HEALTH MANAGEMENT ASSOCIATES

PCHI | Pathways

Pathways HUB:

A Population Health Model That Activates The Community Response to Social Determinants

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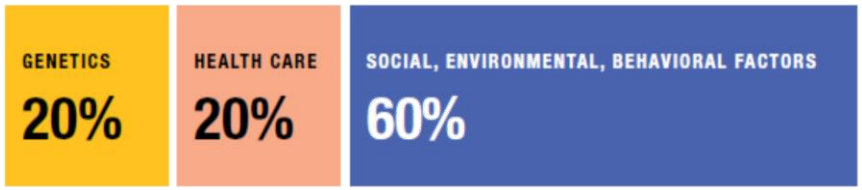
AGENDA

- ❑ Why a Community Response?
- ❑ Common Challenges
- ❑ The Pathways HUB Solution
- ❑ How to Identify and Activate a Community Response

IMPORTANCE OF A COMMUNITY RESPONSE

CBO Value: Evidence

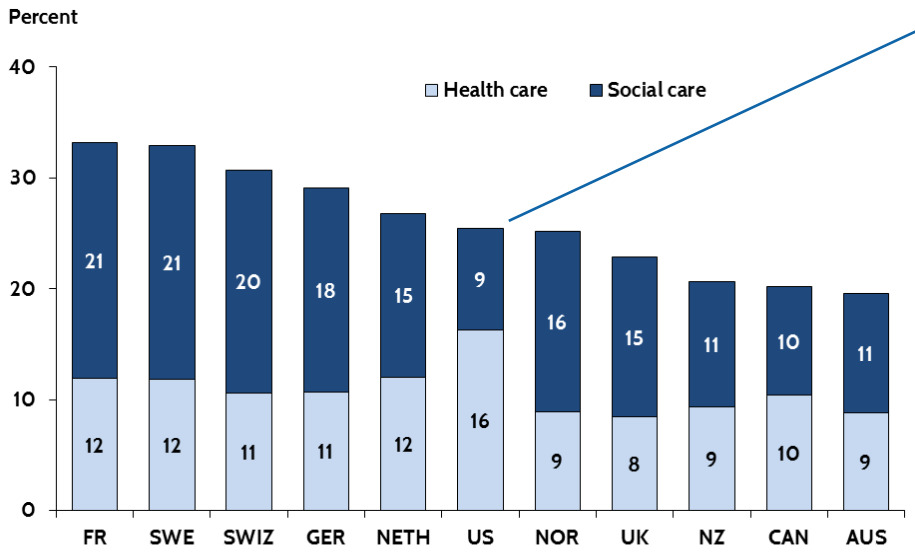
WHAT DETERMINES HEALTH?
(ADAPTED FROM MCGINNIS ET AL., 2002)



What Determines Health?
Not health care spending.

US: 64% of total **%** spent on **health**; **36%** on **social care.**

Exhibit 8. Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

US medical spending is higher, but our life expectancy and infant mortality rates are far lower…if (when?) we balance human services to comparable levels, there would (will?) be $1.19 trillion more spent in human services.

CBO Value

OPPORTUNITIES

+ **Health care systems cannot do what CBOs can do**

+ **CBOs represent diverse groups, address intersectional issues in health planning, health funding, and service organization, engage underserved populations, address SDOH, provide accessible community-based interventions to promote health and wellness, promote cultural competence, and much more!**

