Accountable Health Communities Model
Fact Sheet: First 750,000 Completed Screenings

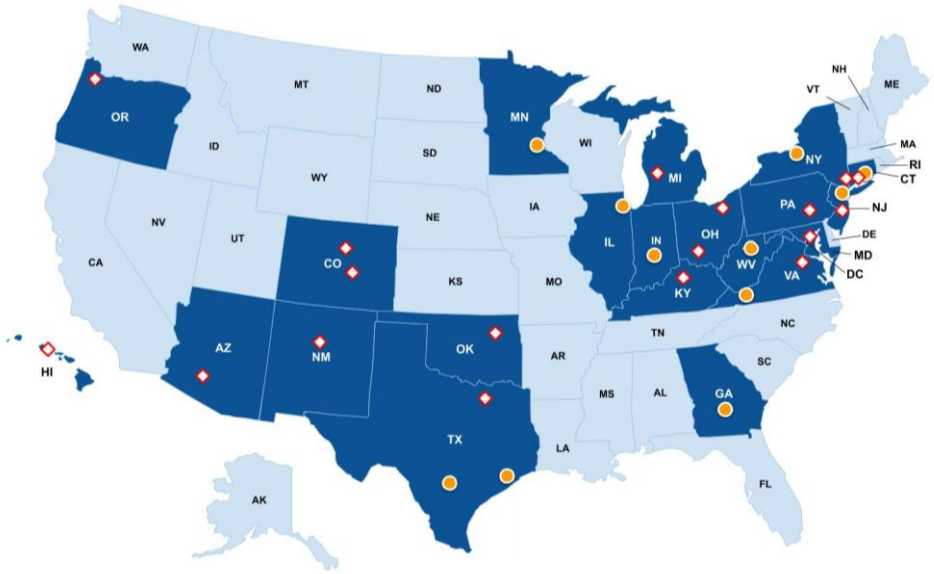
Addressing a Critical Gap

The **Accountable Health Communities (AHC) Model** addresses a critical gap between clinical care and community services in the health care delivery system by testing whether systematically identifying and addressing health-related social needs (HRSN) of eligible Medicare and Medicaid beneficiaries through **screening for HRSN, referral to community resources, and community navigation services** will impact health care costs and reduce health care utilization.

AHC Model Implementation Locations

The AHC Model serves beneficiaries in 21 states:

- Arizona, Colorado, Connecticut, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Texas, Virginia, and West Virginia.



Assistance Track Bridge Organization **Alignment Track Bridge Organization**

Supporting Beneficiaries & Communities

Over a five-year period, the AHC Model supports **community bridge organizations** to test promising service delivery approaches to connect beneficiaries who report HRSNs with community services that may address the needs. **Assistance Track** bridge organizations provide navigation services to high-risk beneficiaries. **Alignment Track** bridge organizations provide navigation services and encourage partner alignment to ensure community services are available and responsive to beneficiaries.

Figures are based on programmatic monitoring data from the Accountable Health Communities (AHC) Model. This report is independent from the official AHC Model evaluation and is for informational purposes only. For more information visit: **https://innovation.cms.gov/initiatives/ahcm**

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Screening for Health-Related Social Needs (HRSNs)

AHC bridge organizations use the **AHC Health-Related Social Needs Screening Tool** to identify whether beneficiaries have one or more of the following core HRSNs: 1) housing instability or housing quality; 2) utility needs; 3) food insecurity; 4) interpersonal violence (safety); and/or 5) transportation needs beyond medical transportation. All beneficiaries who report one or more needs are offered referrals to community services.

Of the first **750,000** completed screenings:

