Accountable Health Communities Model

Understanding RMHP’s AHCM

May, 2019
FACTORS DRIVING HEALTH OUTCOMES

- Physical Environment: 10%
- Social and economic factors: 40%
- Health Behaviors: 30%
- Clinical Care: 20%

THE ACCOUNTABLE HEALTH COMMUNITIES MODEL (AHCM)

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
AHCM COMMUNITY LEADS

Geographic Target Area

Western Colorado
Accountable Health Communities Model

COLOR KEY:
- Northwest Colorado Community Health Partnership
- West Mountain Regional Health Alliance
- Mesa County Public Health
- Tri-County Health Network
- TBD
Community Lead Quality Improvement

- **Housing**
  - West Mountain Regional Health Alliance
- **Food**
  - Northwest Colorado Community
  - Tri-County Health Network
  - Mesa County Public Health
AHCM SCREENING

We aim to screen 100,000:

In Clinical Settings including:

For six social needs:

Using the:

Medicare Enrollees
Medicare-Medicaid Enrollees
Medicaid Enrollees

Primary Care
Behavioral Health
Hospitals

Food
Housing
Transportation

Utilities
Interpersonal Violence
Social Isolation

Quality Health Network
Community Resource Network
“The rung of a ladder was never meant to rest upon, but only to hold a man’s foot long enough to enable him to put the other somewhat higher.”

— Thomas Henry Huxley
AHCM SCREENING

“The last time I looked in my textbook, the specific therapy for malnutrition was, in fact, food”
– Dr. Jack Geiger

Identify social needs to enhance clinical care planning
# AHCM SCREENING

<table>
<thead>
<tr>
<th>County</th>
<th>% Eligible but Not Enrolled in SNAP</th>
<th>County</th>
<th>% Eligible but Not Enrolled in SNAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mesa</td>
<td>44%</td>
<td>La Plata</td>
<td>49%</td>
</tr>
<tr>
<td>Archuleta</td>
<td>56%</td>
<td>Moffat</td>
<td>31%</td>
</tr>
<tr>
<td>Delta</td>
<td>46%</td>
<td>Montezuma</td>
<td>37%</td>
</tr>
<tr>
<td>Dolores</td>
<td>69%</td>
<td>Montrose</td>
<td>44%</td>
</tr>
<tr>
<td>Eagle</td>
<td>75%</td>
<td>Ouray</td>
<td>71%</td>
</tr>
<tr>
<td>Garfield</td>
<td>45%</td>
<td>Pitkin</td>
<td>86%</td>
</tr>
<tr>
<td>Grand</td>
<td>77%</td>
<td>Rio Blanco</td>
<td>53%</td>
</tr>
<tr>
<td>Gunnison</td>
<td>68%</td>
<td>Routt</td>
<td>73%</td>
</tr>
<tr>
<td>Jackson</td>
<td>56%</td>
<td>San Miguel</td>
<td>72%</td>
</tr>
</tbody>
</table>

- Provide information on community resources
- Identify social needs to enhance care planning
AHCM SCREENING

Provide community navigation

Provide information on community resources

Identify social needs to enhance care planning
AHCM SCREENING

1. Identify gaps in social resources
2. Provide community navigation
3. Provide information on community resources
4. Identify social needs to enhance care planning
AHCM SCREENING

