Accountable Health Communities Model

Overview and Update

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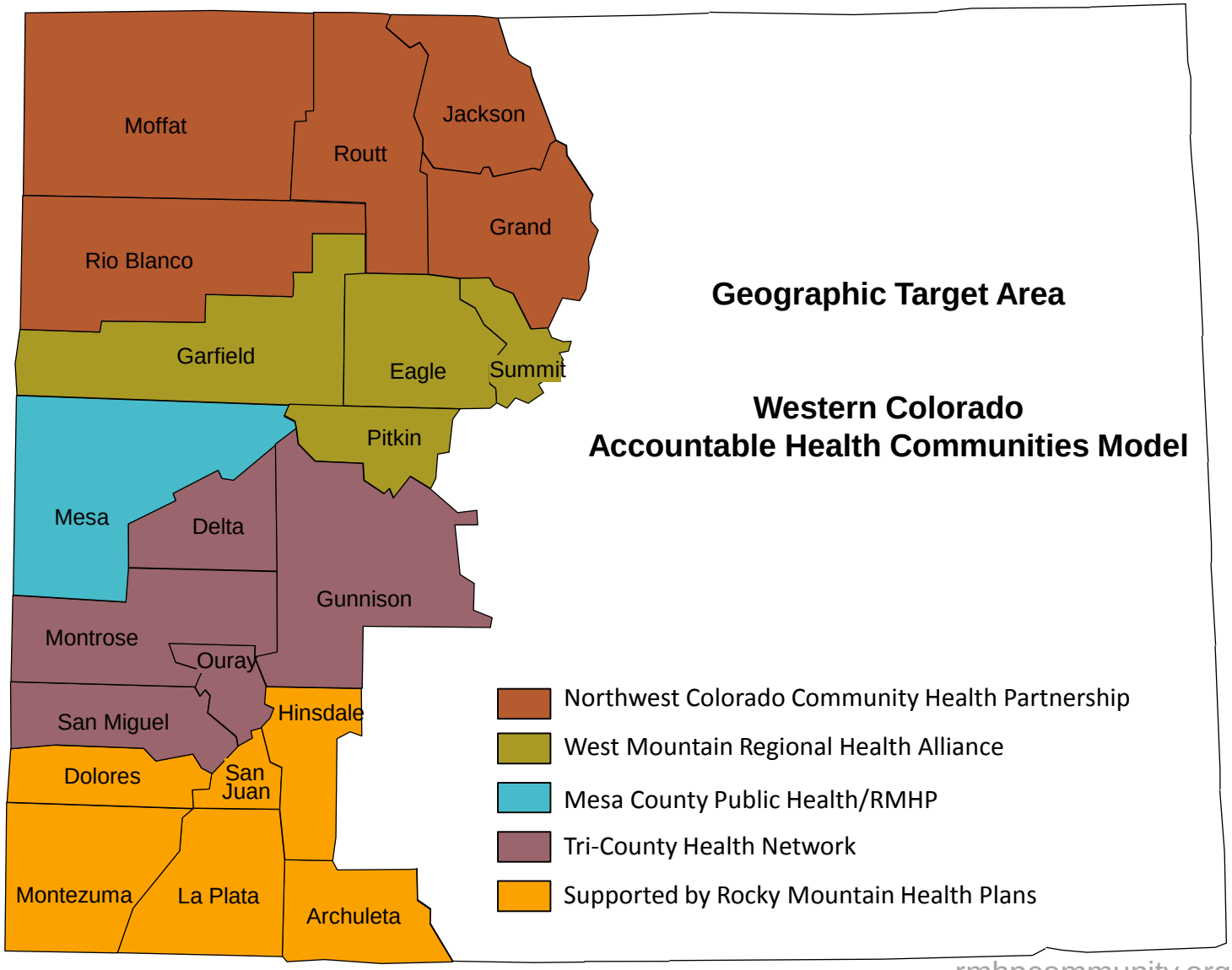
RMHP COMMUNITY

How are YOU?

THE ACCOUNTABLE HEALTH COMMUNITIES MODEL: A FEDERAL EFFORT TO ADDRESS SDoH

CONVENING	*A community infrastructure for supporting addressing social needs. Community Leads identify gaps in social needs and create partnerships to address gaps*
SOCIAL NEEDS SCREENING	*Screening for social needs for clinical sites and providing referrals*
COMMUNITY NAVIGATION	*All screened individuals who have 2 or more ER visits in the last year and a social need should receive community navigation*

THE AHCM COMMUNITIES & LEADS



AHCM SCREENING

We aim to screen 100,000:

- Medicare Enrollees
- Medicare-Medicaid Enrollees
- Medicaid Enrollees

In Clinical Settings including:

- Primary Care
- Behavioral Health
- Hospitals

For six social needs:

- Food
- Housing
- Transportation
- Utilities
- Interpersonal Violence
- Social Isolation

