Strengthens connections between existing resources
- Provides shared frame of inquiry for community health concerns



ACC Components

- Integrated, collaborative, medical and public health models
- Inter-professional teams
- Robust health information technology infrastructure
- Community health surveillance and data warehouse
- Dissemination infrastructure to share best practices
- ACC impact measurement
- Policy analysis and advocacy

High Level Steps Toward an ACC

1. Develop a system of health promotion and disease prevention, access to care and services, and healthcare delivery based on Healthy People 2020
2. Conduct an inventory of community assets and resources, and mapped to the Health Impact Pyramid
3. Identify and rank health priorities with community stakeholders

High Level Steps Toward an ACC

4. Realize improved health outcomes for a defined population
5. Utilize benchmark metrics that include short-term process measures, intermediate outcome measures, and longitudinal measures of impact
6. Demonstrate the economic case for healthcare payment policies that lower the preventable burden of disease, reward improved health, and deliver cost effective care

ACC Strategic Impact Directions and Process Implementation



- **TOBACCO-FREE LIVING**
Prevent/reduce tobacco use and protect people from exposure to tobacco smoke
- **ACTIVE LIVING AND HEALTHY EATING**
Prevent/reduce obesity, increase physical activity and improve nutrition
- **HIGH-IMPACT QUALITY CLINICAL AND OTHER PREVENTIVE SERVICES**
Prevent/control high blood pressure and cholesterol
- **SOCIAL AND EMOTIONAL WELLNESS**
Increase health/wellness, including social/emotional wellness
- **HEALTHY AND SAFE PHYSICAL ENVIRONMENTS**
Improve the community environment to support health



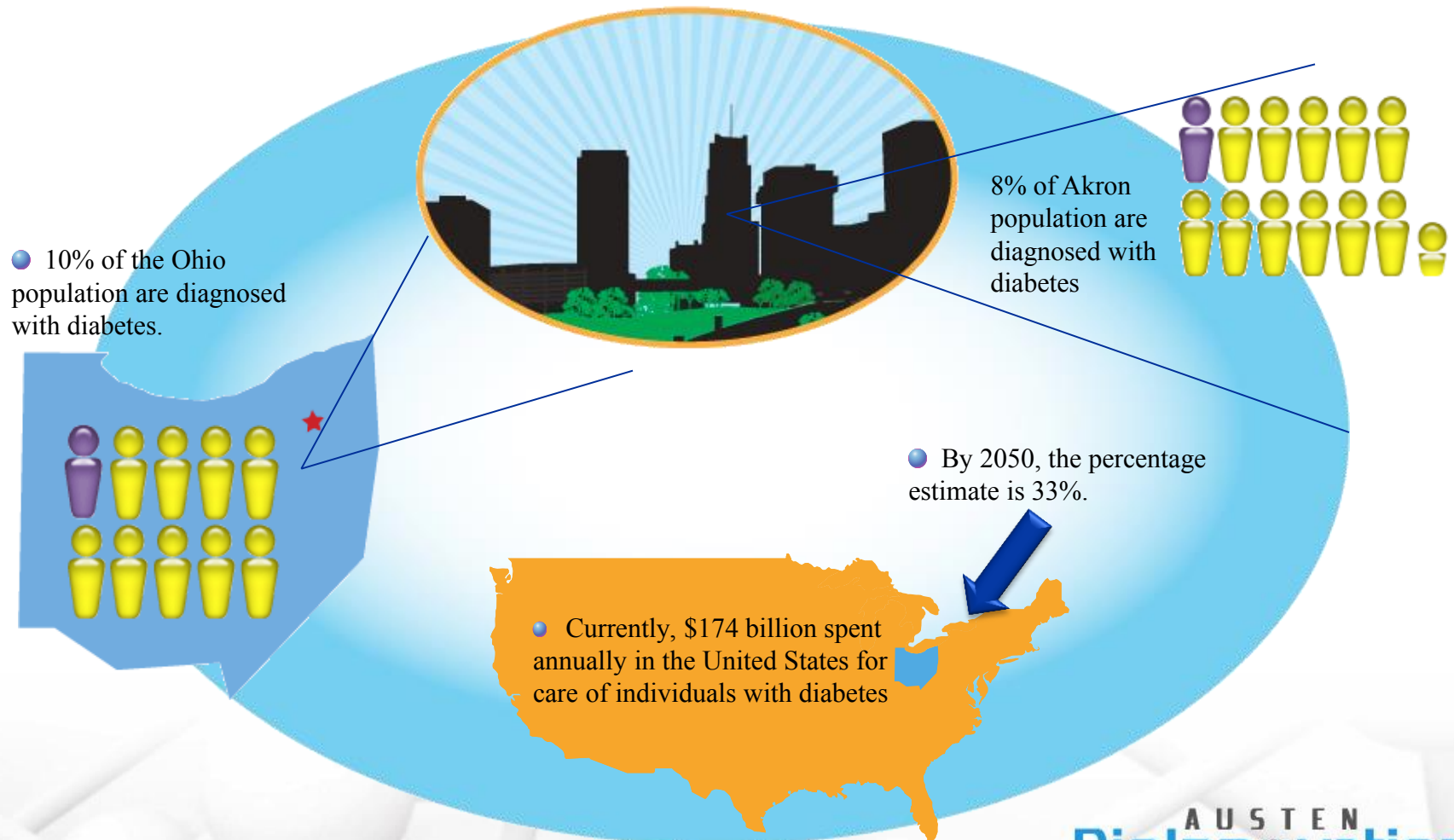
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Diabetes



