Accountable Health Communities Model

Agenda

1. Introductions
2. Quick Overview of the FOA
3. Why should we consider doing this?
4. Time for feedback
5. Rocky’s role
7. Key Question for Community Based Organizations
6. Next Steps

Introductions

Accountable Health Communities Model

SUMMARY OVERVIEW AND CONSIDERATIONS

What is the Accountable Health Communities (AHCM)Model?

- AHCM is a new Center Medicare and Medicaid Innovation opportunity to conduct a **5 year** test on whether identifying and attempting to **address the health-related** social needs through referral and community navigation can **reduce healthcare costs** and **improve quality and delivery** . All Models must address the “core” needs listed below. Applicants may also opt to address “supplemental” needs, not limited to, but including those listed below in the table.

- AHCM is authorized under section 1115A of the Social Security Act (added by section 3021) of the Affordable Care Act.

Core Needs	*Supplemental Needs
Housing Instability	Family & Social Supports
Utility Needs	Education
Food Insecurity	Employment & Income
Interpersonal Violence	Health Behaviors
Transportation	

The model is intended to address community dwelling beneficiaries who have Medicare and/or Medicaid who receive care at a participating clinical site in a target geographic area.

Model Options

Track 1 Awareness – Increase beneficiary ***awareness*** of available community services through information dissemination and referral

Track 2 Assistance – Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services

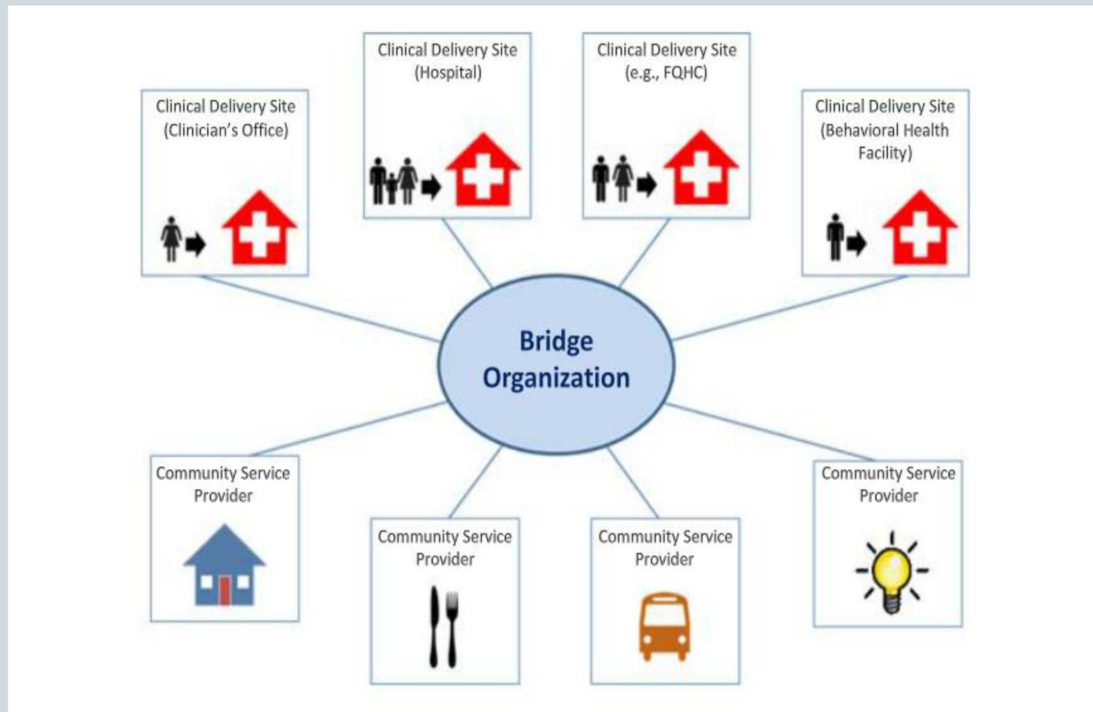
Track 3 Alignment – Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

There are three levels of the ACHM defined in the table to the left. Total funding for each level:

- Track 1: Up to $1 million to 12 awardees ($12 million total)
- Track 2: Up to $2.57 million to 12 awardees ($30.84 million total)
- **Track 3: Up to 4.51 million to 20 awardees ($90.2 million total)**

Notes: Applicants can apply to multiple tracks but will only receive an award for one track. Only one award will be made in any given geographic area. Clinical delivery sites and community partners can support an unlimited number of applications. Applicants can request less than the full amount. .

