Initial Impact of the Accountable Health Communities Model

The Center for Medicare and Medicaid Innovation (CMMI) implemented the Accountable Health Communities (AHC) model in May 2017 to support communities in their efforts to address health-related social needs (HRSNs) using clinical-community partnerships. Similar to other CMMI models, the AHC model looked to improve care quality while reducing costs of delivery; however, this was the first CMMI model to look beyond clinical outcomes to test if identifying and addressing HSRNs reduces costs and leads to effective (i.e. less unnecessary) health care utilization. The model ran for five years, through April 2022.

> The model consisted of two tracks for model participants:
>
> - The **Assistance Track** tested screening beneficiaries for HSRNs and using community navigation services to connect high-risk beneficiaries with needed social services.
> - The **Alignment Track** tested screening, referral, and navigation services combined with engaging key stakeholders to encourage partner alignment to optimize community capacity to address

Via AHC, CMMI administered funding to 28 model participants, referred to as "bridge organizations." The bridge organizations served as a central hub that partnered with clinical sites in the community to screen all community-dwelling Medicare and Medicaid beneficiaries for five health-related social needs: housing instability, food insecurity, transportation problems, utility difficulties, and interpersonal violence. Beneficiaries that reported at least one core HSRN and had at least two emergency department (ED) visits in the previous 12 months were then eligible for navigation services to connect them to needed social services in the community. The bridge organizations used AHC funds to develop the necessary infrastructure and establish necessary staffing to connect beneficiaries to needed social services.

Screening for Health-Related Social Needs

Currently, screening for HSRNs is not a standard practice for most health care organizations. Therefore, CMS developed a screening tool that identifies the five core HRSNs for bridge organizations and shared it for public awareness and use (organizations must use proper citations to use the screening questions).

Along with this screening tool, CMMI released A Guide to Using the Accountable Health Communities Health-Related Social Needs Screening Tool, that details how to cultivate staff buy-in, use the screening tool, and train staff on proper collection practices.

Early Impact of the Accountable Health Communities

The final evaluation for this model is underway. The most recent evaluation – released in December 2020 – finds that the model effectively identified beneficiaries in need of social services, and these

beneficiaries accepted navigation services at higher rates than anticipated. However, there was limited evidence that the intervention resolves HSRNs in the first year, and there were no clear savings or impacts on other outcomes during the first year. The final evaluation will provide more information on the financial savings of the model.

The initial evaluation found that:

- Food insecurity was the most reported HRSN among screened beneficiaries.
- Medicare beneficiaries in the Assistance Track intervention group had nine percent fewer Emergency Department visits than those in the control group during the first year after screening.
- Of the beneficiaries screened, 34 percent had one or more core HRSNs, and 15 percent also had two or more ED visits making them eligible for navigation services. This was higher than CMS' original assumption that 13 percent of beneficiaries screened would be eligible for navigation services. Of those eligible, 74 percent accepted the navigation services.
    - Only 14 percent of beneficiaries who completed the full year had any HRSNs marked as resolved. However, several factors may contribute to why this is, including difficulties with data reporting (i.e. data tracking systems may not be integrated with the health system's electronic health record), loss of contact with beneficiaries, difficulty managing large caseloads, a lack of beneficiary transportation to needed services, and insufficient community resources.
- Navigation-eligible beneficiaries were more likely to be low income, racial and ethnic minorities, and among Medicare beneficiaries, disabled.

Case Study: Making the Business Case for Addressing Health-Related Social Needs

To accompany the initial evaluation of this model, CMS released a business case for addressing social health needs, using Reading Hospital in Pennsylvania as a successful case study in continuing to fund screening for HSRNs. The Community Wellness Department's Community Connections Program (CCP) – which administered the AHC model – worked to secure funding to sustain HRSN screening post AHC model. Given Reading Hospital operates the busiest ED in Pennsylvania, the team selected avoidable emergency department use as the metric most meaningful to leadership. Partnering with Healthify – a closed-loop referral platform vendor – and Reading's Electronic Health Record team, the CCP team calculated the return on investment expected from a decrease in ED visits. Results showed that in the first year of AHC model performance (2018-2019) avoidable ED visits declined by 15 percent among Medicare and Medicaid patients, which resulted in an estimated $1 million in savings. Along with the financial savings, the CCP team highlighted the benefits of a holistic care approach for the patient. The combination of these assessments convinced leadership to continue to invest in HSRN screening; this case study serves as an example for other organizations seeking to begin or continue investing in HSRN screening for patients.