Presented by:
AJ Diamontopoulos
May 17, 2017

The Denver Regional Accountable Health Community
Welcome to the consortium!
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.
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

- Community partners
  - Cost and use data
- Clinical sites
  - Use data
- Medicaid
  - Claims data
- Process and outcome data
- Navigators
  - Evaluation data
- Centers for Medicare and Medicaid Services
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

1. Universal screening and referral for health-related social needs
2. Capacity building in clinical navigation programs
3. Community service provider alignment for quality improvement
4. Data sharing/monitoring and governance infrastructure
5. 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!

AJ Diamontopoulos
Area Agency on Aging
ajdiamontopoulos@drcog.org
303-480-6735