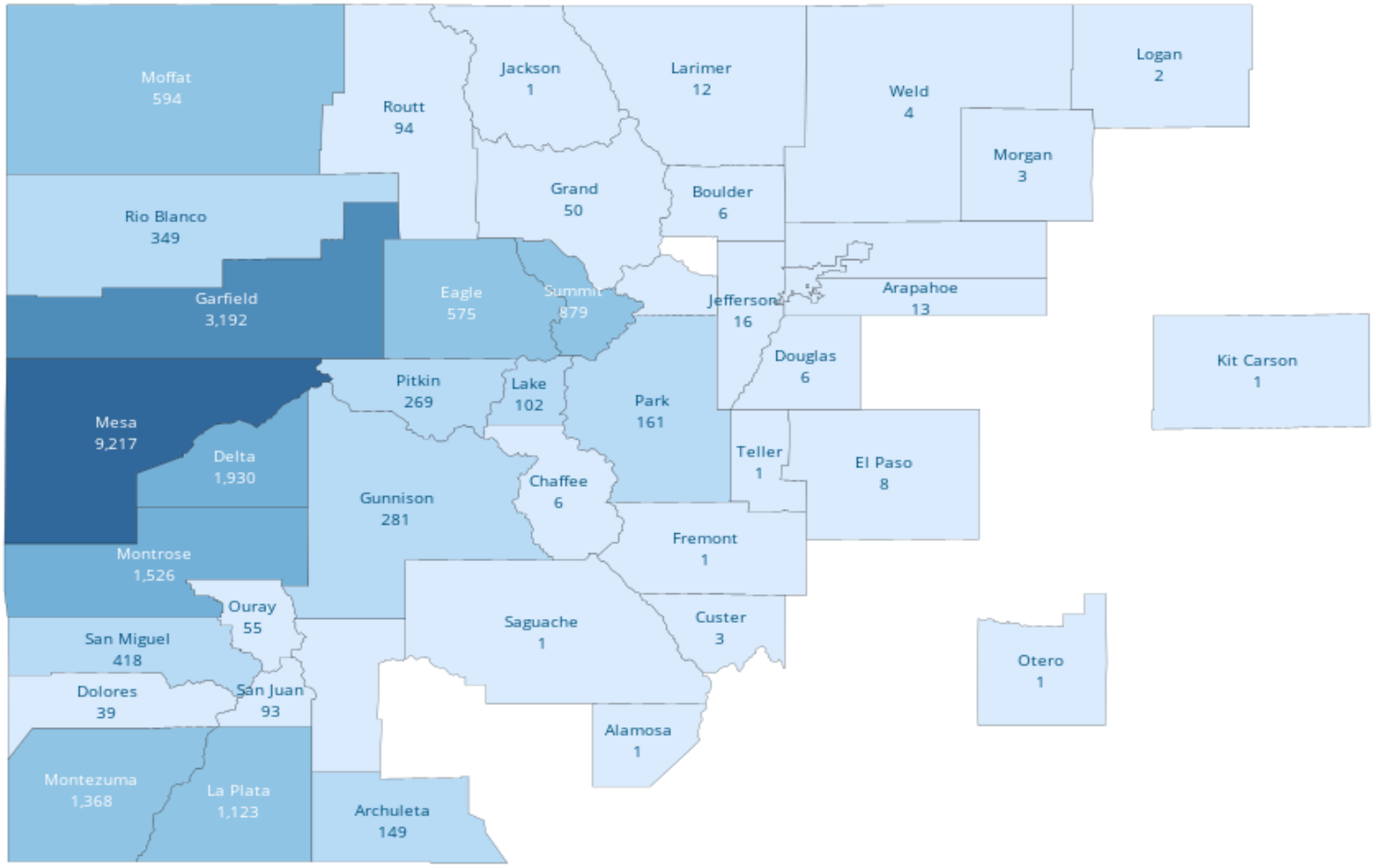
Using the:

- Quality Health Network Community Resource Network

As of April 16th, we have done 28,562 screenings.

AHCM Screening Heat Map

22,597 Screeners in Colorado counties (Medicaid, Medicare, and Medicare-Medicaid only)