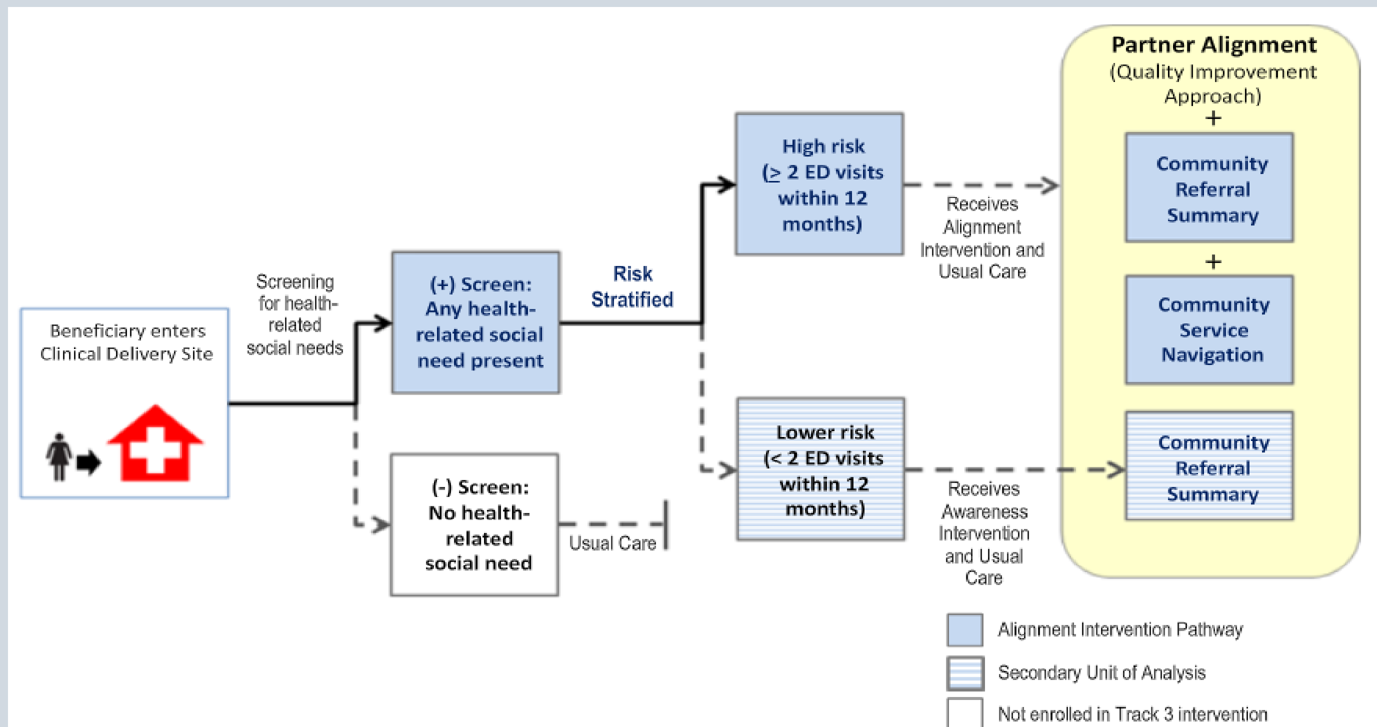
The Bridge Entity & The Consortium



The applying organization is called the Bridge Entity and is responsible for providing the infrastructure to convene and coordinate clinical and community resources.

