INSPIRE • IMPROVE • INNOVATE
COMMUNITYCHOICE
HEALTH and EDUCATION INSTITUTE

North Central Accountable Community of Health

PATHWAYS COMMUNITY HUB

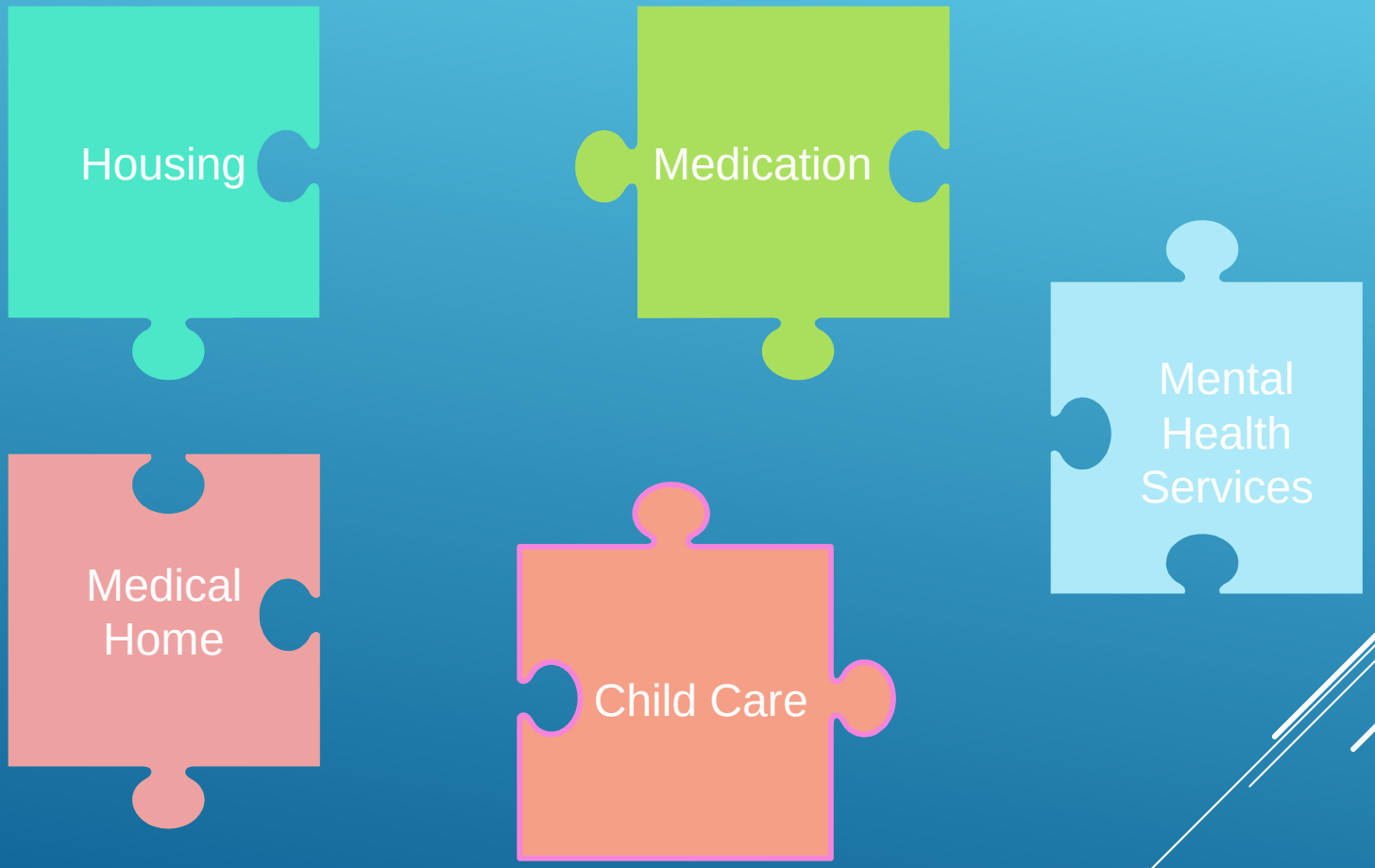
PCHI

WHAT IS A HUB?

