Accountable Health Communities Model

Understanding RMHP's AHCM

May 2019

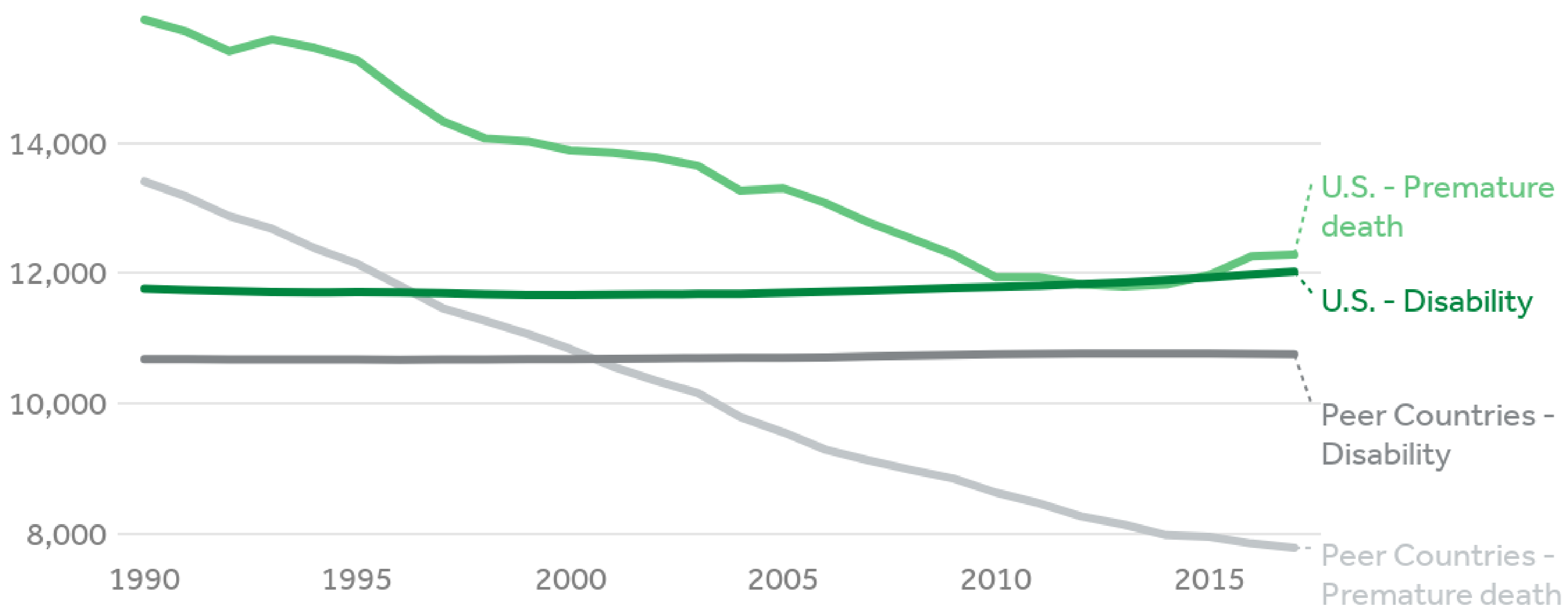
Goals of the Day

- ***Celebrate***
- ***Re-focus on the big picture***
- ***Build relationships***

Introductions

- *Community Leads*
- *QHN Staff*
- *Rocky Mountain Health Plan Staff*
- *Katherine Verlander- CMS*
- *Emily Berry- HCPF*
- *Lauren & Katharine- Energy Outreach Colorado*
- *Jen- Colorado Division of Housing*
- *Emily Hunter- Hunger Free Colorado*
- *Doug McCarthy- Commonwealth Fund*
- *Alayna Grace-Flavin- RecRx*
- *Jennifer Stepleton - DOLA*
- *Clinical Organizations*
- *Community Organizations & Human Services*

Age-standardized premature death and disability rates per 100,000 people due to all causes, 1990-2017



