AHCM community *report*

How a social needs screening, care coordination, and community collaboration effort is improving health for Western Coloradans

QUALITY HEALTH® NETWORK

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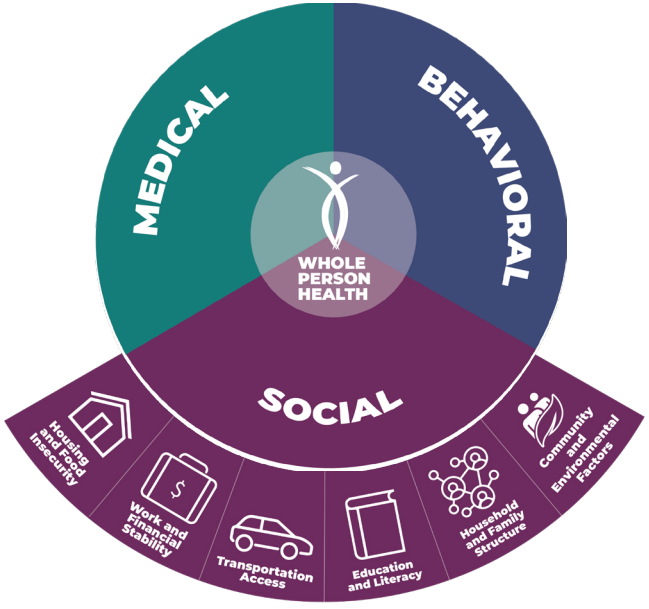
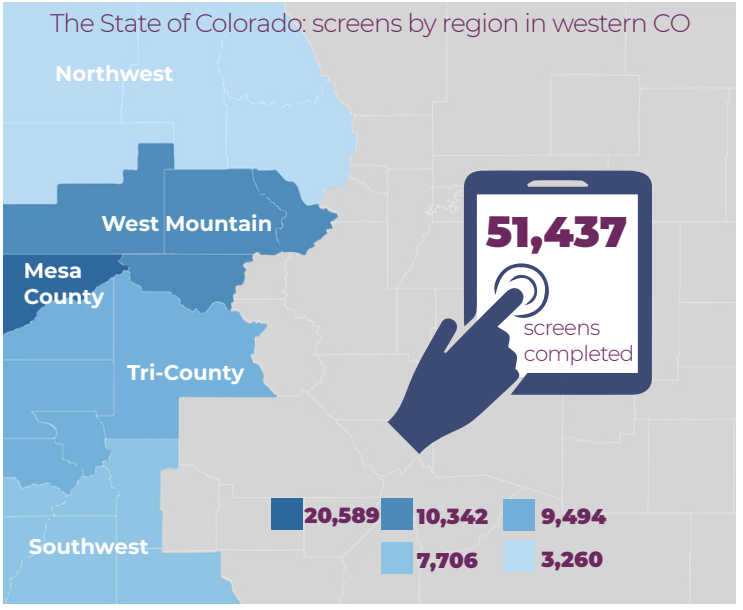
What is **AHCM**?

Centers for Medicare and Medicaid Services Innovation Center (CMS) launched the **Accountable Health Communities Model** (AHCM) to test whether addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs.



The three domains of health: Medical, Behavioral, and Social; with the Social Determinants of Health broken down into basic categories as represented in the ***Community Resource Network***.



The model promotes clinical-community collaboration [1] to

1 CMS AHC Website https://innovation.cms.gov/initiatives/ahcm/

Perspectives **from the field**

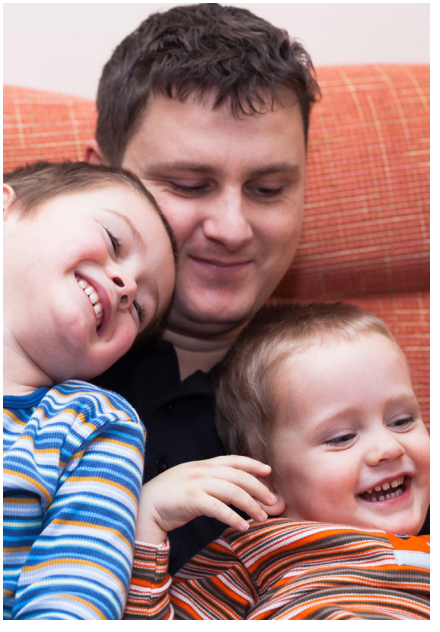
Kathy Capps, Director of Operations, Mind Springs Health

> *It was critical for us to understand what follow-up would look like, including* ***how we would resource it.***
> *~Kathy Capps*

Social Determinants of Health (SDoH) screening can be conducted by physical and behavioral health providers to gain more insights into the needs of their patients. In western Colorado, Mind Springs Health, a leading behavioral health provider in the region, began incorporating the AHCM screening tool for that very reason.

“Anytime we can identify gaps in care, it’s good information to help,” said Kathy Capps, Director of Operations at Mind Springs Health. SDoH screening highlighted broad needs of their patients and facilitated conversations with the care team which had a more holistic view informed by the screening.