The Consortium must include Colorado Medicaid, clinical delivery sites (primary care, behavioral health, hospitals), community service providers who address the core social needs, local government and payers.

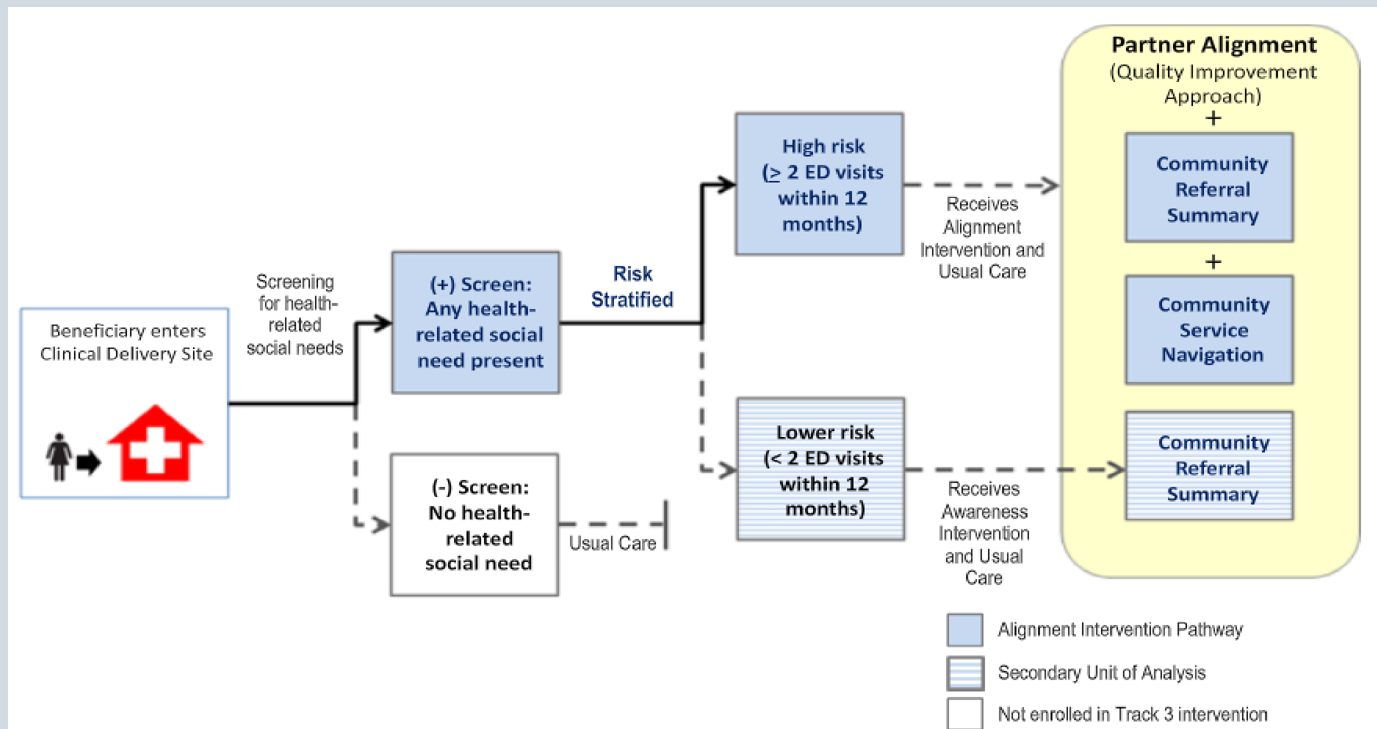
Step 1: Screening



In the ACHM, each Bridge Entity is responsible for ensuring that 75,000 enrollees (accounting for more than 51% of Medicare and/or Medicaid enrollees in the geographic area) are **screened for the five core needs** using questions provided by CMS.

Those screening are expected to happen in primary care clinics, behavioral health clinics, hospital ERs, labor & delivery and psychiatric units.

