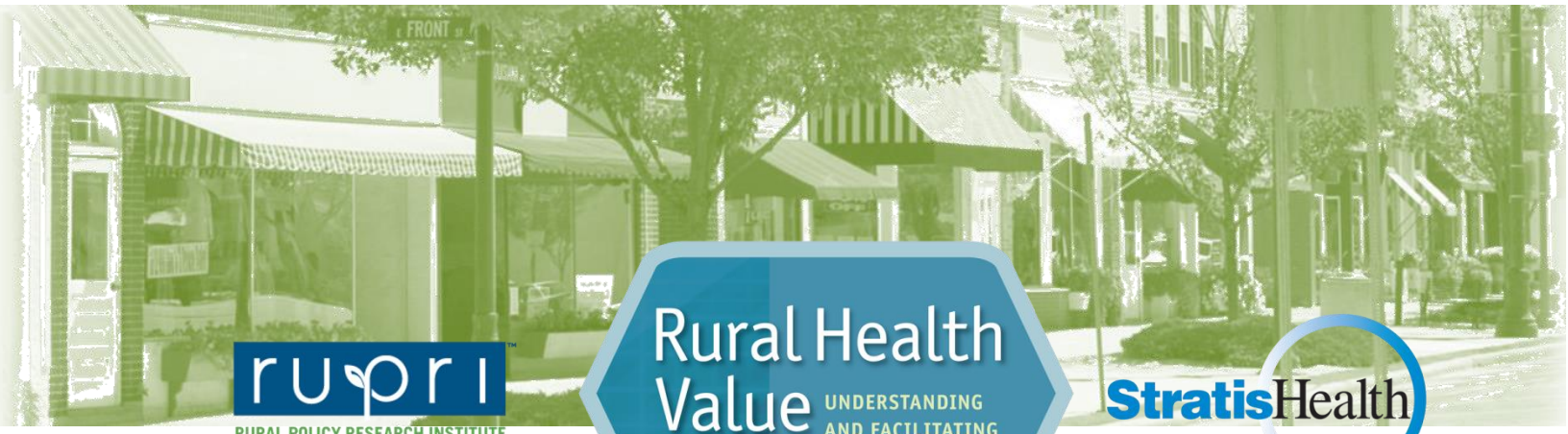

Rural Innovation Profile

Accountable Health Communities Model – Two Rural Participants' Experiences

What: Participants in the Accountable Health Communities (AHC) Model identify and address health-related social needs of Medicare, Medicaid, and dual-eligible beneficiaries.

Why: To reduce health care costs and utilization driven by social determinants of health.

Who: Twenty-nine health systems across the country are participating in the Center for Medicare & Medicaid Innovation (CMMI) AHC Model. Some of the AHCs, including Ballad Health and Rocky Mountain Health Plan, serve largely rural populations.

How: AHC Model awardees screen, refer, and navigate Medicare and Medicaid beneficiaries to community-based organization partners who are able to meet their health-related social needs.

Key Points

- Since AHC Model initiation two years ago, Ballad Health and Rocky Mountain Health Plan have screened 77,000+ rural Medicare and Medicaid beneficiaries for unmet social needs.
- Service needs addressed by the two rural AHCs include housing instability or housing quality; utility needs; food insecurity; interpersonal violence (safety); and transportation needs beyond medical transportation.
- Awardees describe model implementation challenges that include technology issues related to AHC Model data management and a CMMI model based on expectations for urban volume targets and implementation timelines.

ACCOUNTABLE HEALTH COMMUNITIES MODEL

Decades of evidence support correlations between health status and socioeconomic circumstance. The correlation is especially strong for chronic health conditions, such as heart disease and cancer, which account for a large portion of illness in rural America. As illness prevalence and associated health care costs continue to grow, clinicians and policymakers have increasingly considered social determinants of health as important contributing factors to illness burden. One approach to address social determinants of health has been to integrate clinical health care services with community-based resources, with the expectation that doing so will improve health outcomes.