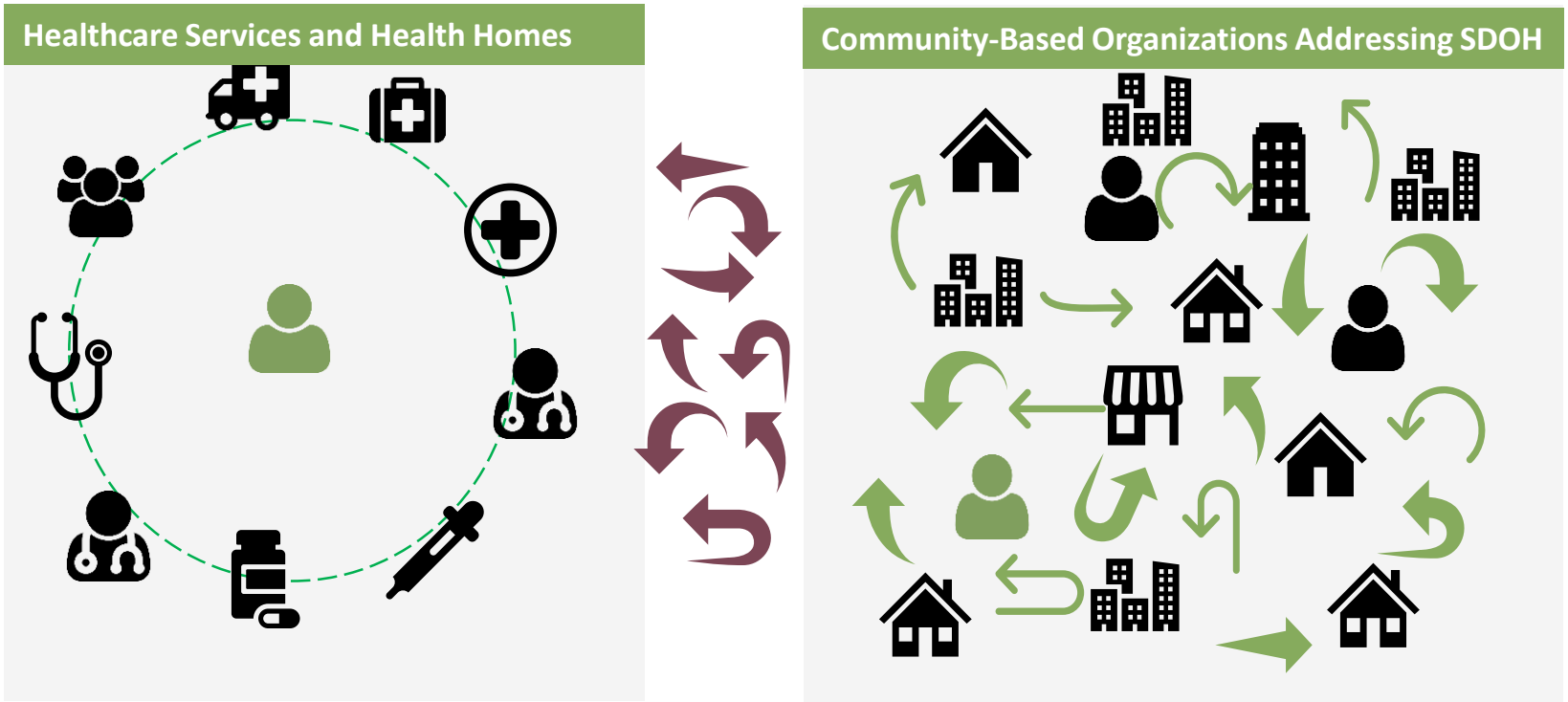
CHALLENGES

+ **Required functions to engage in care delivery system**
+ **CBOs landscape complicated:** CBOs are diverse in size, operate independently
+ **No shared set of goal**
+ **Multiple streams of funding**

HEALTHCARE ENGAGEMENT: OPTIONS FOR CBOs

+ **Individual CBO-HCO partnerships**
+ **Multi-sector or single-sector coalitions**
+ **Focused constituency models**
+ **Network hubs**

CBOs LACK ALIGNMENT WITHIN THE DELIVERY SYSTEM



NO “ONE SIZE FITS ALL”

THE PATHWAYS HUB SOLUTION

PATHWAYS HUB:

A MODEL TO SUPPORT COMMUNITY RESPONSE TO HEALTH INEQUITIES

WHY?

