Western Colorado AHCM Proposal Development

Agenda

1. Introduction
2. What is AHCM (review)
2. Western Colorado AHCM Vision
3. Workflows
4. Community Framework
5. Budget Outline
6. Timeline and Next Steps

Introductions

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.

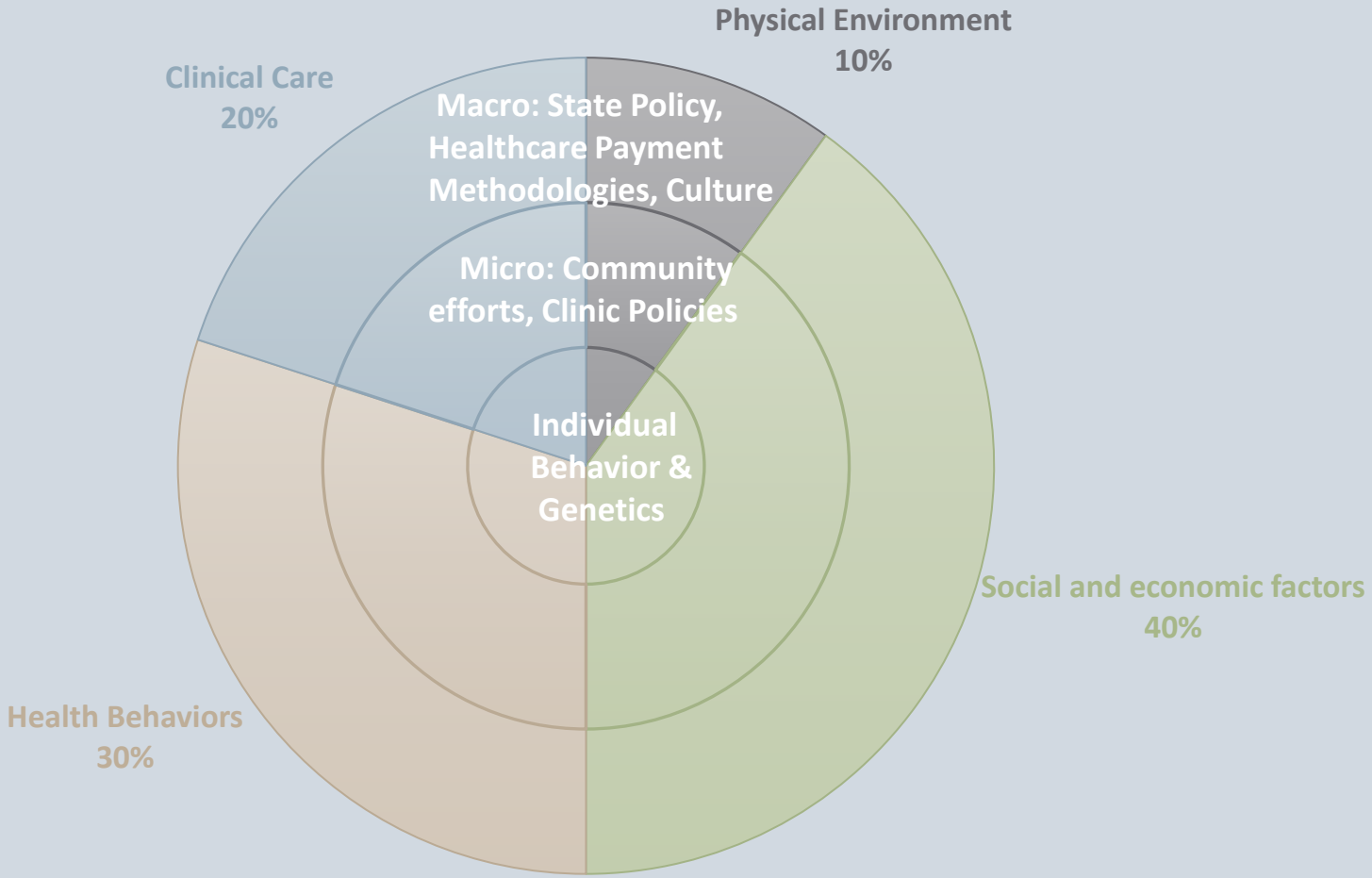
We seek your partnership in creating a more effective network to support the social, emotional and physical health of Western Coloradoans.

By supporting the most vulnerable members of our communities we will improve the health of our entire region.