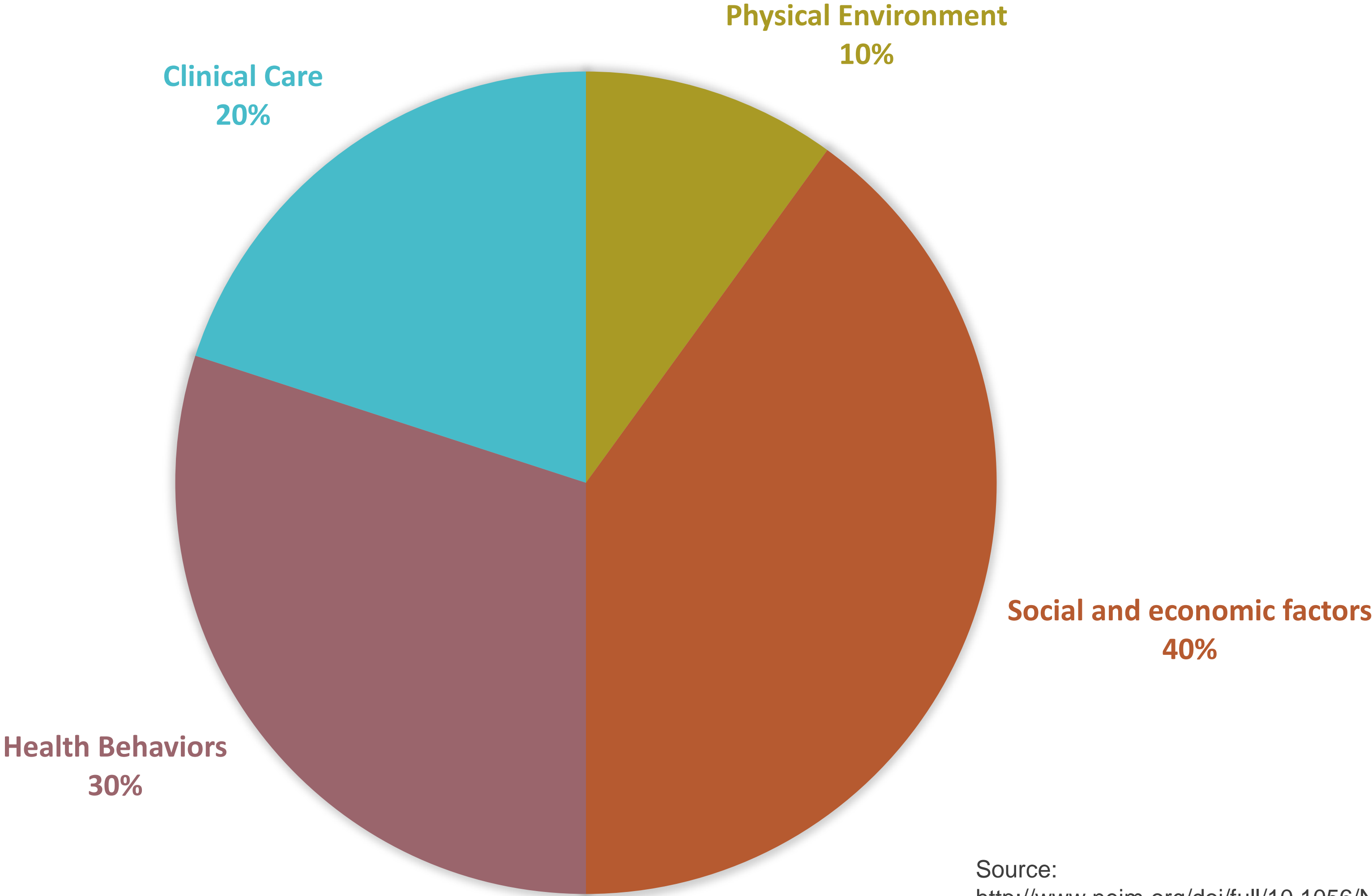
Premature death = years of life lost (YLL); disability = years lived with disability (YLD)

Source: KFF analysis of IHME GBD data • Get the data • PNG

Peterson-Kaiser
Health System Tracker

Source: https://www.healthsystemtracker.org/indicator/health-well-being/years-lived-with-disability/

