ROCKY MOUNTAIN HEALTH PLANS®

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Pitkin, Garfield, Eagle, & Summit Counties

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ACCOUNTABLE HEALTH COMMUNITIES MODEL

WHAT IS AHCM?

AHCM is a federal project designed to test if screening patients for social needs, providing them resources and community care coordination can reduce healthcare costs, reduce emergency room visits and improve patient's health.

Patients who screen positive for a social need will be provided referrals to organizations in the community. Those who have been to the ER two or more times and have screened positive for a social need will get in-person care coordination support.

Our goal is to improve health and the quality and delivery of healthcare to our communities. We expect to increase the number of wellness checks, decrease unnecessary emergency room visits, and reduce healthcare costs.

PROJECT STRUCTURE

Social Needs Screening Healthcare entry points such as hospitals, behavioral health organizations and primary care clinics will screen patients using the AHCM Health-Related Social Needs (HRSN) Screening Tool.

Care Coordination Patients who screen positive for a social need and who say they have been to the ER 2 or more times in the past year will receive local care coordination support. These wraparound services are provided by Rocky Mountain Health Plans Care Coordination team. These services give patients who are high needs and frequent users of the system extra support in connecting to the services they need.

Community Convening Gather stakeholders to guide AHCM, create community conversations and increase the capacity of the Western Slope to address social determinates of health.

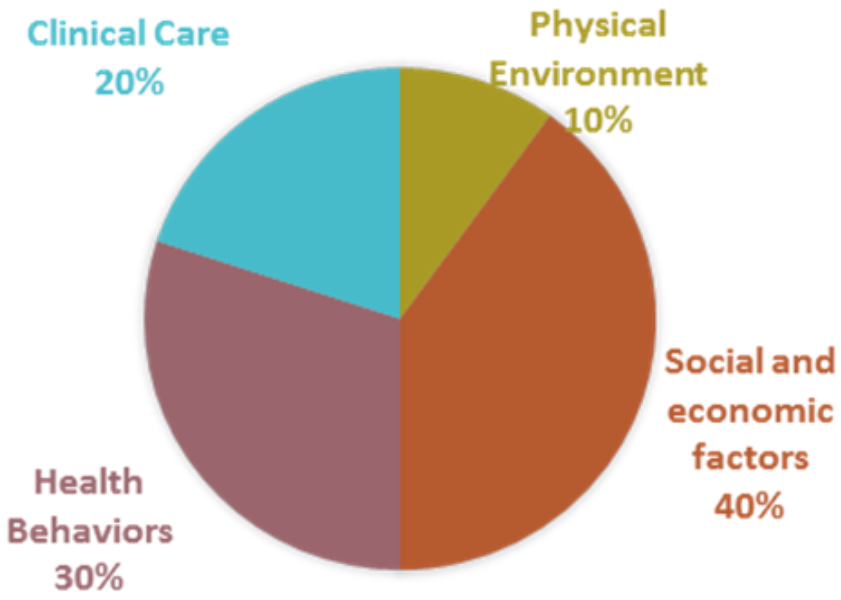
SOCIAL NEEDS INCLUDED IN THE SCREENING TOOL

- Housing
- Transportation
- Social Isolation
- Utilities
- Food Security
- Safety

ACCOUNTABLE HEALTH COMMUNITIES MODEL

CREATING A CULTURE SHIFT

We are starting a conversation about what it means to be healthy and the factors that influence a persons ability to manage their health. Even when a patient does not identify a need, conducting the social determinants of health screening tool sends the signal that non-medical factors are a part of their health.



Source: http://www.nejm.org/doi/full/10.1056/NEJMsa073350#t=article

Clinical care only accounts for 20% of a person's health. Just like other clinical assessment tools, social determinate of health screenings can be used as a tool to inform patients' treatment plans and make referrals to community services.

AHCM provides an opportunity for us to systematically collect data around social needs in our communities and across the entire Western Slope. That data combined with our anecdotal evidence will provide us the ability to invest in strategic solutions to address the gaps identified.

WHERE DOES THE DATA GO?

Quality Health Network (QHN) will house the HIPPA protected social health data in its Community Resource Network. The data will be shared directly with RMHP and Center for Medicaid and Medicare Innovation. Practices will be provided with both practice-level and individual data on a monthly basis. Aggregated data will be shared with community stakeholders – including all providers and organizations participating in AHCM. This aggregate data will be used to find funding, implement new solution strategies and augment current efforts in addressing social needs.

RESOURCES AVAILABLE

We have developed resource lists that align with the socials needs in the screening tool and with the counties included in the project. These lists will be updated regularly by the regional Community Lead in order to save clinic staff time and effort.

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WEST MOUNTAIN REGIONAL HEALTH ALLIANCE

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QUALITY HEALTH NETWORK

ACCOUNTABLE HEALTH COMMUNITIES MODEL

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COMMUNITY LEAD ORGANIZATIONS

Tri-County Health Network

Northwest Colorado Community Health Partnership

West Mountain Regional Health Alliance

Mesa County Public Health

Southwest Area Health Education Center & San Juan Basin Health Department

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MISSION

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

YEAR 2 GOALS

1. Screen 100,000 Western Coloradoans on Medicaid and/or Medicare for social needs
2. Collect utilization data on community services to better understand healthcare impact
3. Provide community navigation to 3,000 Western Coloradoans
4. Identify gaps in community services & a plan to address the gaps

PROJECT STRUCTURE

Community Convening Gather community champions quarterly to guide AHCM and increase the capacity of the Western Slope to address social determinates of health.

Social Needs Screening 57 practices (with 20 different EHRs) have agreed to participate in screening. Clinics will use the AHCM Health-Related Social Needs (HRSN) Screening Tool, which includes transportation, housing, food insecurity, utilities, interpersonal violence and social isolation

Community Navigation Local in-person navigation provided to patients that screen positive for 2 or more ER visits in the past year and at least 1 social determinate of health need

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