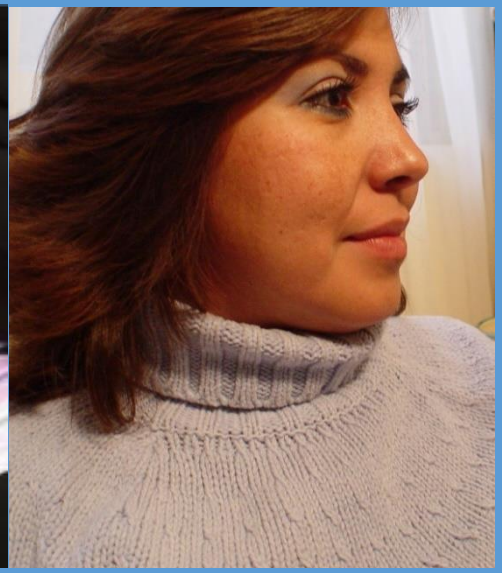
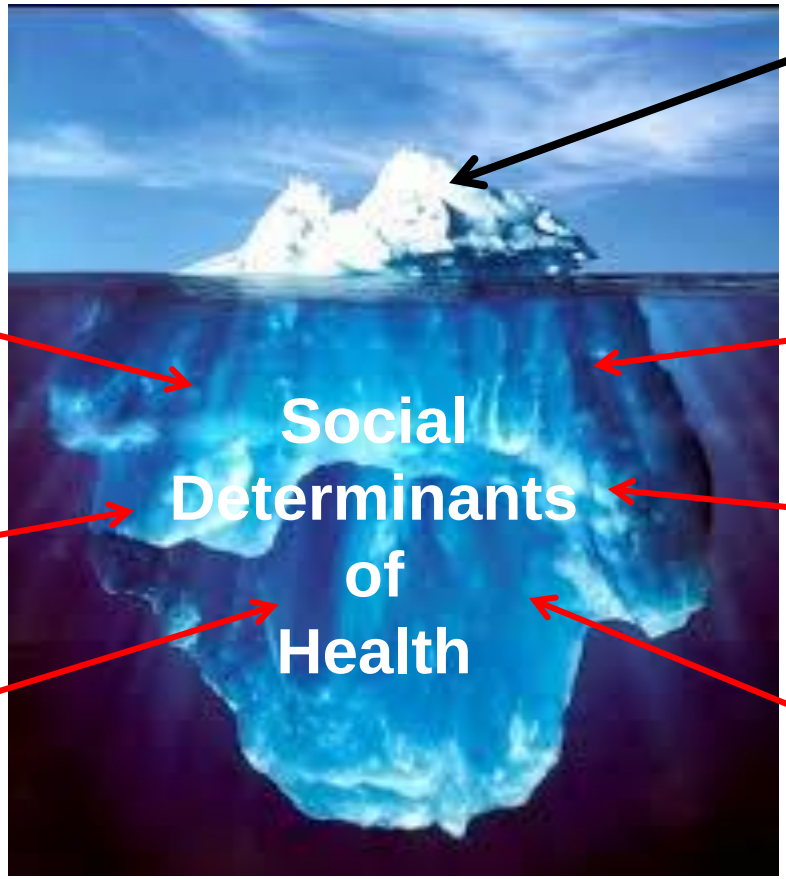
Pathways Community HUB Model




Risk

Social Determinants of Health



Definition of Care Coordination

*"Care coordination is the **deliberate organization of patient care activities between two or more participants** (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."*

AHRQ Care Coordination Measures Atlas Update, June 2014

Direct Services = Intervention

Care Coordination = clinic based

Community Care Coordination = home based

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

A Community Care Coordinator:

- Finds and engages at-risk individuals
- Comprehensive risk assessment
- Confirms connection to care
- Tracks and measures results

Role of a Care Manager in PCMH

- Often a nurse or social worker
- Develops and monitors individualized care plans for patients
- Provides patient education and training in self-managements skills
- Coordinates care with other providers and settings
- Connects patient to community resources and social services
- Participates in QI activities in the practice

Annals of Family Medicine, Vol. 11, No. 1, January/February 2013

Role of a Community Care Coordinator

- Many different types of professionals, including:
  - ***Community health workers***
  - Social workers
  - Behavioral health case managers
  - Nurses
- Meets face to face with clients in a community setting, including the home.
- Connects patient to community resources, social services and health services.
- Provides education and monitors care plans.
- Works collaboratively with care managers in a variety of settings – managed care, PCMHs, hospitals

Why do we need Community Care Coordination?

- More than ½ of patients can't state their diagnosis when leaving the hospital.
- More than ⅓ of patients can't explain their medications.
- Less than ½ of patients saw a primary care physician within 2 weeks of leaving the hospital.
- 1 in 5 patients has an adverse event transitioning from hospital to home. ***2 out of 3 events are related to prescriptions!***

Percentage of Physicians Identifying Problems Coordinating Care with Different Providers and Entities

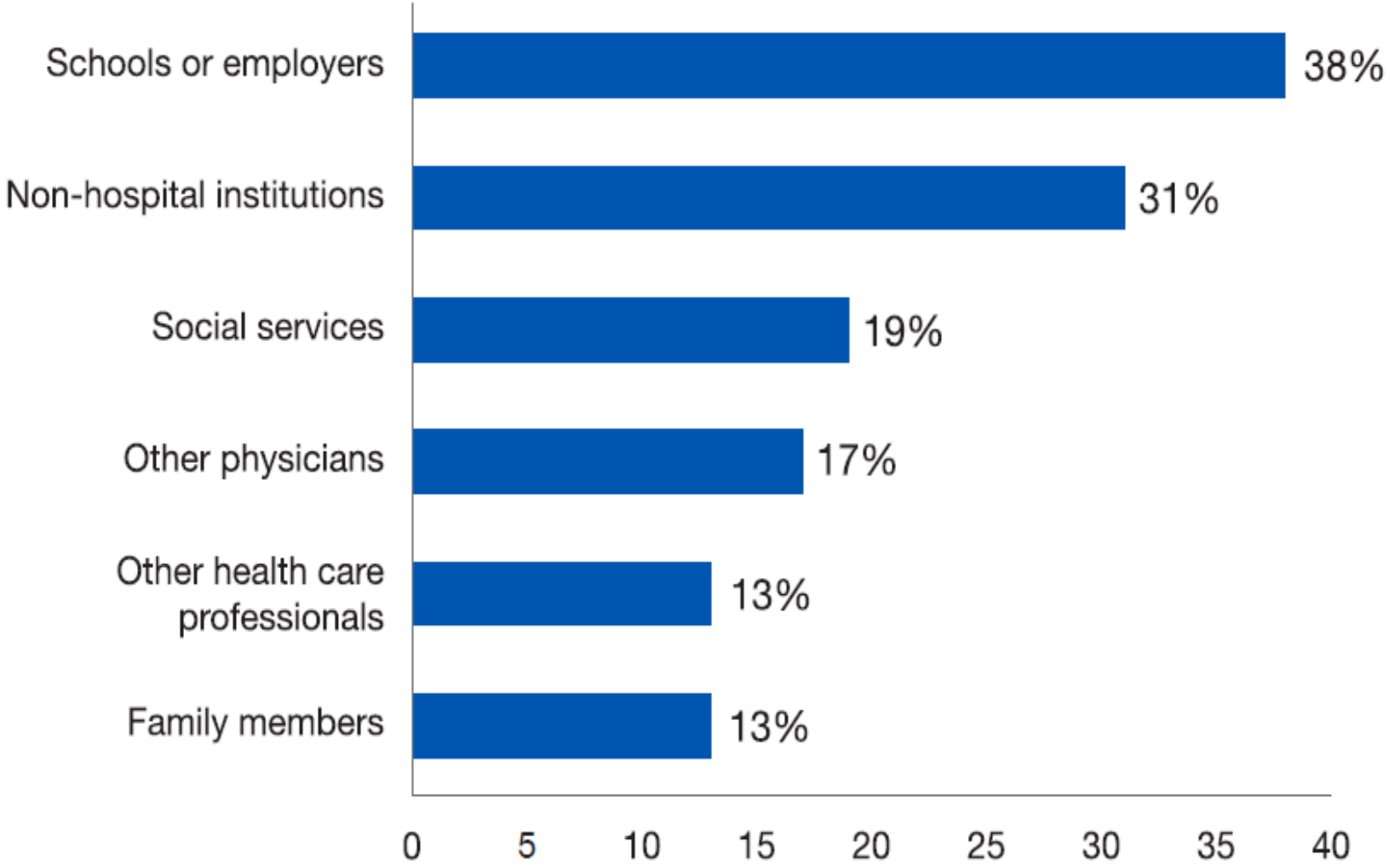


Chart from the Robert Wood Johnson Foundation: http://rwjf.org/pr/product.jsp?id=50968.