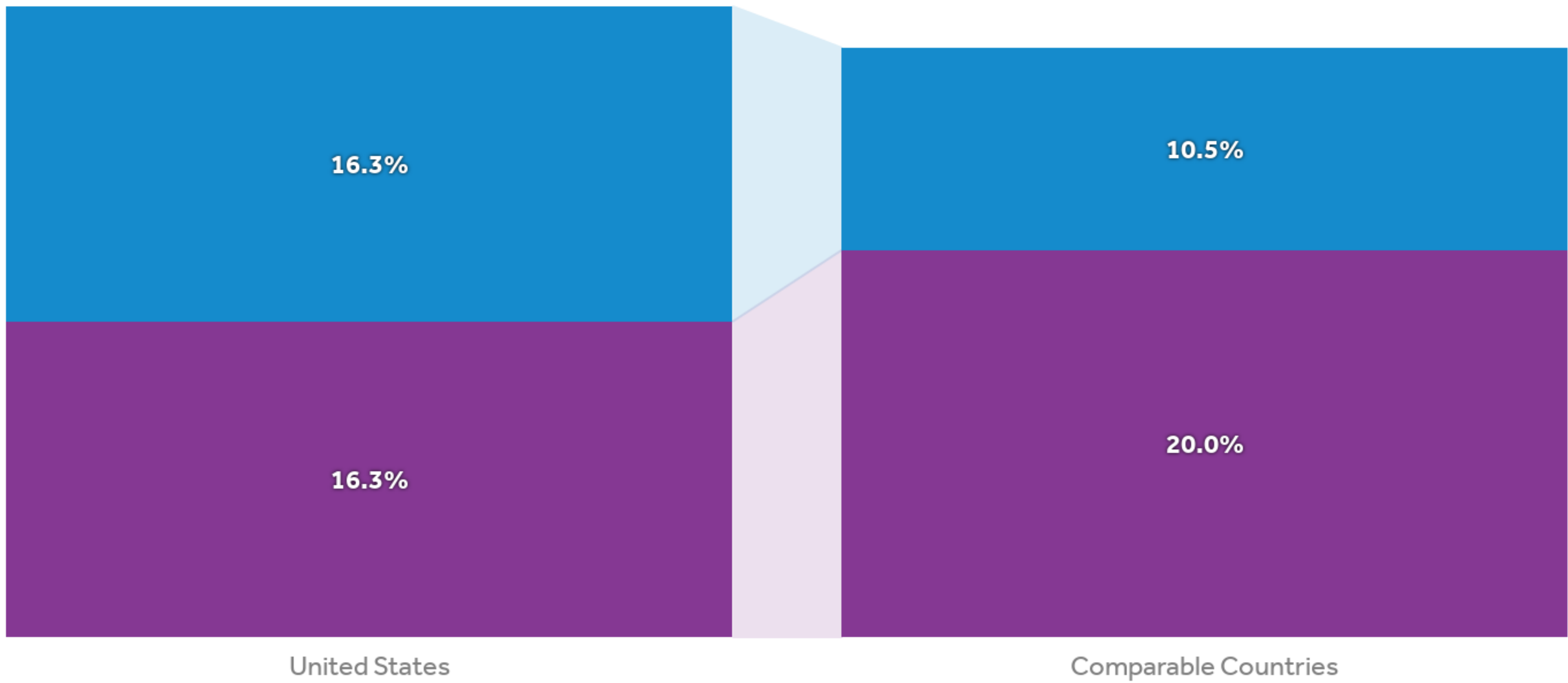
FACTORS DRIVING HEALTH OUTCOMES



Source:
http://www.nejm.org/doi/full/10.1056/NEJMsa073350#t=article

Percent of GDP devoted to public and private social services and health spending, 2013

Social Services (not including health) Health



Source: Kaiser Family Foundation analysis of data from CMS National Health Expenditure and OECD (2018), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database) (Accessed on December 6, 2018).
• Get the data • PNG

Peterson-Kaiser
Health System Tracker

Source: https://www.healthsystemtracker.org/brief/a-generation-of-healthcare-in-the-united-states-has-value-improved-in-the-last-25-years/#item-start

MAJOR CAUSES OF DEATH: THEN & NOW

We have more power over our health than any other generation in history.

1900

- Pneumonia & flu
- Tuberculosis
- Digestive Disease
- Heart Disease

2015

- Heart Disease
- Cancer
- Lung Disease
- Stroke

Source: https://2rdnmg1qbg403gumla1v9i2h-wpengine.netdna-ssl.com/wp-content/uploads/sites/3/2014/10/15-HHB-2258-How-We-Die-FINAL.pdf

SYSTEM PARALLELS: U.S. POSTAL SERVICE

- Is the goal of the postal service to help Americans communicate or to deliver mail?

