



MODEL INSIGHTS

Partnering for Impact: Early Insights from the Accountable Health Communities Model

Overview

On November 12 and 13, 2019, the Centers for Medicare & Medicaid Services (CMS) held its second annual Accountable Health Communities (AHC) Meeting in Baltimore, Maryland. The 2019 AHC Meeting “Partnering for Impact” provided a forum for AHC Model bridge organizations to meet in person to network and discuss challenges and strategies on sustainability, quality improvement, and addressing the health-related social needs (HRSNs) of Medicare and Medicaid beneficiaries. Attendees included representatives of the 29 bridge organizations, CMS staff, federal partners, and CMS contractors. This meeting included a keynote address, panel presentations, and structured and unstructured networking opportunities to facilitate peer-to-peer learning. This summary includes highlights from each session.

CMS held its second annual AHC meeting to provide AHC Model bridge organizations with an opportunity to network and discuss challenges and strategies to address HRSNs.

Day 1 Session Summaries

Keynote Address

Speaker: Alex Billioux, M.D., D.Phil.
(Louisiana Department of Health, Office of Public Health)



Alex Billioux (Louisiana Department of Health, Office of Public Health) delivers the Keynote Address.

In this session, Dr. Billioux discussed the AHC Model’s role in signaling the importance of addressing HRSNs. He described other programs around the country that studied or piloted programs similar to the AHC Model, including a program he oversees at the Louisiana Department of Health. Finally, he explained that the AHC Model will provide stakeholders with important data about how to best address HRSNs in different communities.

- Dr. Billioux noted several key points about the importance of the AHC Model:
 - › **Connecting beneficiaries to social services changes lives.** Dr. Billioux recounted a story about a beneficiary who received social services from a program in Louisiana. This beneficiary was a single, uninsured mother who had terminal breast cancer. The program staff helped enroll the family in Medicaid and connected her children’s guardians with social services.

- › **Sometimes the biggest issue that beneficiaries face is a lack of access to social services.** Systems of care, such as health systems and accountable care organizations, should define “health” broadly and ensure appropriate referrals to services that address social determinants of health.
 - › **Payers, policymakers, and health care providers are becoming aware of the importance of addressing HRSNs.** These stakeholders need examples of how to address social needs in their own communities. Some early, small-scale programs had limited success; stakeholders are now thinking more critically about how to approach this issue.
 - › **As the first large-scale program to test the impact of addressing HRSNs, the AHC Model is poised to guide the nation in doing this work.** The diversity of beneficiaries and communities served by bridge organizations, as well as the data generated by the AHC Model, will be essential in helping communities address HRSNs in the future.
- Dr. Billioux ended his presentation by encouraging attendees to think about sustainability, learn from their fellow attendees at the 2019 AHC Meeting, and take lessons home to their bridge organizations.

AHC Idea Marketplace: Buy or Sell Your Best Practices

Facilitators: Jeffrey Forman (Mathematica) and Dana Jean-Baptiste, M.P.H. (Mathematica)

During this facilitated networking session, bridge organization attendees self-selected four topic areas: (1) improving frontline staff buy-in, (2) designing intern and volunteer staffing models, (3) strengthening community service provider (CSP) partnerships, and (4) serving rural communities. The Idea Marketplace activity provided attendees an interactive way to “buy” and “sell” strategies to address common challenges. At the end of the activity, the two attendees with the best-selling ideas for each topic presented them to the larger group.

- Key strategies selected for each topic included the following:



Bridge organization attendees network and share strategies in the “AHC Idea Marketplace: Buy or Sell Your Best Practices” session.



Bridge organization attendees network and share strategies in the “AHC Idea Marketplace: Buy or Sell Your Best Practices” session.

› **Improving frontline staff buy-in**

- **Strategies:** (1) Providing staff with data on screening and navigation results so they can see the impact of their work; (2) providing frontline staff with a daily list of scheduled appointments for beneficiaries eligible for screening; (3) embedding screening and navigation staff in clinical delivery sites (CDSs), and integrating them as part of the care team; (4) providing index cards with information about the AHC Model for registration staff to reference when describing the screening; and (5) creating a friendly March madness-style competition to incentivize staff to increase screening and navigation rates.

› **Designing intern and volunteer staffing models**

- **Strategies:** (1) Partnering with local universities and community colleges by creating a memorandum of understanding; (2) having a screening and navigation staff member supervise students so the manager can focus on implementing the AHC Model; and (3) in academic health systems, establishing legal agreements with academic hospitals, allowing public health students to get practicum hours at any of the university hospitals and increasing student interest in volunteering for the AHC Model.