Kathy continued, “before we started the screenings, I thought we were already asking really good questions, but the AHCM tool gives us a more complete picture of the patient.”



What have we **learned**?

In 2018, Rocky Mountain Health Plans partnered with Quality Health Network (QHN) to begin rolling out the AHCM screener to a network of primary care, behavioral health and hospital partners.

Implementation for most clinics has taken significant time - a minimum of three months.

Women and men have very comparable rates of social need- even in interpersonal violence.

There are clear racial and ethnic social need disparities in our Western Colorado population. Especially amongst individuals who are Native American.

7% Needs decline as income increases but even in individuals and households with incomes above $50,000 we are seeing food insecurity rates of roughly 7%.

Almost half of the people who have social needs only have one- how do we support this population so that we help them avoid ever having two or more needs?

Thirty percent of people have opted out of care coordination.

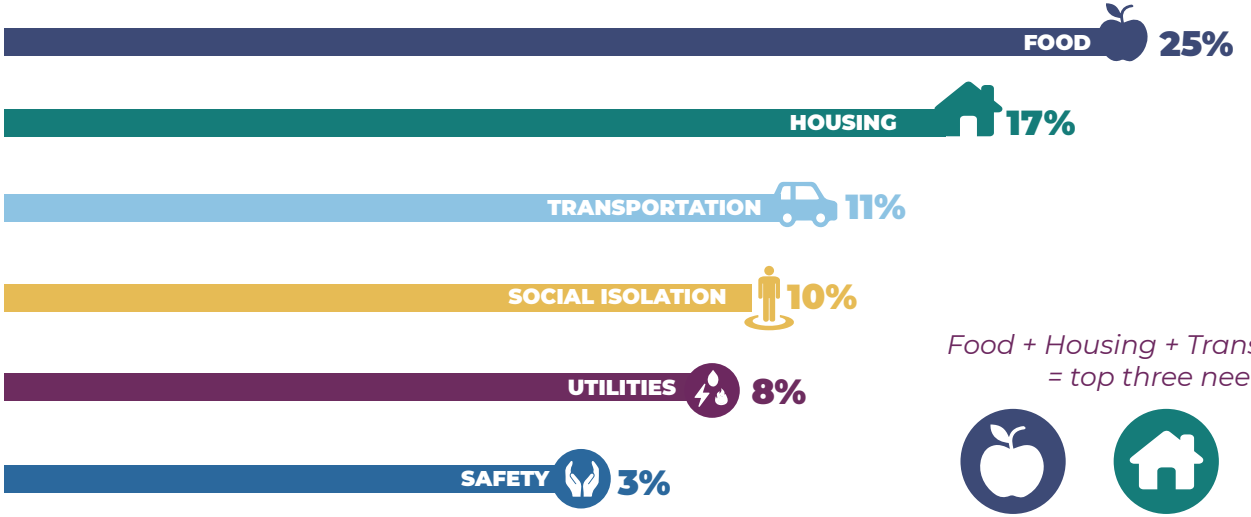
The highest rate of social needs is in the 41-65 year old population in all domains except for social isolation where 19-21 year olds have the highest rate of need. We know most non-disabled, working-age Medicaid adults are employed. This means that as we refer people to community based organizations, we have to consider whether they are accessible to working adults.

The AHCM screener identifies individuals who may have unmet basic needs. 40% of people indicated at least one social determinant of health need.

40% have needs

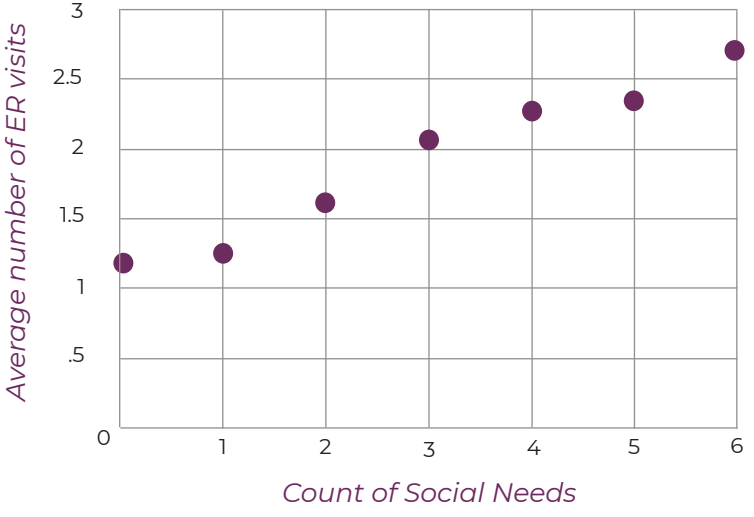
What have we **learned**?

Most prevalent needs identified by the screener to date:



Food + Housing + Transportation = top three needs.