- **Is the goal of the health care system to improve health or deliver healthcare?**

THE ACCOUNTABLE HEALTH COMMUNITIES MODEL

CONVENING	*A community infrastructure for supporting addressing social needs. Community Leads identify gaps in social needs and create partnerships to address gaps*
SOCIAL NEEDS SCREENING	*Screening for social needs for clinical sites and providing referrals*
COMMUNITY NAVIGATION	*All screened individuals who have 2 or more ER visits in the last year and a social need should receive community navigation*

AHCM COMMUNITY LEADS

Moffat
Routt
Jackson
Grand
Rio Blanco
Garfield
Eagle
Summit
Pitkin
Mesa
Delta
Gunnison
Montrose
Ouray
San Miguel
Hinsdale
Dolores
San Juan
Montezuma
La Plata
Archuleta

Geographic Target Area

Western Colorado
Accountable Health Communities Model

COLOR KEY:

- Northwest Colorado Community Health Partnership
- West Mountain Regional Health Alliance
- Mesa County Public Health
- Tri-County Health Network
- TBD

Community Lead Quality Improvement

- ***Housing***
  - West Mountain Regional Health Alliance
- ***Food***
  - Northwest Colorado Community
  - Tri-County Health Network
  - Mesa County Public Health

AHCM SCREENING

We aim to screen 100,000:

Medicare Enrollees | Medicare-Medicaid Enrollees | Medicaid Enrollees

In Clinical Settings including:

Primary Care | Behavioral Health | Hospitals

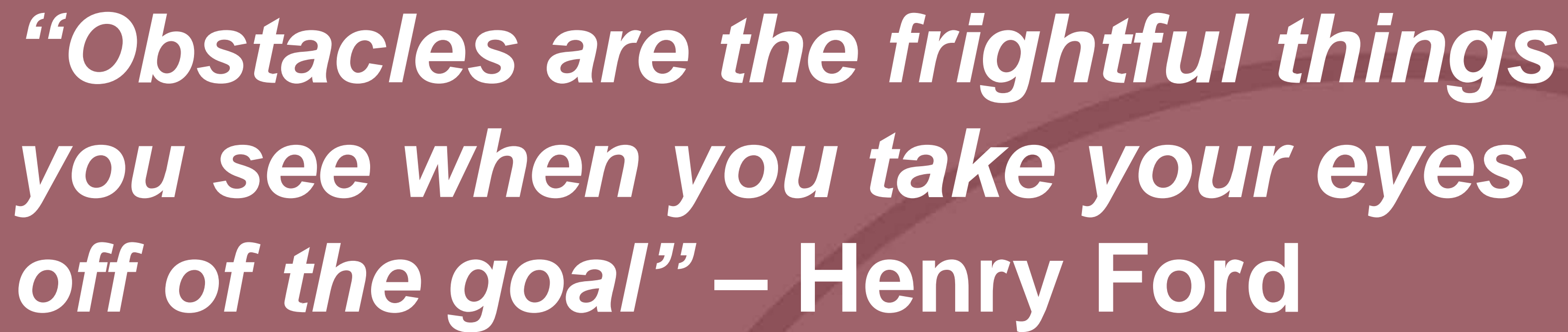
For six social needs:

Food | Housing | Transportation

Utilities | Interpersonal Violence | Social Isolation

Using the:

Quality Health Network Community Resource Network


"Obstacles are the frightful things you see when you take your eyes off of the goal" – Henry Ford

AHCM SCREENING

"The last time I looked in my textbook, the specific therapy for malnutrition was, in fact, food"

– Dr. Jack Geiger

Identify social needs to enhance clinical care planning

AHCM SCREENING

County	% Eligible but Not Enrolled in SNAP	County	% Eligible but Not Enrolled in SNAP
Mesa	44%	La Plata	49%
Archuleta	56%	Moffat	31%
Delta	46%	Montezuma	37%
Dolores	69%	Montrose	44%
Eagle	75%	Ouray	71%
Garfield	45%	Pitkin	86%
Grand	77%	Rio Blanco	53%
Gunnison	68%	Routt	73%
Jackson	56%	San Miguel	72%

