Scaling and Spreading Innovations from the Accountable Health Communities Model

From 2017 to 2022, the Centers for Medicare & Medicaid Services' (CMS) Accountable Health Communities (AHC) Model funded 28 awardee organizations to systematically identify and address Medicare and Medicaid patients' health-related social needs (HRSNs) through screening, referral, and community navigation services.[1] Lessons from the AHC Model may be useful for entities that are subject to finalized and proposed rules that emphasize addressing HRSNs and providing whole-person care. In 2022, CMS finalized in the Inpatient Prospective Payment System (IPPS)[2] final rules changes that would require hospitals to report on measures of screening and identification of patient-level, HRSNs—such as food insecurity and housing instability—driving patients' health and well-being. In the CY 2024 Physician Fee Schedule (PFS) proposed rule, CMS is proposing coding and payment changes for health integration services, including social determinants of health assessments and navigation, to promote redress of HRSNs.[3]

Based on an analysis of sustainability plans developed in 2022 and early 2023, this resource highlights AHC awardees' strategies to scale and spread efforts to identify and address HRSNs beyond the CMS funding period. Figure 1 describes the four themes that emerged across sustainability plans: data collection and use, strategic partnerships, organizational capacity, and health systems transformation and financing. Awardees planned to continue to support screening, referral, and navigation by leveraging the infrastructure and expertise they developed when implementing the AHC Model. Health care systems, payers, and community-based organizations (CBOs) seeking to initiate and support HRSN screening, referral, and navigation in clinical settings can consider these themes and AHC awardees' related activities.

Figure 1. AHC awardees' post-Model activities incorporate four drivers of lasting impact

Sustainability Driver	Considerations	Key Activities
Data Collection and Use	How can organizations improve collection and sharing of social needs data after AHC?	• Create platforms to collect, share, and assess patients' HRSN data among clinical and community providers
Strategic Partnerships	How can organizations engage and collaborate with local community and clinical organizations to address patients' HRSNs and expand the populations they serve?	• Connect patients with HRSNs to community-based resources • Engage community members and people with lived experiences to inform and lead HRSN work • Support and prioritize community outreach • Increase patient awareness and maintain referral systems via social health information exchanges
Organizational Capacity	How can organizations ensure that efforts addressing HRSNs are well-integrated into their organization?	• Increase knowledge of and gain buy-in for HRSN interventions from organizational leadership and staff • Identify and scale efficient workflows • Bolster the network and capacity of CBOs
Health Systems Transformation and Financing	How can organizations finance HRSN work?	• Diversify funding sources • Adopt alternative and value-based payment models • Leverage strategic communications

[1] Awardees included health systems, managed care organizations, academic and research institutions, and nonprofit and community-based organizations. No-cost extensions were available through April 2023.
[2] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates (87 FR 48780)
[3] Calendar Year (CY) 2024 Medicare Physician Fee Schedule Proposed Rule

Data Collection and Use

Creating systems to effectively track and share data on patients' HRSNs allows awardees to improve care coordination for patients, systematically assess patients' needs, and use the data to inform improvements of HRSN interventions. Throughout the model, **Oregon Health & Science University** (OHSU) strategically shared data with its state Medicaid agency, coordinated care organizations (CCOs), clinical delivery sites, and statewide community service providers so these partners could better understand the needs of Medicare and Medicaid beneficiaries. These data sharing efforts also informed quality measurement requirements and efforts to establish closed-loop referral platforms. The state has pursued a social needs screening and referral metric for the state's Quality Incentive Metric program, incentivizing payers to coordinate with CBOs and address upstream causes of health inequity.

The AHC Model experience also helped to inform the development of Connect Oregon, a statewide community information exchange (CIE) platform that connects a coordinated care network of health and social service providers, allowing them to send and receive electronic referrals and address people's HRSNs. The university works with CCOs as they implement the new metric as well as HRSN screening and navigation using Connect Oregon and another CIE platform. To support CCOs, OHSU offers one-on-one technical assistance, hosts webinars, and facilitates collaborative learning opportunities.

Awardees are enhancing sharing of HRSN data between clinical and community providers to improve coordination of care by:

- Integrating health information exchanges with referral platforms for social care services to better align CBOs, health systems, and payers in generating and tracking referrals
- Leading or supporting state and community efforts to develop closed-loop referral platforms for services to meet HRSNs

Awardees are improving HRSN data collection and use to better measure impact and gaps in care by:

- Building HRSN screening tools into their health systems' electronic health records (EHR)
- Cross-walking ICD-10-CM Z codes, such as the Z55-Z65 codes, with identified HRSNs within the EHR to populate claims for billing purposes. The Z55-Z65 codes indicate when people have potential health hazards related to socioeconomic and psychosocial circumstances.
- Leveraging data action committees to collect health equity measures and other data to implement quality improvement projects
- Analyzing HRSN data and the impacts of HRSN interventions on health outcomes and health care use to identify gaps in care and communicate the value of addressing HRSNs to staff and external audiences