Initial findings from the AHCM project show a correlation between the number of needs reported by individuals and the frequency with which they had emergency room visits. People with five or more needs have double the amount of ER visits than those with no needs.



What is **Community Resource Network?**

Powered by Quality Health Network

Quality Health Network's Community Resource Network (CRN) application supports coordination between healthcare providers (physical and behavioral) and non-medical/social service providers. CRN allows for information sharing similar to QHN's award-winning, secure Health Information Exchange that supports coordination between healthcare providers.

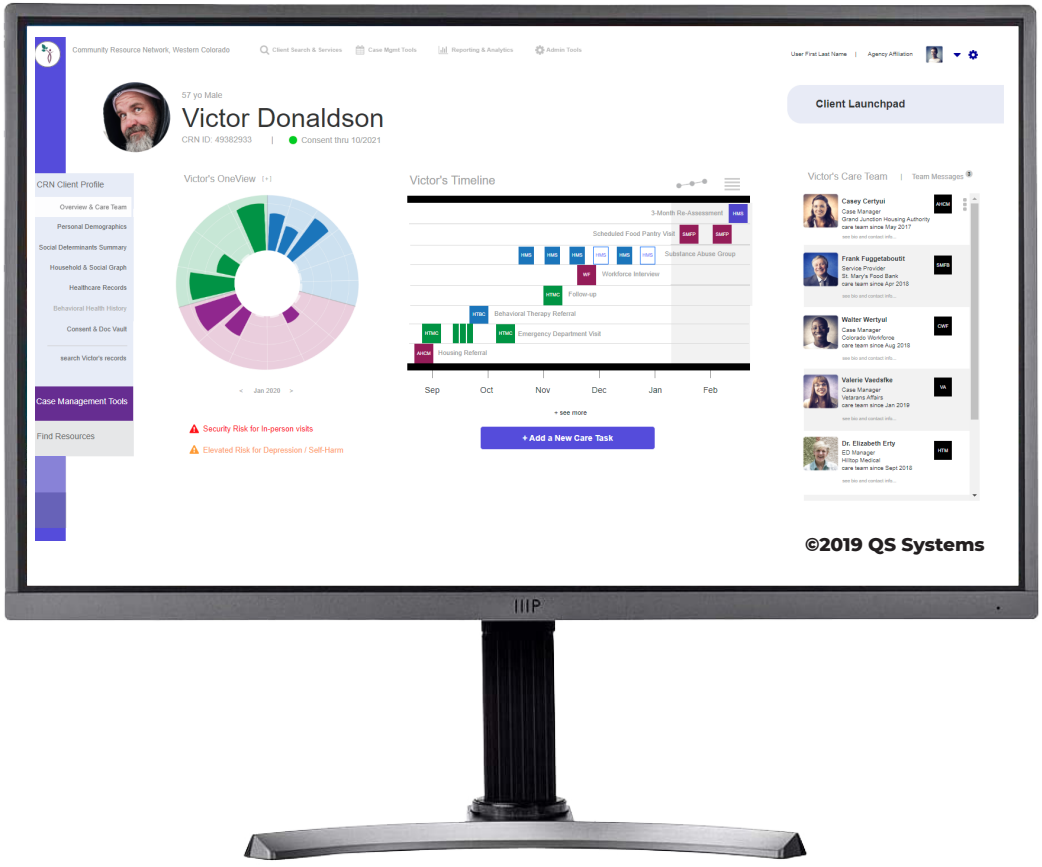
CRN helps align care planning between diverse providers, closed loop referrals, dynamic resource lists, multiple screening tools (AHCM, PRAPARE, and other social screening tools), sharing of medical and non-medical data, aligned care planning and reporting and analytics for all western Coloradans.

Through the hard work of all of the participants involved in AHCM we have learned a lot about what works and what doesn't work in terms of screening and resource identification.

We have **resource listings** for nearly 300 service providers in CRN with more to come, including **data from the 211** Resource Directory

27 There are 27 agencies/programs currently participating in CRN, with many more scheduled to be added in 2021!

SCL Health St. Mary's
Hilltop
Mind Springs Health
2-1-1
Grand Junction Housing Authority
ADRC Aging and Disability Resources for Colorado
Hilltop B4 Babies & Beyond
Homewardbound of the Grand Valley
WMA Western Medical Associates
SummitWest Care
MarillacHealth
Family Health West
Foresight Family Physicians
PTLink
Colorado Canyons Hospital & Medical Center
Colorado Mountain Medical
Eagle Valley Community Foundation
Family & Adolescent Partnership
Garfield County
grand river Health
Hilltop's Health Access
Hope Center Aspen | Eagle River Valley
Lift Up
Mountain Family Health Centers
Vail Health
Valley View



CRN Community RESOURCE N•E•T•W•O•R•K

Connects the teams

Expedites help for those at risk

Creates a whole-person picture

Optimizes well-being

communityresourcenet.org | support@qualityhealthnetwork.org | 970.248.0033

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