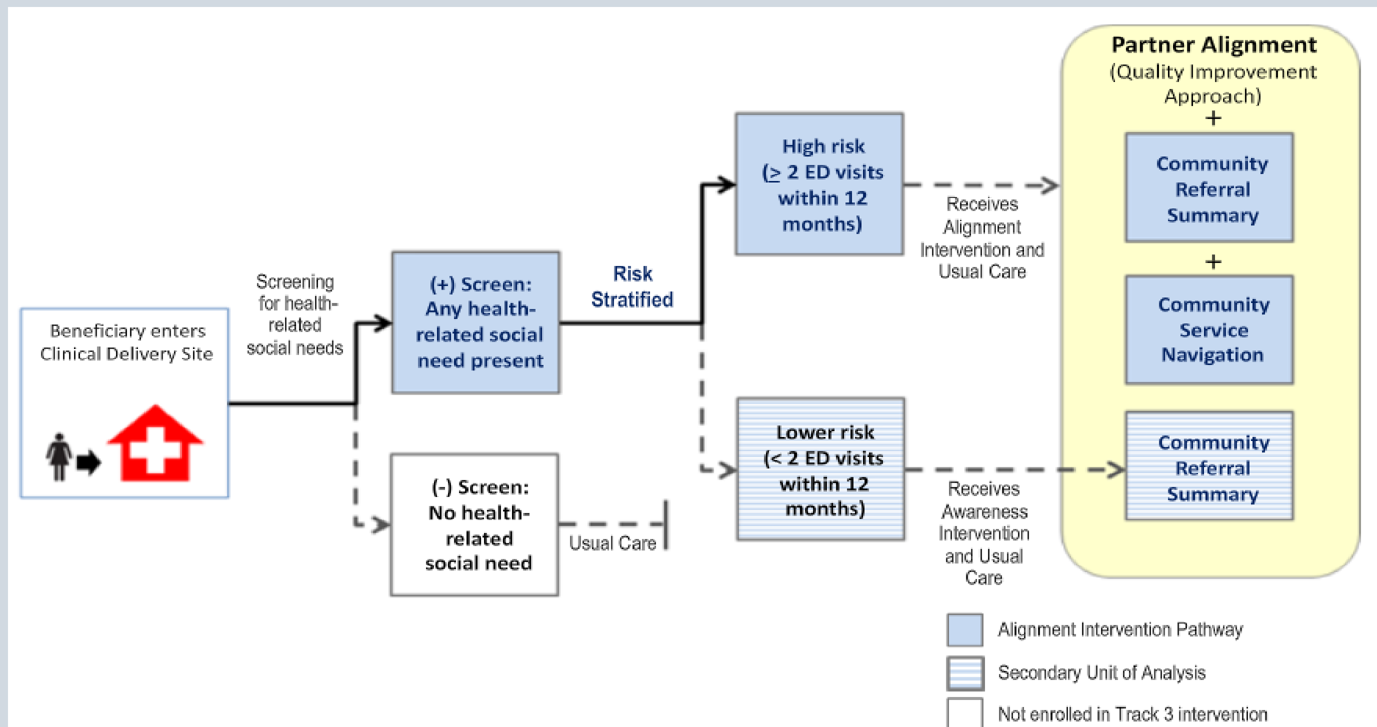
Step 2: Community Referral Summary



Clients with an identified need will receive a tailored **Community Referral Summary** that includes contact information and hours of operation for the Community-Based Organization that will address their needs.