Strategic Partnerships

Improving collaboration between clinical sites and community organizations enables awardees to address patients' HRSNs more effectively and expand the populations they serve. During the model, **Rocky Mountain Health Plans** (RMHP) demonstrated the promise of social health information exchange (S-HIE) platforms, which connect screening with closed-loop referrals to community resources and shared care planning. Lessons from RMHP's experience in the model were incorporated into Colorado's vision for S-HIE coordination. Recognizing the potential to increase the number of referrals for navigation, RMHP's community partners have continued to build new partnerships with S-HIE platforms. Community partners support these

Awardees are partnering and collaborating with CBOs to address HRSNs and identify future opportunities for growth by:

- Appointing community members, including those with relevant lived experience, as project leaders and developing community outreach teams to improve decision making, inform project planning, and ensure an aligned and equitable approach between clinical and community partners
- Working with CBOs and community members to gain feedback on HRSN screening, referral, and navigation processes and inform program improvements

partnerships by defining goals of implementation, facilitating monthly calls, training CBO staff, soliciting feedback, and providing input on program planning and sustainability. RMHP's community partners also collaborate with S-HIEs to maintain and update accurate community resource lists used by clinics. These exchanges encourage and build strong, sustained relationships between clinical sites, navigators, and community resource providers. Read more about how RMHP engaged clinical partners to address HRSNs and provide referral and navigation services.

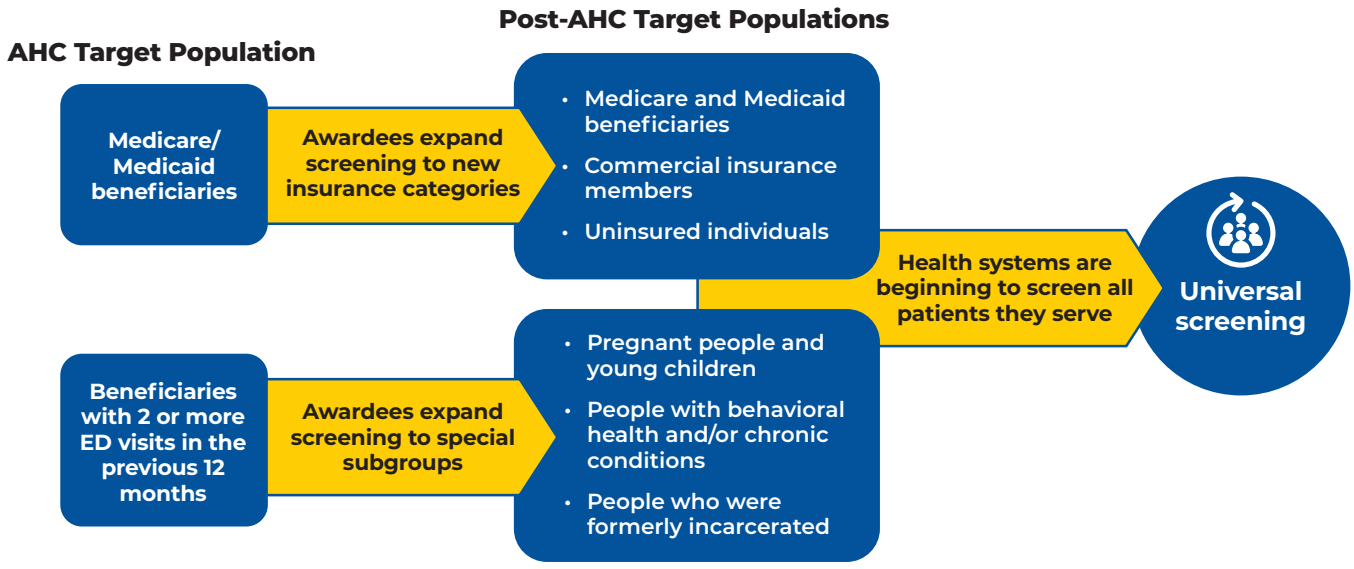
Through multisector advisory boards and community outreach teams, established during the AHC Model, awardees are promoting the importance of addressing HRSNs within the community by:

- Conducting community outreach within the patient population and identifying new community and provider partners for patient engagement
- Building partnerships that increase the availability of community services to meet patients HRSNs
- Communicating the value of addressing HRSNs and sharing educational materials for external community audiences and patient communities

Organizational Capacity

Strengthening the capacity for staff, leaders, and community partners to support and conduct HRSN screening, referral, and navigation allows awardees to integrate HRSN efforts into regular practice. By providing ongoing mentorship and customized and streamlined workflows, **NewYork-Presbyterian Hospital** (NYP) gained staff buy-in to integrate screening and referral into regular clinical care and expand these activities throughout its enterprise. NYP worked with its electronic medical record vendor to embed the referral platform into its electronic medical record and standardize screening and capture of demographic data to better address disparities after the model. The team also leveraged quality improvement tools, regular meetings, and physician champions to iterate on and build site-specific screening and navigation workflows. Additionally, NYP has adopted the NYC Social Factors Questionnaire, rather than the AHC screening tool, to capture the range of needs presented by their patients. Throughout the model, the AHC team aligned its work with organizational priorities and strategic initiatives toward improving community partnerships and addressing HRSNs, which has been critical in raising the importance of and scaling HRSN screening and referral. With staff and leadership support, the hospital dedicated operational funding to expand HRSN screening and follow-up. Like other health systems, NYP is expanding screening to all patients served by its primary care practices and emergency departments. Figure 2 shows the new populations that awardees are serving after the AHC Model. Read more about how another awardee expanded screening, referral, and navigation programs to address additional populations' needs.