Efforts to identify and address the social determinants of health have been growing in parallel with efforts to improve clinical health care value and accountability. In 2017, CMMI launched the AHC Model with two track options: (1) Assistance Track – Provide community-service navigation services to help high-risk beneficiaries access services to address health-related social needs, or (2) Alignment Track – Encourage community partner alignment to ensure that community services are available and responsive to the needs of Medicare and Medicaid beneficiaries. CMMI originally awarded AHC Model funds to 32 health care organizations. In late 2019 when this project began, there were 30 AHC awardees. And as of September 22, 2020, there were 29 AHC awardees. To fulfill AHC Model requirements, AHCs

- identify and partner with clinical delivery sites (e.g., primary care clinics, behavioral health providers, and hospitals) to conduct systematic health-related social needs screenings of community-dwelling beneficiaries and make referrals to community services that may be able to address the identified health-related social needs,
- coordinate and connect high-risk community-dwelling beneficiaries to community service providers through community-service navigation, and
- align model partners to optimize community capacity to address health-related social needs.

Focusing on social determinants of health, AHC Models work to resolve patient issues related to housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety. AHCs raise beneficiary awareness of available services and then direct them to those services. Advocates for value-based care see the AHC Model as a critical step toward improving population health and slowing the growth of health care costs.

Most of the AHC awardees are in urban settings. Twenty of the 30 AHC awardees listed on the CMMI website in late 2019 served only urban counties, while six of the 30 AHC awardees served either mostly rural counties or served exclusively rural counties. This profile focuses on two rural awardees in exclusively rural counties. As a CMMI demonstration project, the AHC Model will be evaluated before it is expanded. Policymakers will benefit from analysis of rural and urban approaches to addressing social determinants of health. This profile documents the experience of AHC awardees Ballad Health and Rocky Mountain Health Plan that are predominately providing social-services navigation to rural Medicare and Medicaid beneficiaries, and highlights opportunities and challenges for future AHC Models in rural areas.

BALLAD HEALTH

Ballad Health is a large, integrated health care system serving 29 counties in Appalachia (northeast Tennessee, southwest Virginia, northwest North Carolina, and southeast Kentucky). A recent merger between Mountain States Health Alliance and Wellmont Health Systems created Ballad Health, resulting in synergies necessary to address regional population health.

Many people in Appalachia live in poverty and experience more frequent health concerns (e.g., opioid use, black lung disease, teen pregnancy, obesity, and advanced age) than does the general population. To formally address social determinants of health within the AHC Model, Ballad Health was funded through the CMMI-designated Assistance Track, which facilitates community-service navigation services to help high-risk beneficiaries access services to address health-related social needs. Ballad Health initially collaborated with five community service boards and the Virginia State Medicaid Agency, considering this an optimal way to increase population health improvement services.

Ballad Health signed memorandums of understanding with 50 clinical delivery sites, which all serve as direct care provider partners. All screening activities are conducted by Ballad Health. These 50 partners included 10 hospitals and 40 clinical practitioners. However, some practices have recently closed due to COVID-19. Under the AHC Model, 9.5 FTE staff are paid directly from the cooperative agreement, including one program manager, one screening and referral specialist, one data analyst, and one lead navigator managing six full-time navigators. The six full-time navigators are familiar with the communities they serve and often personally know the beneficiaries they assist. A shared experience of Appalachian living breaks down barriers related to pride and fear of sharing private information with outside providers. The navigators are considered experts in locating and utilizing local resources. They actively ensure the beneficiary is connected, and the need is (ideally) resolved.

With an annual budget of $500,000, all of which comes from the CMMI cooperative agreement, Ballad Health screens for unmet social needs and navigates rural beneficiaries to appropriate services. After nearly 18 months (November 17, 2018 – April 30, 2020), 49,416 screenings have been completed resulting in 4,902 beneficiaries eligible for navigation. Under the AHC Model, 70 percent of beneficiaries eligible for navigation will be in the treatment group. Ballad Health developed its own data system to manage screening results. Sixty-three percent of the navigated patients reported utilizing appropriate services (3,128 total). It is likely that even more services have been utilized as there is no patient reporting requirement for continued services.

Similar to a preferred-provider network, a preferred community resource network has been created by Ballad Health that currently consists of 12 organizations that have provided excellent service within the partnership. Half of these preferred community partners are faith-based organizations. Ballad Health has also established a patient assistance fund to provide limited financial support to beneficiaries in need. Process improvement has been embedded in the navigation delivery through a beneficiary satisfaction survey that evaluates navigator effectiveness.