Care Coordination

"While all experts with whom we spoke agreed that better communication with community organizations and social services is critical, especially for Patient Centered Medical Homes (PCMHs) that focus on treating low-income patients or frail elders, ***many describe the connections with the broader community as the most challenging for the medical neighborhood at large*.**

. . . connections between primary care and community services . . . ***simply are absent or highly fragmented and disorganized***."

AHRQ #11-0064: White Paper on Coordinating Care in the Medical Neighborhood


Kotzebue Alaska, Spring 1991

To eliminate health and social disparities in our community by finding those at risk, connecting them to care, and measuring the outcomes.


OCIE HILL
NEIGHBORHOOD CENTER

CHW Certification in Ohio

- Ohio certification of CHWs began in July 2004 (legislation), law regulating CHWs signed in 2005
- Based on 6 competency areas (230 hours: 100 didactic and 130 practicum)
- “certificate to practice”
- 15 hours of continuing education every 2 years

Initial Results

Disappointing . . . . . No change in data.

Hard to capture all of the work CHWs were doing.

. . . . . *Needed a better strategy!*

“Typical” Family at Risk

Marisol, 28

- Pregnant
- Lost housing
- Car isn’t working well
- Afraid of losing job

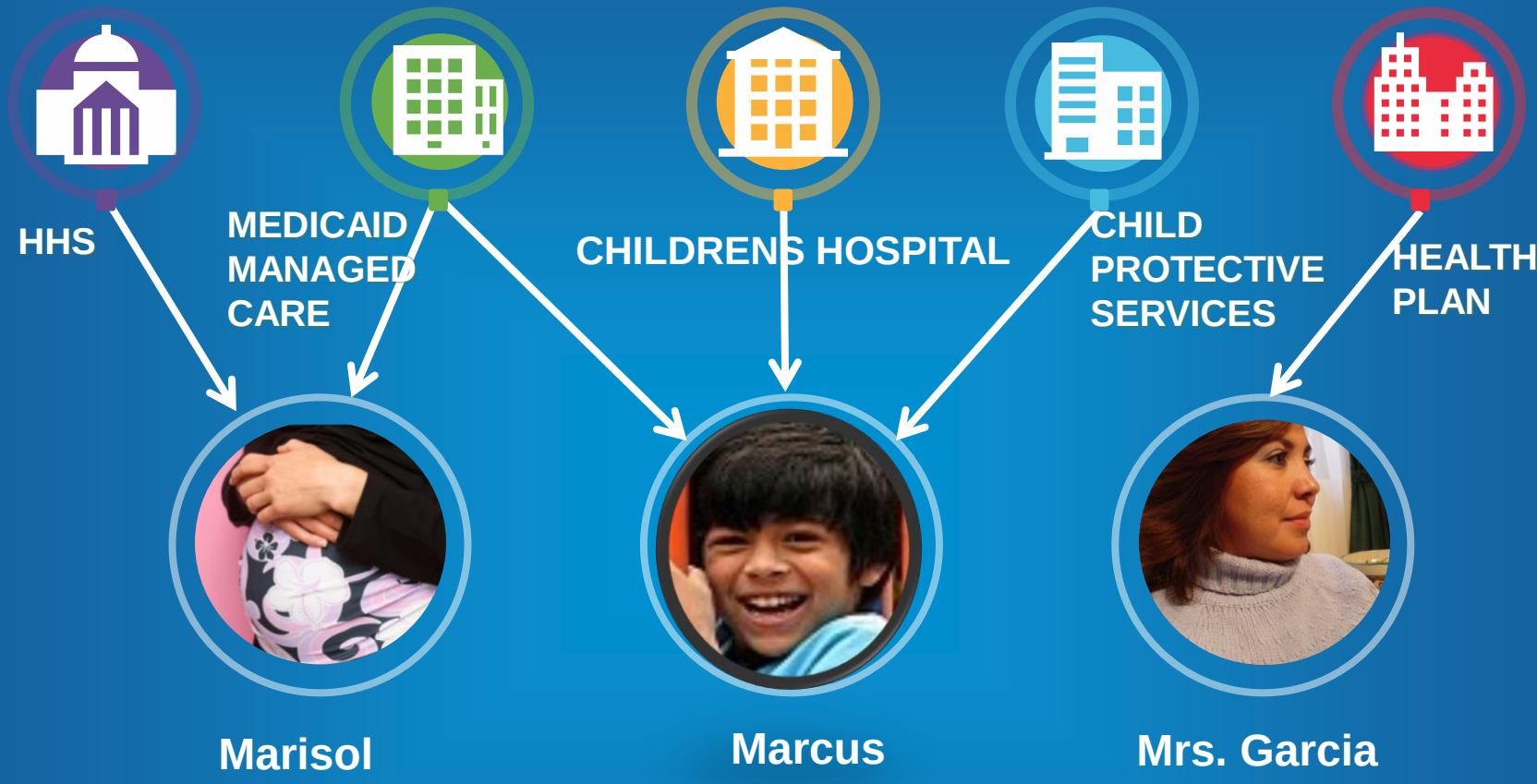
Marcus, 6

- Needs new medical home
- Frequent ED visits
- No asthma action plan
- Struggling at school

Mrs. Garcia

- One bedroom apartment
- Works part-time
- Type 2 Diabetes
- Smoker

Current *Community* Care Coordination



Multiple care coordinators involved – limited communication

Foundation of the Model

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 offic
- ☐ School
- ☐ Employment
- ☐ Community c
- ☐ Other: _____

Total Prep Time for

Total Travel Time fo

Informal Assessmer

HFA Level: ☐Prenat

Persons present for

- ☐ Mother
- ☐ Father of child
- ☐ Child/children
- ☐ Maternal grandmoth
- ☐ Maternal grandfathe
- ☐ Paternal grandmoth
- ☐ Paternal grandfather

Due Date (EDC) ___

Prenatal Provider _

Total Prenatal Visits

Medical Home Pathway

MEDHOME1 Initiation Date

Initiation
Client needs a medical home (an ongoing source of primary medical care).

Determine payment source for health care

Find appropriate primary medical provider options for payment source.

MEDHOME2 Scheduled Appt. Date

1. Obtain release of information from client.
2. Assist family in scheduling appointment.
3. Provide education about the importance of keeping the appointment - Use education sheet.

MEDHOME3 Completion Date

Completion

Confirm that appointment was kept.