Western Colorado Engagement in Health Activities

Western Colorado has a history of **successful community collaboration** to promote health. Currently, several local partners are engaged in efforts to develop a strong network that will provide more effective, whole-person support to individuals with multiple health, behavioral and social needs. These programs include an array of federally-funded initiatives that are focused upon prevention and integrated behavioral health, such as the **Comprehensive Primary Care (CPC) initiative** and the **State Innovation Models (SIM) Cooperative Agreement**. Western Colorado stakeholders are also engaged in the **Colorado Opportunity Project**, an effort to improve the social and economic prospects of Coloradans.

Promoting Health at Every Level of the System



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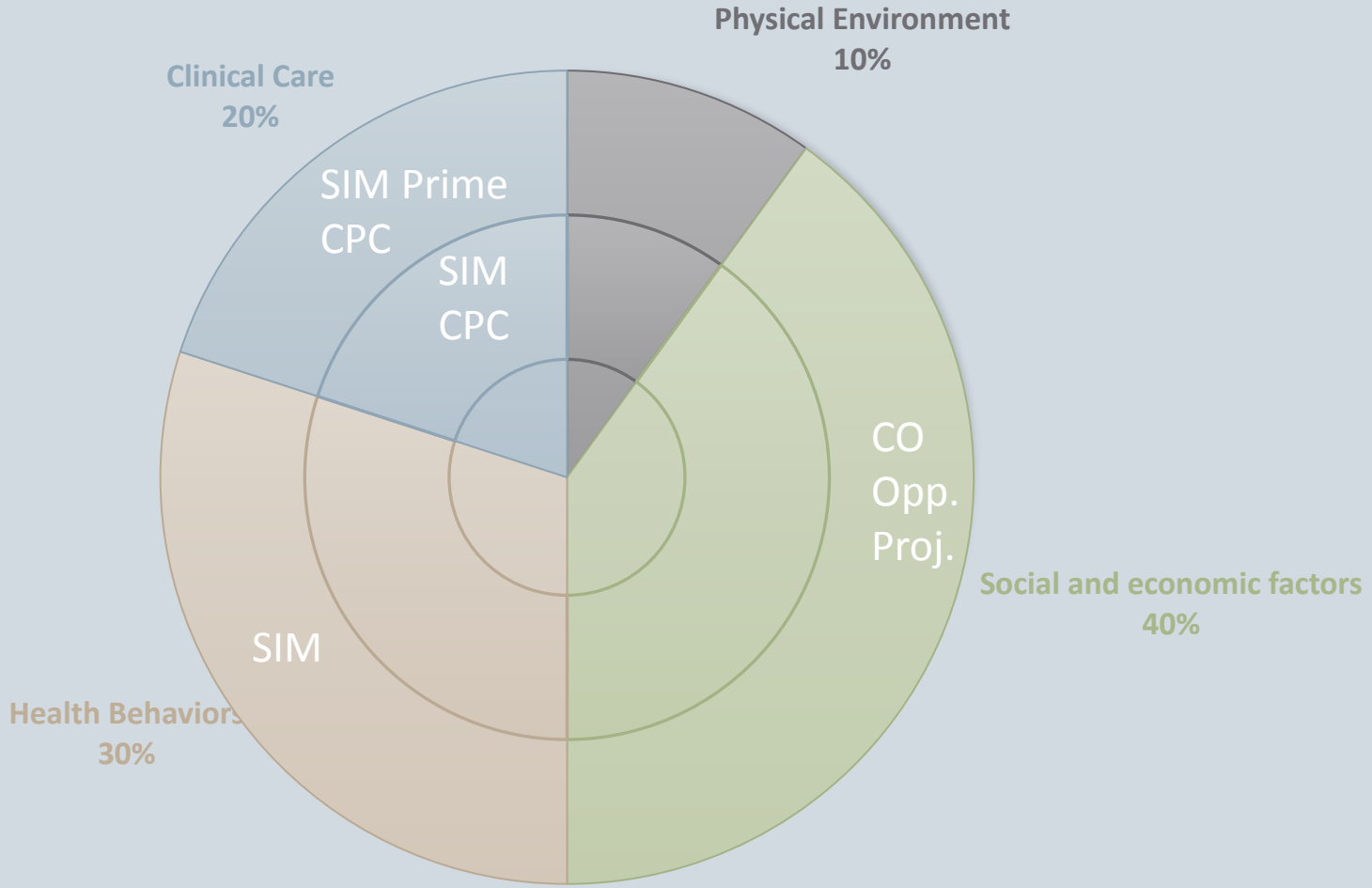


AHCM Vision Continued

Creating healthy and equitable communities in Western Colorado will require a **multipronged effort** to address all of the factors that influence health outcomes – **health care, health behaviors, physical environment, social and economic factors, and physical environment**. Work must be done local level, as well at the state and national level – to **speak with one voice** regarding the industry, public programs and policies that impact the health of Western Colorado communities.