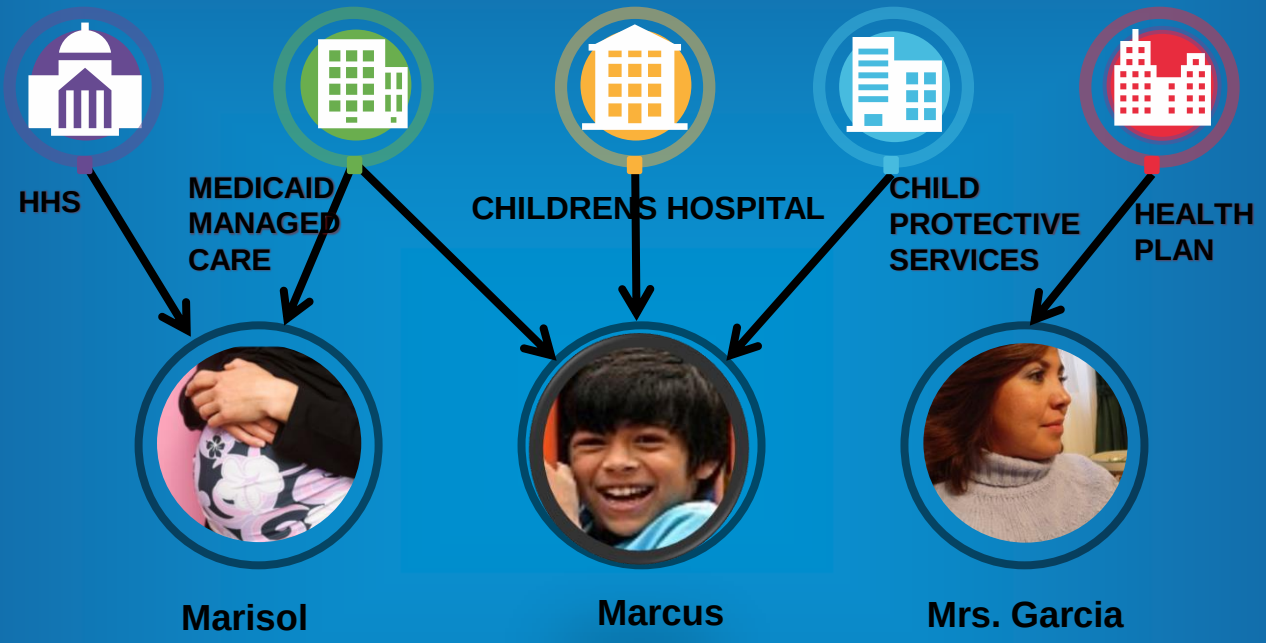
The **Pathways Community HUB** reduces the gap between the medical community and community based support services by creating a bridge to whole person, integrated care.

Community Care Coordination – care coordination provided in the community; confirms connection to health and social services.

Addressing Risk Through Siloes



Current *Community* Care Coordination



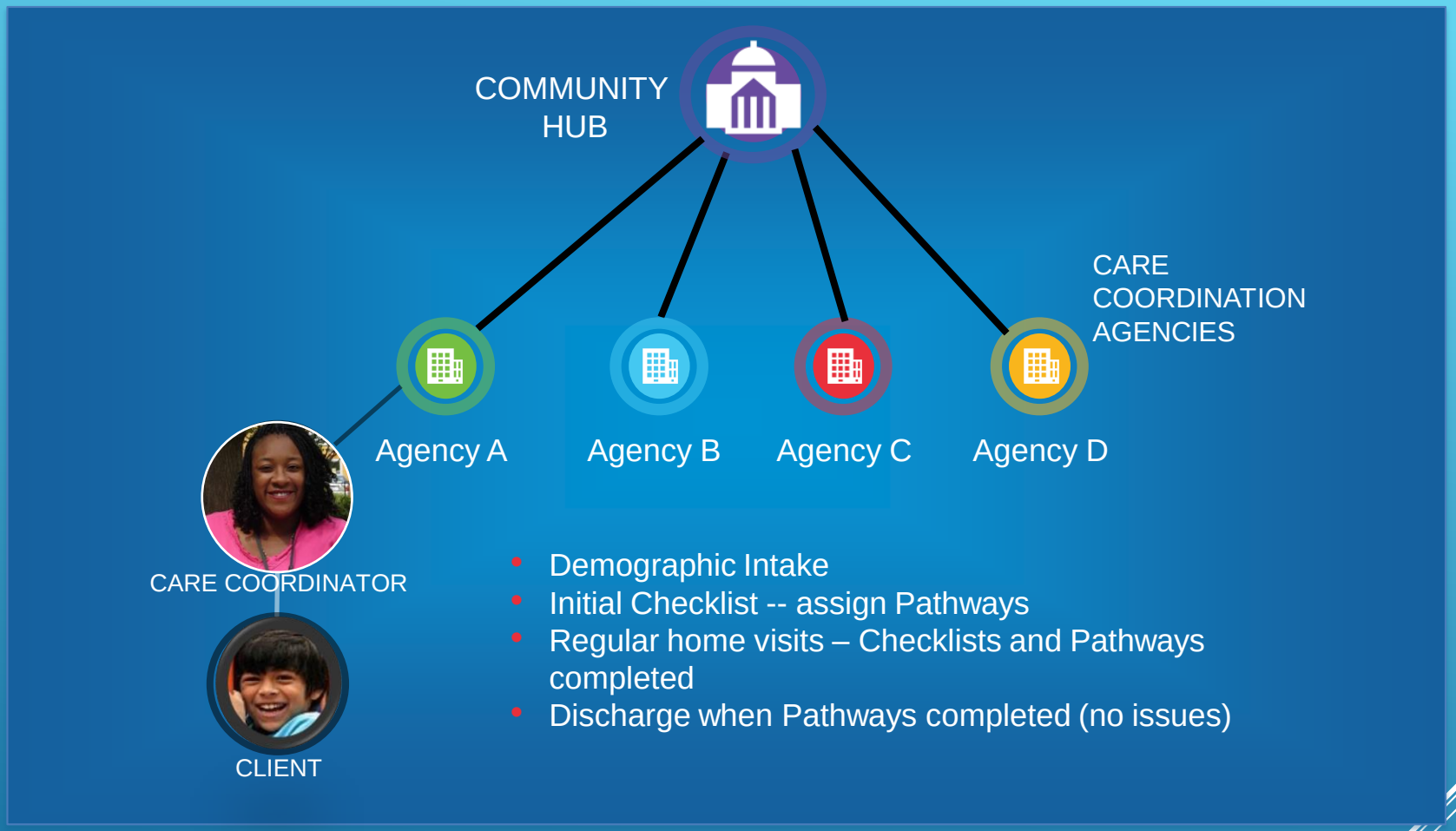
Multiple care coordinators involved – limited communication