ROCKY MOUNTAIN HEALTH PLAN

Rocky Mountain Health Plan is a wholly owned subsidiary of United Healthcare. As a Regional Accountable Entity for Colorado Medicaid, Rocky Mountain Health Plan aims to address the social determinants of health within their served population. Rocky Mountain Health Plan believes the AHC Model to be the best approach to support the health and well-being of their Medicaid members.

Rocky Mountain Health Plan has partnered with over 70 small clinics and rural hospitals throughout its rural and frontier region. Rocky Mountain Health Plan staffs the AHC Model with two FTE staff employees and additional contracted partners. CMMI is the only funder for an average $900,000 annual budget to support the Alignment Track. The initial-year budget was higher than average due to technology and system development costs.

With the goal of universal screening, clinics and hospitals have screened 30,081 rural Medicaid and Medicare beneficiaries since October 2018, resulting in 12.4 percent eligible for care coordination services (3,730 beneficiaries). Rocky Mountain Health Plan has implemented a process to create personal action plans for each beneficiary receiving care coordination. These coordination services have primarily focused on accessing affordable and healthy food and appropriate housing.

Rocky Mountain Health Plan has employed an innovative analytics system that provides clinical site, regional and region-wide data on population needs on a monthly basis. The resulting data have demonstrated correlations between certain social needs and follow-up service utilization, suggesting a need to shift priorities within a hierarchy of unmet rural member needs. Furthermore, data tracking has identified social service resource gaps, and prioritized those gaps for action.

OBSTACLES ENCOUNTERED

Ballad Health and Rocky Mountain Health Plan each utilize different modalities (paper, computer, tablet) concurrently to complete initial beneficiary screenings. These data-entry variations risk data-entry error and user accessibility challenges. This issue was especially pronounced in Ballad Health, which created a screening system at 50 clinical sites concurrently. In hindsight, Ballad Health suggests implementing screening in phases.

Ballad Health decided to create its own data system instead of using the Centers for Medicare & Medicaid Services data system. While doing so created an added investment for Ballad Health, they report that their data system delivers increased speed and flexibility.

The AHC Model employs volume-based performance targets which are challenging in sparsely populated rural areas. Rocky Mountain Health Plan participation in the AHC Model has highlighted the unique challenges of rural AHCs related to the barriers of scale, investment requirements, and appropriate metrics for developing rural and frontier models. For example, Rocky Mountain Health Plan has been implementing screening at many geographically dispersed clinic and rural hospital screening sites for its AHC, based on the patient population and sites of care delivery in its rural service area. The task of

developing many screening sites with low beneficiary volumes at each site is much more difficult and time-consuming than hiring and training one screener at one site with a high volume of beneficiaries. Rocky Mountain Health Plan reports that as a result, they have not reached the targeted number of screenings established by CMMI for the AHC Model. Rocky Mountain Health Plan welcomes the opportunity to work with CMMI to learn from the rural experience and modify the model design and targeted numbers to more realistically reflect rural care delivery so that beneficiaries are well served, and innovation is supported in rural areas.

The AHC Model focuses care coordination on patients with two or more Emergency Department (ED) visits. But in rural areas with distant EDs, ED use is not a good predictor of high acuity. Thus, Rocky Mountain Health Plan reported far fewer patients eligible for navigation than what has been reported nationally.

FUTURE DIRECTION

The AHC Model shows promise connecting Medicare and Medicaid beneficiaries to social resources. The rural experiences of these two early adopters can help design future systems to address social determinants of health. Both Ballad Health and Rocky Mountain Health Plan acknowledged support from upper management and consistent engagement across provider partnerships. Interviewees reported that leadership commitment to the AHC Models has resulted in cultural shifts toward engaging patients in optimal health and directing efforts to address social determinants of health.

Ballad Health and Rocky Mountain Health Plan are two CMMI-funded AHC Models that serve predominantly rural beneficiaries. In less than two years, the two AHCs have screened nearly 80,000 rural Medicare and Medicaid beneficiaries for social needs, and directed many to community-based resources. Technological challenges and rural realities (such as low beneficiary volumes, geographically dispersed populations, and under-resourced rural providers) may have limited AHC applicability and uptake. The AHC Model will continue through April 2022, so final AHC Model outcomes are yet to be determined. But identifying individuals in need of social services and connecting them to community-based resources appears to be a positive step toward improved rural population health.

More information about the ACH Model is available here: https://innovation.cms.gov/innovation-models/ahcm

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