Hackensack Meridian *Health*

Hackensack University Medical Center Accountable Health Communities Track 2 Assistance Intervention: Improving Population Health in Bergen County, New Jersey

Project Narrative

Hackensack University Medical Center's (HackensackUMC) Accountable Health Communities Model (AHC Model) is located in Bergen County, New Jersey, eight miles west of New York City. HackensackUMC is the largest provider of inpatient and outpatient services in the state. As part of the broader Hackensack University Health Network (HUHN), HackensackUMC is committed to delivering exceptional patient care and will serve as a bridge organization under the AHC Model.

Bergen County's health disparities and health-related social needs currently result in health care over-utilization and unnecessarily high costs. Addressing health-related social needs through clinical-community service partnerships that increase awareness and help high risk Medicaid and Medicare beneficiaries access services will help reduce health-related expenditures, improve health outcomes, and reduce disparities. The AHC Model will help build the body of evidence regarding which strategies are most effective in addressing social needs to improve health and reduce health care costs for community-dwelling Medicare, Medicaid, and dual-eligible beneficiaries.

The second track of the AHC model will test whether assisting high-risk community-dwelling beneficiaries with accessing community services through community service navigation impacts total health care costs and inpatient and outpatient health care utilization. High-risk community-dwelling beneficiaries may need assistance overcoming barriers to resolving those needs; simply having a referral may not be enough for these patients. This intervention incorporates innovations from Track 1 (universal screening for health-related social needs and use of a community resource inventory to connect community-dwelling beneficiaries to available community services) with two additional features: (1) identifying high-risk community-dwelling beneficiaries as part of a smarter spending strategy to target additional resources where they are needed the most; and (2) community service navigation to assist high-risk community-dwelling beneficiaries with resolving health-related social needs.