Let’s take a quick POLL

IS THERE WORK LIKE THIS ALREADY HAPPENING IN THE NCACH REGION?

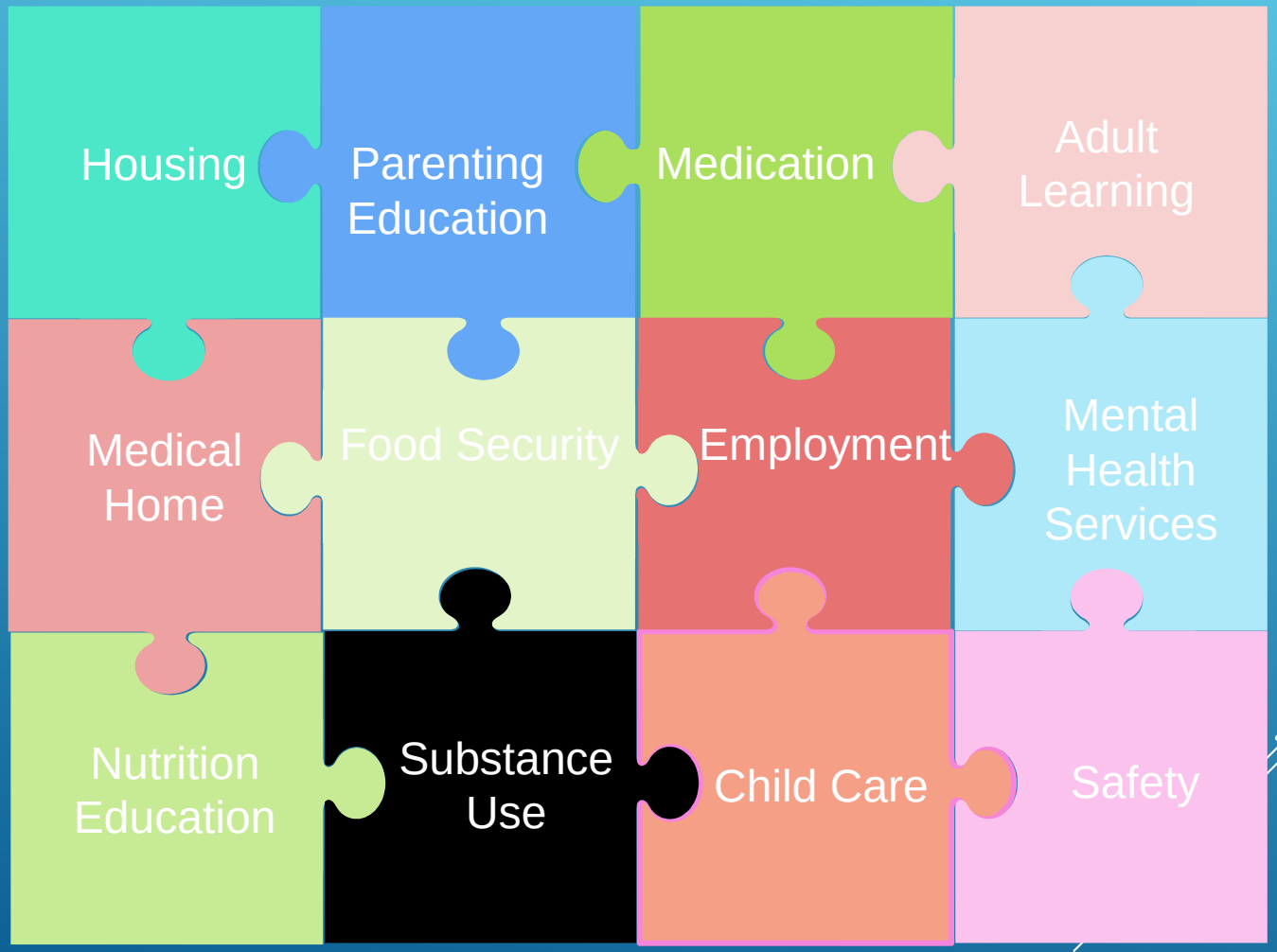
The work of the HUB is accomplished by building a network of **Care Coordination Agencies** that employ trained **Community Health Workers (CHW)** who are sent out into the community to meet with individuals referred into the HUB.