Figure 2. AHC awardees expand screening to new populations after the AHC Model



In addition to establishing workflows to support screening and closed-loop follow-ups, NYP recognized the importance of building community capacity to respond to referrals. The health system has committed funding to a community-based food insecurity and obesity prevention program. Because food insecurity is a significant need among its patient population, NYP built a "food security order" into its electronic medical record, allowing clinical staff to refer patients directly to the program for resources.

Awardees are identifying and scaling efficient workflows customized for their organizations and partners by:

- Leveraging quality improvement activities to improve staff trainings and efficiency of closed-loop referral processes. Examples of activities include establishing benchmarks and regularly monitoring data for screening, navigation, and health outcomes
- Developing, piloting, and refining screening and navigation processes based on literature and interviews with staff and patients

Awardees are bolstering the network and capacity of CBOs to ensure CBOs will have the resources to meet people's HRSNs by:

- Staffing CBOs and hospitals with community health workers to provide referrals and navigation services
- Maintaining community resource inventories and making them publicly available to ensure the public has up-to-date information about local resources and social services
- Creating micro-networks of community resources, clinics, and health systems to meet region-specific needs and provide care coordination and assistance with state benefits
- Addressing upstream causes of food insecurity by partnering with local food banks, businesses, and organizations to transform the local food economy and promote local availability of healthy foods, workforce development, and access to affordable housing

Awardees are ensuring organizational buy-in and that there are adequate, motivated, and knowledgeable staff within their organizations to conduct screening, referral, and navigation by:

- Creating training strategies and programs to close skills gaps in addressing HRSNs
- Increasing staff and organizational leaders' awareness of health inequities and their connection to HRSNs. Read more about awardees' strategies to communicate the value of addressing HRSNs.
- Communicating the value and return on investment of addressing HRSNs through marketing materials and regular meetings. Read more about how Reading Hospital made the business case to hospital leaders for addressing HRSNs and secured funding to continue HRSN screening, navigation, and referral

Health Systems Transformation and Financing

By working to diversify funding sources, particularly for screening and navigation, awardees can expand and transform health systems financing to continue addressing HRSNs. **University of Texas Health Science Center at Houston** (UTHealth) is developing a new alternative payment model (APM) that acknowledges the role of both health care systems and CBOs in addressing HRSNs. Health care providers, state agencies, and payers are using alternative payment approaches to transform health care, test new models of care, and focus the health care system on increasing high-quality and cost-efficient care. UTHealth is employing a collaborative and participatory approach to financing to address a historic lack of engagement and participation from providers during the creation of APMs. UTHealth formed an APM planning team in May 2022, which includes all their AHC Model partners, and initiated a six-month planning project to co-develop the new APM together with an expanded network of state and community-based partners.

Since APM development is a new area of expertise for the awardee, UTHealth is pursuing co-development of the APM with partners from health systems, accountable care organizations, managed care organizations, and federal funders with experience in APM development. Co-development helps to expand UTHealth's knowledge, tailor the APM to the policy climate in Texas, and share the financial risk and return on investment for the cost of addressing HRSNs. With this approach, UTHealth's goal is to have at least one of their AHC Model clinical delivery sites

adopt the new APM and develop a sub-agreement with their network of CBOs through their Community Care Hub for HRSN resolution. This new collaborative partnership will share pilot funding from at least one of their respective managed care organizations in the region. These partnerships directly align with UTHealth's goal to expand financing efforts to CBOs and organizations that work to resolve HRSNs.

To learn more about strategies to address HRSNs and impacts from the AHC Model, check out the resources and reports on the Centers for Medicare & Medicaid Services Innovation Center's AHC Model webpage.

Awardees are diversifying funding sources and contributing to the development of alternative and value-based payment models by:

- Pursuing financial support for screening, referral, and navigation efforts through a variety of sources, including health systems and commercial payers, accountable care organizations, Medicaid managed care organizations, and Medicaid flexibilities such as section 1115 waivers. Read more about how Allina Health partnered with a payer to address HRSNs for patients and communities in a way that is operationally and financially sustainable
- Adopting alternative and value-based payment models, such as hospital quality incentive payments for sharing race, ethnicity, and language data; identifying disparities; and screening for HRSNs
- Directing strategic communications to leaders and external audiences, such as payers or grantors, to pursue continued funding for HRSN screening and relevant internal staff positions

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