+ Measure and address local health risk factors
+ Coordinate community level outreach, engagement, and connections to social and clinical care
+ Resource sharing for contracting, finance, and quality management
+ Cross sector data collection to identify gaps in SOC

WHO?

+ Community led collective (hub)

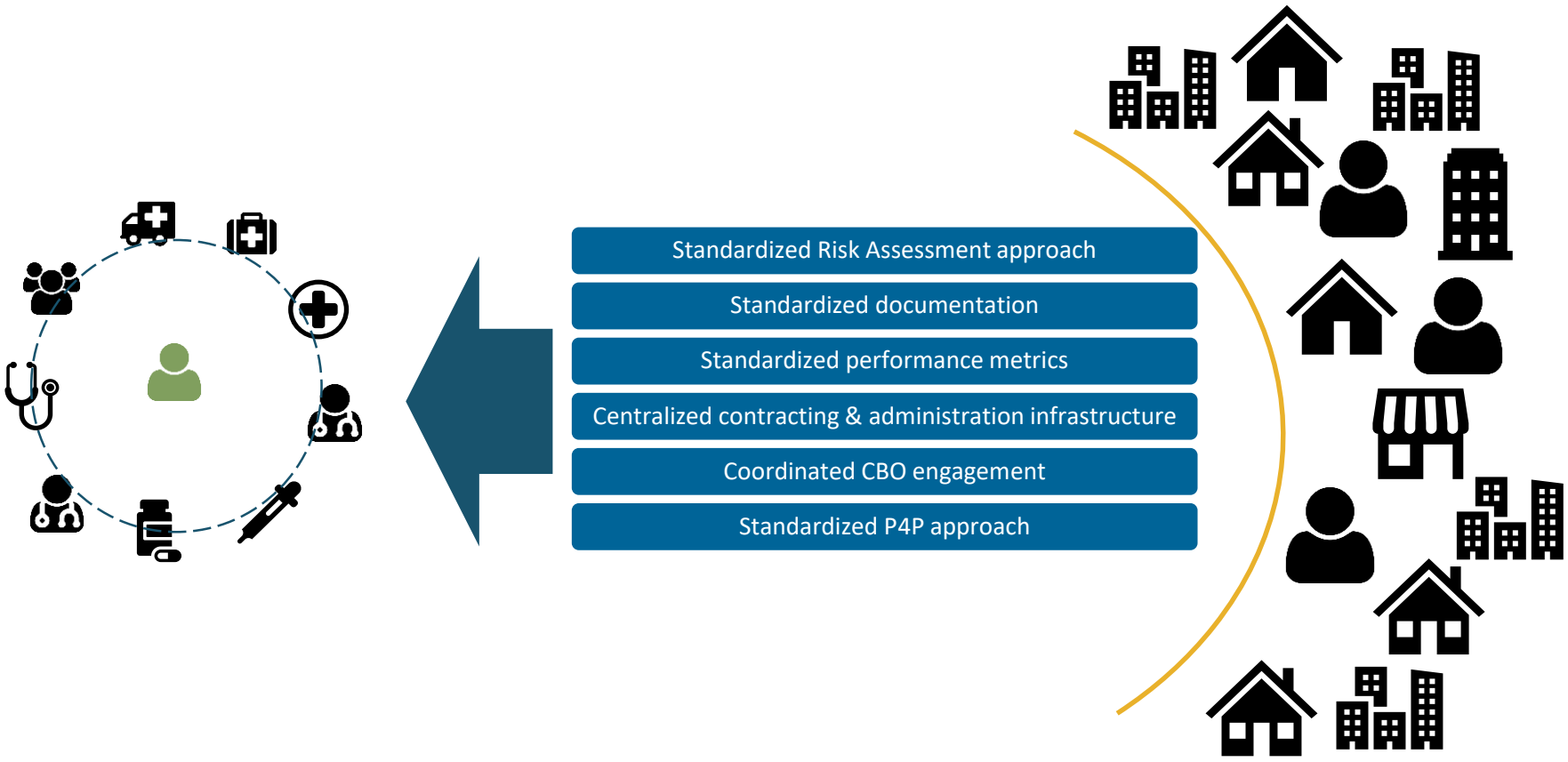
WHAT?