HOW WILL THE HUB BREAK DOWN THE SILOS?


COMMUNITY HUB
CARE COORDINATION AGENCIES
Agency A
Agency B
Agency C
Agency D
CARE COORDINATOR
CLIENT
Demographic Intake
Initial Checklist -- assign Pathways
Regular home visits – Checklists and Pathways completed
Discharge when Pathways completed (no issues)

Risk Factors Addressed to Achieve

Wellness



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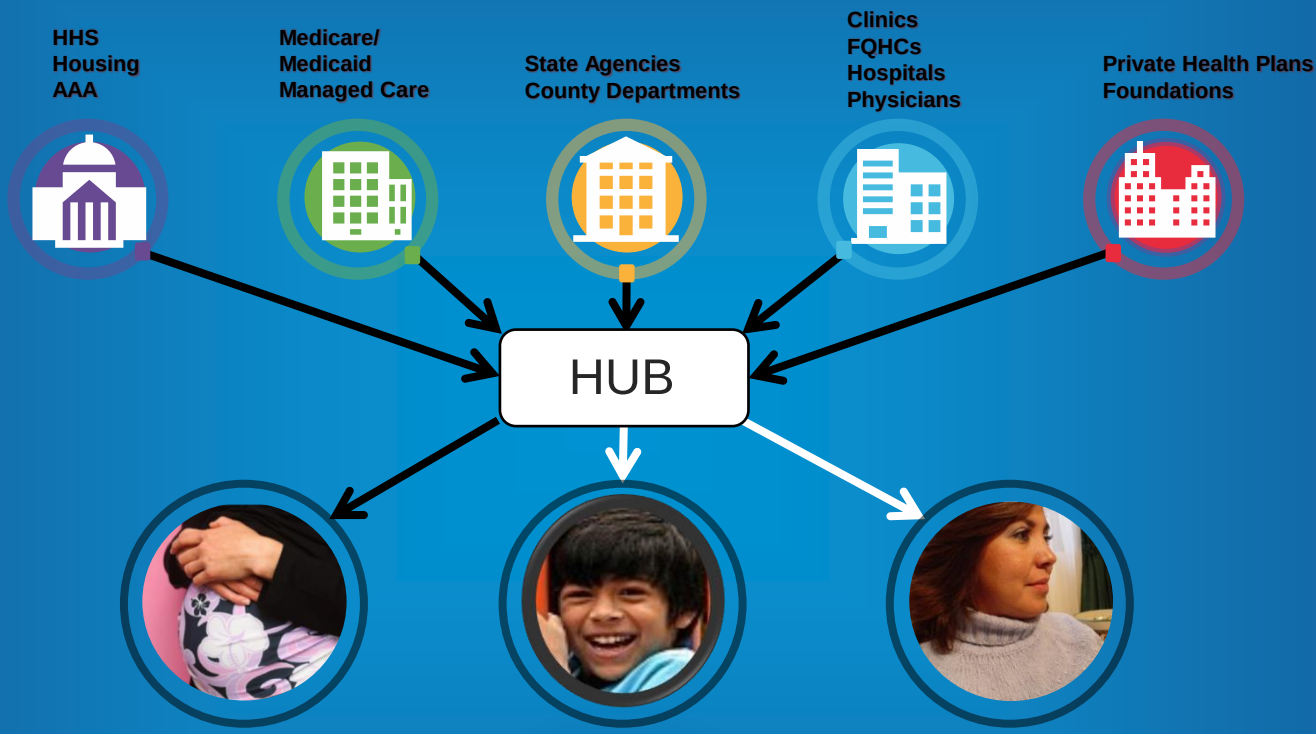


<u>One</u> Community-Based Care Coordinator for the Entire Family

The **Pathways Care Coordinators** (sometimes known as CHW) are *community peers* who are trained to work out in the community in partnership with individuals to assess and identify potential barriers to health.