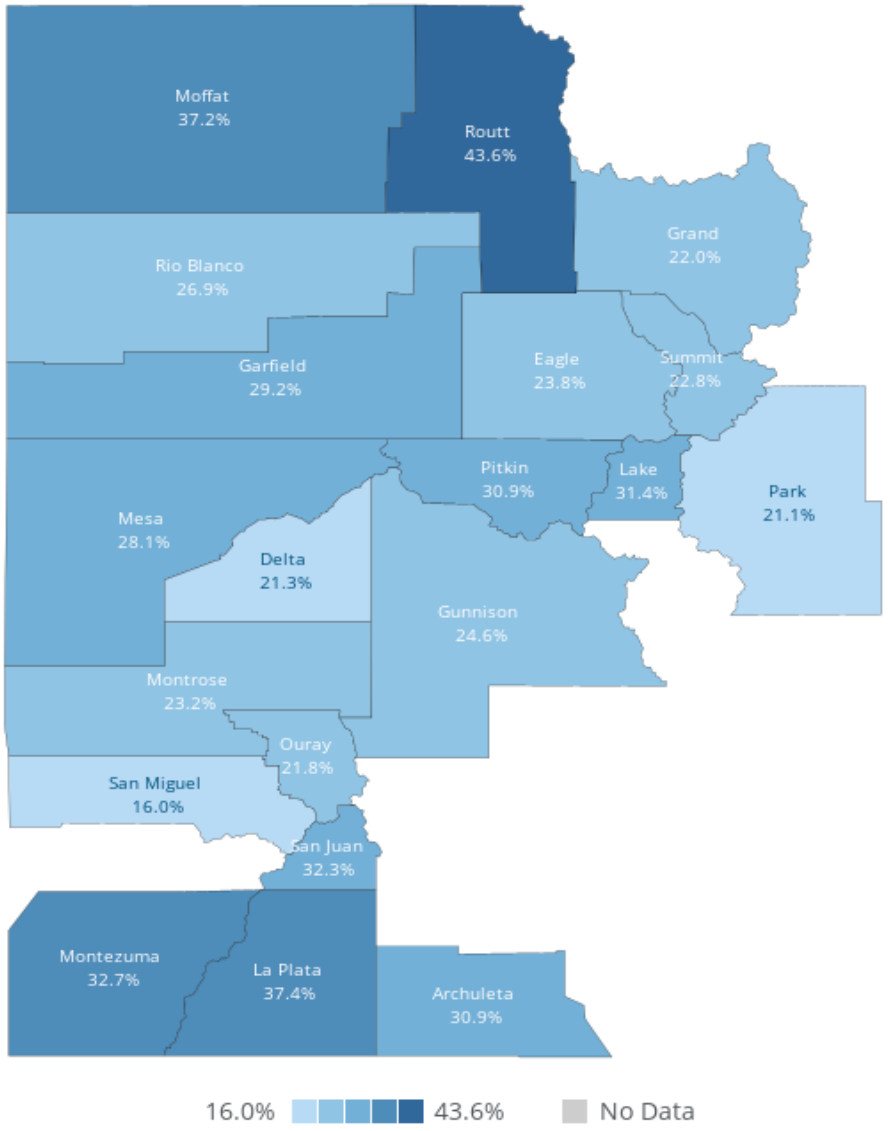
Total

22,597

9,217
5,000
3,000
1,500
500
100
1

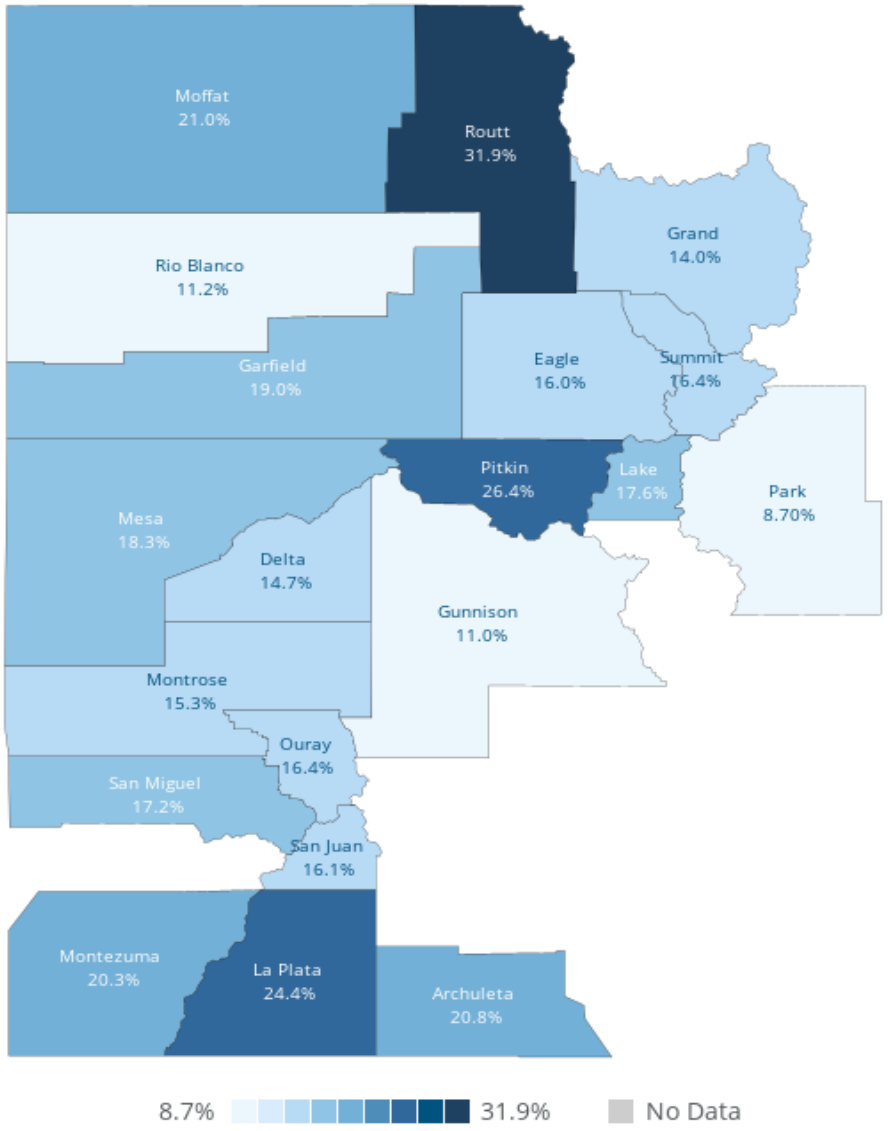
Food Need Heat Map

27.8 % of AHCM screeners were positive for a food need