Provide information on community resources

Identify social needs to enhance care planning

AHCM SCREENING

AHCM SCREENING

Identify gaps in social resources

Provide community navigation

Provide information on community resources

Identify social needs to enhance care planning

AHCM SCREENING

Create Community Solutions to Gaps in Social Resources

Identify gaps in social resources

Provide community navigation

Provide information on community resources

Identify social needs to enhance care planning

AHCM SCREENING

Health Equity & Culture Change

Create Community Solutions to Gaps in Social Resources

Identify gaps in social resources

Provide community navigation

Provide information on community resources

Identify social needs to enhance care planning

Celebration

Total Screened: 5,037

Total Screenings Sent to CMMI: 1,825

Total Clients Eligible for Navigation: 337

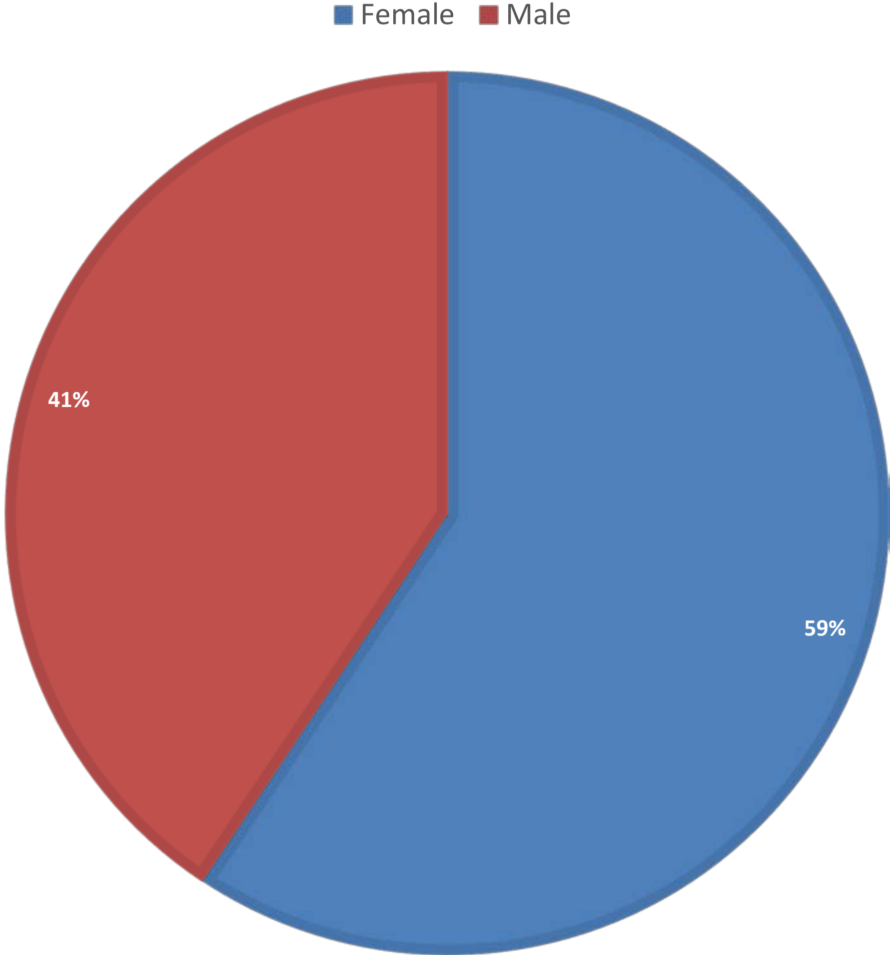
Social Need	*Count of Positive Responses*
Food	*1,062*
Housing	*519*
Transportation	*706*
Utilities	*327*
Safety	*102*
Social Isolation	*340*

RMHP Clinical Partners (a sample)	Total Screenings	CMS Submitted Screenings	Navigation
Summit Community Care Clinic	689	464	35
Mountain Family Health Center	882	366	47
Rocky Mountain Health Plans	152	141	61
Foresight Family Physicians	103	97	25
Surface Creek Family Practice, PC	163	81	14
Rangely District Hospital	136	77	29
Memorial Regional Health Clinic	258	76	19
Axis Health System	284	66	15
River Valley Family Medicine	1,313	62	28
Ebert Family Clinic	227	62	3
Pediatric Associates of Durango	70	61	5
Valley View Hospital	84	42	18
Gunnison Valley Health	160	38	7
Northwest Colorado Health	69	35	7
Mid Valley Family Practice	39	35	1