› **Strengthening CSP partnerships**

- **Strategies:** (1) Supporting CSPs financially by redirecting community benefit funds (where available) to them; (2) assisting CSPs in writing grants in exchange for their partnership in the AHC Model; (3) easing data-sharing burden on CSPs by ensuring that they need to use only one tool to share data with multiple partners, and eliciting input from CSPs on their preferences for a data-sharing tool before building it.

› **Serving rural communities**

- **Strategies:** (1) Sharing performance metrics on the number of screenings with rural CDSs in a weekly email; (2) discussing challenges and strategies in engaging rural beneficiaries via phone calls with screening staff in rural CDSs; and (3) using pre-visit screening by phone from a central location to increase efficiency in reaching rural beneficiaries.

AHC Model Updates

Speakers: Louise Amburgey, C.G.M.S. (CMS); Bisma Sayed, Ph.D. (CMS); and Alek Shybut, M.P.H. (CMS)

This panel session provided attendees with updates on managing the AHC Model federal award, the AHC Model evaluation, and Model-wide progress to date.

- **Louise Amburgey, the Lead Grants Management Specialist from the Office of Acquisition and Grants Management (OAGM)**, provided an overview of the updated requirements for managing federal awards and working with subrecipients. She encouraged bridge organizations to review the updates to federal requirements, tips for managing subrecipients, and resources related to managing a federal award. For questions, bridge organizations can contact OAGM.
- **Bisma Sayed, Social Science Research Analyst and the AHC Evaluation Lead**, provided an overview of and the planned approach for addressing the following CMS evaluation goals: (1) what is the context? (2) what took place? (3) what were the impacts? and (4) how, why, and to whom? Bisma also shared updates about the evaluation team's upcoming data collection activities, including site visits, beneficiary and CSP surveys, and community service provider and advisory board member interviews.
- **Alek Shybut, Project Officer for the AHC Model**, provided an overview of bridge organizations' Model-to-date performance on screening and navigation milestones. In addition, he shared the frequency of each HRSN and preliminary data on resolution of needs. Alek announced that CMS will be rolling out a bridge organization-facing data report (similar to a dashboard) in early 2020 that will be updated regularly. This report will allow each bridge organization to review its progress in comparison to the overall AHC Model average and the Track-specific average. He also announced that CMS will continue to measure the navigation milestone based on the number of "unique beneficiaries navigated" for the remainder of this contract year. Beginning in Year 4, the navigation milestone will be measured by the number of completed action plans. On behalf of the CMS Model team, he thanked the bridge organizations for their efforts thus far.



Alek Shybut (CMS) presents during the "AHC Model Updates" session.

Engaging Beneficiaries with Unique Needs

Facilitators: Dana Jean-Baptiste, M.P.H. (Mathematica) and Sara Pittman, M.P.H. (Mathematica)

During this session, bridge organization attendees divided into six groups to discuss challenges and potential strategies for engaging (1) beneficiaries with behavioral health needs, (2) beneficiaries in rural areas, (3) non-English speaking beneficiaries, (4) LGBTQ+ beneficiaries, (5) elderly beneficiaries, and (6) beneficiaries with disabilities. Each group rotated to five of the six stations and reported out key takeaways to the larger group of attendees at the end of the session.

- Key challenges and strategies discussed by population included the following:
 - › **Beneficiaries with behavioral health needs**
 - **Challenge:** Concerns around data sharing and privacy due to beneficiaries not fully understanding the purpose of the screenings and how their information will be used.
 - **Strategies:** Providing electronic health record (EHR) access to screening and navigation staff and holding staff trainings on how to share data so as to coordinate care without violating the Health Insurance Portability and Accountability Act (HIPAA).
 - **Challenge:** Lack of trust
 - **Strategies:** Training staff on effective communication strategies to build trust, such as active listening and trauma-informed care; leveraging partnerships with peer supports, existing mental health providers, and other organizations to build rapport with this population; building trust through frequent contact and in-person navigation; and referring beneficiaries to multiservice organizations that can address multiple needs to minimize the number of entities beneficiaries encounter.
 - **Challenge:** Screening fatigue due to overscreening for comorbidities across multiple appointments.
 - **Strategies:** Combining AHC Model screening with other screenings.
 - › **Beneficiaries in rural areas**
 - **Challenges:** Beneficiaries may not be in proximity to a CDS or other community resources; this issue is greater for those who do not have access to transportation. Many beneficiaries do not have cell reception in their homes, use a post office box for mailing, or do not have access to reliable internet service.
 - **Strategies:** Setting up electronic hubs to provide virtual visits that can help improve the accessibility of CDSs and allow for greater communication with beneficiaries who do not have a means of transportation; engaging faith-based organizations that have existing programs in place, such as food pantries or programs that provide transportation; and leveraging partnerships with other organizations that provide delivery services (such as food) and can address transportation challenges.