MEDHOME4 Finished Incomplete Date

Finished incomplete reason:

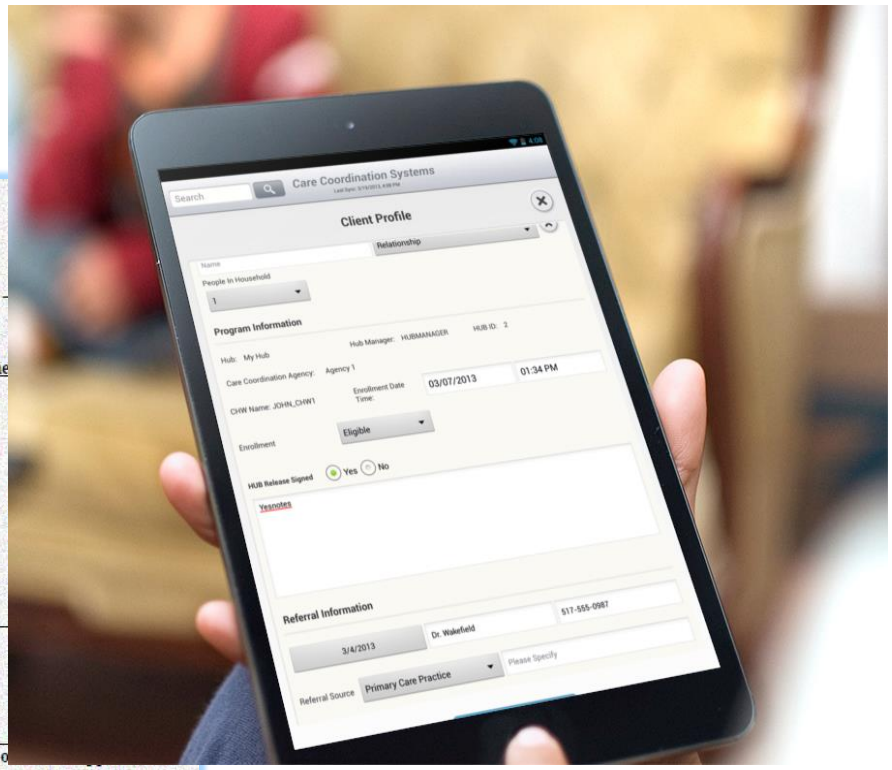
_____
_____
_____

Payme

Date o

Education provided
☐ Yes ☐ No

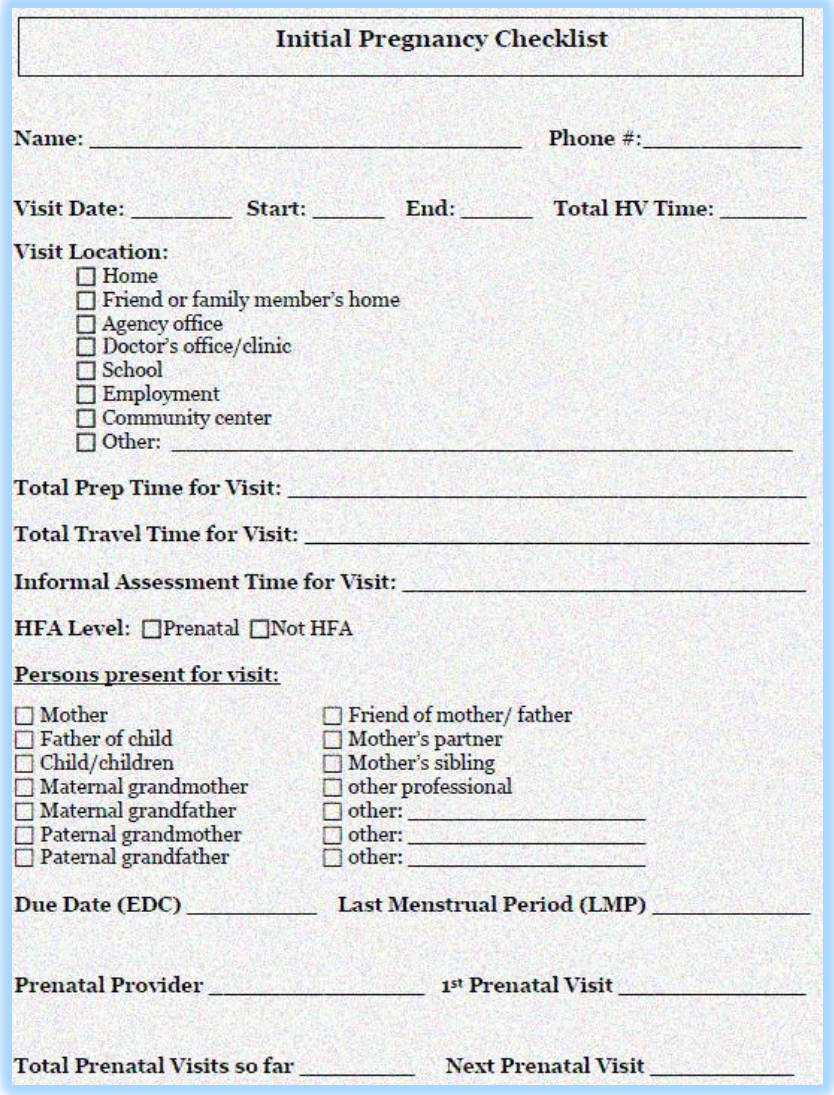
_____
Date of kept appointment



Find: Comprehensive Risk Assessment

Standard Data Collection:

- 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)** _____

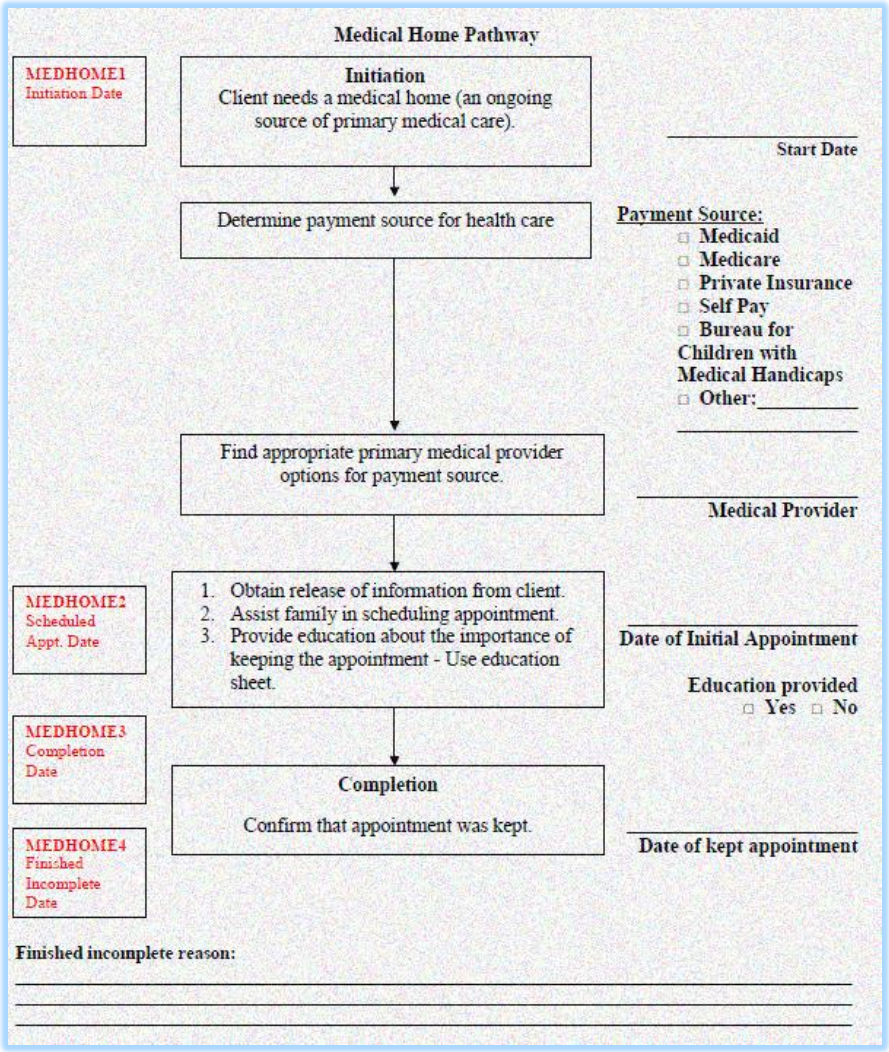
Prenatal Provider _____ **1st Prenatal Visit** _____

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

Treat: Risk = Pathways (PW)