Create Community Solutions to Gaps in Social Resources

Identify gaps in social resources

Provide community navigation

Provide information on community resources

Identify social needs to enhance care planning
AHCM SCREENING

Health Equity & Culture Change

Create Community Solutions to Gaps in Social Resources

Identify gaps in social resources

Provide community navigation

Provide information on community resources

Identify social needs to enhance care planning
Celebration

**Total Screened:** 5,037  
**Total Screenings Sent to CMMI:** 1,825  
**Total Clients Eligible for Navigation:** 337

<table>
<thead>
<tr>
<th>Social Need</th>
<th>Count of Positive Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>1,062</td>
</tr>
<tr>
<td>Housing</td>
<td>519</td>
</tr>
<tr>
<td>Transportation</td>
<td>706</td>
</tr>
<tr>
<td>Utilities</td>
<td>327</td>
</tr>
<tr>
<td>Safety</td>
<td>102</td>
</tr>
<tr>
<td>Social Isolation</td>
<td>340</td>
</tr>
<tr>
<td>RMHP Clinical Partners (a sample)</td>
<td>Total Screenings</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Summit Community Care Clinic</td>
<td>689</td>
</tr>
<tr>
<td>Mountain Family Health Center</td>
<td>882</td>
</tr>
<tr>
<td>Rocky Mountain Health Plans</td>
<td>152</td>
</tr>
<tr>
<td>Foresight Family Physicians</td>
<td>103</td>
</tr>
<tr>
<td>Surface Creek Family Practice, PC</td>
<td>163</td>
</tr>
<tr>
<td>Rangely District Hospital</td>
<td>136</td>
</tr>
<tr>
<td>Memorial Regional Health Clinic</td>
<td>258</td>
</tr>
<tr>
<td>Axis Health System</td>
<td>284</td>
</tr>
<tr>
<td>River Valley Family Medicine</td>
<td>1,313</td>
</tr>
<tr>
<td>Ebert Family Clinic</td>
<td>227</td>
</tr>
<tr>
<td>Pediatric Associates of Durango</td>
<td>70</td>
</tr>
<tr>
<td>Valley View Hospital</td>
<td>84</td>
</tr>
<tr>
<td>Gunnison Valley Health</td>
<td>160</td>
</tr>
<tr>
<td>Northwest Colorado Health</td>
<td>69</td>
</tr>
<tr>
<td>Mid Valley Family Practice</td>
<td>39</td>
</tr>
</tbody>
</table>
Additional Sites Screening

• Primary Care Partners
• Uncompahgre Medical Center
• A Kidz Clinic
• Glenwood Medical Center
• Pioneer Medical Center
• Northside Child Health Center
• Aspen Valley Hospital
Gender

- Female: 59%
- Male: 41%
Race and Ethnicity

- American Indian: 4%
- Asian: 76%
- Black: 17%
- Hawaiian or Pacific Islander: 4%
- White: 4%
- Hispanic or Latino: 4%
Count by Income

- Less than 10K
- More than 10K, less than 15K
- More than 15K, less than 20K
- More than 20K, less than 25K
- More than 25K, less than 35K
- More than 35K, less than 50K
- More than 50K, less than 75K
- More than 75K
Education

- No School
- Grade 1-8
- Grade 9-11
- Grade 12
- 1-3 years of college
- 4 year college
Prevalence of Social Needs

- Food: 30%
- Housing: 25%
- Transportation: 15%
- Utilities: 10%
- Safety: 5%
- Social Isolation: 5%
ER Visits and Social Needs

Percent of Screened Population with No ER visits in the Last Year

- No Social Needs: 60%
- Food Needs: 40%
- Transportation Needs: 30%
- Utilities Needs: 40%
- Housing Needs: 50%
Prevalence of Needs in People with 2 ER Visits

- Housing: 20%
- Food: 45%
- Transportation: 25%
- Utilities: 15%
- Safety: 5%
- Social Isolation: 10%
Barriers to Increasing Navigation

• **Consent Question?**

*May a care coordinator contact you to help you access community resources related to the needs you identified?*

- Yes, have a care coordinator contact me. I understand that by checking this box I am agreeing to allow the information in this screening to be shared with a care coordinator who will use this information to help me connect with appropriate community resources.

- No, do not contact me.
CONTACT RMHP TO LEARN MORE

Kathryn Jantz
*AHCM Program Director*
Rocky Mountain Health Plans
kathryn.jantz@rmhp.org
303-638-9897

Sally Henry
*AHCM Project Coordinator*
Rocky Mountain Health Plans
sally.henry@rmhp.org
970-640-7722
MAKING A DIFFERENCE IN WESTERN COLORADO