- **Challenges:** Stigma associated with HRSNs, the need for education about the benefits of navigation, and beneficiaries' concerns about privacy.
- **Strategy:** Leveraging those providers who have established trust within the community to begin conversations regarding the role of navigators and the confidentiality of the information collected.

› **Non-English speaking beneficiaries**

- **Challenge:** The screening tool, community referral summaries, and other resources are not available in certain languages or dialects, and there is a lack of interpreters who can assist with translation needs. The beneficiary may also need assistance with reading the materials in their own language because of a lower literacy level.
- **Strategy:** Using three-way calls between the CSP, translator, and beneficiary to facilitate a warm handoff.
- **Challenge:** Fear and mistrust about how the government will use the information.
- **Strategies:** Offering legal services as an available resource; broadcasting relationships with trusted community partners to build trust with beneficiaries; and providing training for staff on issues related to working with mixed-status families, refugee communities, and undocumented status beneficiaries.

› **LGBTQ+ beneficiaries**

- **Challenge:** The HRSN screening tool question about gender reflects binary categories and gives no option for beneficiaries who identify as non-binary.
- **Strategies:** Using the section in EHRs that asks beneficiaries how they would like to be addressed and including beneficiaries' pronouns in their EHR so that staff throughout the workflow are aware of how to address them properly.

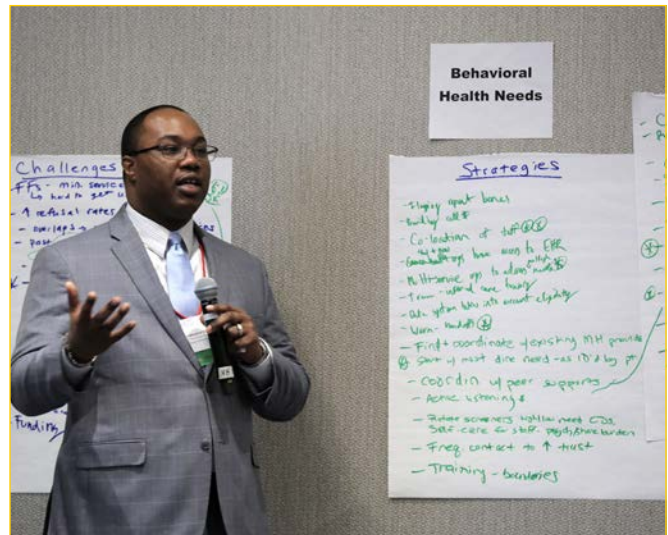
- **Challenge:** Lack of resources, especially for males who have experienced interpersonal violence.
- **Strategy:** Noting locations that serve the LGBTQ+ populations in the beneficiary's community resource summary.
- **Challenge:** Fostering a welcoming culture at CDSs.
- **Strategy:** Engaging leadership to promote a welcoming culture and align it with organizational values, because culture change is driven from the top down; signaling a LGBTQ+ friendly establishment through a sign, sticker, or flag indicating that LGBTQ+ individuals are welcome; providing training to staff on working with the LGBTQ+ population; and holding staff accountable for creating a safe space.

› **Elderly beneficiaries**

- **Challenge:** Stigma associated with admitting they have a need.
- **Strategies:** Leveraging clinicians who have a foundation of trust with the beneficiary and using beneficiary success stories to normalize screening efforts.
- **Challenge:** Fear of losing independence and concerns about privacy. These fears sometimes lead to elderly beneficiaries refusing resources because they are in denial that they need them or do not want to take them away from others.
- **Strategies:** Leveraging nurses, volunteers, retirees, and caregivers to facilitate screening and build relationships with the beneficiaries by using empathic inquiry and active listening. Organizations that specialize in working with elderly beneficiaries can be a valued partner in this work.
- **Challenge:** Varying literacy levels pertaining to reading, language, and technology.
- **Strategies:** Taking more time when working with this population because they are more likely to have visual, hearing, or cognitive impairments that make screening



Attendees discuss challenges and brainstorm strategies during the "Engaging Beneficiaries with Unique Needs" session.



