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

Prevention & Population Health Group
The CMS Innovation Center

Alexander Billioux, MD DPhil

Director, Division of Population Health Incentives and Infrastructure

January 25, 2017
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.

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.
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

<table>
<thead>
<tr>
<th>Core Needs</th>
<th>*Supplemental Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Instability</td>
<td>Family &amp; Social Supports</td>
</tr>
<tr>
<td>Utility Needs</td>
<td>Education</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Employment &amp; Income</td>
</tr>
<tr>
<td>Interpersonal Violence</td>
<td>Health Behaviors</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
</tbody>
</table>

* 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
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

Bridge Organization

Clinical Delivery Site (Hospital)
Clinical Delivery Site (e.g., FQHC)
Clinical Delivery Site (Behavioral Health Facility)
Community Service Provider
Community Service Provider
Community Service Provider
Community Service Provider
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
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
Alexander Billioux, MD, DPhil
alexander.billioux@cms.hhs.gov

https://innovation.cms.gov/
https://innovation.cms.gov/initiatives/AHCM