20 Standard Pathways:

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



20 Core Pathways – National Certification

- 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

Measure

Track and Measure Progress with Pathways

By Community Care Coordinator

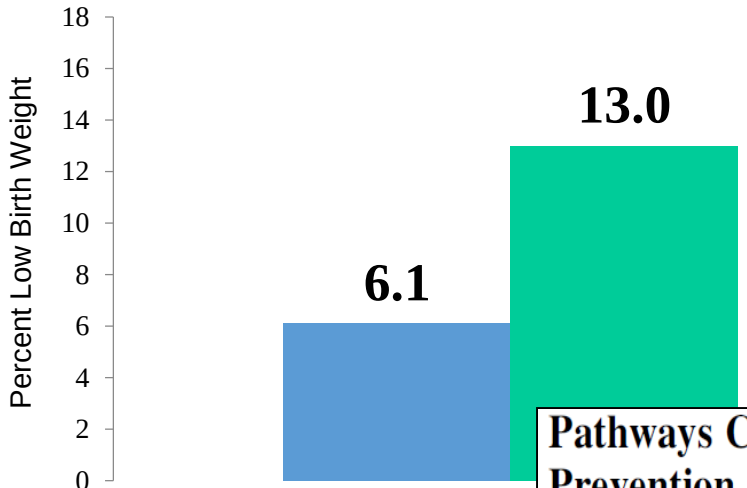
Name	Medical Home	Pregnancy	Social Service
CHW A	5	2	10
CHW B	1	3	4
CHW C	9	15	18

By Agency

Site	Medical Home	Pregnancy	Social Service
Agency A	50	25	22
Agency B	64	17	35
Agency C	40	32	19

- **Care Coordinator**
- **Agency**
- **HUB**
- **Community**
- **Region**
- **Etc…**

Published Study on Results



Pathway intervention over 4 years

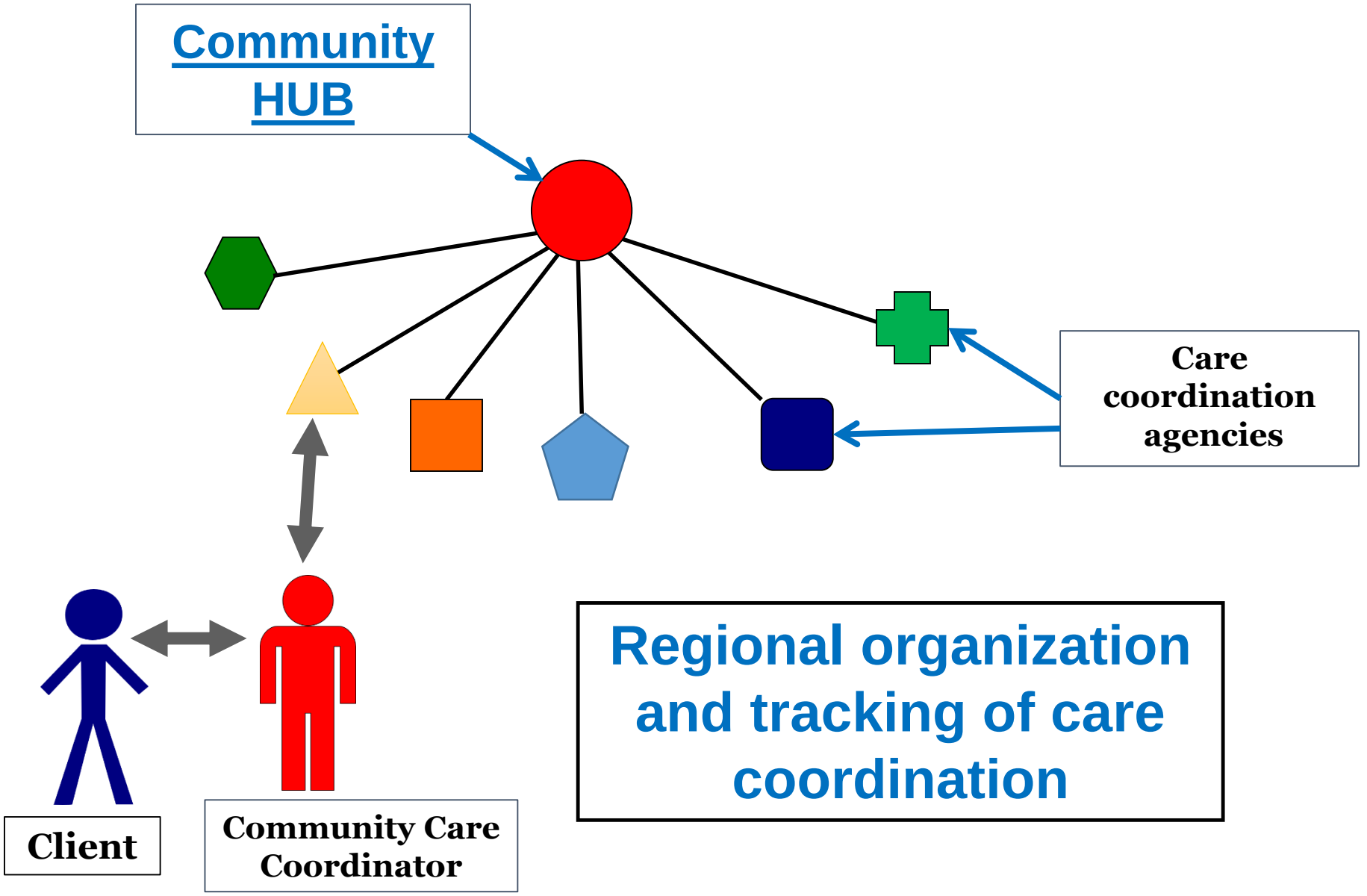
Cost Savings:
$3.36 for 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

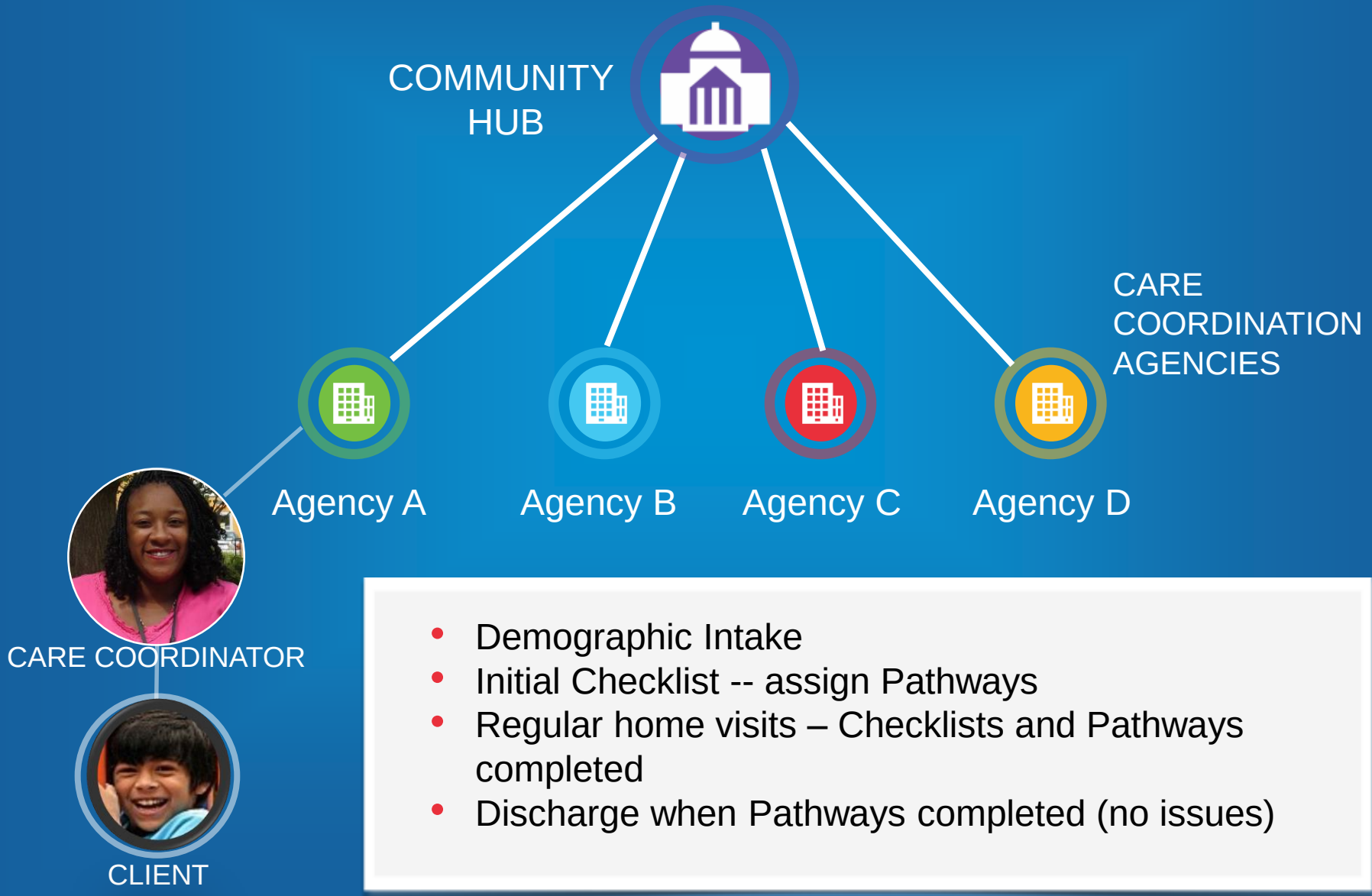
Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