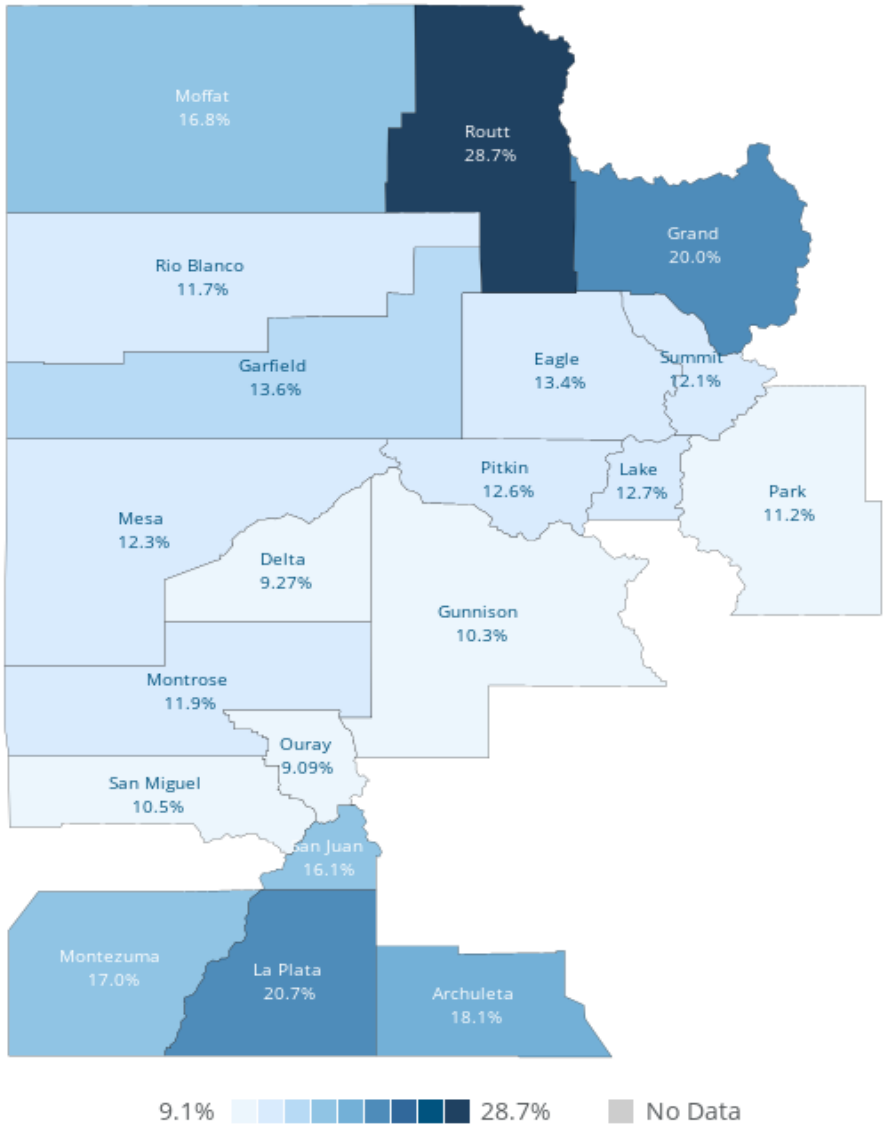
Housing Need Heat Map

18.1 % of AHCM screeners were positive for a housing need



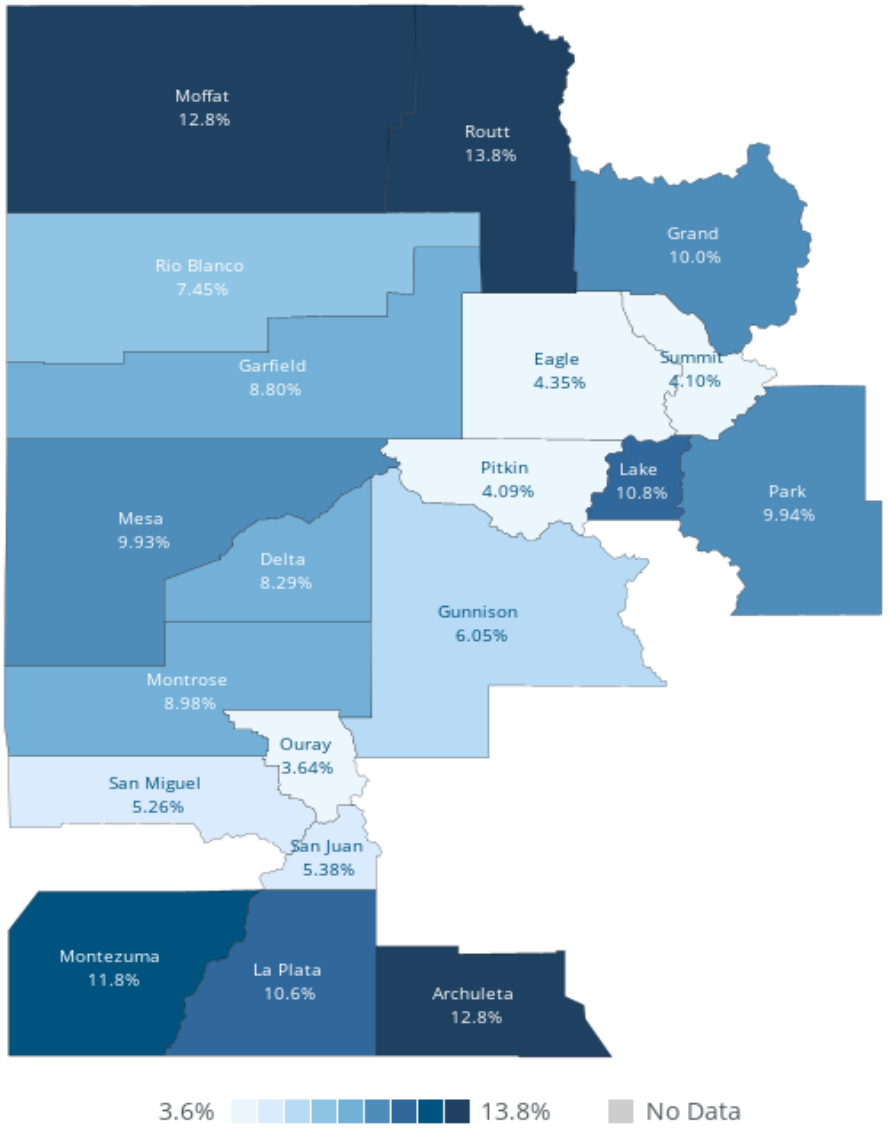
Transportation Need Heat Map