Diabetes has a significant impact on health, economics, and quality of life.

ACC Success: Personalized Educational and Experiential Modules for Diabetes Management

- Patients with diabetes at 3 independent health systems, varying insurance status (38% private, 31% public, 31% none)
- Multi-disciplinary team with multi-focal modules (medical care, nutrition, physical activity, social and emotional well-being, and self-management)
- Results included
 - Cost \$25/person/contact hour (comparison Diabetes Prevention Project \$37.50/person/contact hour)
 - Better management leading to decrease in A1C and LDL cholesterol levels
 - More than half of participants lost weight (more than 115 pounds), decreased BMI (almost 23 points), and reduced waist size (more than 25 inches)
 - No amputations and a decline in emergency department visits because of diabetes
 - Increase in reported exercise and flexibility

ACC Success: Return on Investment (ROI)

- Examination of ROI program connecting more than 2000 adults with the ACC
- Results included
 - The average cost per month of care for individuals with diabetes reduced by more than 10% per month
 - After one year of involvement, consistent reduction in costs are in excess of 25%

Recognized Benefits of Diabetes Interventions

Per Person Annual Health Care Savings of Decreasing HbA1c

	2012 USD
10% to 9%	\$570
9% to 8%	\$415
8% to 7%	\$285
10% to 9% w/ complications	\$1,955

Per Person Annual Savings of Decreasing % of Body Weight

	Medical	Absenteeism
5%	\$60	\$30
10%	\$140	\$50
15%	\$210	\$80
20%	\$280	\$110

ACC Results:

- Estimated Program Savings = \$3,185/year
- Average Pre-Program HbA1c = 8.20%
- Average Post-Program HbA1c = 7.74%

- Estimated Program Savings = \$580/year
- Average Weight Decrease = 2%

Recognized Benefits of Diabetes Interventions

ED Visits per 1,000 Diabetics in Same Condition

Years HbA1c < 8%	ED Visit Rate
0 years under 8%:	276.3
1 year under 8%:	230.6
2 years under 8%:	200.0
3 years under 8%:	127.1
4 years under 8%:	115.9

ACC Results: Total Number of ED Visits

	HbA1c < 8%	HbA1c > 8%
6 Months Prior:	6	9
During Program:	3	7

- Individuals with HbA1c<8% had a total of 6 ED visits six months prior to the program and 3 during the program.
- Individuals with HbA1c>8% had a total of 9 ED visits six months prior to the program and 7 during the program.

ACC Metrics for Success

- Community participation
- Local, regional, and national burden of disease (Impact Equations)
- Institute of Medicine Specific Aims for 21st century healthcare
- Primary, secondary, and tertiary prevention indicators
- Community intervention measures
- Care coordination metrics
- Determinants of health
- Health information technology utilization and information sharing
- Clinical improvement
- Patient safety
- Patient self-management
- Patient-centered medical home measures

ACC Impact Equation

- ACC Impact Equation is proxy for overall benefits and costs of ACC efforts (macro) and useful in considering specific projects (micro)
- Examines 3 elements: Quality Improvement, Scope of Population Served, and Costs of Disease (in Summit County)
- Impact is a function of:

(Quality Improvement) * (Population Served)
Disease Burden

ACC Impact Equation

- Alternatively, burden can be measured in terms of Delay of Disease Progression, Cost of Treatment, and Loss of Productivity
- This frames ACC impact from population perspective
- Impact is a function of:

(Delay of Progression /
Total Cost of Treating Disease)

ACC Sustainability

- Systemic changes that help move collaborative behavior into the norm
- Sophisticated knowledge management tools to drive positive change
- A knowledge base of policy, financing, and regulatory levers
 - focus on health promotion and disease prevention
 - coordinated and integrated public health, social service, and health systems
 - payment reform

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