



# The Denver Regional Accountable Health Community

Welcome to the  
consortium!

*Presented by:*

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# The Denver Regional Accountable Health Community

- \$4.51 million over 5 years
- DRCOG is the “Bridge Organization”

## Designed to:

- lower costs for Medicare and Medicaid
- Improve patient outcomes
- Streamline the referral of patients to community organizations

The data that we will gather will prove that community-based organizations like the AAA save tax payer money and improve the well-being of the communities we serve.



# Goals of the AHC

## **Primary:**

To integrate and align the screening and referral of Medicare and Medicaid beneficiaries from clinical care to community care.

## **Secondary:**

Reduce total health care costs and improve outcomes for community-dwelling beneficiaries by addressing unmet health-related social needs by April 30, 2022.





# The consortium

## Community health providers

- Visiting Nurse Association
- Seniors' Resource Center
- Brothers Redevelopment
- Volunteers of America
- Colorado Coalition Against Domestic Violence
- Energy Outreach Colorado
- Jewish Family Services
- Denver Housing Authority
- City and County of Denver Adult Protective Services

## Clinical health partners

- Centura Health
- Metro Community Provider Network
- Denver Health

## Behavioral health partners

- Excelsior Youth Center
- Aurora Mental Health Center
- Jefferson Center for Mental Health



# Core health-related social needs

- Housing instability and quality
- Food insecurity
- Utility needs
- Interpersonal violence  
(elder abuse, child abuse, domestic violence)
- Transportation needs



# Schedule and core functions

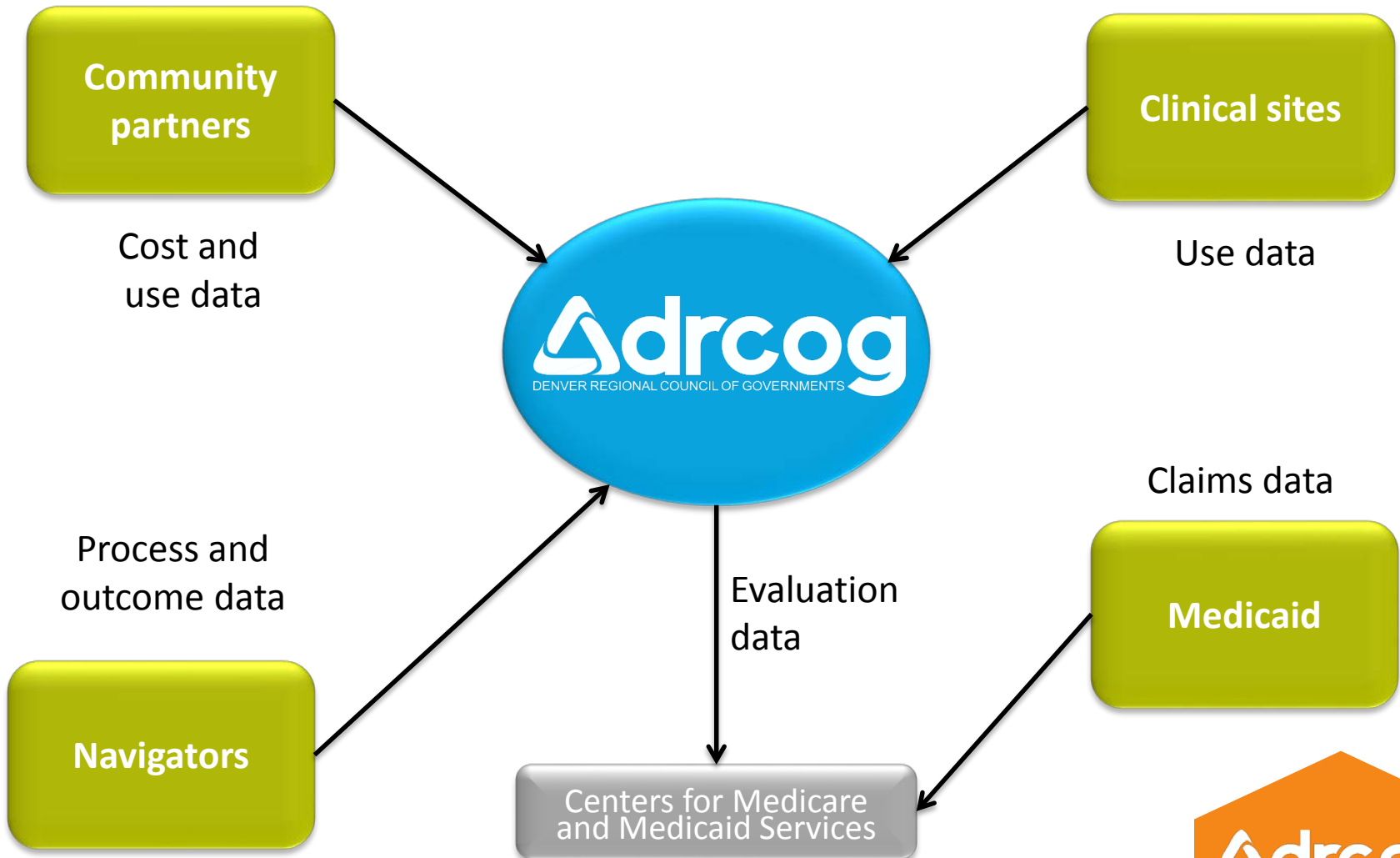
**Year one:** Start-up activities

**Years two through five:**

- Screen 75,000 people for health-related social needs in a clinical setting each year.
- Provide navigation services to 3,000 people each year
- Track data and provide reports
- Develop a care plan for each enrollee
- Make referrals to community services consistent with care plans
- Deliver community services
- Conduct an annual gap analysis of community needs and resources
- Create and update a resource directory
- Implement a quality improvement plan



# Data flow





# Our plan for change

## Aim

Reduce total health care costs and use (inpatient and outpatient) for community-dwelling beneficiaries by addressing unmet health-related social needs by March 31, 2022.

## Primary drivers

Universal screening and referral for health-related social needs

Capacity building in clinical navigation programs

Community service provider alignment for quality improvement

Data sharing/monitoring and governance infrastructure

Leadership/stakeholder engagement

## Secondary drivers

Provide reporting and project management support to integration of social needs screening in clinical settings

Converge clinical delivery sites to plan for implementation and avoid duplication or burdening clinical staff

Assemble community resource directories to construct a central inventory and generate referral summaries

Assess training needs of clinic-based navigator workforce and provide training on community-based resources

Establish collaborative learning system across clinic-based and community-based navigation programs

Develop, pilot and implement a risk-assessment tool to identify beneficiaries needing community-based navigation

Facilitate transparent gap analysis with advisory board

Further develop and partner with other quality improvement activities

Facilitate and monitor rapid-cycle improvement projects to increase service availability

Provide navigation programs with feedback from community service providers on beneficiary outcomes

Provide clinical providers with information on status of beneficiaries' health-related social needs via electronic health record

Develop scorecards with advisory board to establish transparency and address issues in screening and navigation

Designate clinical champions at each clinical delivery site and establish process for feedback to the advisory board

Recruit community-dwelling beneficiaries to serve on advisory board; highlight their perspectives at every meeting



THANK YOU!

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