NCACH Pathways Community HUB – Assessment, Recommendations

Center for Community Health and Evaluation

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Background

North Central Accountable Community of Health (NCACH) is implementing the Pathways Community HUB (HUB) care coordination model as part of their Medicaid Transformation Project work. An initial pilot is being conducted in Moses Lake and enrollment is lagging behind expectations. NCACH engaged the Center for Community Health and Evaluation (CCHE) to conduct stakeholder interviews to help identify ways of increasing enrollment and improving overall program implementation.

CCHE interviewed a range of stakeholders, including HUB staff from Action Health Partners (AHP), Community Specialist Services Agency (CSSA) leadership, Pathways Community Specialists (PCSs), Managed Care Organizations (MCOs), and leadership from Samaritan Hospital in Moses Lake. CCHE also reviewed relevant documents, including the initial HUB RFP, contract templates, audit instruments, meeting minutes & presentations.

This report summarizes the results of the interviews and other data gathering and makes recommendations. Sections include:

- Brief overview of the HUB model
- Desired state for community care coordination
- Assessment of the current state, challenges to reaching the desired state, and recommendations

Pathways Community HUB model

The HUB is managed by a coordinating organization designed to support a sustainable community-based care coordination system, that includes a network of CSSAs and PCSs (who function as Community Health Workers (CHWs))[1]. The core of the program consists of 20 Pathways that range from social determinants (e.g., housing, education, employment) to more medically focused (e.g., medication management, immunizations, finding a medical home). Each Pathway includes a series of steps and desired outcomes, that patients are coached through by the PCS.

In NCACH, the HUB target population is frequent emergency department (ED) users – 3 or more visits in the past 12 months. An initial pilot of the program began in October 2018 in Moses Lake (Grant County), with the Samaritan ED as the referral source and a single zip code (98837) as the initial geographic area. The Grant County geography was expanded in July 2019 to include additional zip codes. An expansion into Chelan-Douglas counties is scheduled for the fourth quarter of 2019. More details on the Moses Lake pilot are provided below.

NCACH is committed to financially supporting the HUB through the initial planning and implementation phases in order for it to become a viable and sustainable program. Funding for the selected HUB lead agency–Action Health Partners-is being provided to build its capacity to:

- identify, recruit, and support a network of CSSAs
- create referral networks to bring patients into the HUB
- coordinate training and provide ongoing support for PCSs to support patients through Pathways
- administer the program, including the outcome-based payment system

[1] Nationally, the Pathways Community HUB model often is described as a network of care coordination agencies (CCAs) and their community care coordinators (CCCs, aka Community Health Workers). The North Central region uses the terms Community Specialist Services Agency (CSSA) and Pathways Community Specialists (PCSs) to distinguish these entities and roles from other care coordination or care management efforts in the region.

Elements of a successful HUB

The long term goal is to build and sustain the full evidence-based HUB model, including a HUB coordinating agency and CSSAs paid through the HUB outcome-based reimbursement system. Based on conversations and reading HUB documents, the elements that need to be in place for a sustainable and effective HUB are:

- Referral networks capable of providing CSSAs/PCSs with adequate caseloads, along with a workflow and supporting communications and IT infrastructure that facilitates inputting patient information into the CCS data system[2]
- Trained and supported PCSs capable of leading patients to Pathways completion at HUB standards. The training for new PCSs must be efficient and provide them with the skills to recruit, retain, and lead patients through Pathways. The support provided will include structured training, informal training and mentoring, and providing real-time answers to questions that arise in day-to-day operations
- Communication networks that ensure that all organizations that touch a patient are able to communicate with each other about relevant aspects of the patient's care
- A well-functioning HUB agency that provides overall coordination for the system and can respond to challenges that arise in the ongoing HUB operation, as well as creatively identifying new opportunities for collaboration and referral
- Information technology (IT) infrastructure that can facilitate transfer of information about patient interventions and outcomes. This should include providing information *from* the HUB to patient medical and administrative homes (e.g., Primary care providers (PCPs) and MCOs); and may include providing information and referrals *to* the HUB via electronic (as opposed to paper/fax) methods.
- Funding sources to support the HUB system, including the PCSs and HUB/CSSA administrative costs. Payment mechanisms may include the standard HUB model of paying for Outcome Based Units[3]

Current state, successes and challenges

Current state. The Pathways Community HUB model has been in operation since October 2018 in Moses Lake. Partners involved in the pilot implementation include:

- Action Health Partners – HUB (the central HUB agency administering/managing model)
- Grant Integrated Services – CSSA employing one PCS
- Moses Lake Community Health Center – CSSA employing one PCS
- Rural Resources – CSSA employing one PCS, currently on leave of absence
- Samaritan Healthcare – referral partner

Given the selected target population, the HUB currently relies on a referral system where Samaritan generates a list of patients with 3+ visits to the ED, determines whether they are on Medicaid, gives them information about the program, and then sends the list to the HUB. The HUB enters the list into the Care Coordination System (CCS) that houses the HUB data and assigns them to one of three CSSAs. The PCSs at each CSSA then do cold calling of patients on their list to recruit them into the program.

[2] Care Coordination Systems LLC provides the licensing for the Pathways HUB connect software platform that supports the Pathways HUB model, also known as the Care Coordination System. .

[3] Completed Pathways are assigned values known as Outcome Based Units (OBUs). Different Pathways have different OBUs based on the difficulty and impact of completing the Pathway; e.g., housing may have higher OBUs than assistance with utility bills, since housing is more challenging and represents a more significant well-being improvement for clients.