13.1 % of AHCM screeners were positive for a transportation need



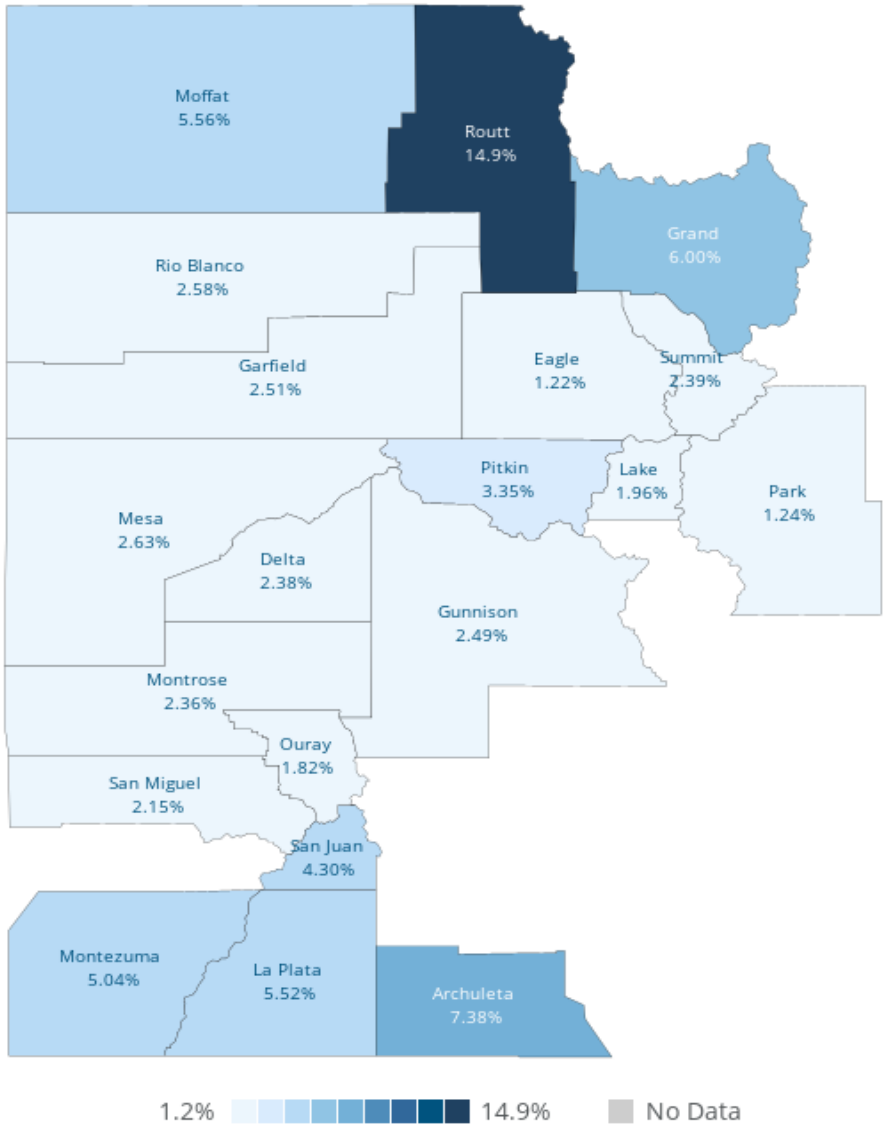
Utilities Need Heat Map

9.2 % of AHCM screeners were positive for a utilities need



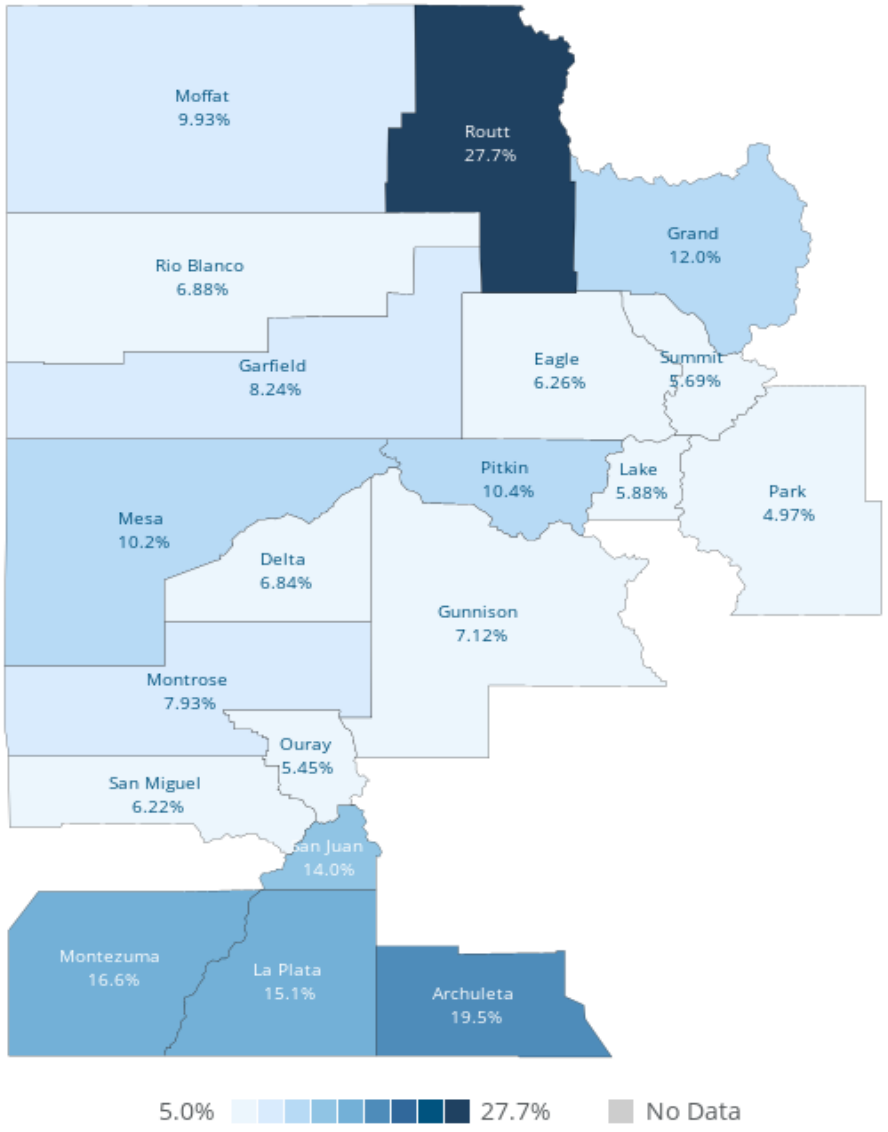
