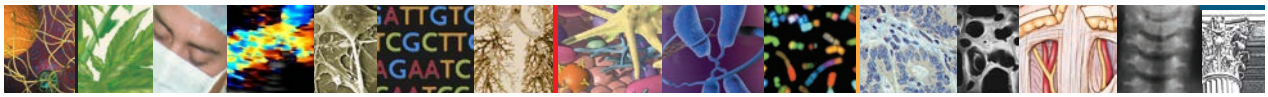

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Perspective

Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid

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For decades, experts have described a profound imbalance between public funding of acute medical care and investments in upstream social and environmental determinants of health.[1] By some estimates, more than 95% of the trillion dollars spent on health care in the United States each year funds direct medical services, even though 60% of preventable deaths are rooted in modifiable behaviors and exposures that occur in the community.[1]

Most clinicians are familiar with the stories behind these statistics: the child with asthma whose substandard housing triggers repeated emergency department visits; the patient with repeated visits for severe abdominal pain caused by her violent home life; the older adult with diabetes forced to choose between paying for heat and buying groceries. But in our current system, patients' health-related social needs frequently remain undetected and unaddressed. Despite calls for obtaining an expanded social history at the point of care,[2] most health care systems lack the infrastructure and incentives to develop comprehensive, systematic screening-and-referral protocols and relationships with the array of community service providers that would be required to address their patients' health-related social needs.

If the rate of preventable hospitalizations among residents of low-income neighborhoods could be reduced to the level among residents of high-income neighborhoods, there would be 500,000 fewer hospitalizations per year.[3] As health systems are increasingly being held accountable for health outcomes and reducing the cost of care, they need tools and interventions that address patient and community factors contributing to excess utilization. Effective partnerships among medical care, social services, public health, and community-based organizations could improve population health outcomes, but developing sustainable payment models to support such partnerships has proved challenging.[4]

Some encouraging innovations

have emerged. Catalyzed in part by statewide all-payer delivery-system reform and the growth of value-based or shared-risk payment models, some purchasers and providers of medical care have found innovative ways to support high-value community-focused interventions. For example, Hennepin Health, a county-based Medicaid managed-care organization in Minnesota, has reduced emergency department visits by 9% by using housing and community service specialists who are part of a tightly integrated medical and social service system. Tracking patients' service utilization across clinical and human-service systems allows Hennepin to target upstream interventions so that its patient care can be more effective (as documented in composite quality metrics of asthma, diabetes, and vascular care); the organization has improved patients' access to social services and reinvested savings in a broad range of programs.[5]

Other examples come from the Health Care Innovation Awards granted by the Centers for Medicare and Medicaid Services (CMS); these awards have supported organizations such Chicago-based CommunityRx, which generates prescriptions for community services through an interface linking the patient's electronic health record with a community-resource database, and the Michigan Public Health Institute Pathways to Better Health Community Hub model, in which community health workers perform a structured assessment of clients' health and social service needs and use standardized "pathways" to link beneficiaries to community resources and track outcomes.

These projects have generated valuable insights regarding addressing the social determinants of health, including the importance of establishing cross-sector partnerships, building data systems that bridge health and community services, and developing a workforce to deliver interventions to vulnerable populations. We still lack expertise, however, in the best ways of scaling these approaches across myriad settings; we remain unsure whether broad-based investments improve health care utilization and costs; and we need to develop and test a template that allows a wide variety of communities to undertake transformation efforts.

To accelerate the development of a scalable delivery model for addressing upstream determinants of health for Medicare and Medicaid beneficiaries, CMS recently announced a 5-year, $157 million program to test a model called Accountable Health Communities (AHC). Funded under the auspices of the CMS Innovation Center, the test will assess whether systematically identifying and addressing health-related social needs can reduce health care costs and utilization among community-dwelling Medicare and Medicaid beneficiaries.

The foundation of the AHC model is universal, comprehensive screening for health-related social needs — including but not limited to housing needs (e.g., homelessness, poor housing quality, inability to pay mortgage or rent), food insecurity, utility needs (e.g., difficulty paying utility bills), interpersonal safety (e.g., problems of intimate-partner violence, elder abuse, child maltreatment), and transportation difficulties — in all Medicare and Medicaid beneficiaries who obtain health care at participating clinical sites. Using the data gathered through this systematic screening — which form a social-needs diagnostic snapshot of patients and their community — the AHC model aims to address these underlying health-related social needs through three tiers of approaches, with each tier linked to a payment method (see table).