+ Hub is a single point of access for healthcare partners to refer people for care and to share administration functions related to Pathways

HOW?

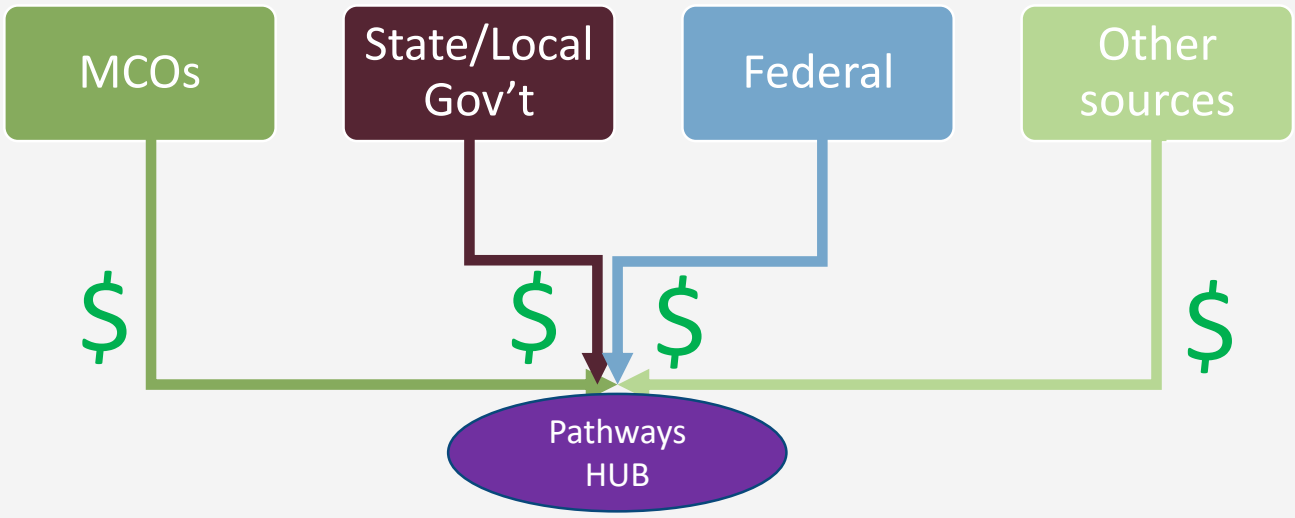
+ Blended and braided funding from multiple sources to support hub functions
+ Plans pay for CHWs to screen and mitigate health risks (pathways)