Christopher Rogers (Hackensack University Medical Center) participates in the report-out during the "Engaging Beneficiaries with Unique Needs" session.

more difficult; using mobile screening that allows beneficiaries to use personal devices with which they are not only familiar but have settings configured to work with their needs; and communicating telephonically, which allows this population to pick up the phone, especially if they see a call from a local area code.

› **Beneficiaries with disabilities**

- **Challenge:** Staff having unconscious biases toward beneficiaries based on their physical appearance or ability when working.
- **Strategy:** Having monthly care conferences to serve as a space to discuss challenging cases and using the diversity and inclusion committee at bridge organizations or CDSs to conduct continuous training and increase awareness of how to work with various groups of beneficiaries.
- **Challenge:** Lack of accessible resources. For example, many housing buildings do not have elevators or may have other structural limitations, or there is a lack of handicap-accessible transportation to CSPs.
- **Strategy:** Partnering with local organizations that provide transportation or food delivery.

Day 2 Session Summaries

Transformation in Action: Addressing Health-Related Social Needs Through Enhanced Clinical-Community Linkages

Panelists: Glenn Landers, Sc.D., M.H.A., M.B.A. (Georgia Health Policy Center); Rachel Gold, Ph.D., M.P.H. (Kaiser Permanente and OCHIN); A. Seiji Hayashi, M.D., M.P.H., F.A.A.F.P. (Mary’s Center); and Lauren Taylor, M.Div., M.P.H. (Harvard University)

This panel discussion highlighted emerging evidence and best practices in fostering community partnerships between clinical providers, social service entities and other stakeholders to engage collaboratively in addressing HRSNs.

- **Dr. Rachel Gold** discussed emerging best practices related to implementing screenings for social determinants of health from her work at **OCHIN, Inc.**, a nonprofit health care innovation center that focuses on using health information technology to reduce health disparities. Best practices include maximizing existing technology to facilitate HRSN screening by integrating standard screening tools into EHRs, training staff and encouraging staff to use EHR capabilities to support HRSN screenings, and enlisting the support of organizations like OCHIN or practice facilitators to provide technical assistance and support for technological transformation.
- **Dr. A. Seiji Hayashi** shared his experience at **Mary’s Center**, a federally qualified health center (FQHC) in the Washington, D.C. area that emphasizes the Social Change Model. While



Dr. A Seiji Hayashi (Mary’s Center) and Lauren Taylor (Harvard University) participate in the “Transformation in Action: Addressing Health-Related Social Needs Through Enhanced Clinical-Community Linkages” panel.

Mary’s Center believes screening for social determinants is important, its core mission is to address social needs, so it focuses heavily on identifying solutions to address social determinants of health. Dr. Hayashi discussed how integrating HRSN screening in clinical settings requires an intentional transformation in organizational culture. As part of this intentional transformation, organizations must think about each step in the workflow including the different points of interaction with the beneficiary and who is involved in each interaction. He shared one example of this organizational transformation when Mary’s Center worked with the Department of Education in Washington, D.C. to establish a multi-generational charter school that offers career training courses and early childhood education, which now operates in three of Mary Center’s FQHC locations. In this example, Mary’s Center felt that expanding its scope to also operate a charter school was important, because it saw that education could improve the social and economic trajectory of the families.

- **Lauren Taylor’s** research at **Harvard University** focuses on how the health and social service sectors can come together with integrity. She noted the importance of recognizing that health and social service sectors have very different cultures, including the language used, professional dynamics, and expectations of partnerships. She shared best practices for brokering relationships, including establishing mutual trust, assuming good intent on both sides, bringing together point people in the organization who have some commonality (for example, both are lawyers), and mapping out referral processes so that all stakeholders understand their roles.