WHAT IS THE ROLE OF THE PATHWAYS CARE COORDINATOR?

Foundation of the HUB Model.

Jordan, 23 years old

- Pregnant
- Lost job
- No housing
- No transportation
- Depressed ?

Alexis, 13 months

- Needs medical home
- Behind on immunizations
- Behind on well visits
- Developmental concerns?

A TYPICAL FAMILY “AT-RISK”. . .

HEALTH & HUMAN SERVICES

MEDICAID MANAGED CARE

EARLY CHILDHOOD

Jordan

Alexis

- Multiple agencies
- Limited communication across agencies
- Minimal tracking of identified and addressed risk factors
- Minimal financial accountability for reducing risk factors

The tools used to breakdown the identified barriers are **outcome based pathways** that guide the steps to health, while at the same time **measure and report of value** of the services delivered.

WHAT ARE THE TOOLS THAT MAKE THIS PROGRAM WORK?

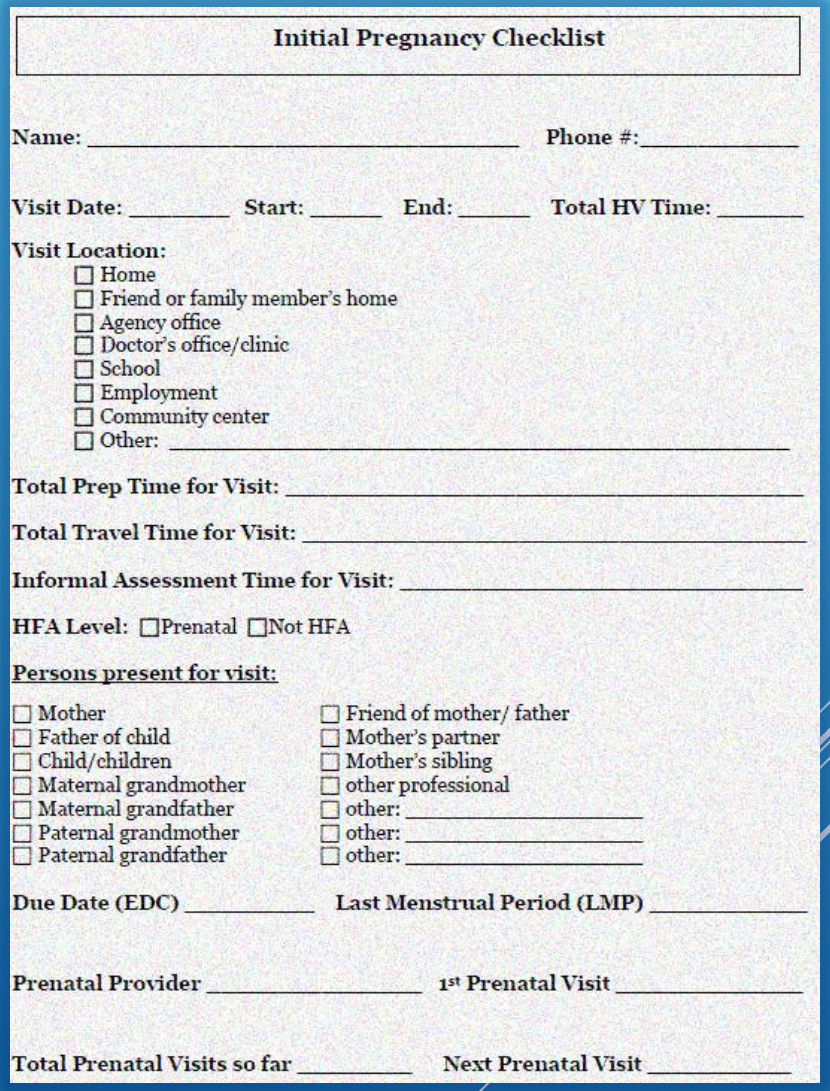
20 CORE PATHWAYS

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum

FIND: COMPREHENSIVE RISK REVIEW

Standard Data Collection:

- Release of Information (ROI)
- Client Profile
- Initial Checklist (enrollment)
- Ongoing Checklist at each face-to-face visit



Initial Pregnancy Checklist

Name: _____ **Phone #:**_____

Visit Date: _____ **Start:** _____ **End:** _____ **Total HV Time:** _____

Visit Location:

- ☐ Home
- ☐ Friend or family member's home
- ☐ Agency office
- ☐ Doctor's office/clinic
- ☐ School
- ☐ Employment
- ☐ Community center
- ☐ Other: _____

Total Prep Time for Visit: _____

Total Travel Time for Visit: _____

Informal Assessment Time for Visit: _____

HFA Level: ☐Prenatal ☐Not HFA

Persons present for visit:

- ☐ Mother
- ☐ Father of child
- ☐ Child/children
- ☐ Maternal grandmother
- ☐ Maternal grandfather
- ☐ Paternal grandmother
- ☐ Paternal grandfather
- ☐ Friend of mother/ father
- ☐ Mother's partner
- ☐ Mother's sibling
- ☐ other professional
- ☐ other: _____
- ☐ other: _____
- ☐ other: _____

Due Date (EDC) _____ **Last Menstrual Period (LMP)** _____

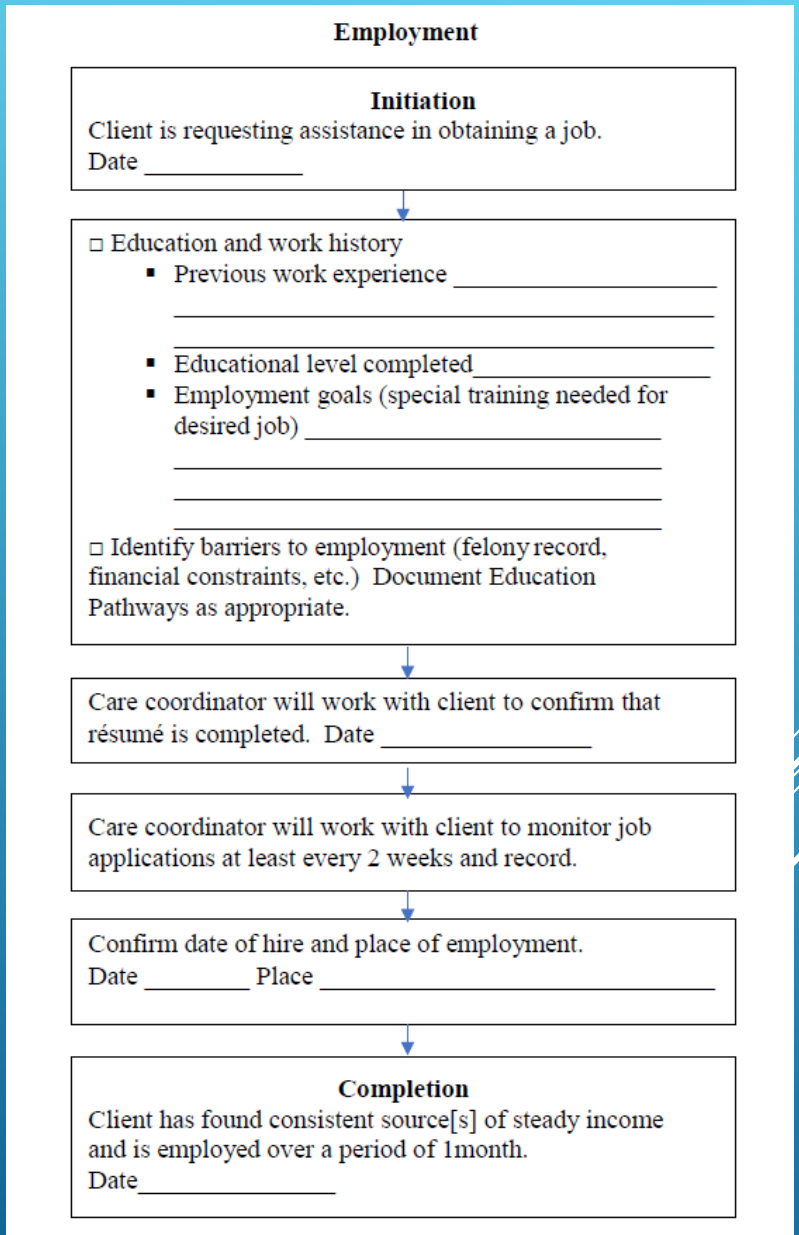
Prenatal Provider _____ **1st Prenatal Visit** _____

Total Prenatal Visits so far _____ **Next Prenatal Visit** _____

TREAT: RISK FACTOR = PATHWAYS

20 Standard Pathways:

- One risk factor at a time
- Outcome achieved = finished PW & Payment!
- Outcome not achieved = finished incomplete PW



Employment

Initiation
Client is requesting assistance in obtaining a job.
Date _____

□ Education and work history
- Previous work experience _____
- Educational level completed _____
- Employment goals (special training needed for desired job) _____

□ Identify barriers to employment (felony record, financial constraints, etc.) Document Education Pathways as appropriate.