PATHWAYS HUB APPROACH



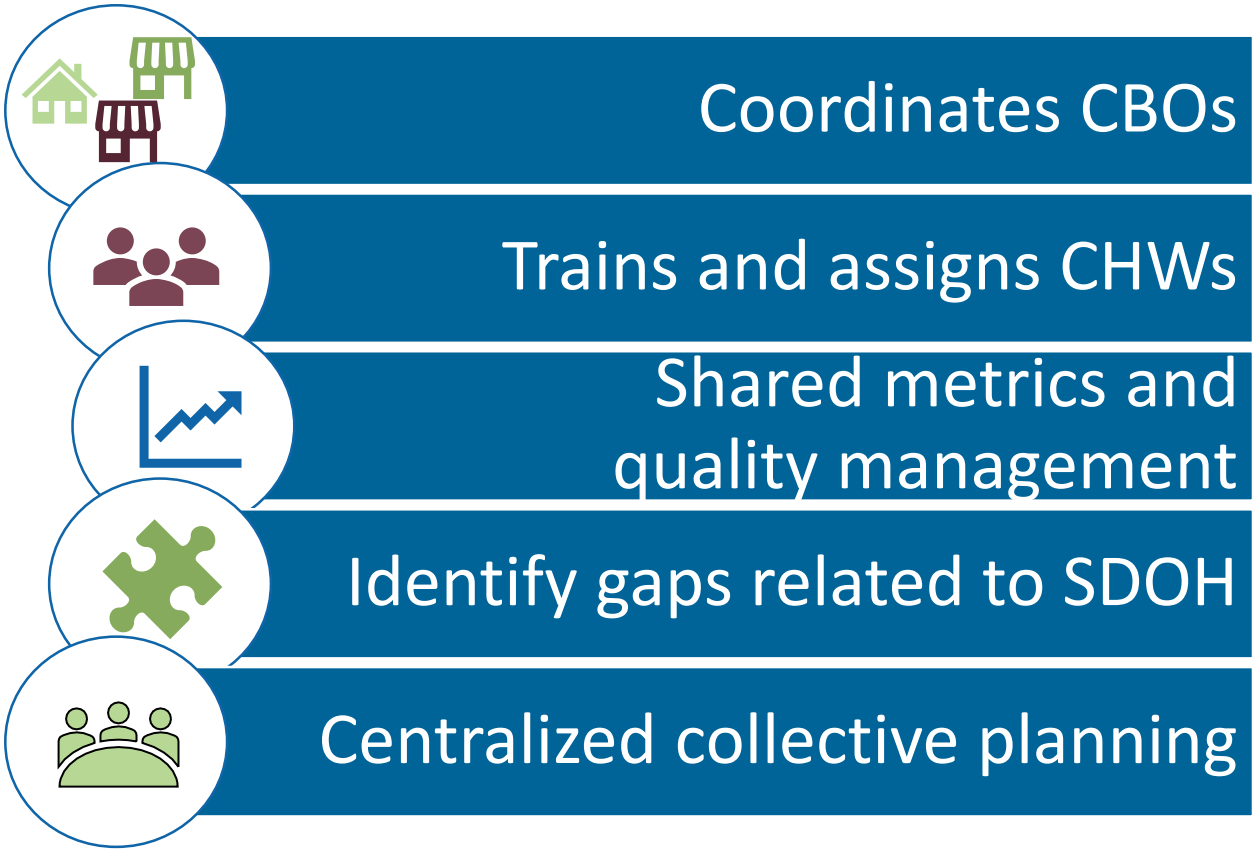
P-HUB INFRASTRUCTURE FOR CBO CONTRACTING

HUB facilitates contracting with multiple payers; braids and blends funds from an array of sources.



THE HUB:

INFRASTRUCTURE FOR CBO COORDINATION & QUALITY MANAGEMENT

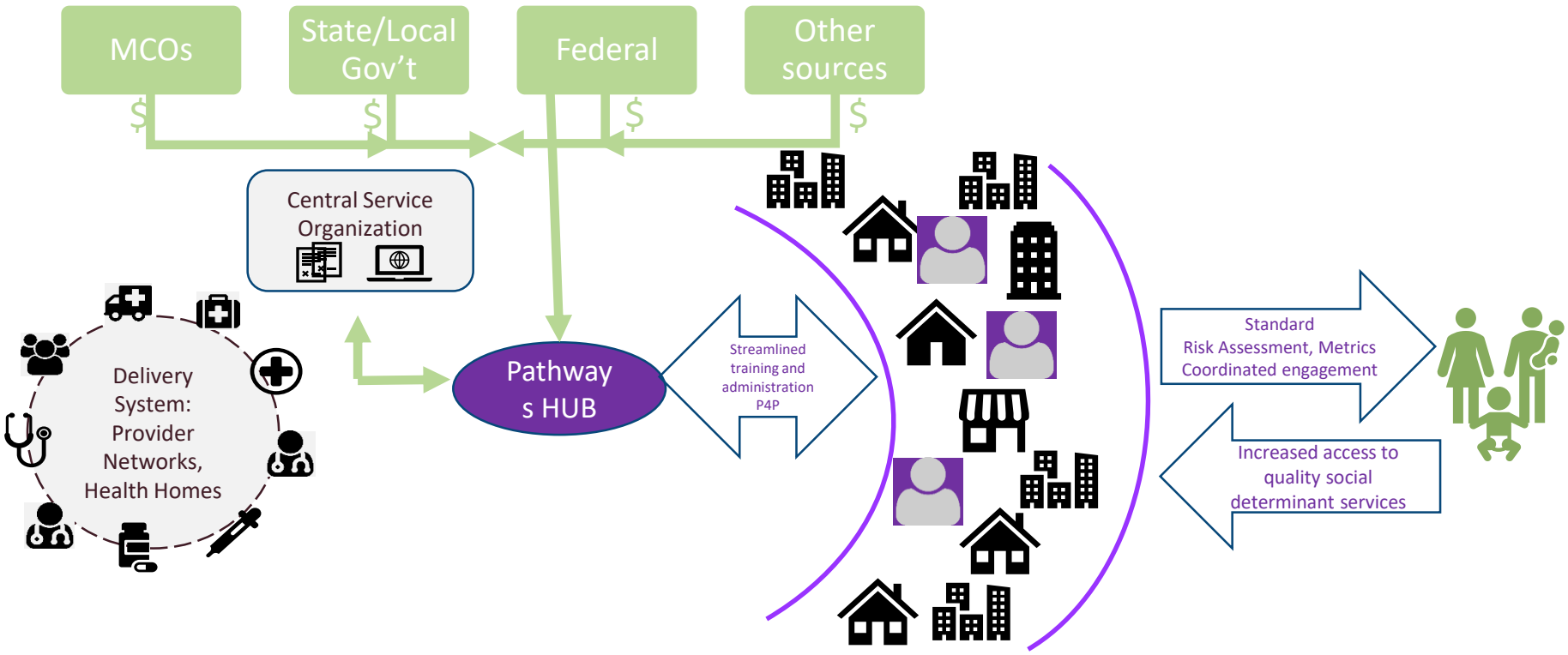


PATHWAYS:
P4P METHODOLOGY BASED ON RISK REDUCTION

Shared risk screening tool identifies “pathways” for risk reduction

Tracks each identified health risk as a standardized *Pathway* for connection to evidence-based and best practice interventions

PATHWAYS HUB IN ACTION



EXAMPLES OF SERVICES MCOS REIMBURSE

Counseling and connecting members to use of long acting reversible contraception

Connecting to three consecutive behavioral health appointments

Food, utility, and domestic violence assistance

Connecting members to affordable and suitable housing

Move member to tobacco cessation for 6 months

Connection to a medical home

IMPROVES OUTCOMES

Retrospective Cohort Study

+ **3,702** deliveries in Health Council of Northwest Ohio
+ All deliveries between March 2013-February 2017
+ Variables included: mother's age, race/ethnicity, gestational age, birthweight, and whether the baby needed neonatal care.

Methodology:
Bivariate and multivariate analysis to identify odds ratios for Neonatal/NICU Admission by select predictors for all deliveries and separately for deliveries to high-risk, moderate-risk, low-risk, and unknown risk mothers in the service area.

RESULTS OF COMMUNITY HUB ENROLLMENT

HIGH RISK PREGNANCY
Significantly less chance of neonatal admission

ALL RISK LEVELS
Approached significance in reduced chance of neonatal admission

Source:
Lucas, B., Detty, A. "Improved Birth Outcomes through Health Plan and Community Hub Partnership." December 2018. BuckeyeHealthPlan.com.

IMPROVES OUTCOMES & SAVES MONEY

For every dollar spent on Community Hub activities, there was a savings of $2.36.