Addressing Service Gaps Identified in Quality Improvement (QI) Plans

Panelists: Deborah Kozick, M.P.H. (Center for Health Care Strategies); Kate Talbert, M.P.A., B.S.N., R.N. (Baltimore City Health Department); Holly Freishtat, M.S. (Baltimore City Department of Planning); Andrew Katz, M.S.W. (Camden Coalition of Healthcare Providers); Eva Lerner, M.S.W., M.P.A. (New York-Presbyterian); Dodi Meyer, M.D. (New York-Presbyterian); and Leigh Caswell, M.P.H. (Presbyterian Healthcare Services)

This panel session highlighted challenges and key successes in addressing gaps identified in QI plans. Panelists shared insights on how data can be useful to build partnerships and advocate for internal and external changes.¹ They also described how they collaborate with community stakeholders to assess the existing service landscape and align efforts, and their sustainability strategies for their work beyond the AHC Model.

- **Kate Talbert and Holly Freishtat** discussed how **Baltimore City Health Department (BCHD)** used its gap analysis to focus on operational gaps and identified food insecurity as one of the top priority areas. BCHD found little alignment across existing food resources and noted that many existing resources are funded by grants and are not sustainable. BCHD conducted interviews to identify opportunities to partner with other city departments and community organizations that address food insecurity, one of which was the Baltimore City Department of Planning. Together, BCHD and the Department of Planning address other state-level efforts, such as diabetes, ensuring adequate funding for food resources, and advocating for policies on food insecurity that address barriers and sustain efforts.¹ The bridge organization is also building a coalition and conducting research to identify policy levers to address food insecurity.
- **Andrew Katz** described the **Camden Coalition of Healthcare Providers'** barriers for addressing food insecurity as a lack of beneficiary and provider awareness of available resources and confusion over eligibility and the accessibility of existing resources. Through a journey-mapping exercise with providers, community advisory board members, and other stakeholders, the bridge organization identified strategies to address these barriers, including developing a food forecast newsletter to highlight available food resources and using and updating MyResource Pal, a Southern New Jersey local food bank application. The Camden Coalition of Healthcare Providers also found several structures and programs that exist to address housing needs. By mapping the stakeholders in the housing landscape, Andrew highlighted the complexity of the relationships of existing providers and leveraged this map as a way to determine the role of the bridge organization's Housing First Program within the network of existing organizations.
- **Eva Lerner and Dr. Dodi Meyer** shared **New York-Presbyterian Hospital's (NYP)** efforts to address food insecurity in northern Manhattan. By establishing a proof of concept through Plan-Do-Study-Act (PDSA) cycles, NYP tested



Holly Freishtat (Baltimore City Department of Planning) and Andrew Katz (Camden Coalition of Healthcare Providers) present at the "Addressing Service Gaps Identified in Quality Improvement Plans" session.



Bridge organization panelists share insights for addressing gaps identified in their QI plans and how they collaborate with community stakeholders to align efforts during the "Addressing Service Gaps Identified in Quality Improvement Plans" session.

several strategies to address food insecurity. For example, it established an emergency food resource at a local church, used hospital community benefit dollars to allow doctors to prescribe food so individuals with food insecurity needs could be referred to a nutritionist and receive money for food, and brought a Supplemental Nutrition Assistance Program enroller to the clinic. As an academic medical center, NYP carries out the research arm of its mission by researching the root causes of food insecurity and seeking to develop evidence-based solutions for the target populations. The bridge organization found the AHC Model helped the hospital identify a subset of high-risk beneficiaries and address their needs using light-touch interventions. NYP uses the AHC data to align and reinforce the need for existing efforts to address HRSNs.

- **Leigh Caswell** represented **Presbyterian Healthcare Services**, located in Albuquerque, New Mexico and surrounding counties, covering both urban and rural areas. Leigh discussed how Presbyterian Healthcare Services' gap analysis and QI plan

helped identify several existing coalitions in the community that addressed HRSNs and service gaps; however, no single organization owned a total vision, so the bridge organization is aligning organizations and developing a common vision among coalitions. The organization created a flexible emergency fund to help navigators address immediate needs and used data on safety and interpersonal violence as evidence to revisit policies for reporting interpersonal violence in health care settings. Presbyterian Healthcare Services found that one successful strategy for implementing the AHC Model was using the community health worker (CHW) model for navigation. This strategy aligns with state-wide initiatives for CHW certifications and managed care organization requirements for having CHWs.

- Resources referenced during this session include the following:
 - [Social Interventions Research & Evaluation Network \(SIREN\)](#)
 - Schleifer, David, Antonio Diep, and Kirk Grisham. “It’s About Trust: Low-Income Parents’ Perspectives on How Pediatricians Can Screen for Social Determinants of Health.” San Francisco, CA: Public Agenda, 2019. Available at <https://uhfnyc.org/publications/publication/its-about-trust-SDH/>.