The Accountable Health Communities Model presents a groundbreaking opportunity improve coordination among clinical, behavioral and community service providers. Leaders in several domains, from public health and human services – to hospitals and health care professionals – share a common vision for Western Colorado . Participation in this effort will ensure that the needs of rural and frontier areas are better incorporated in public policy and financing arrangements .

Poll: What do you think?

Proposed Western Colorado AHCM Workflow

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. Screenings are to occur within Primary Care Behavioral Health, and hospital ER, Labor & Delivery and Psych Units.
Screening will occur using the following avenues:

1. **Open secure web form entry**

2. **Health Information Exchange (HIE) Portal**

3. **Electronic Health Record and HL7 Message Type**

4. **AHCM care coordination applications (RMHP sponsored):**. RMHP will make one or more care coordination application solutions for AHCM available, such as *Essette*™, *Crimson Care Management*™

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.

Western Colorado Proposed Protocol:

- **Community Resource Inventory:** Through AHCM, the 211 database will be expanded and updated more frequently.

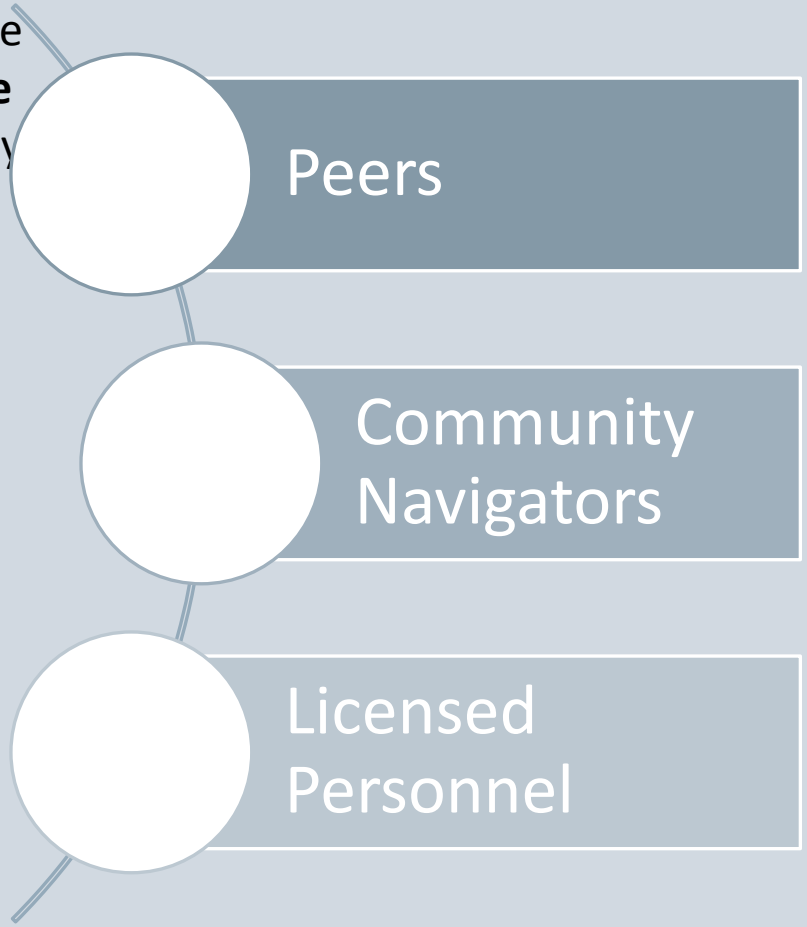
- **Referral Summary:** The screening will generate a real-time referral summary based on the resource inventory that can be provided in writing to the client before they leave the clinical site.

We have the option of providing information to the organizations to the Community Based Organization to whom the referral was provided. We will use records from these referrals to aid in tracking the utilization of community based services.

Step 3: Community Navigation

Clients with an identified need who have used the ER more than twice in the last year and have a will be referred to the **Community Service Navigation Network,** a network of navigators built on systems already providing care coordination or navigation.