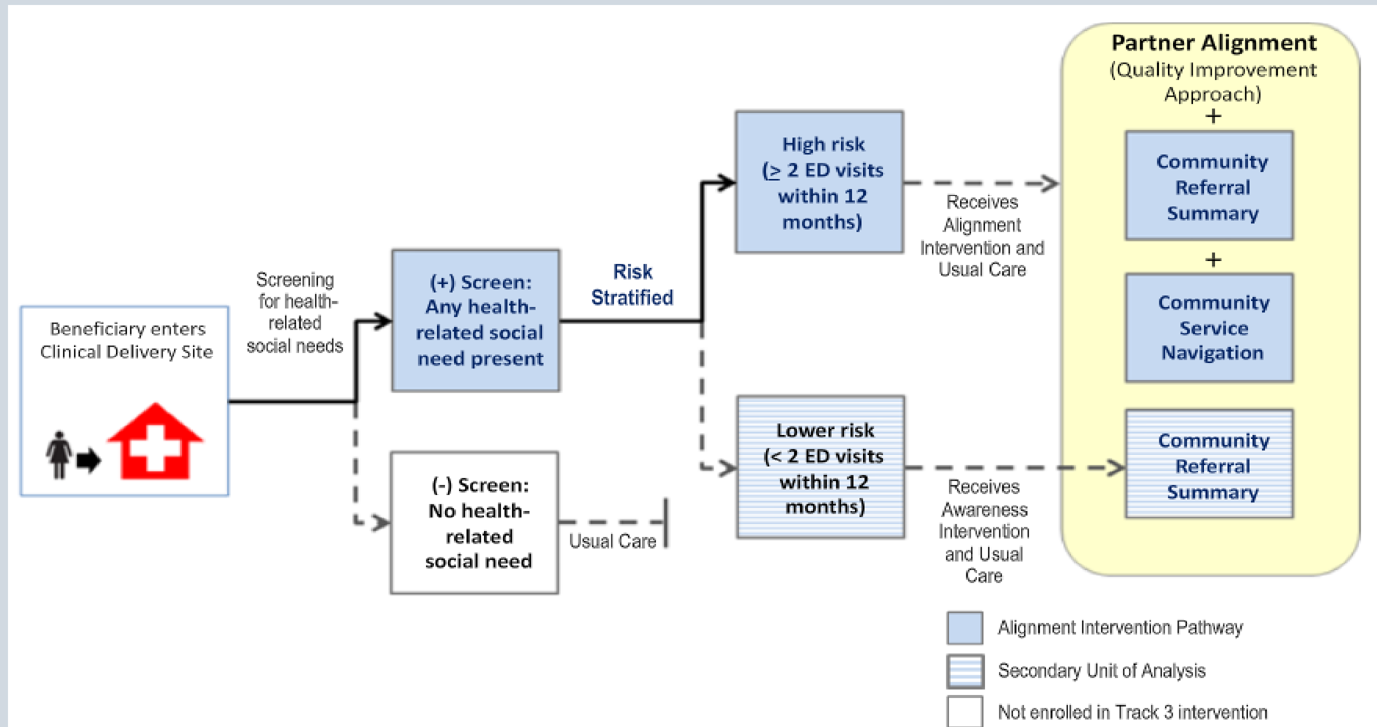
Bridge Entities must retain records of these summaries.

Step 3: Community Navigation



Clients with an identified need who have used the ER more than twice in the last year will be offered **Community Service Navigation.** Community Service Navigation is an in-depth personal interview, development of a person-centered action plan, follow up, and documentation of each encounter.

Step 4: Partner Alignment



Track 3 requires partner alignment and quality improvement. This means Bridge Entities must perform an annual gap and resources analysis, convene an advisory board that can assess and prioritize needs, create and implement a quality improvement plan that improves systems efficiency between clinical care and community organizations.

Community Based Organizations Role

Receive Referrals: Many Community Based Organizations already provide services to individuals who meet the navigation criteria (>2 ER visits & 1 social need). Better coordination and collaboration between clinical and non-clinical providers may result in improvements in services for these clients. Community Based Organizations may have an increase in referrals.

Track data: CMS wants to capture the outcome and the costs of the Community Based Organizations interventions

Participate in the Advisory Committee: In the Advisory Committee, Community Based Organizations will have an opportunity to partner with clinical/medical settings to identify gaps in the community service continuum, prioritize community needs and develop a plan to address some of those community needs.

