



Western Colorado Accountable Health Community Model (AHC Model)



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Values

We, individuals and communities, have a right to **achieve our greatest potential of health.**

We have an opportunity and responsibility to **foster more leaders** in our communities.

There is **room for improvement** in the systems that support health. We have a responsibility and an opportunity to improve those systems.

We value **funding the social determinants** that impact individual and community positive health outcomes and well-being.

Healthcare and systems of health are **local.**

We seek **continuous learning** and improvement.

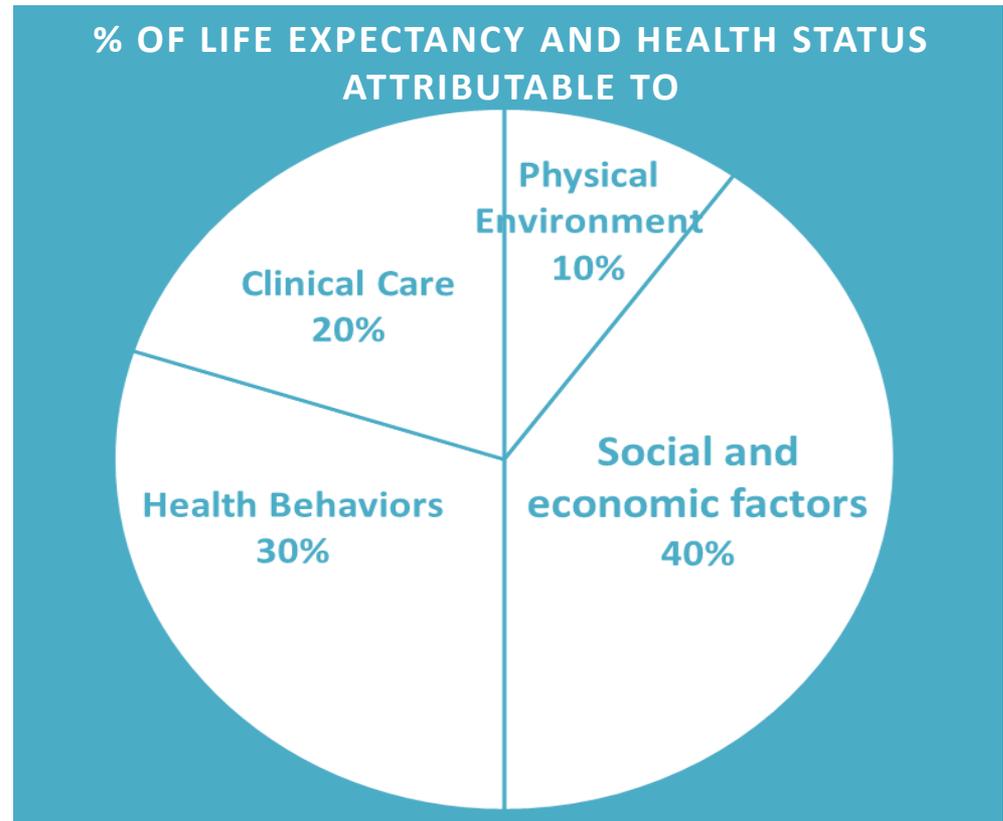
Collaboration is **built on trust** and trust is built on relationships. We will be intentional and patient with the time-consuming process of relationship-building.

We work to **identify the value proposition** of our efforts; to be transparent in discussing and communicating those tangible/non-tangible short-term/long-term benefits.

Achieving needed change will require **risk taking, being nimble, adaptable, and bold.**

Why now?