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


Community HUB
Care coordination agencies
Client
Community Care Coordinator
Regional organization and tracking of care coordination

Regional Organization and Tracking of Care Coordination



- Demographic Intake
- Initial Checklist -- assign Pathways
- Regular home visits – Checklists and Pathways completed
- Discharge when Pathways completed (no issues)

“Typical” Family at Risk

Marisol, 28

- Pregnancy PW
- Housing PW
- Social Service Referral PW – Transportation
- Employment PW

Marcus, 6

- Medical Home PW
- Medication Assessment PW
- Tool – Asthma Action Plan
- Social Service Referral PW – Education support

Mrs. Garcia

- Medical Referral PW
- Education PW
- Employment PW
- Education PW - Diabetes
- Smoking Cessation PW

Asthma Action Plan

Personal best peak flow: _____

IMPORTANT INFO

Name:
Date:
Doctor name:
Doctor phone:
Emergency contact:
Emergency phone:

EXERCISE-INDUCED FLARE-UP

Instructions for an exercise-induced asthma flare-up

Medicine: _____
How much: _____
When: _____
Additional instructions:

TRIGGERS: ☐ pollen ☐ mold ☐ dust mites ☐ animals ☐ smoke ☐ food ☐ exercise ☐ cold/flu ☐ weather ☐ air pollution ☐ other _____

The GREEN Zone (also known as the safety zone)

Symptoms

- Breathing is easy
- No cough or wheeze
- Can do usual activities
- Can sleep through the night

Peak flow from ____ to ____

Use these long-term control medicines as listed:

Medicine	How much	How often / when

The YELLOW Zone (also known as the caution zone)

Symptoms

- Some shortness of breath
- Cough, wheeze, or chest tightness
- Some difficulty doing usual activities
- Sleep disturbed by symptoms
- Symptoms of a cold or flu

Peak flow from ____ to ____

Continue with long-term control medicines as above, and add these quick-relief medicines:

Medicine	How much	How often / when

Call your doctor if: _____

The RED Zone (also known as the danger zone)

Symptoms

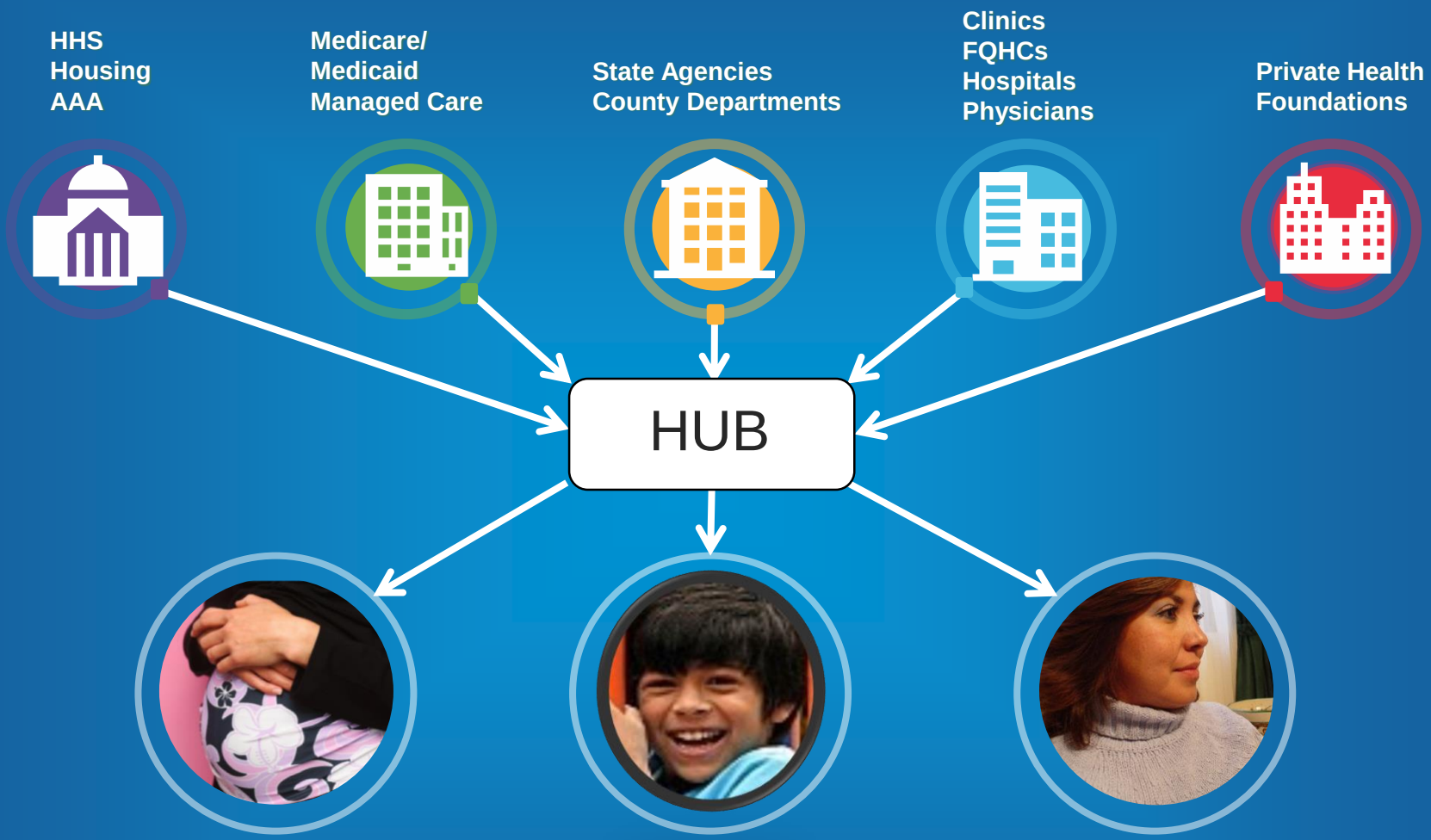
- Severe breathing problems
- Cannot do usual activities
- Difficulty walking and talking
- Rescue medicine is not helping

Peak flow from ____ to ____

Take this medicine and call the doctor now!

Medicine	How much	How often / when

If symptoms don't improve and you can't contact the doctor, go to the hospital or call 911.