Identifying Tests of Change for Continuous Quality Improvement

Speaker: Sara Bader, M.C.D., C.P.H.Q. (HealthBegins)

This facilitated networking session introduced attendees to the concept of small tests of change and challenged bridge organizations to identify tests they can implement at their organizations over the next three months to achieve a specific goal.

- Sara Bader began the session with an exercise, in which attendees tested several numerical patterns to identify the rule that makes the “2-4-6” sequence “work.” This exercise emphasized the effectiveness of rapid-cycle tests, demonstrating the importance of testing frequently and continuously to collect data to validate predictions or assumptions.
- Attendees created aim statements for the next 90 days, including specific details relevant to their bridge organizations. Attendees shared their aims, such as increasing conversion from being eligible for navigation to being navigated by 10 percent, increasing staffing by 20 percent, and increasing screening by 40 percent. Attendees also discussed common barriers to achieving their goals, including (1) low acceptance for screening, (2) beneficiaries not responding to phone calls or letters, (3) lack of trust, (4) lack of staff, and (5) no autonomy to increase the number of screeners at hospitals. Sara prompted attendees to use an Upstream QI Workflow Canvas worksheet to consider how existing roles and tools within their organizations’ workflow could be refined to address these barriers.

- This session concluded with an example of a small test of change. Sara walked through the steps to address a hypothetical organization’s barrier by (1) identifying who will conduct the test, (2) when and where the test will be conducted, (3) what is needed to conduct the test, and (4) determining how to know whether the test is successful. She encouraged bridge organization attendees to implement one test of change in the coming weeks to work toward a goal or aim related to the AHC Model.

Sustainability: Planning Beyond the AHC Model

Panelists: Dawn Alley, Ph.D. (U.S. Department of Health and Human Services); Michael Monson, M.P.P. (Centene Corporation); Alyia Gaskins, M.U.R.P., M.P.H. (Center for Community Investment); Amanda Van Vleet, M.P.H. (North Carolina Department of Health and Human Services); and Thomas Johnson, J.D. (Family Matters of Greater Washington)

In this panel session, representatives from the private and public sectors working to address the social determinants of health at local, state, and national levels provided insights on scaling and sustainability from their organizations’ experience, and provided sustainability strategies to consider for the AHC Model.

- **Dawn Alley** discussed the priorities of the **U.S. Department of Health and Human Services (HHS)** for addressing social determinants of health and how the department is building evidence and learning from bridge organizations and leaders on this panel about what works, how to scale, and how to spread their work. At the agency level, she noted that the CMS Administrator announced forthcoming guidance on how states can maximize opportunities to address social determinants of health and support value-based payment strategies in Medicaid, and the Administration for Community Living is building capacity in community organizations to partner with Medicare and Medicaid. She also discussed HHS’s efforts to coordinate data sharing among stakeholders to address HRSNs and added that the department looks forward to learning from the outcomes of the Model.
- **Thomas Johnson** discussed **Family Matters of Greater Washington’s** focus on accountable care and its partnership with behavioral health organizations. He also discussed funding challenges to sustain the organization’s operations and noted its strategies for sustainability by focusing on efficiencies in providing the most essential services and reducing the number of programs. He said that both public and private sectors can address unmet needs together and suggested that organizations need to set examples as collaborators and establish roles within health systems to sustain the partnership.
- **Alyia Gaskins** presented the **Center for Community Investment’s** strategy for addressing social needs by accelerating investments to transform and promote healthy communities. She used an example of working with a hospital system that leveraged its resources to invest in the community’s housing



Dawn Alley (U.S. Department of Health and Human Services), Thomas Johnson (Family Matters of Greater Washington), Alyia Gaskins (Center for Community Investment), Amanda Van Vleet (North Carolina Department of Health & Human Services), and Michael Monson (Centene Corporation) present at the “Sustainability: Planning Beyond the AHC Model” session.

needs and found partners with which to invest, resulting in the system and its partners developing a large housing unit for the community. Making the initial financial contribution and using data to show the need and how future investments would benefit the community can encourage stakeholders to invest and work together collectively to address community needs. She suggested that sustainability requires reimagining roles for organizations and their partners as investors.