Additional Sites Screening

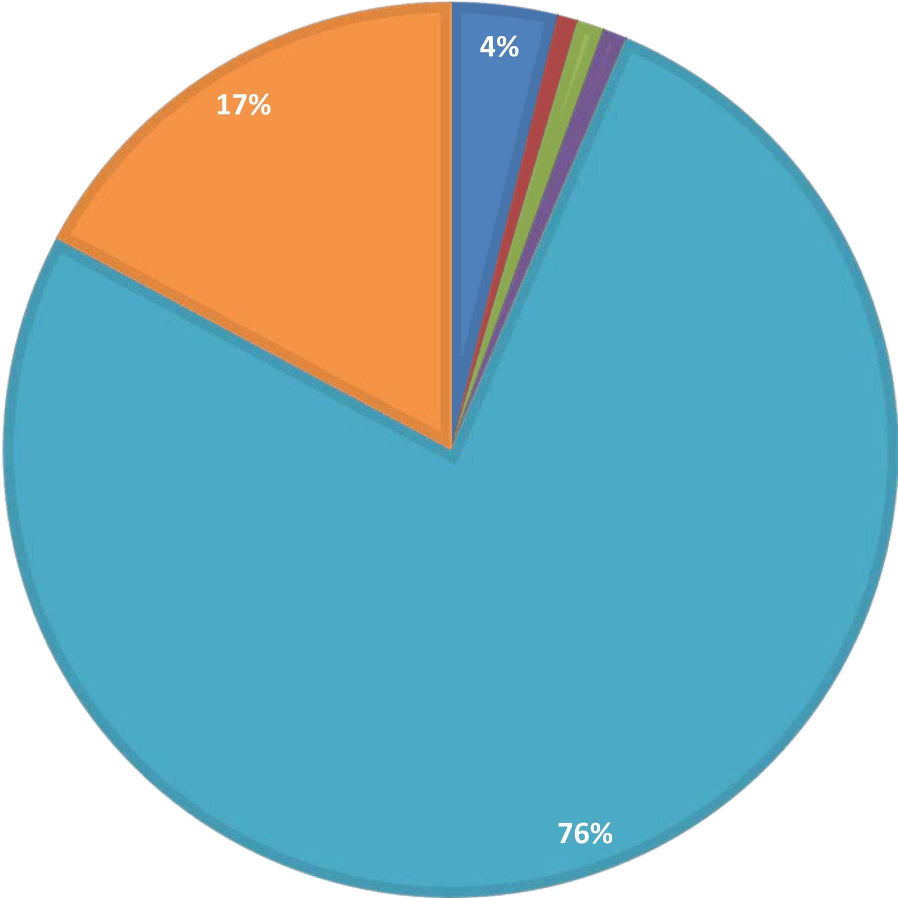
- Primary Care Partners
- Uncompahgre Medical Center
- A Kidz Clinic
- Glenwood Medical Center
- Pioneer Medical Center
- Northside Childe Health Center
- Aspen Valley Hospital

Gender



Race and Ethnicity

American Indian
Asian
Black
Hawaiian or Pacific Islander
White
Hispanic or Latino