- The network will include a **range of provider types** from peers to bachelor level navigators to licensed clinicians.
- High quality regardless of navigator type and location will be achieved through **robust orientation and ongoing training.** New navigators will receive a standardized train the trainer orientation built in partnership with all the navigators. Navigators will have opportunities to shadow clinicians in a variety of settings to gain additional hands on training and experience.
- The Community Service Navigation Network will coordinate with other care coordinators and providers in the community.



Care Navigation Process

- Clients are identified in clinical sites and referred to the navigator network

Assessment

- The navigator either meets the client at their next clinical appointment or contacts them via phone to offer care navigation
- If the client agrees to care navigation, the care navigator meets the client at a place of their choosing (home, coffee shop, mental health center) to conduct a complete assessment focused primarily on social needs. All client interactions will be tracked in an AHCM approved care coordination platform

Care Plan

- The client and the navigator create a care plan together that includes specific action steps and timeframes.
- Care plans will span a wide continuum from short interventions (3 months) for one or two social needs to ongoing care navigation for up to (12 months)

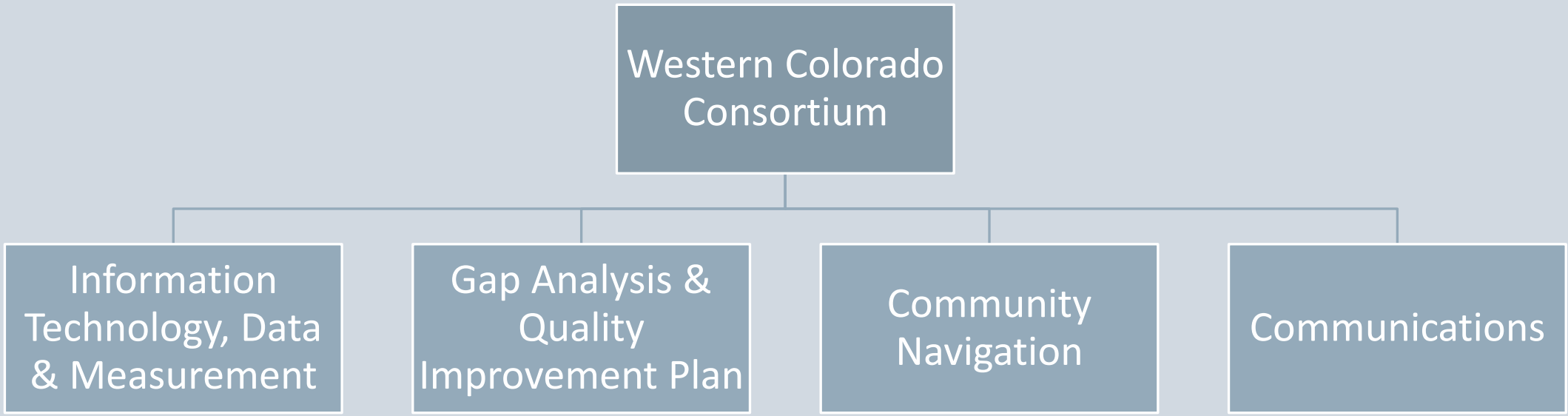
Graduation

- When the action plan is completed, the care navigator and the client will acknowledge any successes or achievements of their work together.
- Clients will be surveyed about their experience.

Community Leadership

Public Health Regions	Engaged Leaders
Jackson, Routt, Moffat, Rio Blanco	Lisa Brown- Northwest Visiting Nurse Association
Montrose, San Miguel, Ouray, Gunnison, Delta, Hinsdale	Lynn Borup-Tri-County Health Network Jeremey Caroll, River Valley Family Health Center
Mesa	Sarah Robinson- Mesa County
Pitkin, Garfield, Eagle, Summit, Grand	Jennifer Ludwig, Eagle County Public health Ross Brooks-Mountain Family Health Center Jordana Sabella, Pitkin County Sarah Vaine, Summit Community Care Clinic Jen Fanning, Grand County Rural Health Network
Dolores, San Juan, Montezuma, La Plata, Archuleta	Kathleen McInnis, Southwest Area Health Education Center Lisa Barrett, San Juan Basin Health Department

