The Accountable Health Communities Model:
A clinical-community partnership model for addressing health-related social needs

Prevention & Population Health Group

The CMS Innovation Center

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CMS Strategic Goal 2

Prevention and Population Health

All Americans are healthier and their care is less costly because of improved health status resulting from use of preventive benefits and necessary health services.

http://intranet.cms.gov/Component/CSP/documents/CMS-Strategy.pdf

The CMS Innovation Center was created by the Affordable Care Act to develop, test, and implement new payment and delivery models

"The purpose of the [Center] is to test innovative payment and service delivery models to **reduce program expenditures…while preserving or enhancing the quality of care** furnished to individuals under such titles"

Section 3021 of Affordable Care Act

Three scenarios for success

1. **Quality improves; cost neutral**
2. **Quality neutral; cost reduced**
3. **Quality improves; cost reduced (best case)**

If a model meets one of these three criteria and other statutory prerequisites, the statute allows the Secretary to expand the duration and scope of a model through rulemaking

Why the Accountable Health Communities Model?

- Many of the largest drivers of health care costs fall outside the clinical care environment.
- Social and economic determinants, health behaviors and the physical environment significantly drive utilization and costs.
- There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and impact costs.
- The AHC model seeks to address current gaps between health care delivery and community services.

Key Innovations

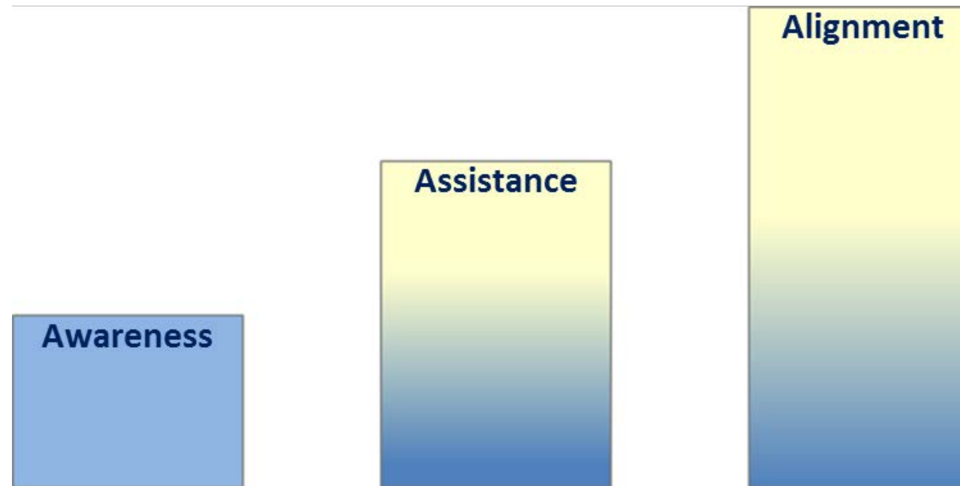
- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Testing the **effectiveness of referrals** to increase beneficiary awareness of community services using a rigorous mixed method evaluative approach
- Testing **the effectiveness of community services navigation** to provide assistance to beneficiaries in accessing services using a rigorous mixed-method evaluative approach
- **Partner alignment** at the community level and implementation of a quality improvement approach to address beneficiary needs

Health-Related Social Needs

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

* This list is not inclusive

Accountable Health Communities Model Intervention Approaches: Summary of the Three Tracks