Safety Need Heat Map

3.0 % of AHCM screeners were positive for a safety need



Social Isolation Map

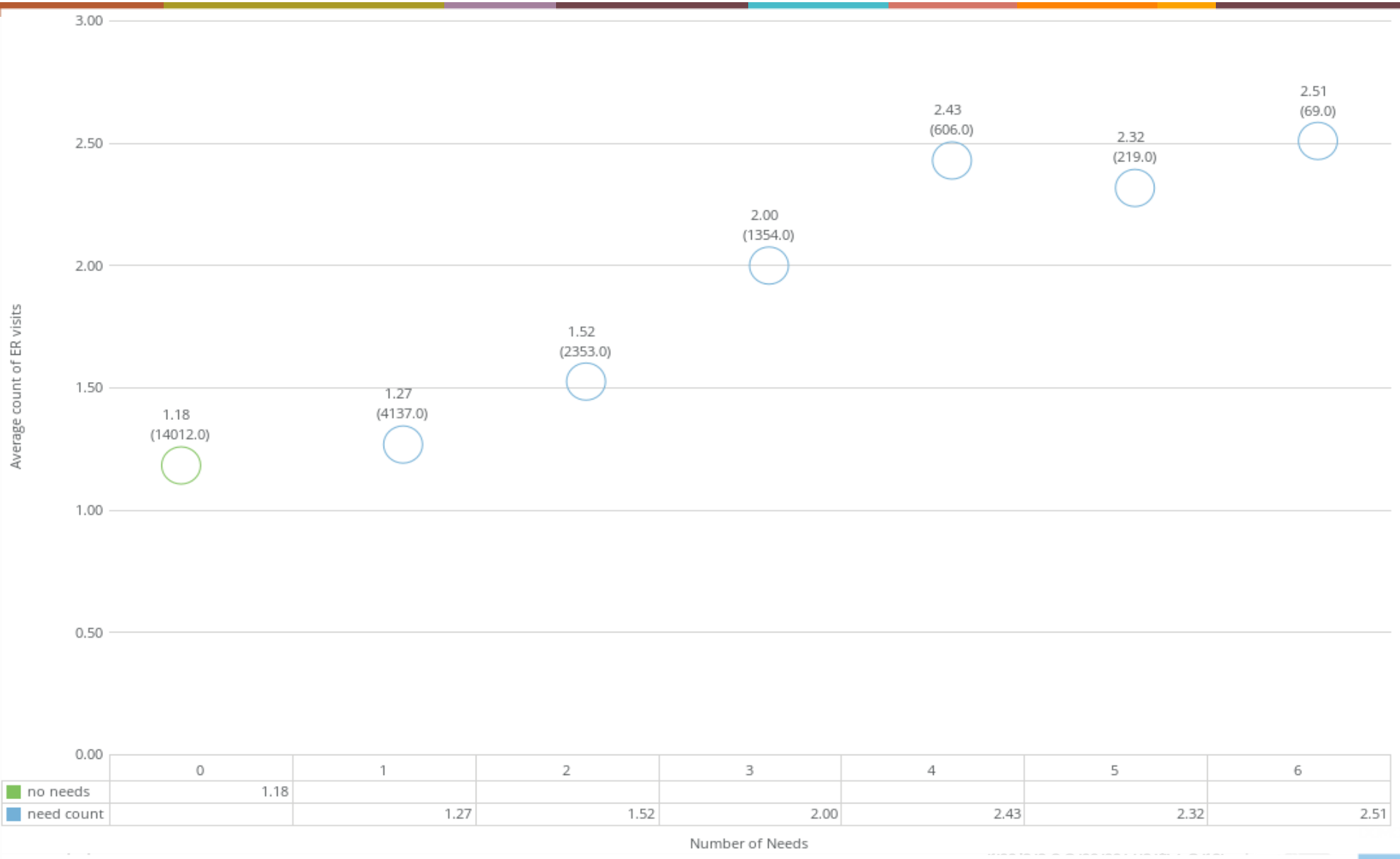
9.8 % of AHCM screeners were positive for a social isolation need