Care coordinator will work with client to confirm that résumé is completed. Date _____

Care coordinator will work with client to monitor job applications at least every 2 weeks and record.

Confirm date of hire and place of employment.
Date _____ Place _____

Completion
Client has found consistent source[s] of steady income and is employed over a period of 1month.
Date_____

MEDICAL HOME PATHWAY

Identify risk factor

Initiation

Client needs an ongoing source of pediatric care

Date_____

Identify and overcome barriers

Determine and record client's payer source:

- ❑ Medicaid
- ❑ Medicare
- ❑ Private Insurance
- ❑ Self Pay
- ❑ Other_____

1. Identify provider _____
2. Assist client in scheduling appointment
   Date_____
3. Document education pathways as appropriate

Outcome
Confirm risk factor addressed

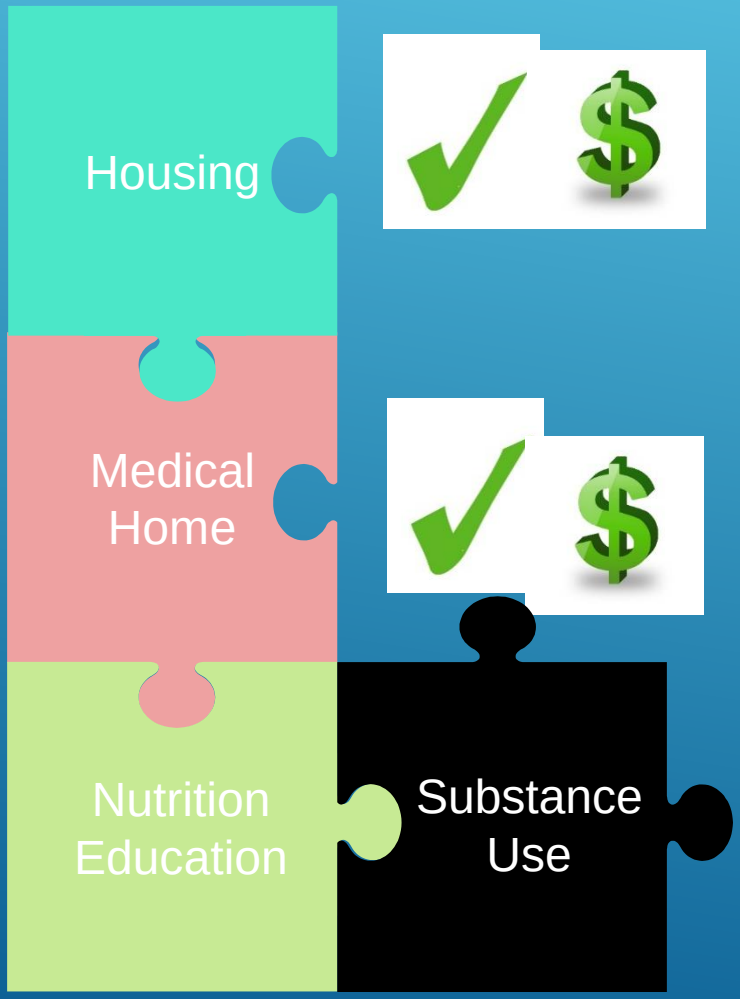
Completion

Confirm that appointment was kept

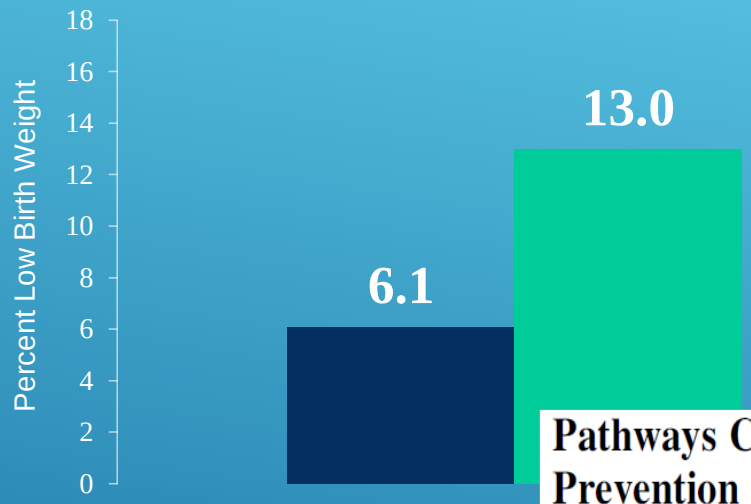
Date_____

PCHI

Payment is tied to each risk factor as they are addressed



PUBLISHED STUDY ON RESULTS



Pathway intervention over 4 years

Cost Savings:
$3.36 for 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

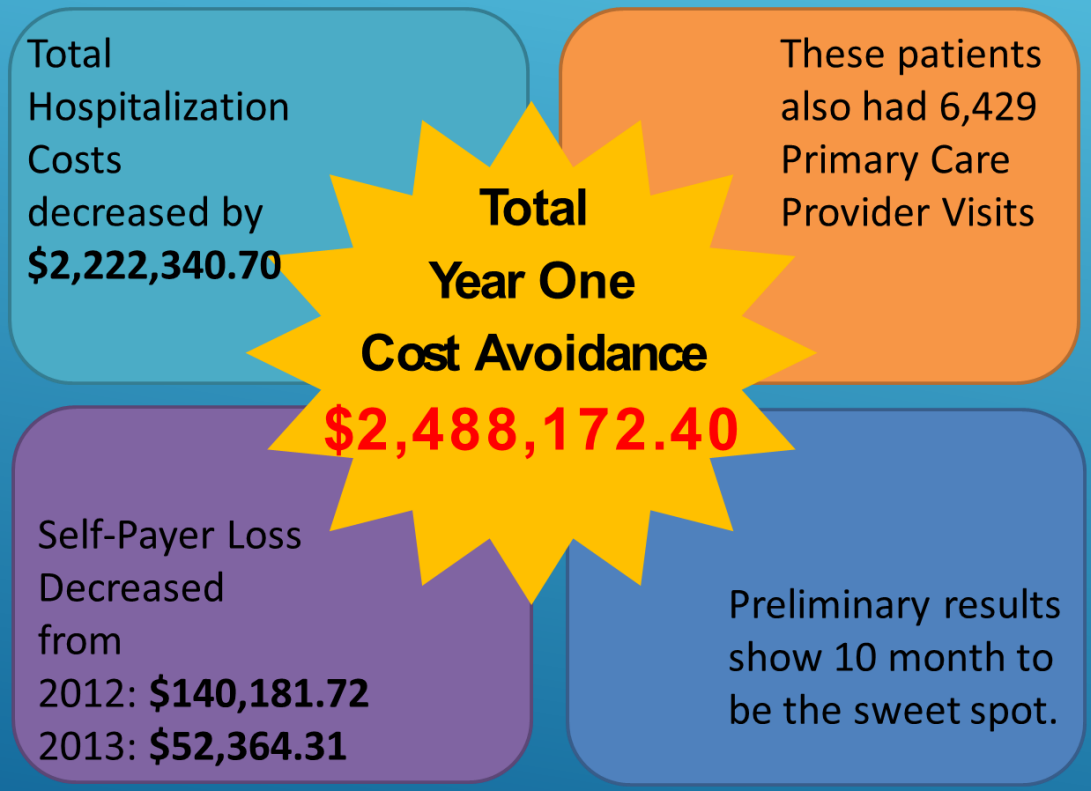
Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social

Women participating in CHAP and having a live birth in 2001 through 2004 constituted the intervention group. Using birth certificate records, each CHAP birth was matched through propensity score to a control birth from the same census tract and year. Logistic regression was used to examine the association of CHAP participation