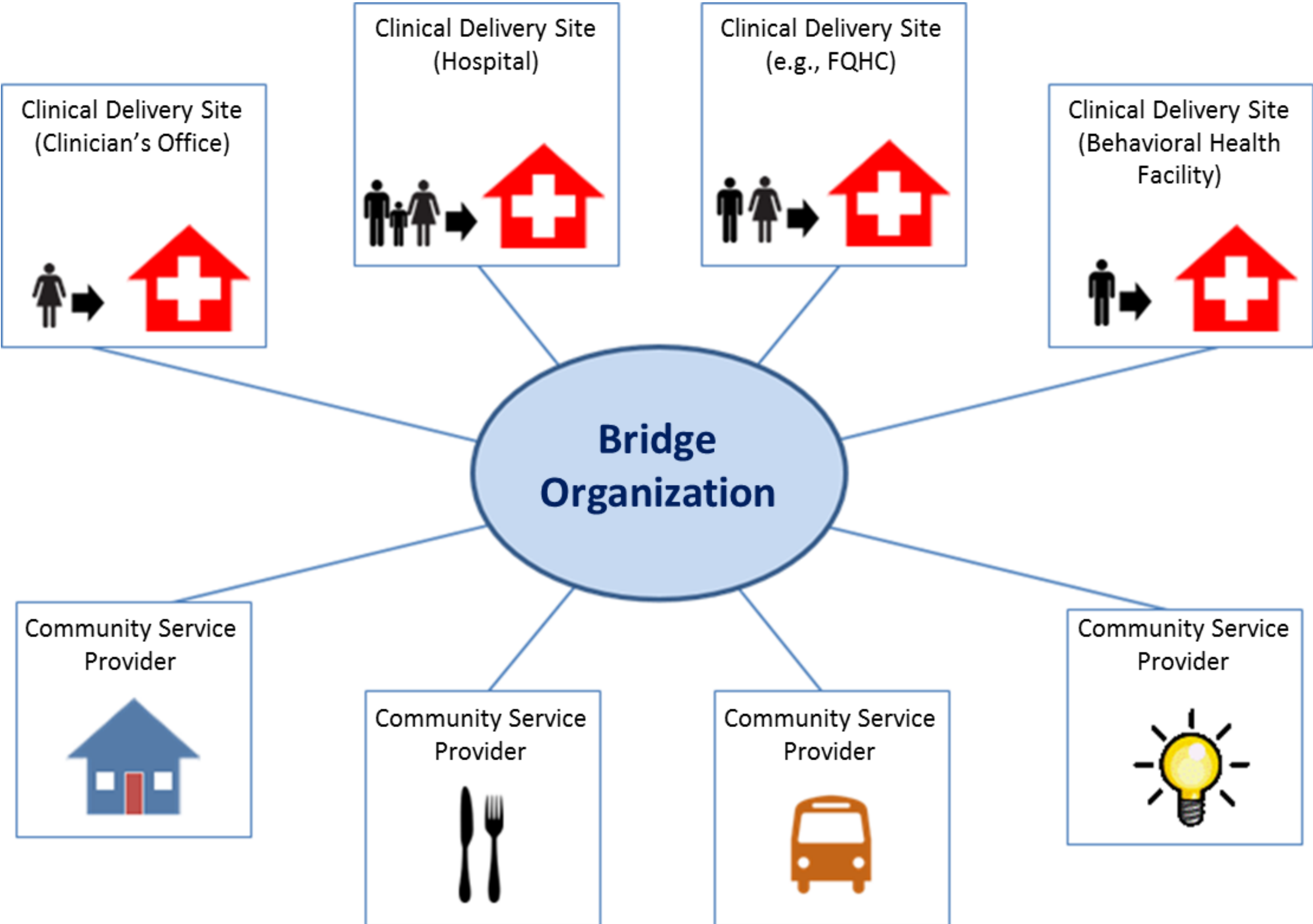


- **Track 1: Awareness –** Increase beneficiary ***awareness*** of available community services through information dissemination and referral
- **Track 2: Assistance –** Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services
- **Track 3: Alignment –** Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

Model Structure

- The AHC model will fund award recipients, called bridge organizations, to serve as “hubs”
- These bridge organizations will be responsible for coordinating AHC efforts to:
  - Identify and partner with clinical delivery sites
  - Conduct systematic health-related social needs screenings and make referrals
  - Coordinate and connect community-dwelling beneficiaries who screen positive for certain unmet health-related social needs to community service providers that might be able to address those needs
  - Align model partners to optimize community capacity to address health-related social needs

Accountable Health Communities Model Structure



Model Performance Metrics

- Healthcare utilization: emergency department visits, inpatient admissions, readmissions and utilization of outpatient services
- Total cost of care
- Provider and beneficiary experience

Health Resource Equity Statement

- Disparity Impact Statement that assists Bridge Organizations in:
  1. Identifying and targeting minority and underserved populations (geographic and otherwise) in model participation;
  2. Assessing their total model in relation to these targeted subpopulations;
  3. Evaluating the inclusion of subpopulations in the AHC model; and
  4. Tracking progress on outcomes and engagement of these subpopulations throughout the AHC performance period
- Includes a statement of need, an action plan, and a performance assessment and data summary
- Award recipients will be required to review, update, and report on their HRES every six months

Learning System

The learning system will:

- Support shared learning and continuous quality improvement between bridge organizations, their partners and CMS
- Facilitate movement of timely, accurate, and relevant information to allow bridge organizations and partners to share promising practices and learn from their peers about Accountable Health Communities activities

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https://innovation.cms.gov/
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