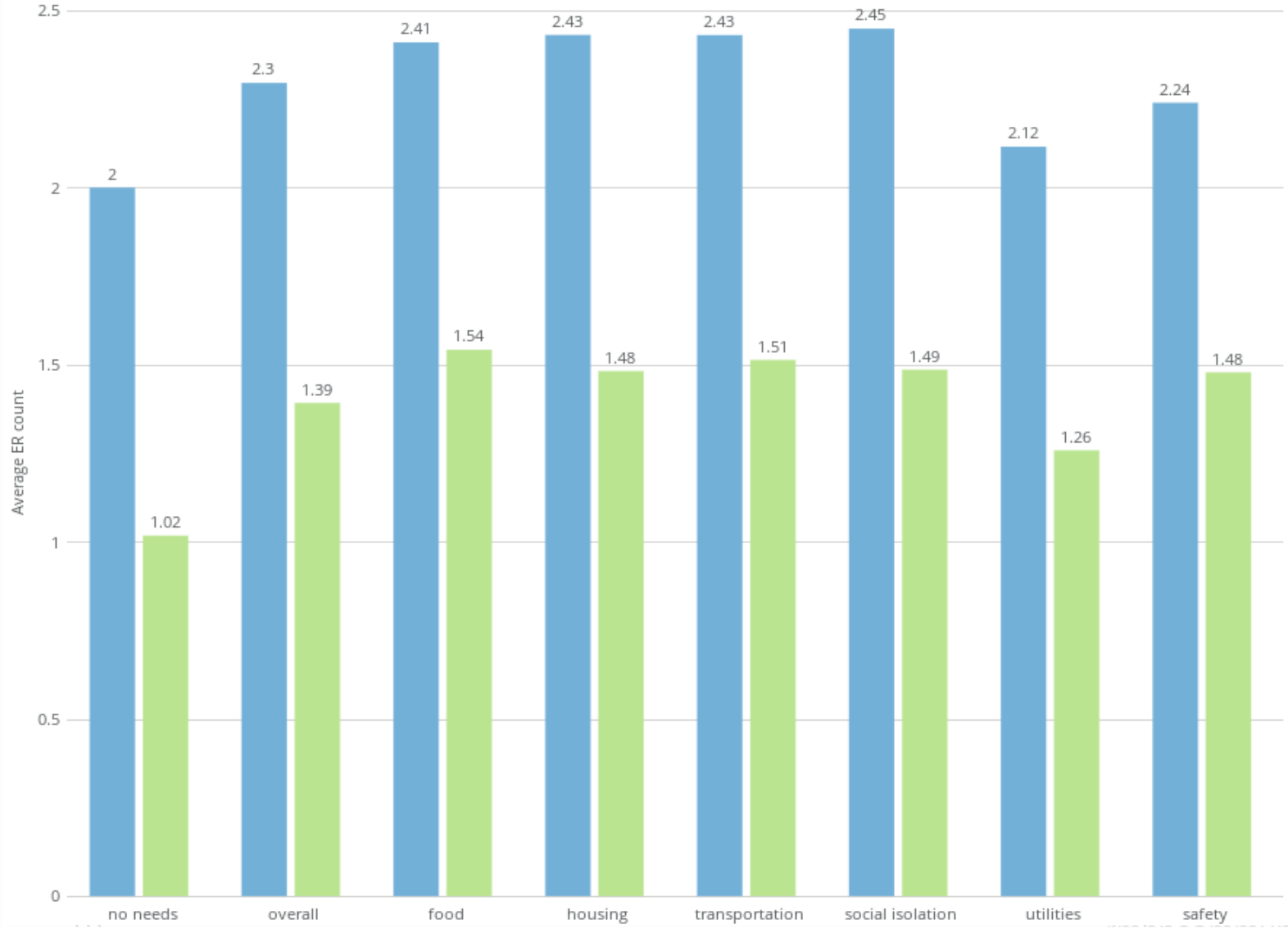
Average ER visits 12 months prior to screening for people with and without needs

	at least one need	food	housing	transportation	social isolation	utilities	safety
has need	1.57	1.74	1.66	1.97	1.72	1.82	2.21
does not have need	1.18	1.19	1.26	1.24	1.29	1.28	1.31

