Accountable Health Communities
Evaluation of Performance Years 1–3 (2017–2020)

MODEL OVERVIEW

The Accountable Health Communities (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by addressing health-related social needs (HRSNs). The model has two tracks:

- **Assistance Track:** Screens beneficiaries for core HRSNs and provides navigation to eligible beneficiaries, connecting them to needed community services
- **Alignment Track:** Offers screening and navigation COMBINED WITH engagement with key stakeholders in continuous quality improvement to align community resources with the community's HRSNs

The AHC Model focuses on five core HRSNs:

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Housing instability

Food insecurity

Transportation problems

Utility difficulties

Interpersonal violence

PARTICIPANTS

- 29 entities known as bridge organizations serving communities across the United States implement the AHC Model in collaboration with clinical delivery sites, community service providers, state Medicaid agencies, and other stakeholders.

- Bridge organizations are required to screen all community-dwelling Medicare and Medicaid beneficiaries. Beneficiaries who report at least one core HRSN and at least two emergency department (ED) visits in the 12 months before screening are eligible for navigation services.
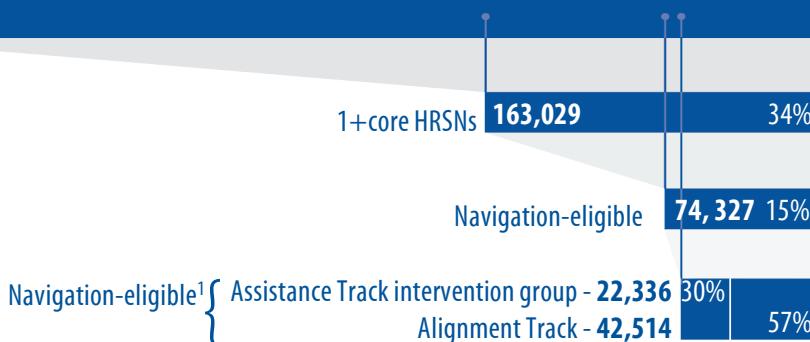
FINDINGS

Bridge organizations screened many beneficiaries to identify the navigation-eligible population.

About 15% of the nearly half million screened beneficiaries were navigation eligible.

Navigation Eligibility of Screened Beneficiaries

AHC-screened — 482,967

1+core HRSNs — 163,029 — 34%

Navigation-eligible — 74,327 — 15%

Navigation-eligible[1] {
Assistance Track intervention group - **22,336** — 30%
Alignment Track - **42,514** — 57%
}

[1] The percentages represent the share of navigation-eligible beneficiaries in each track. Excludes 9,477 Assistance Track beneficiaries with one or more core HRSNs and two or more ED visits who were assigned to the control group (n=9,068) or had no group assignment (n=409). Navigation-eligible beneficiaries are community-dwelling beneficiaries with one or more core HRSNs and two or more ED visits in the 12 months before screening.

Most navigation-eligible beneficiaries were screened in hospitals, which have high volumes of nonrepeat patients who can complete the screening while they wait for care.

Screening and navigation processes and staffing varied across clinical settings to accommodate differences in existing infrastructure and workflows.

Medicare FFS beneficiaries in the Assistance Track intervention group had 9% fewer ED visits than those in the control group in the first year after screening. Results for the Alignment Track and Medicaid beneficiaries are not yet available.

## The AHC Model targets a vulnerable population.

Among Medicare fee-for-service (FFS) beneficiaries, the AHC eligibility criteria target a high-use, high-cost population. Compared to AHC-screened beneficiaries who had at least one need but did not have at least two self-reported ED visits in the past 12 months, navigation-eligible beneficiaries had more than three times as many ED visits and two times higher spending 3 years before screening.
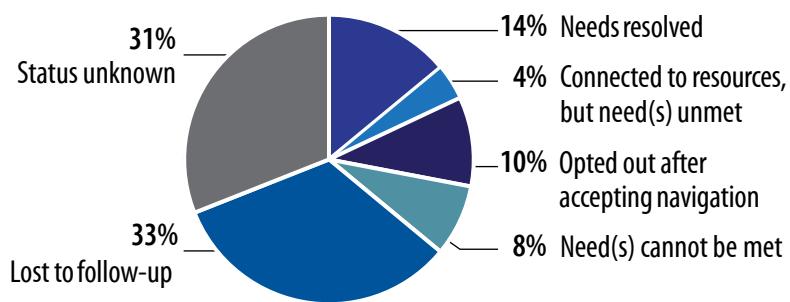
Navigation-eligible beneficiaries were disproportionately likely to be low income; racial and ethnic minorities; and, among Medicare beneficiaries, disabled.

Number of Core Needs Among Navigation-Eligible Beneficiaries

Core Needs	Percentage
1 need	41%
2 needs	29%
3 needs	20%
4 needs	9%
5 needs	1%
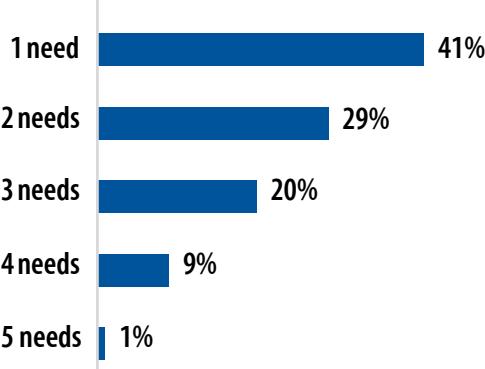
More than half of navigation-eligible beneficiaries reported more than one core need. Food insecurity was the most commonly reported need (median prevalence of 69% across bridge organizations).

HRSN Resolution Among AHC Beneficiaries with a Closed Navigation Case

- 31% Status unknown
- 33% Lost to follow-up
- 14% Needs resolved
- 4% Connected to resources, but need(s) unmet
- 10% Opted out after accepting navigation
- 8% Need(s) cannot be met

Fully 74% of eligible beneficiaries accepted navigation, but only 14% of those who completed a full year of navigation had any HRSNs documented as resolved. Factors contributing to low documented resolution rates include difficulties with data reporting, loss of contact with beneficiaries, difficulty managing large caseloads, a lack of transportation to needed services, and insufficient community resources.

KEY TAKEAWAYS

The AHC Model is effectively identifying higher cost and utilization beneficiaries, and these beneficiaries are accepting navigation at higher rates than anticipated. However, evidence of navigation effectiveness in resolving HRSNs was low during early stages of implementation. Early results show a 9% reduction in ED visits among Medicare FFS beneficiary enrollees, but no Medicare savings or impacts on other outcomes in the first year. Future reports will include impacts on Medicaid beneficiaries, who comprise almost three-quarters of model enrollees.