- **Amanda Van Vleet** discussed the changes implemented in **North Carolina’s Medicaid program** when it transitioned to a managed care model focusing on whole-person care and addressing unmet social needs. The Medicaid program also has pilot programs, based on the AHC Model, that show evidence of improved health when investing in upstream unmet social needs. To address funding issues, North Carolina developed statewide social determinants of health initiatives by leveraging public and private partnerships to encourage payers to provide similar services; it is also developing a statewide resource and referral platform to track and close loops on referrals and encourage investment and social resources needs across payers. She suggested embedding pilot programs into existing managed care infrastructure while designing a Section 1115 waiver with the state, leveraging existing infrastructure, conducting rapid-cycle evaluations to assess the return on investment for what works, and investing in upstream unmet social needs.
- **Michael Monson** discussed **Centene’s** focus on local communities; it has 150 programs across states that relate to social determinants of health by assessing the determinants and forming partnerships. He suggested that issues related to funding are a collective action problem, and that there are market-based solutions to some social determinants of health. He recom-

mended creating a scaled model in a market by paying community organizations that have an aggregate of people and resources. For sustaining the AHC Model, he recommended starting with consumers to understand the problem, identify their cost challenges, and then invest for value. He recommended bridge organizations to think of themselves as businesses by assessing what they offer of value and then refocusing their assets and repositioning themselves to help solve problems.

Screening and Navigation Engagement: Considering the Beneficiary’s Perspective

Speakers: Sadena Thevarajah, J.D. (HealthBegins) and Rishi Manchanda, M.D., M.P.H. (HealthBegins)

This session introduced the use of a beneficiary journey mapping tool that focuses on the beneficiaries’ experience and used the lessons learned to help attendees examine and revise scripts for introducing screening and navigation.

- Sadena Thevarajah introduced beneficiary journey mapping, a process that examines the beneficiary’s emotional experience in a clinical workflow from pre- through post-visit. This tool is used to map out encounters between the beneficiary and clinical staff and make improvements by understanding the beneficiary’s emotional experience. Attendees worked together to map a beneficiary’s journey. During the debrief, they noted that this tool would be particularly useful for frontline staff who usually consider the beneficiaries’ experiences only from the CDS perspective. Attendees also noted that they could use this tool to tell a story about the beneficiary’s experience in a systematic way.
- Considering the beneficiary’s experience from the journey mapping exercise, attendees used the lessons learned to review and revise one of the seven types of screening and navigation



Bridge organization attendees participate in a group discussion during the final session, “Screening and Navigation Engagement: Considering the Beneficiary’s Perspective.”

scripts: (1) role-play scripts for training screening staff, (2) role-play scripts for training navigation staff, (3) screening scripts for rural communities, (4) navigation scripts for rural communities, (5) screening scripts to engage non-English speakers, (6) scripts to encourage eligible beneficiaries to opt in to navigation, and (7) scripts to recruit or engage volunteers and/or interns.

- During the debrief, attendees described the following strategies for scripting: (1) keeping the script conversational, (2) removing medical jargon that can alienate beneficiaries (one bridge organization provided a health literacy crosswalk for its clinical staff to find alternative language for medical jargon), and (3) improving scripts using a continuous QI approach. After the leadership team reviews the script, it can be tested in a role-playing exercise. Frontline staff can use their experiences to revise the script and incorporate beneficiaries’ perspectives,

ensuring the script meets beneficiaries’ needs. AHC project managers can confirm that the revised script is accurate and compliant with AHC Model requirements.

Closing Remarks

Speaker: Katherine Verlander, M.P.H. (CMS)

Katherine Verlander thanked attendees and described the AHC Model as the only active Innovation Center model addressing social determinants of health, with more than 800 CDSs nationwide. Thirty-five states now require screening for social needs and many stakeholders are turning to the AHC Model as the leader in social determinants of health as its work continues to progress. She acknowledged that bridge organizations have progressed halfway through the Model and concluded that CMS looks forward to continuing this work.



Katherine Verlander (CMS) delivers closing remarks for the 2019 AHC Meeting.



Representatives of the AHC bridge organizations, CMS, and CMS contractors attend the annual AHC Meeting on November 12 and 13, 2019 in Baltimore, Maryland.

Endnote

¹ While bridge organizations’ AHC activities may impact policies, awardees of the U.S. Department of Health and Human Services may not use federal funds to lobby federal, state, or local officials or their staff to receive additional funding or influence legislation, according to Section 11 of the Standard Terms and Conditions (see details in the [Federal Restrictions on Lobbying for HHS Financial Assistance Recipients](#)).

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