63% were Medicaid beneficiaries*

37% were Medicare beneficiaries*

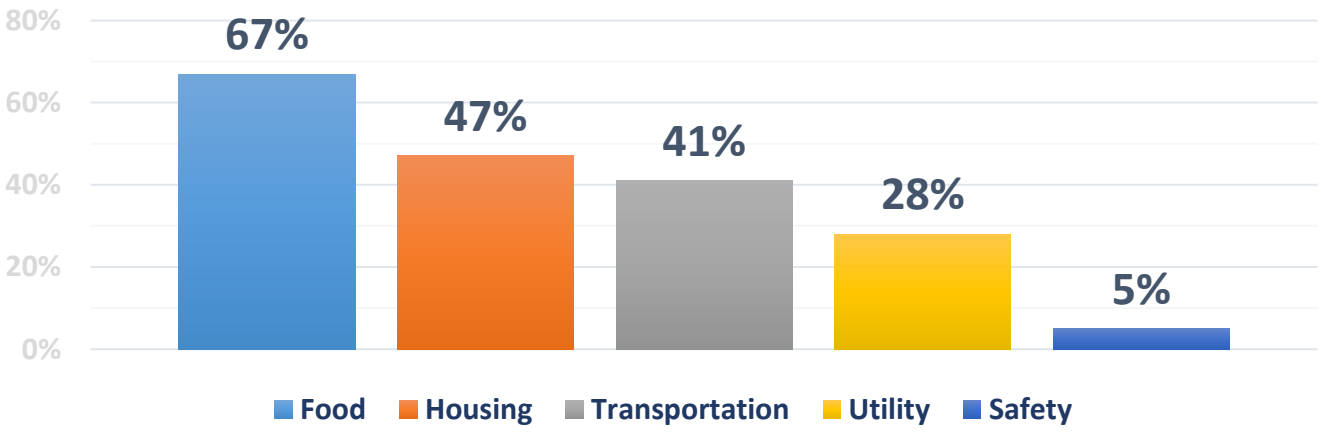
67% reported no core HRSNs

33% reported at least one core HRSN

**Includes dual-eligible beneficiaries*

Percent of Beneficiaries who Reported Each Core Health-Related Social Need

Of all beneficiaries who completed a screening and reported at least one core HRSN (**33%** of all completed screenings), food was the most common need identified, followed by housing, transportation, utility, and safety needs. For example, 67% of beneficiaries who reported at least one core HRSN reported a food need.



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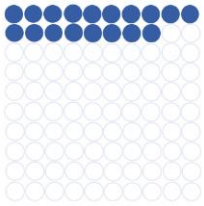
Community Navigation Services

AHC bridge organizations offer community navigation services to beneficiaries who have one or more HRSNs and two or more emergency department visits in the last year. Community navigation services aim to connect beneficiaries to community services to resolve HRSNs identified by the AHC HRSN Screening Tool. AHC community service navigation includes an in-depth **beneficiary interview** conducted by an AHC navigator followed by the creation of an **individualized action** plan for the beneficiary to resolve the reported needs.

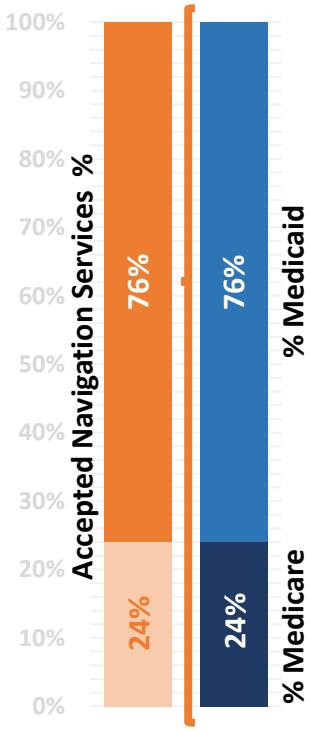
Eligibility

Of the first 750,000 completed screenings*, an average of **18% across all bridge organizations were eligible** for community navigation services.



**Includes beneficiaries who completed a screening more than once.*

Accepting Navigation Services



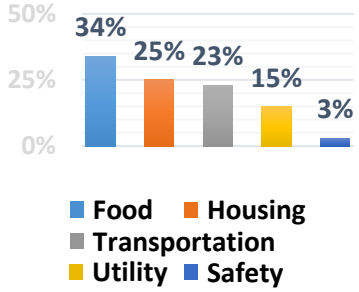
Out of all beneficiaries eligible for navigation services across all bridge organizations, an average of **76% of beneficiaries accepted** the navigation assistance.

Of those beneficiaries who accepted navigation assistance, **76% were Medicaid** recipients, and **24% were Medicare** recipients.

Navigation Needs

Once a beneficiary accepts assistance, the navigator opens a navigation case for the beneficiary. The navigator then works with the beneficiary to address identified HRSNs.

Percent of navigation cases addressing each core Health-Related Social Need



Resolving Health-Related Social Needs

AHC navigators follow up with beneficiaries receiving navigation services until the beneficiary reports their needs are resolved or one or more of their health-related social needs is documented as unresolvable. In order to fully address the complex needs of beneficiaries, they are eligible to receive navigation services for 365 days.

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