- Increasing recognition of importance of social determinants of health
- Shift towards value based purchasing
- Accountable Health Communities Model



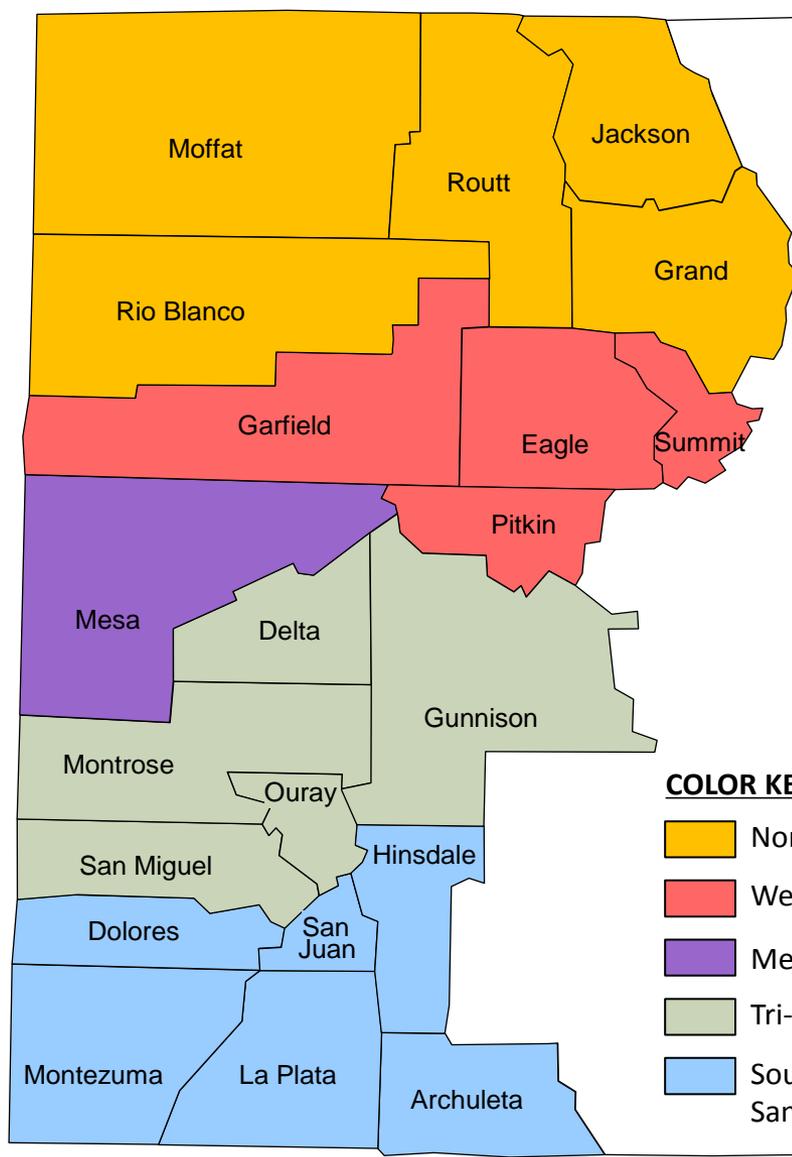


The Accountable Health Communities Model

Community Convening – Plan to address gaps

Social Needs Screening

Community Navigation



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
-  Southwest Area Health Education Center
San Juan Basin Health Department



Community Convening

Goals:

- Review available data on gaps in community resources with clinical and community based partners.
- Prioritize gaps in resources.
- Develop a quality improvement plan for prioritized gaps.
- Leverage existing forums and existing needs assessments (public health and community hospitals)

Social Needs Screening

Clinical Sites:

Primary Care



Behavioral Health



Hospitals

ER | Psychiatric Units | Labor & Delivery

Screen For:

Transportation

Housing

Food

Utilities

Interpersonal
Violence

Social
Isolation

*Medicaid
Enrollees*

*Medicaid-Medicare
Enrollees*

*Medicare
Enrollees*

Referrals Based on 2-1-1:

United Way
of Larimer County



IT Platform: The
Community
Resource Network
(a QHN platform)