Average ER visits in 12 months prior to screening for each count of needs

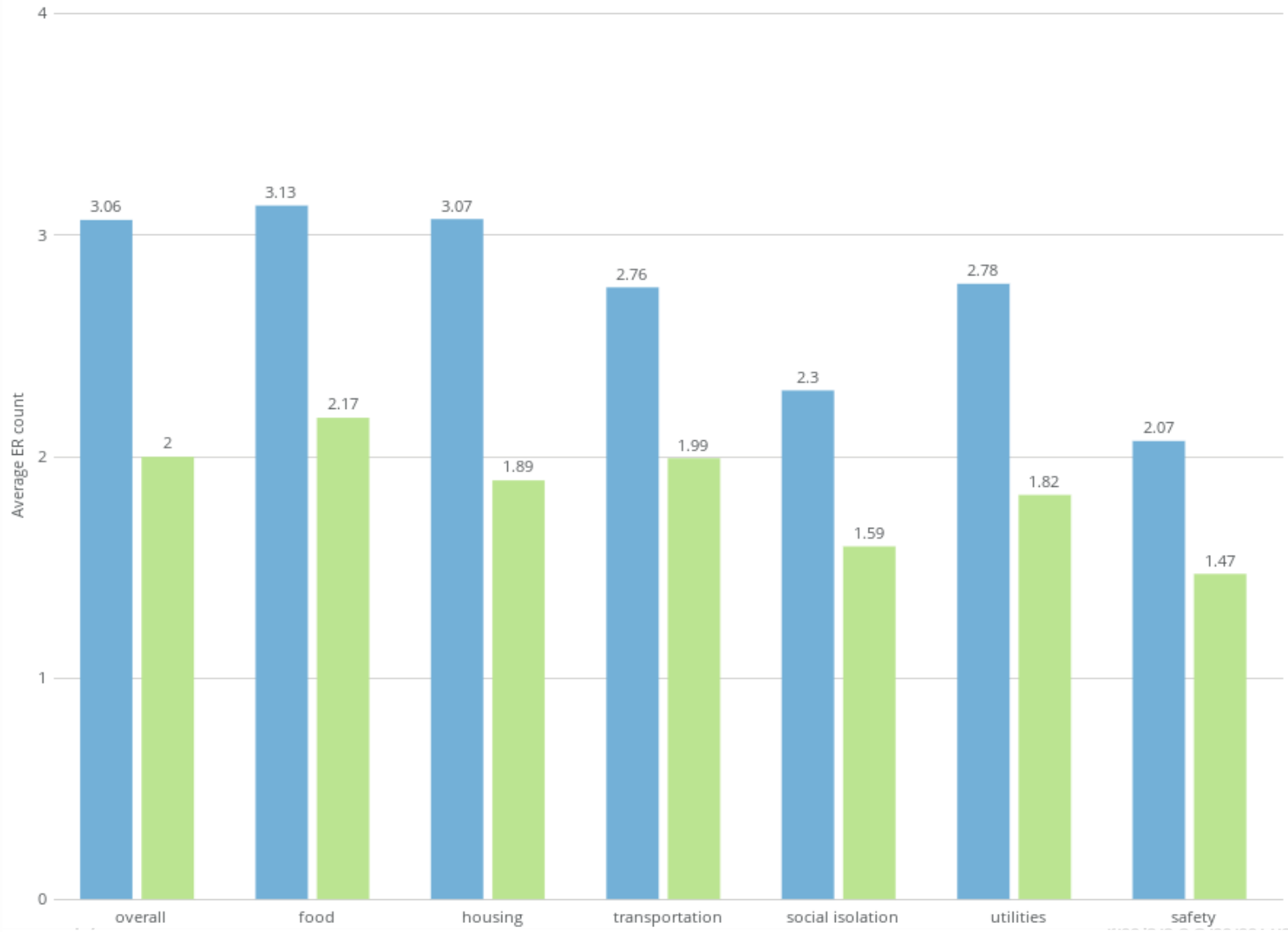


ER average- 6 months before/after screening



4,604 distinct screenings

ER average – 6 months before/after navigation



263 distinct screenings

Screening during and after COVID-19

MORE SOCIAL NEEDS

MORE AND NEW RESOURCES

NEW WAYS TO SCREEN

Connecting to Care Coordination

Of those patients identified as eligible for navigation:

- 35% opt out of navigation at the clinic (check "no" on screener)
- Of the number who did not check "no" on the screener 51% are either unreachable or opt out when reached

- ***As of 4/13/2020 <u>1,831</u> individuals have accepted care coordination***

Use the chat function to share at least one thing you are grateful for

MAKING A DIFFERENCE IN WESTERN COLORADO