One Care Coordinator for the Entire Family

Distinctions between Pathways & HUB

Pathways

- Patient-centered, care coordination tool
- Identifies and “translates” patient risks
- Measured outcomes
- Payments for measured Pathway outcomes

Community HUB

- Tracks Pathways (outcomes) across agencies
- Eliminates duplication
- Streamlines referrals
- Provide infrastructure for community-based care coordination
- Involve braided funding – Pathways can be purchased by different funders

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

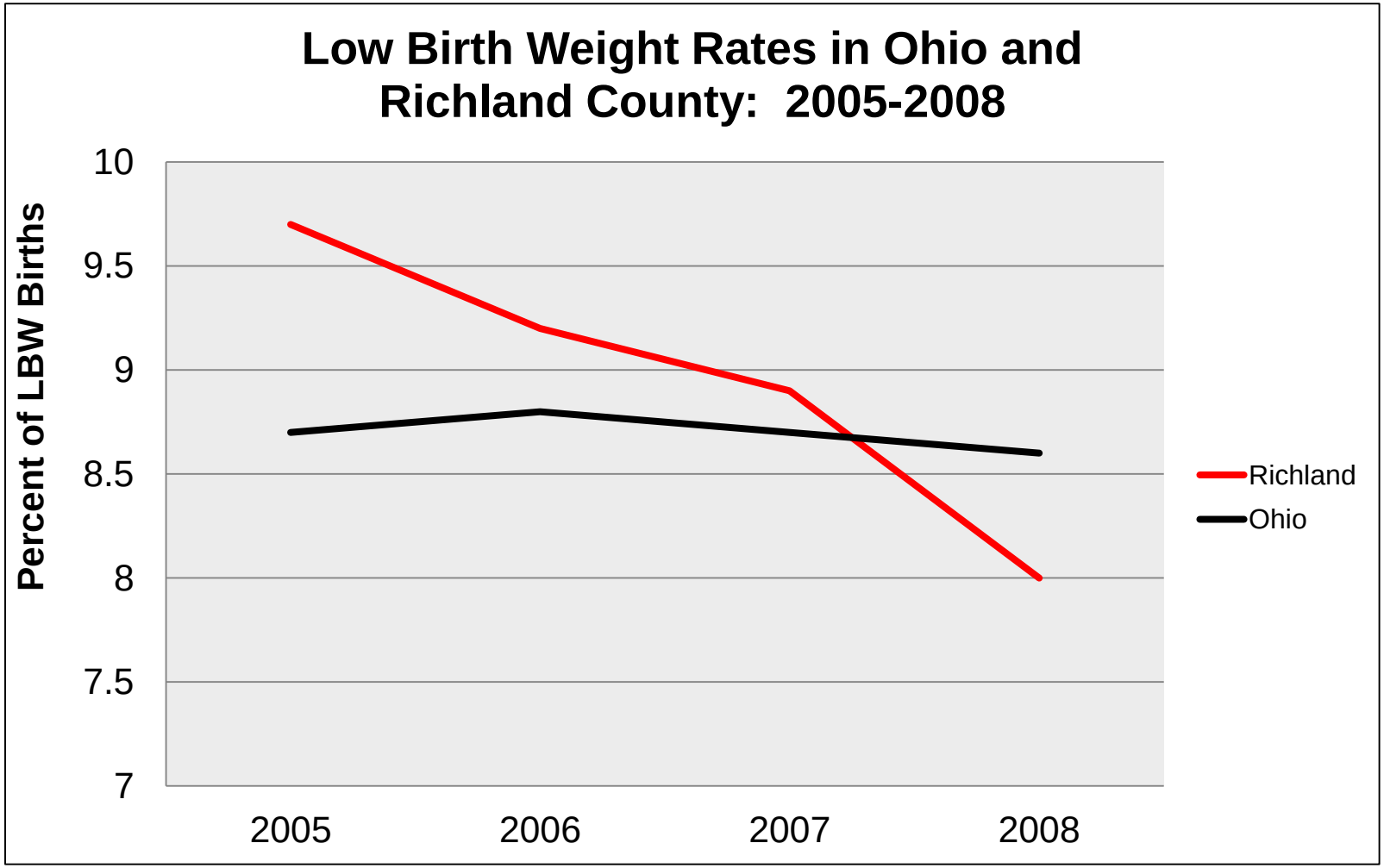
ODH Ohio Department of Health

The CMS Innovation Center

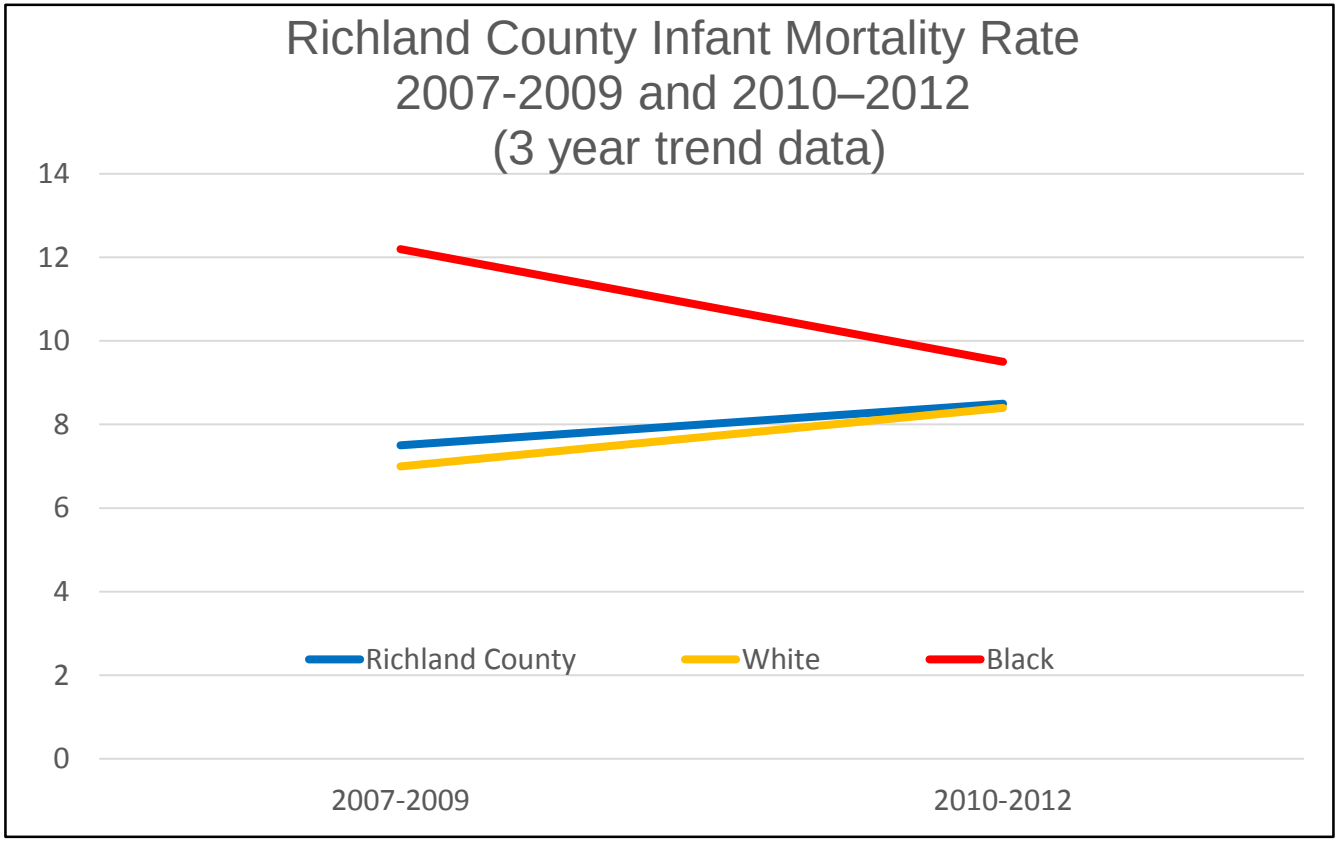
NIH National Institutes of Health
Turning Discovery Into Health