Clinical Partners who signed MOUs

- A Kidz Clinic
- Axis Health System
- Castle Valley Children's Clinic
- Delta County Memorial
- Ebert Family Clinic
- Foresight Family Physicians
- Grand River Health
- Gunnison Valley Health
- Juniper Valley Family Medicine
- Marillac Clinic
- Memorial Hospital-Craig
- Mid Valley Family Practice
- Midwestern Colorado Mental Health Center, Inc
- Mindsprings, Inc
- Moffat Family Clinic
- Montrose Memorial Hospital
- Mountain Family Health Centers
- New Castle Family Health
- Northwest Colorado Health
- Peach Valley Family Medical Center
- Peak Family Medicine
- Pediatric Associates of Durango
- Pediatric Associates
- Pediatric Partners of the SW
- Pioneer Medical Center-DBA Meeker Family Health Center
- Primary Care Partners, Inc
- Rangely District Hospital
- River Valley Family Health
- Roaring Fork Family Practice
- Southwest Medical Group
- St. Mary's Family Practice
- St. Mary's Hospital
- Summit Community Care Clinic
- Surface Creek
- Telluride Medical Center
- Uncompahgre Medical center
- Valley View Hospital
- Whole Health
- Yampa Valley Hospital



Community Based Organizations

- 71 Across Western Colorado signed MOUs
- If they submit data, RMHP will send the organization monthly population-level data about the impact their interventions have on healthcare costs and outcomes for the patient

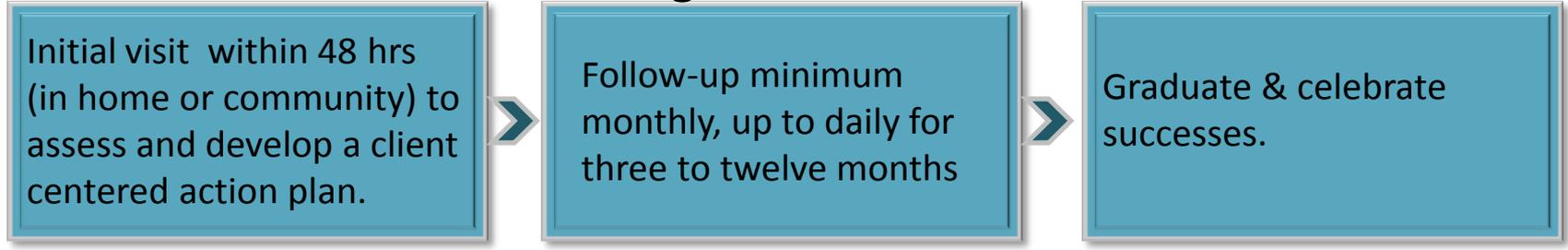


Community Navigation

A Community Navigator is someone who can help clients identify and access community services such as food banks. Community navigation typically involves meeting clients in the community rather than at a doctors office.

For the AHC Model, we will both provide training and support to current community navigators

Navigation Process:



Community based navigators - region-wide network

Supported by a Region-wide Navigation Program Manager



Screened Population Measures

Cost/Utilization

ER visits, hospital admissions, skilled nursing facility admissions, total cost, discharge to home rather than a nursing facility (claims)

Health

BMI
(Clinical data, QHN)

Client Engagement

Patient
Activation
Measure (PAM,
RMHP)

Quality

Increase screening
for clinical
depression and
ensure follow up
plan
(clinical data,
QHN)

Social

Prevalence of
social need,
prevalence of
social need
with no referral
Navigation pop.
only: resolution
of social need
(social needs
screening data)



Community Health Measures

<p>% of adults that report a BMI > 30%</p>	<p>% of high school students who seriously considered attempting suicide in the last 12 months</p>	<p>% of adults and children who state that their general health was fair or poor</p>	<p>Food environment index</p>	<p>Rate of population with inadequate or unstable housing</p>	<p>Rates of child and elder adult maltreatment</p>
<p><i>CDC Diabetes Interactive Atlas</i></p>	<p><i>Health Kids Colorado Survey</i></p>	<p><i>Colorado Behavioral Risk Factor Surveillance</i></p>	<p><i>USDA Food Environment Atlas, Map the Meal Gap</i></p>	<p><i>Comprehensive Housing Affordability Strategy data</i></p>	<p><i>Colorado Health Indicators</i></p>