Community Based Organization MOU

- Demonstrate understanding of the goals of AHCM design and implementation
- Commitment to participate in planning process and development of referral design
- Commitment to support AHC navigator tracking of beneficiary utilization of community service provider resources and related outcomes
- Commitment to tracking cost of provision of community services and total number of community dwelling beneficiaries served
- Description of expertise in the areas for which the organization will receive referrals
- Understanding of the population that will be referred; and
- Description of relationship and collaboration experience with applicant

Benefits for Community Based Organizations

Short-term

- Meaningful partnership with clinical sites that serve the same population
- Access to a robust care coordination platform (not required)
- Support of the clinical community in identifying and addressing gaps in social needs

Long-term

- Opportunity to demonstrate at a national scale the financial impact on healthcare costs of community resource activities.

A Few More Considerations

- Funding cannot **be used for any service delivery**.
- Funding is **tied to milestone completion --** as determined by CMS.
- No more than **15% of the funding can be spent on Health Information Technology**.
- This is a Cooperative Agreement rather than a grant from CMS. That means that there will be **significant oversight and involvement CMS**.
- Data collection: At its core, this opportunity is an attempt to prove that referrals to community organizations from clinical sites can reduce healthcare expenditure. There is a **significant data collection and reportin**g components within the AHCM. All **screenings, client assessments, referral summaries** and **community navigation summaries** will need to be recorded and transmitted reliably to CMS.

Timelines

Funding Opportunity Announcement Posting Date:	January 5, 2016
Letter of Intent to Apply Due:	February 8, 2016
Electronic Cooperative Agreement Application Due:	March 31, 2016 (1 PM Eastern Time)
Anticipated Issuance of Notices of Award:	December 15, 2016
Anticipated Start of Cooperative Agreement Period of Performance:	January 2017

Feedback?

Scale and Scope

	RCCO	Prime	Rocky Medicare	Total
Northwest Colorado				
Jackson	218	0	7	225
Grand	1,606	2	107	1,715
Routt	3,088	3	49	3,140
Moffat	3,048	8	115	3,171
Rio Blanco	520	502	231	1,253
				9,504
West Central				
Delta	7,912	144	1228	9,284
Montrose	5,411	5,249	1460	12,120
San Miguel	1,084	30	23	1,137
Hinsdale	120	5	12	137
Gunnison	1,039	1,699	76	2,814
Ouray	597	11	110	718
				26,210
Grand Junction				
Mesa	17,430	21,381	8230	47,041

	RCCO	Prime	Rocky Medicare	Total
West Mountain				
Pitkin	288	764	40	1,092
Garfield	7,088	5,419	676	13,183
Eagle	5,144	145	214	5,503
				19,778
Summit				
Summit	3,366	3	37	3,406
				3,406
Southwest Colorado				
Dolores	460	2	46	508
La Plata	8,903	5	775	9,683
Archuleta	2,763	3	233	2,999
San Juan	136	0	80	216
Montezuma	6,696	3	577	7,276
				20,682

Grand Total	**126,621**

Key Questions for Community Based Organizations

- What supplemental social needs should the region address?
- Other than contact information-is there other key information that should be included in a referral to your organization?
- What software do you currently use to track your client interactions?
- Do you currently participate in your health alliance advisory committee?
- Do you currently track per client costs of your services?

Next Steps

1. Email Kathryn Jantz (kathrynjantz@steadmangroup.com) if you are willing to participate (no time like the present ☺). She will communicate with your Community Lead (listed below)

County	Community Lead
Jackson, Grand, Routt, Moffat, Rio Blanco	Lisa Brown
Montrose, San Miguel, Ouray, Gunnison, Delta	Lynn Borup
Mesa	TBD
Pitkin, Garfield, Eagle	Jordana Sabella
Summit	Sarah Vaine
Dolores, La Plata, Archuleta, San Juan, Montezuma, Hinsdale	Kathleen McInnis & Lisa Barrett

Next Steps

2. Provide Input on the Model. One way to provide input is to participate in a call on March 4th at 7:30 AM

Complete the Memorandum of Understanding by March 11.

3. Keep doing what you are doing until January 2017!