NSF National Science Foundation
WHERE DISCOVERIES BEGIN

LBW in Richland County



Infant Mortality – Richland County

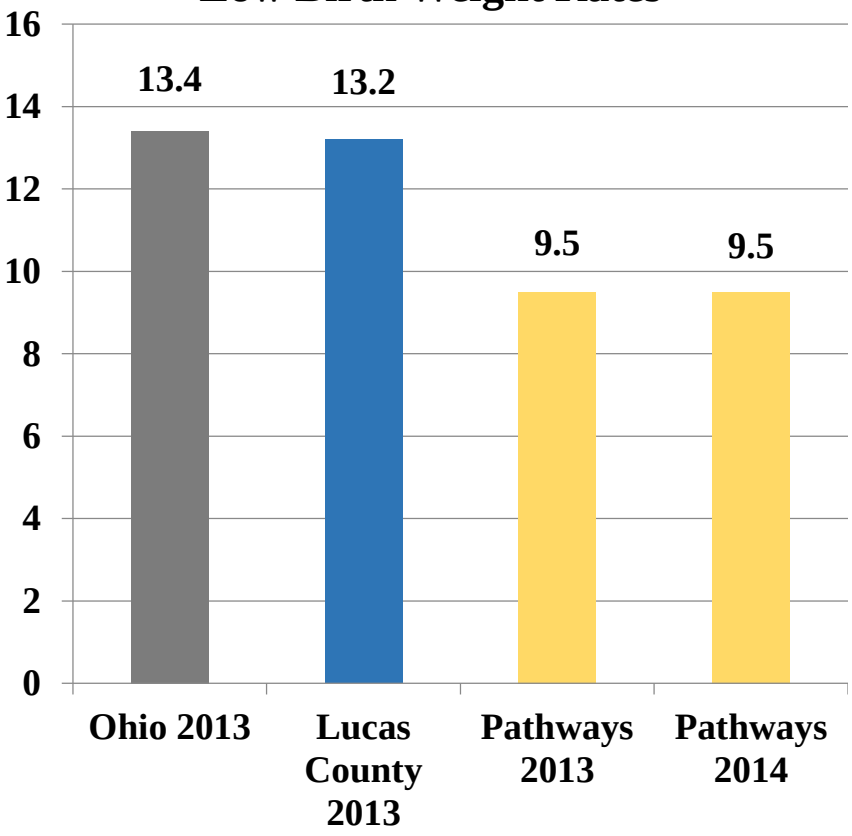


	2007	2008	2009	2010	2011	2012
Infant Deaths Total	15	6	14	15	14	6
White Deaths	11	6	12	13	13	5
Black Deaths	4	0	2	2	1	1
Births, Total**	1,606	1,523	1,517	1,339	1,353	1,410
White Births	1,436	1,365	1,353	1,199	1,220	1,260
Black Births	170	158	164	140	133	150

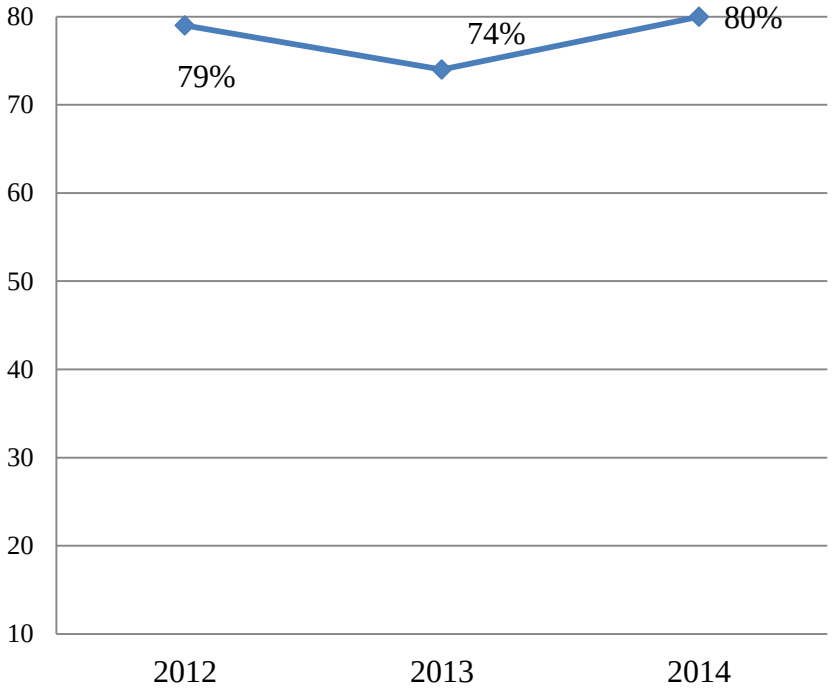
northwest ohio

pathways HUB

Lucas County African American Low Birth Weight Rates

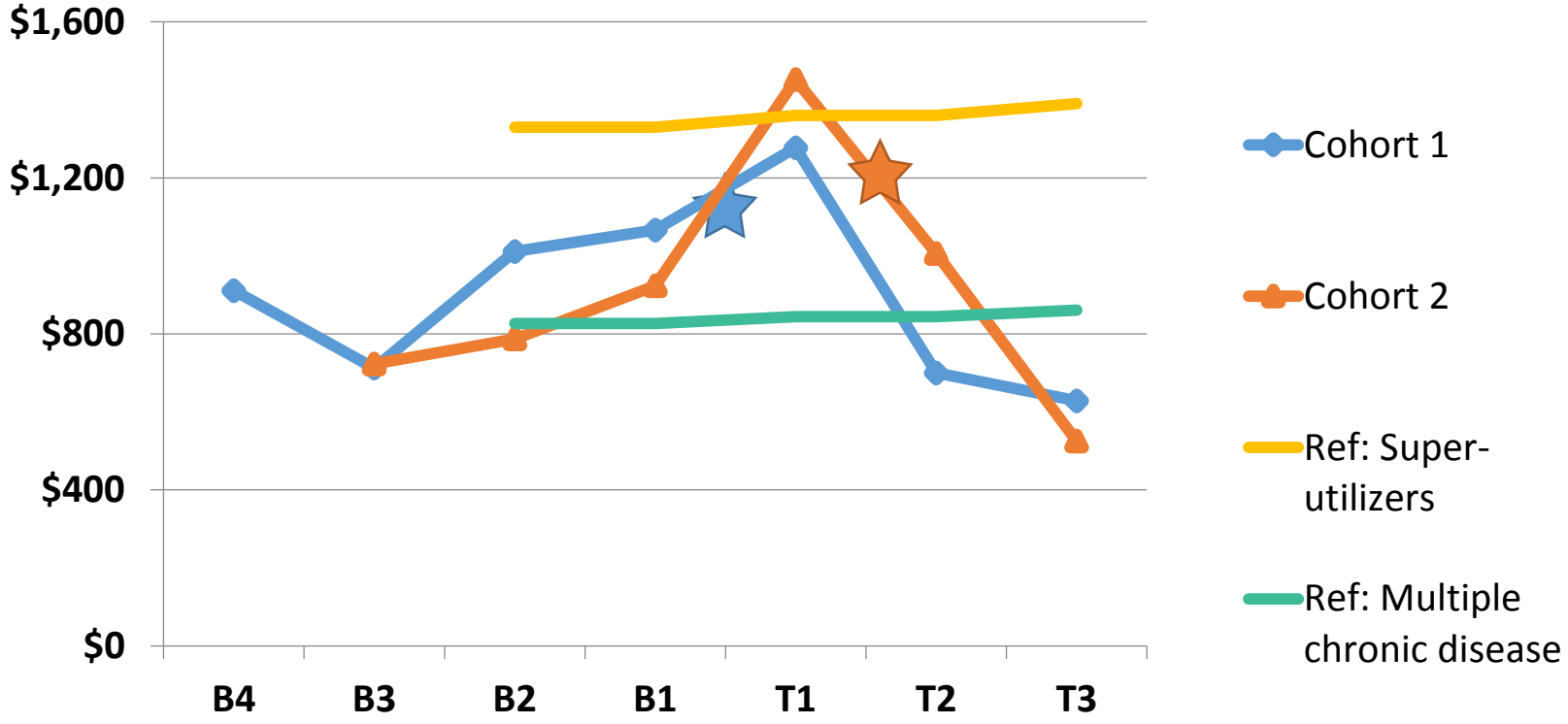


Percentage of NW Ohio Pathways Clients Attending Post-Partum Appointment 2012-2014