The model's design recognizes that communities' needs and capacity vary widely, necessitating a flexible, tracked approach keyed to various levels of readiness for change. The tracks — which we have named "Awareness," "Assistance," and "Alignment" — were developed on the basis of growing evidence that linking high-cost beneficiaries to social services can improve health outcomes and reduce costs. Prospective participants in the test, termed "bridge organizations," can be community organizations, local health departments, managed-care organizations, clinical networks, or other organizations that can demonstrate that they have strong relationships with clinical and community partners.

The AHC model is the first Innovation Center model designed specifically to test building community capacity to address the needs of a geographically defined population of beneficiaries. Our test will involve robust evaluation methods (including randomization at the beneficiary level and matched comparisons at the community level, which are exempt from human-subjects review under the Common Rule), is powered to detect cost savings associated with each track, and will have a qualitative-evaluation component.

To be successful, the AHC model will have to overcome several challenges that have plagued earlier efforts to build and evalu-

Key Features of the Accountable Health Community 5-Year Payment-Model Test.*

Variable	Track 1: Awareness	Track 2: Assistance	Track 3: Alignment
Intervention	Screening and referral only	Screening, referral, plus community service navigation	Screening, referral, community service navigation, plus partner alignment
Question being tested	Will increasing awareness of community service availability through information dissemination and referral reduce total cost of care, ED visits, and admissions?	Will providing community service navigation to assist beneficiaries with overcoming barriers to access to services reduce total cost of care, ED visits, and admissions?	Will a combination of community service navigation (at the individual beneficiary level) and partner alignment at the community level reduce total cost of care, ED visits, and admissions?
Required partners	State Medicaid agency; clinical delivery sites; community service providers	State Medicaid agency; clinical delivery sites; community service providers	State Medicaid agency; clinical delivery sites; community service providers; local government; local payers (MA Plans and Medicaid MCOs)
Intervention components	Inventory of local community services Universal screening of all Medicare and Medicaid beneficiaries by medical provider Referral to community services with beneficiary responsible for completing referral	All in Track 1 plus intensive community service navigation (in-depth assessment and follow-up until needs are resolved or unresolvable)	All in Track 2 plus backbone organization focused on community-wide continuous quality-improvement approach, including an advisory board that ensures service provision, adequate capacity to meet needs, and data sharing to inform a gap analysis
Payment to bridge organization (applicant)	Startup funds ($250,000) Payments for screening and referral of Medicare and Medicaid beneficiaries at participating clinical delivery sites ($2 per person per year)	Startup funds ($750,000) Same payments for screening and referral as in Track 1 Payments for each high-risk beneficiary who elects to receive community service navigation services ($86 per person per year)	Same startup funds, payments for screening, referral, navigation as in Track 2 Annual lump-sum payments to support backbone organization ($350,000 per year)
Evaluation strategy	Randomization at the beneficiary level	Randomization at the beneficiary level	Matched comparison group and matched comparison communities
No. of award sites	12	12	20
Total funds per awardee	$1 million	$2.57 million	$4.51 million

* Tracks are mutually exclusive; communities will be selected to participate in a single track. ED denotes emergency department, MA Medicare Advantage, and MCO managed-care organization.

ate clinical–community collaborations. First, major gaps exist in the evidence base needed to inform the selection of screening items and the collection of data for detecting health-related social needs, as highlighted by a recent report from the Institute of Medicine.[2] AHC sites will be required to select items from a question bank prepared by CMS in consultation with experts after extensive review of existing screening items; however, ensuring that these questions are reliable for various delivery modes and patient populations will be a key challenge. Maintaining a motivated and skilled stable of community navigators will also be challenging.

Second, community needs and the quality of resources vary significantly, resulting in a challenging degree of complexity for a national test. That's why the AHC project includes three incremental levels of integration of care delivery, which can be deployed in multiple settings. The model permits flexibility in each track and incorporates extensive local support and technical assistance to help sites integrate interventions into their workflows. For example, in addition to the standard list of social needs that all participants will try to address, bridge organizations can, on the basis of community needs assessment, select additional needs to target. Sites can also choose how an intervention is delivered — by mobile device, in person at clinical sites, or through home visits — depending on the setting (for instance, whether it is rural or urban). In the advanced track ("Alignment"), CMS will fund a "backbone" organization that will facilitate data collection and sharing among all partners and try to enhance ser-

vice capacity, testing the scalability and effectiveness of this backbone structure.

The AHC model reflects a growing emphasis on population health in CMS payment policy, which aims to support a transition from a health care delivery system to a true health system. The AHC test will improve our understanding of whether savings can materialize when upstream factors are addressed through collaboration among stakeholders who are accountable for the health and health care of their community.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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