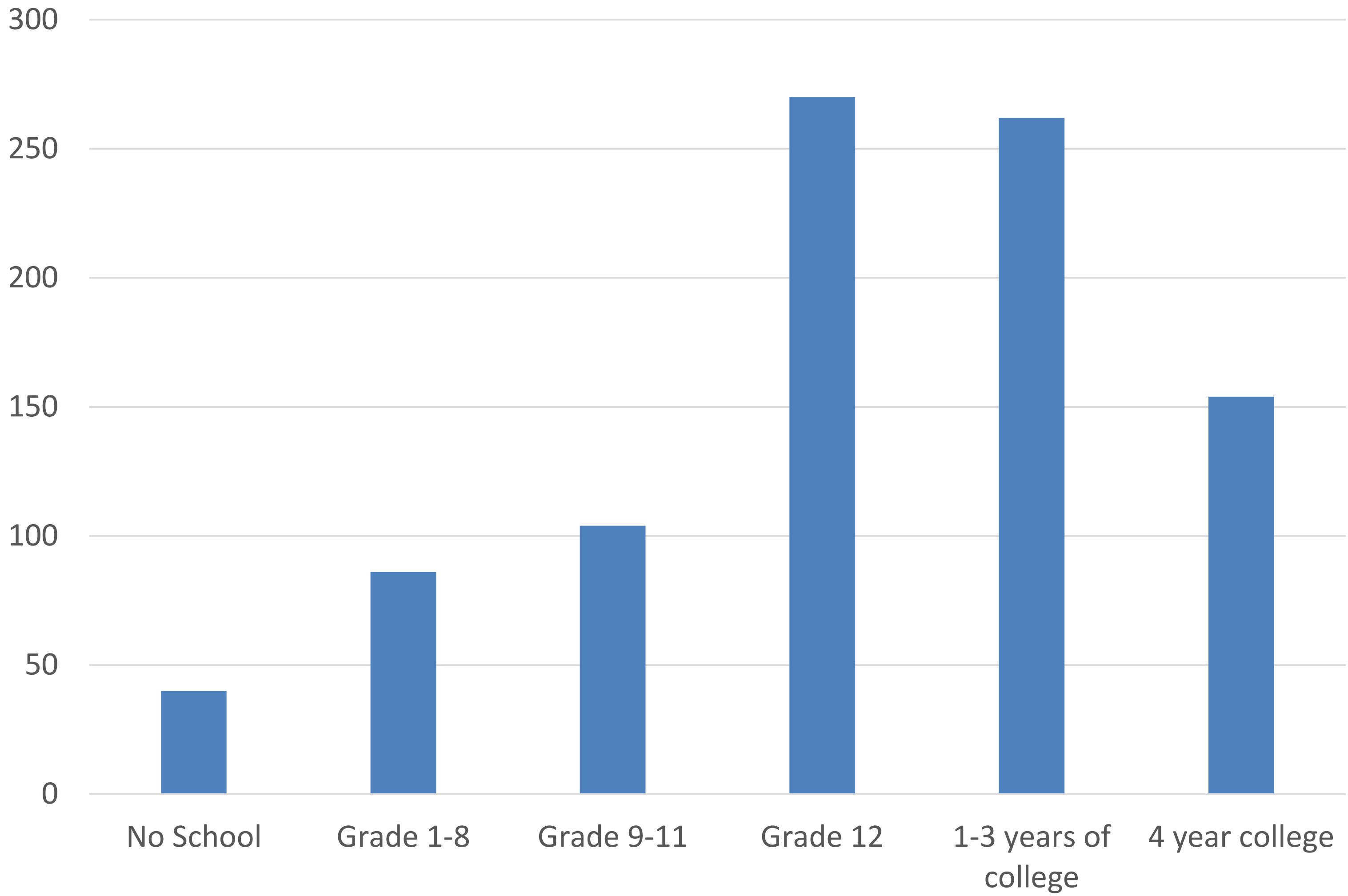


Count by Income

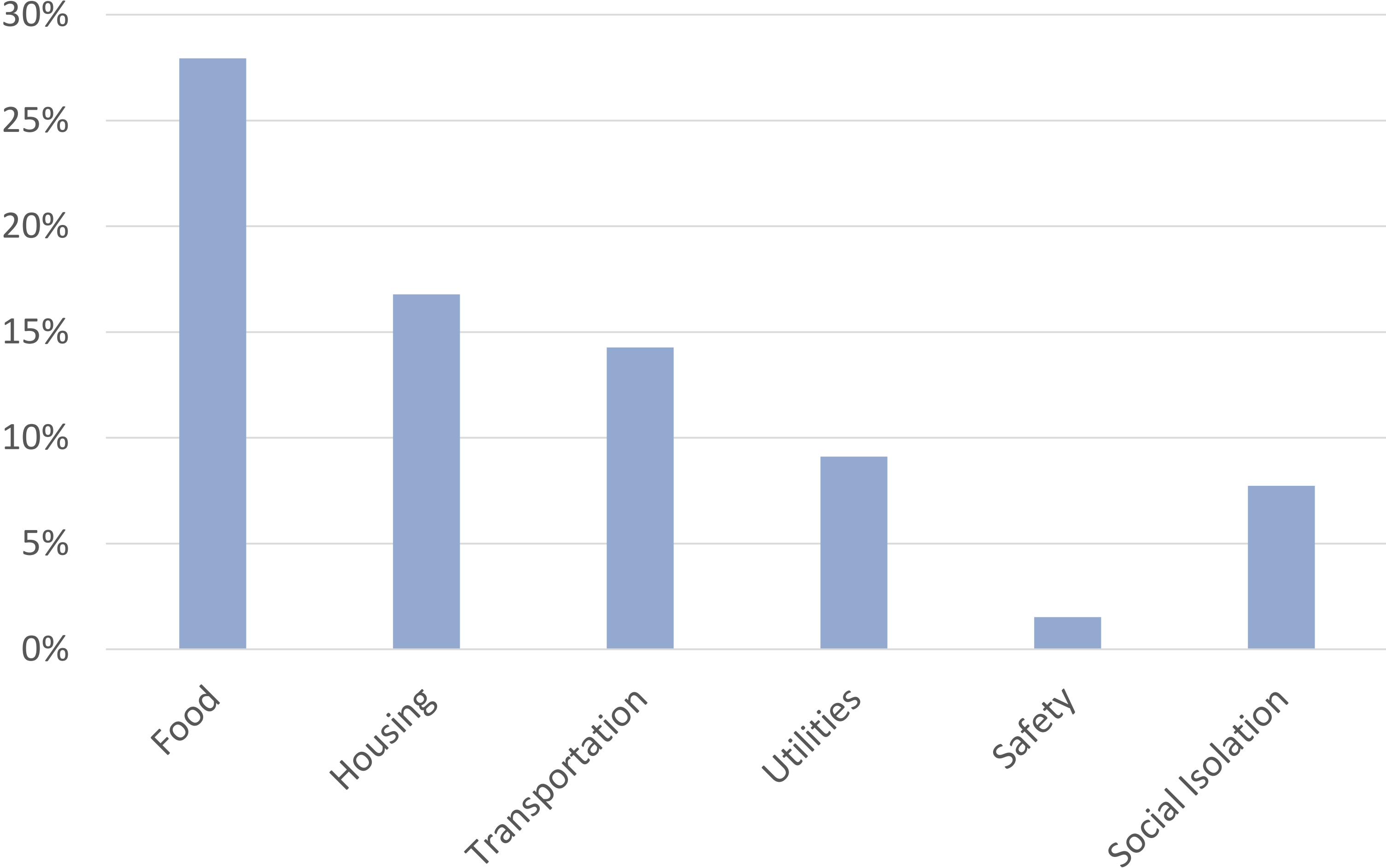
More than 75K
More than 50K, less than 75K
More than 35K, less than 50K
More than 25K, less than 35K,
More than 20K, less than 25K
More than 15K, less than 20K
More than 10K, less than 15K
Less than 10K

0 50 100 150 200 250 300 350

Education



Prevalence of Social Needs



ER Visits and Social Needs

Percent of Screened Population with No ER visits in the Last Year

60%
50%
40%
30%
20%
10%
0%

No Social Needs
Food Needs
Transportation Needs
Utilities Needs
Housing Needs

Prevalence of Needs in People with 2 ER Visits

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

Housing Food Transportation Utilities Safety Social Isolation

CONTACT RMHP TO LEARN MORE

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MAKING A DIFFERENCE IN WESTERN COLORADO

Community Resource Network

Connecting for Healthier Communities

An update

Cindy Wilbur RN and Tessa McInnis

May 2019

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Community Resource Network

- The CRN is a Community Information Exchange (CIE) .
- What is a CIE? *A CIE is an ecosystem comprised of multidisciplinary network partners that use a shared language, a resource database, and an integrated technology platform to deliver enhanced community care planning.* (San Diego 2-1-1)
- CRN shares a Master Person Index with QHN, the Health Information Exchange (HIE) for Colorado's Western Slope.

CRN Community RESOURCE N•E•T•W•O•R•K

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- **Client Centric**: a rich 360 degree Whole Person view to better address interrelated healthcare, behavioral health and SDoH needs
- **Data sharing**: increased visibility across agencies and domains
- **Care Teams**: Self organizing and flexible care coordination tools
  - Asynchronous communication, messaging and alerts
  - Longitudinal record
- **Resource Directory**: with integrated 'closed-loop' referral system

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- **Enter Once**: any data field in the system should be prepopulated (and still editable) into the same field in subsequent forms and documents
- **Robust Reports and Analytics** : Using the network's linked data sets to report and analyze in ways not possible individually
- **Shared Consent**
- **Client Engagement**: decreasing barriers and improving the ability for clients to access their own data and interact with their service providers

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Community Resource Network and AHCM

- AHCM is an important part of the CRN.
- We are building on your success and learning from the tough stuff.
  - Over the past year, we have been revamping and re-designing the 'rest of' the CRN
    - Based on AHCM lessons
    - Community focus groups and design meetings
- Engaged with a new vendor, Stella Technologies

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Timeline

- Design and beta testing by fall 2019
- Version 1 in production early 2020

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