In 2013, 63% of women on Medicaid attended post-partum appointment within 90 days

Medicaid Costs: Per Member Per Month



B4-B1: 6 month periods before the beginning of MPBH (Jan 2011 – Dec 2012)

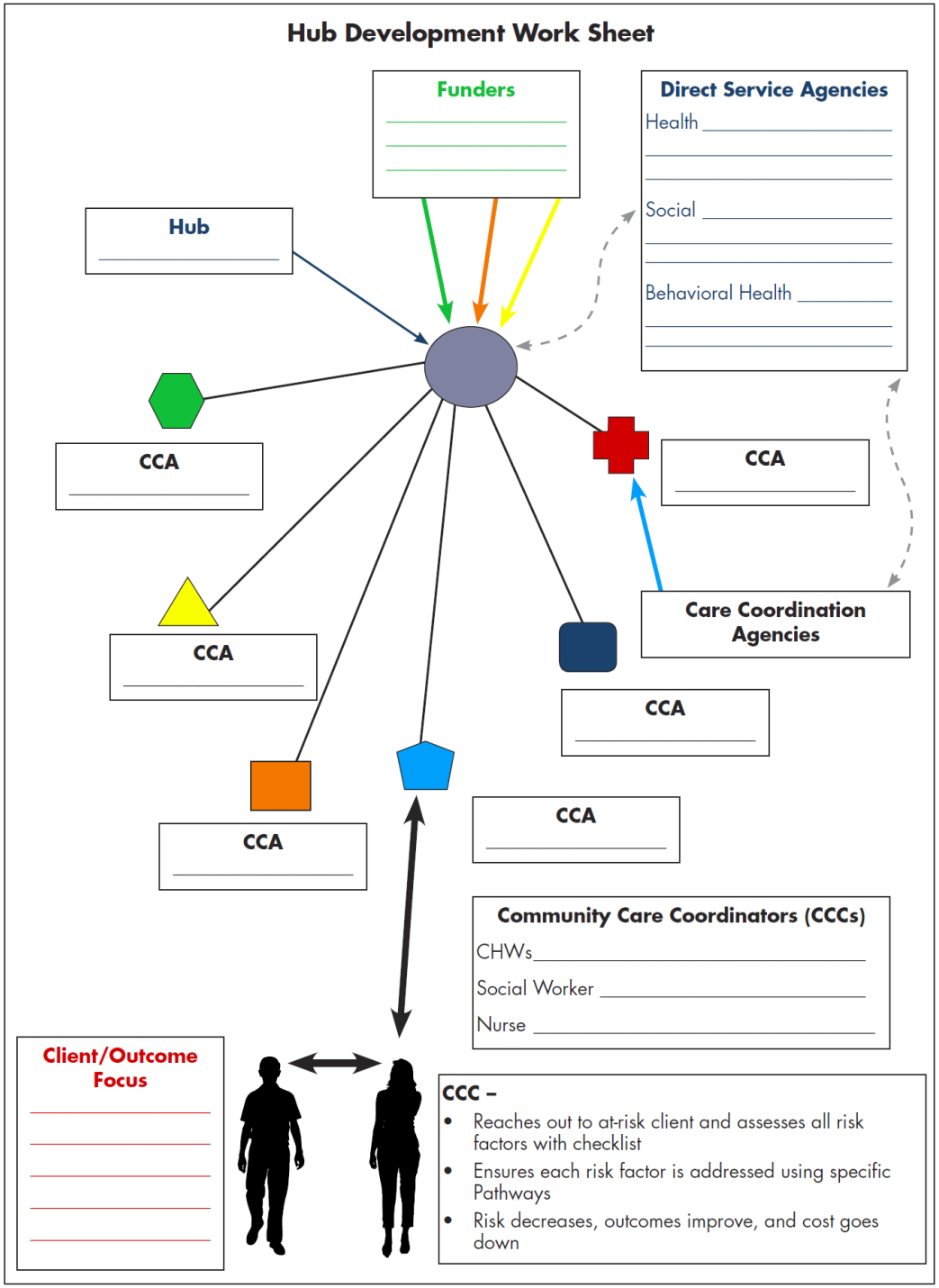
T1-T3: 6 month periods since MPBH services began (Jan 2013 – June 2014)

★ : indicates cohort enrollment into MPBH

Key Points in Building a HUB

- The HUB must be a neutral entity in the community and cannot employ its own care coordinators.
- There is only one Pathways Community HUB in a community or region.
- The HUB must be an independent legal entity or an affiliated component of a legal entity.
- The HUB must be based in the community or region it serves.
- There must be a Community Advisory Board made up of members reflecting the community or region the HUB serves.

Pathways Community HUB Manual



Pathways Community HUB Certification

PATHWAYS COMMUNITY HUB MODEL AND CERTIFICATION PROGRAM

RockvilleInstitute
Research for the Advancement of Social Science

Pathways

Rockville Institute

Pathways

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HOME

ACHIEVING BETTER CARE, BETTER OUTCOMES AT LOWER COST

Form B: Certification Standards
Rockville Institute,
Kresge Grant: 245873

HUB Certification Pre-requisites & Standards

Pre-requisites

1) The Pathways Community HUB (HUB) must be an established community-based organization.
2) The HUB has utilized the HUB model for a minimum of six months.
3) The HUB is the only HUB in its regional service area.
4) The HUB has documentation of coordinating a network of agencies, comprised of a minimum of two agencies, each having at least one care coordinator with assigned caseloads of active at-risk clients identified within the agency's respective service area.
5) The HUB is able to contract with more than one payer on behalf of participating agencies.
6) The HUB is tracking outcomes using standard Pathways.
7) The HUB ties measured outcomes and results to dollars within financial contracts with payers.
8) The HUB has written program requirements and documentation to include client eligibility for services.
9) The HUB has written policies to ensure HIPAA-compliant client privacy and personal health information protections.
10) The HUB is an independent legal entity or an affiliated component of a legal entity.
11) The HUB is free of actual and perceived conflicts of interest (e.g., the HUB cannot employ care coordinators).

HUB Standards

20 Core Pathways – National Certification

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- Behavioral Referral
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- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum

Standard Billing Codes

		Normal Risk	High Risk	Modifier
Checklists				
Initial Pregnancy Checklist	Completed one time at Member enrollment, 1st trimester engagement	G9001	G9003	R1
	Completed one time at Member enrollment, 2nd trimester engagement	G9001	G9003	R2
	Completed one time at Member enrollment, 3rd trimester engagement	G9001	G9003	R3
Pregnancy Checklist	Completed at each face-to-face encounter with Member	G9005	G9010	R
Pathways				
Behavioral Health	Kept three scheduled behavioral health appointments	G9002	G9009	RB
Education	Educational module delivered.	G9002	G9009	RE
Family Planning	LARC (long-acting, reversible) or permanent method	G9002	G9009	G1
Family Planning	All other family planning methods	G9002	G9009	G2
Housing	Residing in affordable & suitable housing for 2 months.	G9002	G9009	RI

Pathways Community HUB Model

- Removes “silos” and fragmentation
- Uses existing community resources efficiently and 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

Resources

Journal of Mat and Child Health – 60% reduction in low birth weight and %500 return on investment
http://link.springer.com/article/10.1007/s10995-014-1554-4

AHRQ – Pathways Manual, Connecting Those at Risk to Care, and other supporting network publications.
http://www.innovations.ahrq.gov

Voices for Ohio's Children

Medicaid Braided Funding Policy Brief, Nov 2013
http://www.raiseyourvoiceforkids.org/Media/Documents/Policy%20Briefs/MedicaidBraided_Brief%20FINAL.pdf

Policy Recommendations - Comprehensive approach to assess and address risk factors in conjunction with EPSDT – Feb, 2016

http://www.raiseyourvoiceforkids.org/Media/VFC/EPSDT_Recommendatins_v3.pdf

NQF - Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination
https://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Care_Coordination.aspx

AHRQ Publication Discussing Risk Scoring
http://www.innovations.ahrq.gov/content.aspx?id=3991&tab=2

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