Consortium/Region-wide Advisory Committee



The Consortium

Community Leads

Behavioral Health

Community Based Organizations

Medicare ACOs & health systems

Local Public Health

Human Services

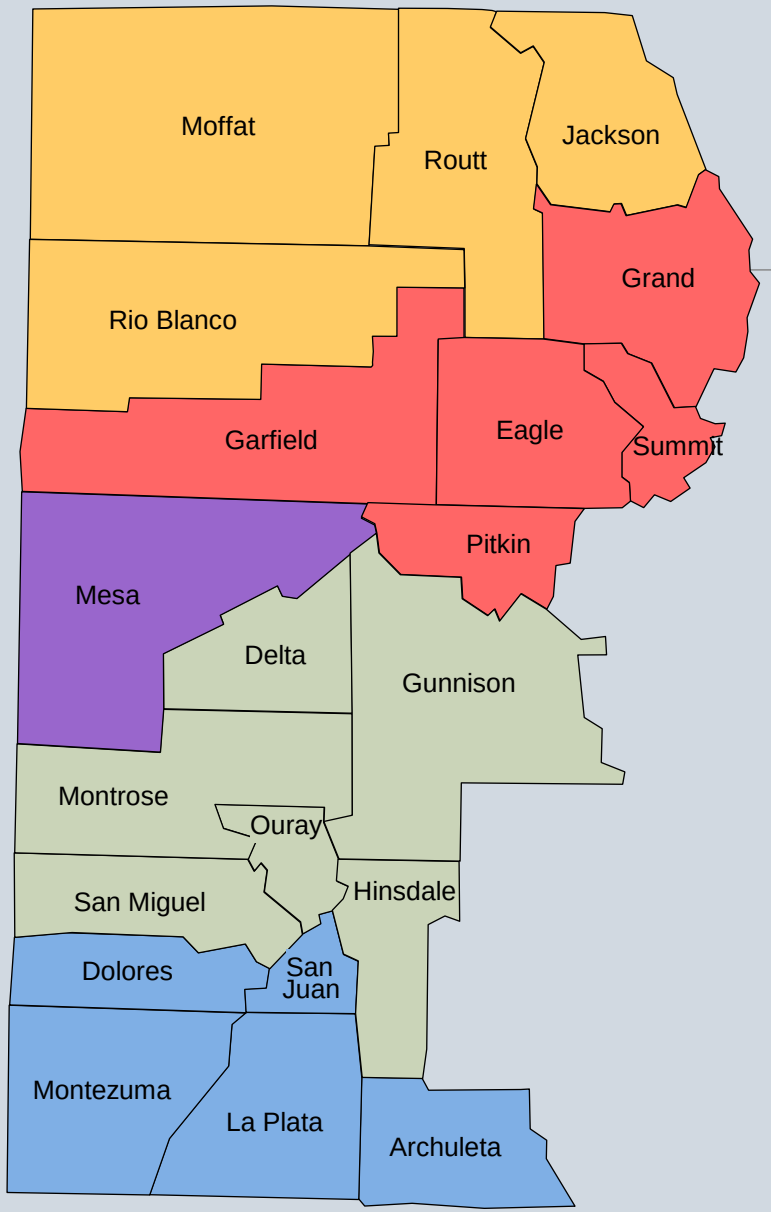
Health Information Networks

Client & Advocacy

211

HCPF

Long Term Service and Supports Providers

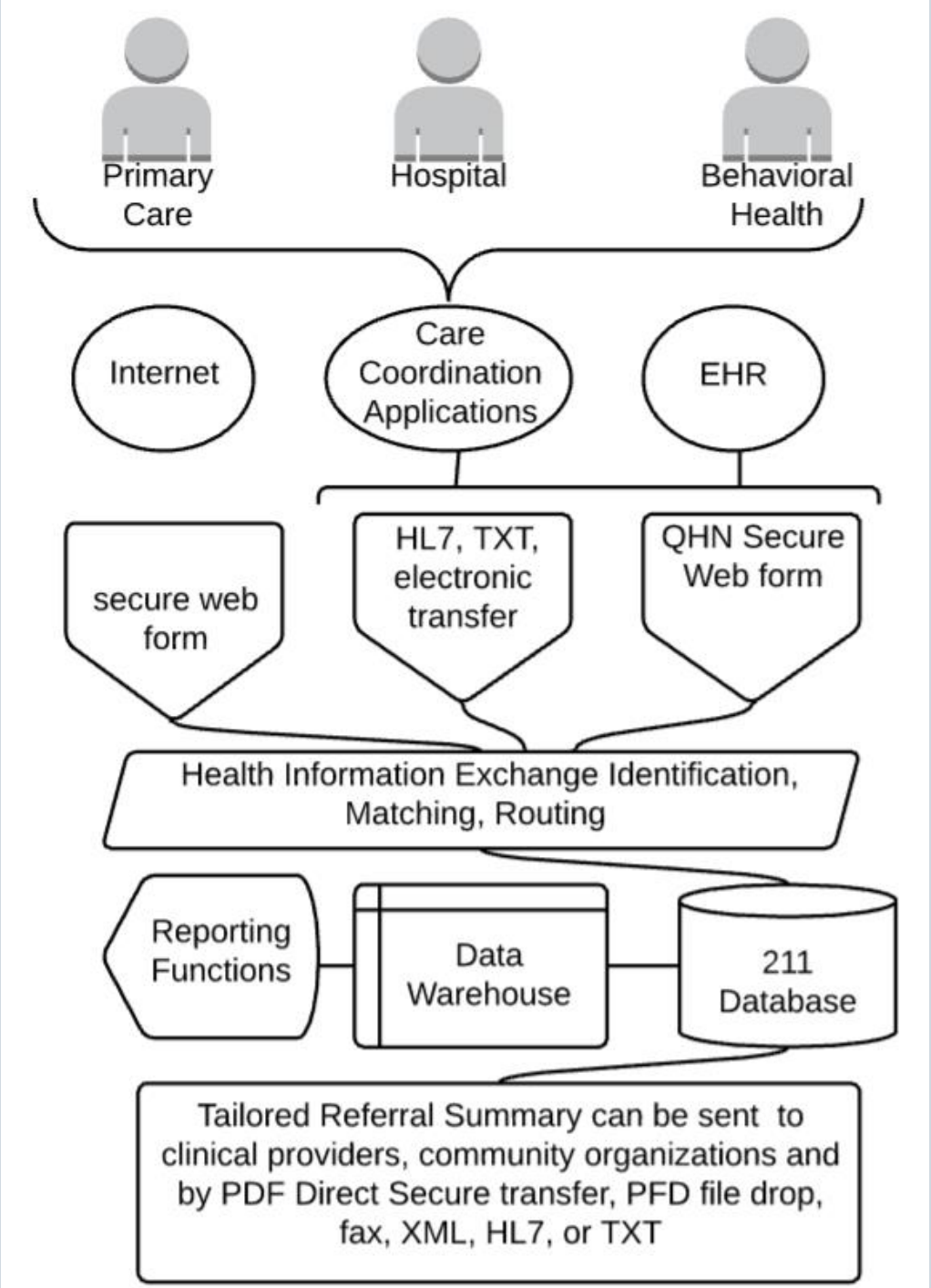


Regional Advisory Structure

Each region will have an advisory meeting that includes strong community based organization presence and clinical presence.

This regional advisory committee will be responsible for supporting a community gap analysis and supporting a quality improvement plan to address gaps in community services.

Planned Architecture and Data Flows



Measuring Program Impact

	Structural:	Process:		Outcomes		
		Clinical	**Social**	**Health Outcomes** (BMI, Depression rates etc.)	**Cost/Utilization** (ER, hospital readmission)	**Social** (rates of homelessness, food insecurity, violence)
Individual Client Interventions	Infrastructure for screenings and navigation (information sharing and loop closure processes)	Appropriate Mental Health, Obesity and related clinical quality measures	Are the social needs screenings occurring regularly and referrals being provided?	Intervention population	Intervention population	Intervention population
Community	Advisory structure, leadership and resources	Availability and strength of clinical provider network	Availability of Community Resources to address social needs	Entire community	Entire community	Entire community

Back of the Napkin Budget

Major Funding Areas	Total 5 year funding
Planned Architecture and Data Flows	$400,000
Resource Management and 211 Integration	$425,000
Community Lead for Each of the Five Regions	$1,250,000
Community Advisory Committee and Community Infrastructure Building Funding	$250,000
Community Navigation	$1,500,000
Targeted Gap Closure	$125,000
AHCM Program Development, Reporting, Compliance and Accountability	$561,000

Timelines

Funding Opportunity Announcement	**January 5, 2016**
Letter of Intent to Apply	February 8, 2016
MOUs submitted to RMHP	March 11, 2016
Draft Proposal due to HCPF	March 15, 2016
Final Proposal due	March 31, 2016
Anticipated Issuance of Notices of Award	December 15, 2016
Anticipated Start of Cooperative Agreement Period of Performance	January, 2017
First Clients Screened	January, 2018

Poll: MOUs with Clinical Providers

Poll: Community Based Organization MOUs

Questions??

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