Timeline

May - September

Develop Policies and Procedures

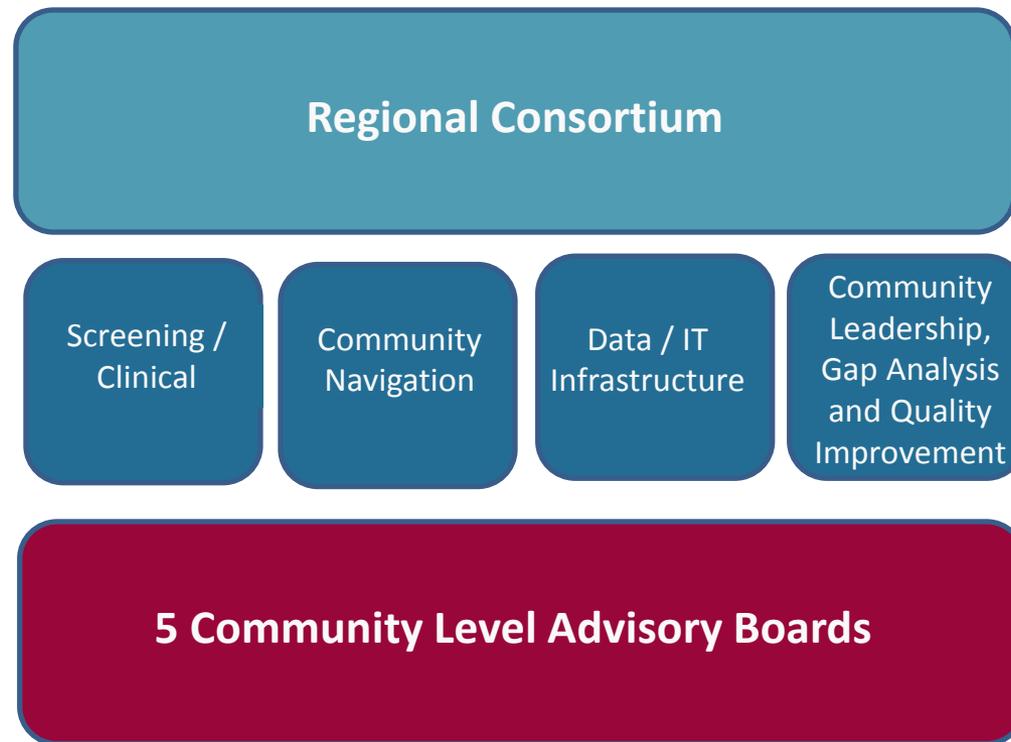
March- June

Begin piloting screening and referrals and navigation
Conduct community gap assessments, prioritization and improvement plan

July 2018 - April 2022

Screen ~100,000 people annually

Governance





Consortium Responsibilities

Program Performance

Review quarterly program performance reports such as rates of screening, clinical visits and completed community navigation assessments

Identify issues in program operations

Develop plans to address those issues

Gap Analysis & Quality Improvement

Review the Advisory Board Gap Analysis and Quality Improvement Plans for each region

Identify areas of alignment and opportunities for partnership between the regions

Provide the regional Advisory Boards with feedback & support

Report to State & Federal Partners

Provide progress assessment, performance assessments, strategic feedback w/state & federal partners as necessary to address state & federal policy issues that impact the Western Slope

Document successes, failures & improvement strategies & share meeting summaries & minutes publicly

Information Technology, Data & Measurement Activities

Annually review the information technology, data & measurement infrastructure of the program

Where possible, provide guidance to align the AHCM model w/other state initiatives

Program Communications

Provide guidance on project communication to ensure that community engagement remains strong, & that state & federal leaders understand & support AHCM objectives

Annual Summit

Identify collaborative learning & program direction objectives for the annual AHCM Summit

Program Operations

Provide guidance on AHCM policies and procedures