ROI: 236%

Source:
Lucas, B., Detty, A. "Lower First Year of Life Costs for Babies through Health Plan and Community Hub Partnership." December 2018. BuckeyeHealthPlan.com.

Newborns born to mothers at risk for low birthweight delivery

+ High risk: PMPM cost savings of **$403**
+ Medium risk: PMPM cost savings of **$252**
+ Low risk: PMPM cost savings of **$171**

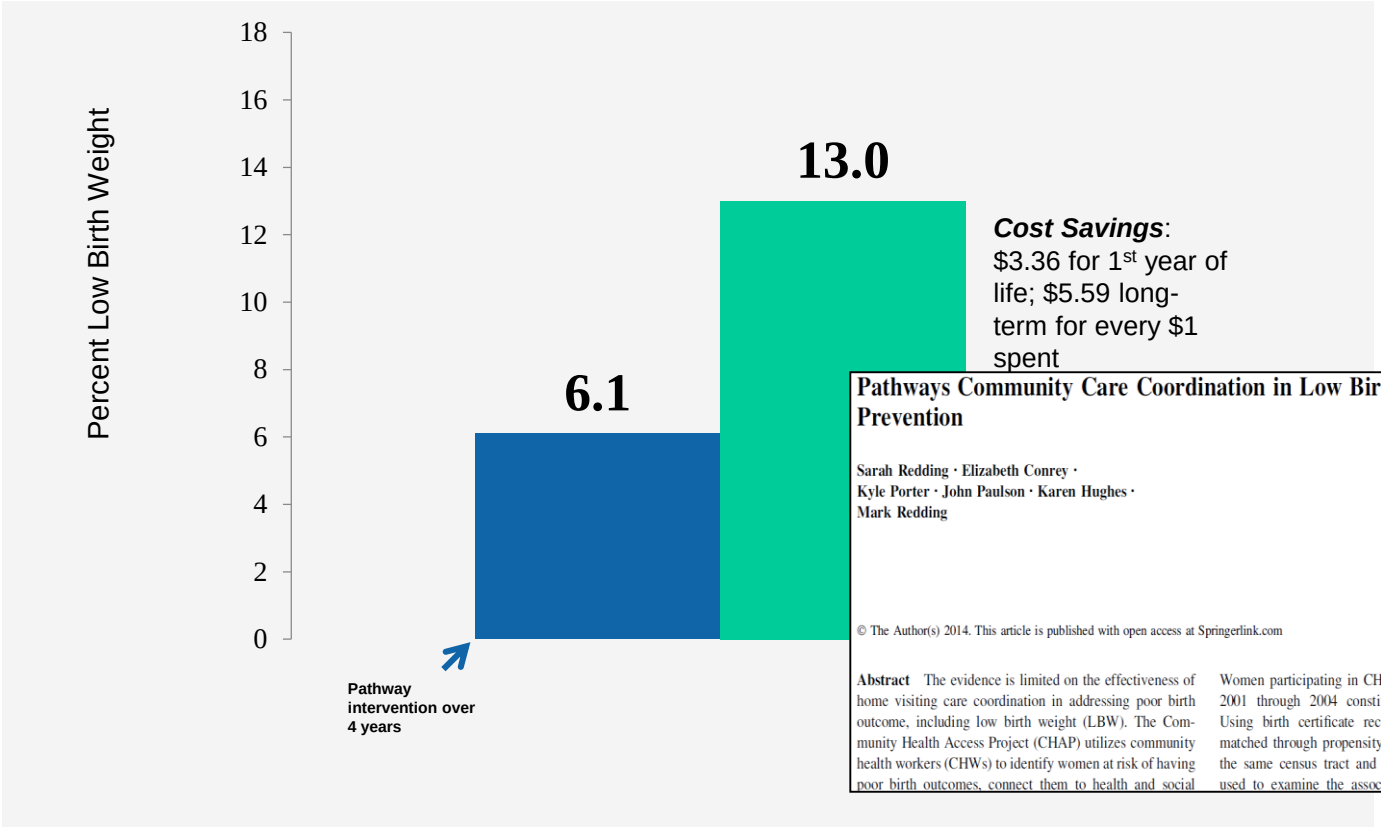
