Western Colorado Accountable Health Community Model (AHC Model)
Funding & Disclaimer

The project described in these slides is supported by Funding Opportunity Number 1P1CMS331575-01-00 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

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The Mission

We seek your partnership in creating a more effective network to support the social, emotional and physical health of Western Coloradoans.

By supporting and empowering our entire community, especially those members who may have additional resource needs, we are able to improve the health of the entire community.

We are here to make a real difference for real people.
# Values

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

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

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

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

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

We seek **continuous learning** and improvement.

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

% of Life Expectancy and Health Status Attributable to

- Clinical Care 20%
- Physical Environment 10%
- Health Behaviors 30%
- Social and economic factors 40%
The Accountable Health Communities Model

Community Convening – Plan to address gaps

Social Needs Screening

Community Navigation
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

ScreenFor:
- Medicaid Enrollees
- Medicaid-Medicare Enrollees
- Medicare Enrollees

Referrals Based on 2-1-1:

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 Heath 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 doctor’s office.

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

Navigation Process:

1. Initial visit within 48 hrs (in home or community) to assess and develop a client centered action plan.
2. Follow-up minimum monthly, up to daily for three to twelve months.
3. Graduate & celebrate successes.

Community based navigators - region-wide network

Supported by a Region-wide Navigation Program Manager
## Screened Population Measures

<table>
<thead>
<tr>
<th>Cost/Utilization</th>
<th>Health</th>
<th>Client Engagement</th>
<th>Quality</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits, hospital admissions, skilled nursing facility admissions, total cost, discharge to home rather than a nursing facility (claims)</td>
<td>BMI (Clinical data, QHN)</td>
<td>Patient Activation Measure (PAM, RMHP)</td>
<td>Increase screening for clinical depression and ensure follow up plan (clinical data, QHN)</td>
<td>Prevalence of social need, prevalence of social need with no referral Navigation pop. only: resolution of social need (social needs screening data)</td>
</tr>
</tbody>
</table>
## Community Health Measures

<table>
<thead>
<tr>
<th>Metric</th>
<th>Description</th>
<th>Source</th>
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</thead>
<tbody>
<tr>
<td>% of adults that report a BMI &gt; 30%</td>
<td></td>
<td>CDC Diabetes Interactive Atlas</td>
</tr>
<tr>
<td>% of high school students who seriously considered attempting suicide</td>
<td></td>
<td>Health Kids Colorado Survey</td>
</tr>
<tr>
<td>% of adults and children who state that their general health was fair</td>
<td></td>
<td>Colorado Behavioral Risk Factor Surveillance</td>
</tr>
<tr>
<td>% of adults and children who state that their general health was poor</td>
<td></td>
<td>USDA Food Environment Atlas, Map the Meal Gap</td>
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<tr>
<td>Food environment index</td>
<td></td>
<td>Comprehensive Housing Affordability Strategy data</td>
</tr>
<tr>
<td>Rate of population with inadequate or unstable housing</td>
<td></td>
<td>Colorado Health Indicators</td>
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<tr>
<td>Rates of child and elder adult maltreatment</td>
<td></td>
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</tbody>
</table>
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

Regional Consortium

- Screening / Clinical
- Community Navigation
- Data / IT Infrastructure
- Community Leadership, Gap Analysis and Quality Improvement

5 Community Level Advisory Boards
## 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