Enrollment results to date (as of June 30, 2019) are:

- A total of ~350 HUB eligible patients have been identified
- ~50 patients have been enrolled (15% of those eligible) – with caseloads ranging from 6 to 25 across the four PCSs

All of the PCSs have been through the Pathways training, including two one-week didactic sessions, with a six-month practicum in between the two sessions. Clients are being served and Pathways completed. A total of 266 Pathways had been initiated for current and past enrollees through June 30, 2019 and 51 (19%) of these have been completed. Leading Pathways initiated include social services referrals (32% of all Pathways), education (22%), medical referral (12%), and tobacco cessation (7%). Most of the completed Pathways have been for education (33 completed or 65% of all completed pathways).

Successes and challenges. The positives with respect to the six required HUB elements outlined above are:

- Trained PCSs housed at agencies that are well-suited to the CSSA role. The CSSAs have successfully recruited PCSs from a diversity of backgrounds, including some that fit the profile of a peer lay health worker with a high-school education
- Potential future funders with a relatively positive view of the HUB model, particularly the structure it provides to the care coordination process, who are interested in exploring the sustainability of the HUB and are in active conversations with AHP about potential funding models

Challenges to date include:

- Small caseloads, despite a considerable amount of cold-calling by the PCSs. An ED is a challenging environment for recruiting patients into a care management program such as the HUB. Patients are often stressed and focused on their visit and not receptive to information being provided by ED staff about a new program. The caseloads to date fall well short of the estimates from the Pathways Community HUB Institute (PCHI) of 40-50 per PCS needed to sustain a HUB - based on an estimated total OBU payment of $1700-1800 per client and current PCS salaries
- Referral process – Samaritan ED has been a committed referral partner, developing workflows and encouraging their staff to recruit people into the program. Despite these efforts there has been a lack of recognition of the Pathways HUB by potential HUB recruits when they are called by the PCSs
- Administrative challenges– There have been delays in some administrative tasks (e.g., contracts, MOUs) as a result of staff turnover and the substantial data-entry burden with the current referral system. The HUB is required to hand enter hundreds of referral records into the CCS system, and then the PCSs need to contact potential clients from the list repeatedly to determine interest and recruit
- Expensive, ineffective training – Training costs have been $4,000 per PCS and the training was not viewed as valuable by the PCSs interviewed. Particular weaknesses were in training around Community Health Worker skills and providing workflows for PCS activities
- Imperfect communication among the different elements of the HUB. For example, regular channels are not available for the MCOs, health systems, and other patient medical homes to find out whether their patients are enrolled in the HUB and, if so, the Pathways that they are working on or have completed. And the HUB is unable to complete soft handoffs to the MCOs when it identifies a Health Homes client who has been referred to the HUB or one that is enrolled in the HUB who becomes Health Homes eligible
- Inadequate IT infrastructure – The HUB CCS data system is not currently able to serve as an effective IT platform to facilitate communication and information exchange. It can not send and receive information from health care systems, providers and MCOs

Recommendations

The following are recommendations, in order of priority, for improving HUB performance:

1. Recruit other referral partners. Federally Qualified Health Centers (FQHCs) and Rural Health Centers are good candidates for referral partners: they have a high proportion of Medicaid patients who can benefit from the HUB model and they may have access to Collective Medical to verify that they meet the 3+ ED visit criteria. AHP is currently in conversations with Moses Lake Community Health Center to add being a referral source to their current role as a CSSA.

Using clinics as referral partners has the added advantage of addressing some of the structural challenges with the HUB noted above - communication, referrals, and a well-functioning IT infrastructure. For example, an FQHC or Rural Health Center can serve as both a referral partner and a CSSA. They can search their own patient records for candidate referrals (using their access to Collective Medical to confirm eligibility), work with their own providers to confirm potential candidates, and have preliminary conversations with patients before sending them to the HUB. The HUB can then assign the FQHC patients to their own PCSs which makes communication between the HUB/PCS and health care providers much simpler and potentially more effective.

It may be advantageous for MCOs to be involved in the new clinic-based referral process, especially in the pilot phase where value of the HUB to potential payors is being determined. MCOs can generate lists of patients that meet the 3+ ED visit criteria (and perhaps other criteria, including cost of care). These lists can be sent to the clinic referral partners and used as a starting point for recruitment.

2. Pursue other enrollment strategies. Other strategies to promote recruitment into the HUB include:

- Provide better marketing and program materials to sell the value of the program to referral partners and clients – including videos and PowerPoints.
- Implement texting and emailing (vs. phone calls) as a contact option for recruiting patients.

3. Improve the PCS training and support system.

- Approach the Washington State Department of Health (DOH) and ask them to add a module to their CHW training that is specific to the PCS/pathways. This would be more cost-effective than the current CCS training and would provide standardization across HUBs from different ACH regions
- Reach out to other ACHs and the PCHI to see if there are existing online or other modules that can be used to onboard a PCS
- Work with CCS to write up work flows for each position (e.g., PCS, supervisor) so there is a guide for each aspect of the process and each staff person knows their responsibilities.
- Provide better 1-1 support from the HUB to the PCSs; that support has been limited/inadequate to date partly due to HUB capacity issues

4. Take steps to improve the IT infrastructure. A sustainable HUB will require bi-directional communication among organizations through their IT platforms. Specific things to focus on include:

1. Create a connection from the HUB to clinics and health systems so that Pathways information can be transmitted efficiently into EHRs
2. Identify ways of sending MCOs patient lists from the HUB so they can track cost, utilization and clinical outcomes for those patients Work to document the value of HUB services using key MCO cost and health outcome metrics