PCHI

MUSKEGON MICHIGAN:
IN THE FIRST YEAR…CHRONIC DISEASE



- Removes “silos” and fragmentation
- Reduces duplication by using existing community resources efficiently & effectively
- Focuses on common metrics to identify & track risks (risk reduction)
- Holistic community care coordination - one care coordinator
- Pays for outcomes – sustainable
- Owned by the community

SUMMARY. . .

PATHWAYS HUB IN NCACH

- Target launch date= **OCTOBER 1**
- Target Population= **Medicaid or Medicaid eligible clients in 98837 Zip Code that have 3 or more ED visits within 12 months**
- Initial Pilot Site=**Moses Lake**
- Initial Target Size=**200**
- Initial Care Coordination Agencies:
  - **Moses Lake Community Health Clinic**
  - **Grant Integrated Services**
  - **Rural Resources**

Preliminary Expansion Plan

Grant County	Chelan/Douglas	Okanogan
Late 2018	Mid 2019	Late 2019

PATHWAYS HUB NCACH

ENDORSERS OF THE PATHWAYS COMMUNITY HUB MODEL

Ohio Commission On Minority Health

Institute for Healthcare Improvement

Ohio Department of Medicaid

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

HRSA

Ohio Department of Health

The CMS Innovation Center

NIH National Institutes of Health
Turning Discovery Into Health

NSF National Science Foundation
WHERE DISCOVERIES BEGIN

QUESTIONS