94%

High risk have highest cost savings through inpatient services

$379

High risk: inpatient PMPM cost savings

FIRST PUBLISHED STUDY ON RESULTS



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

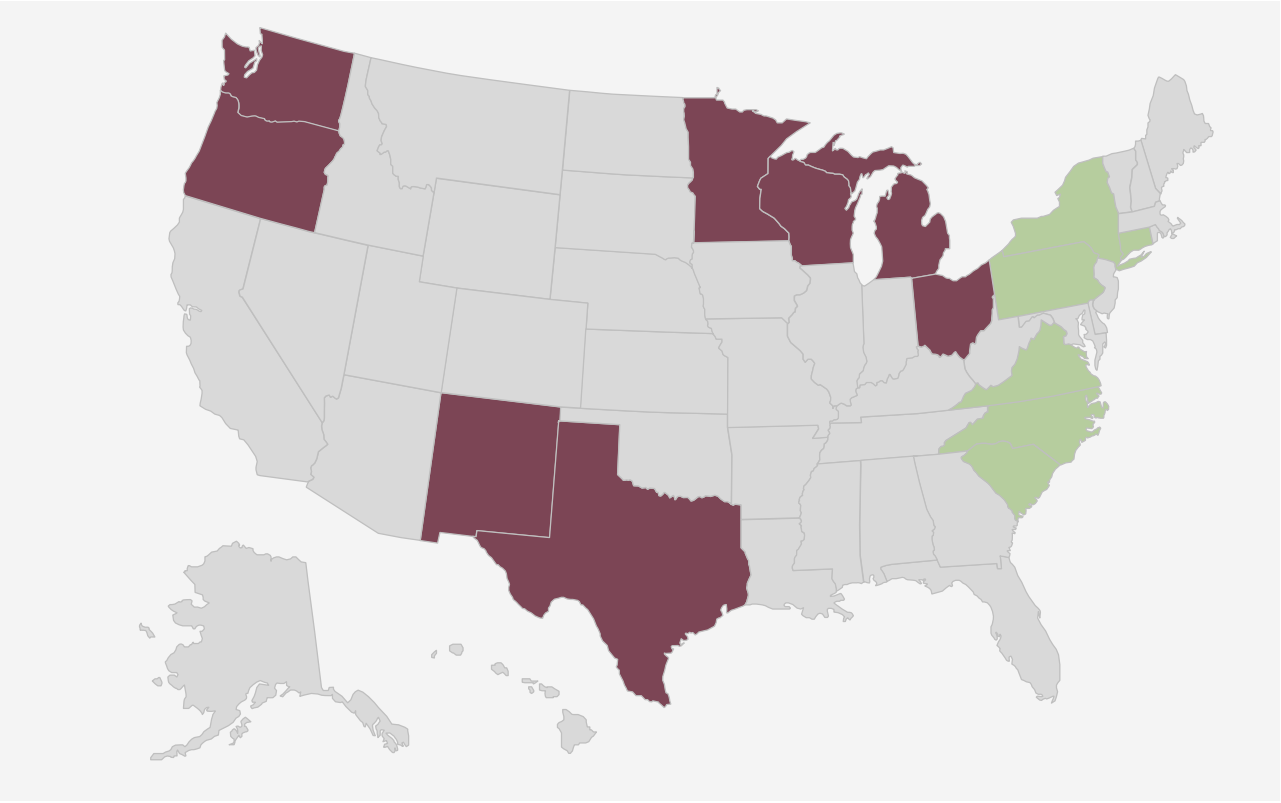
Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

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

PHUB RECOGNITION

TRIED AND TESTED

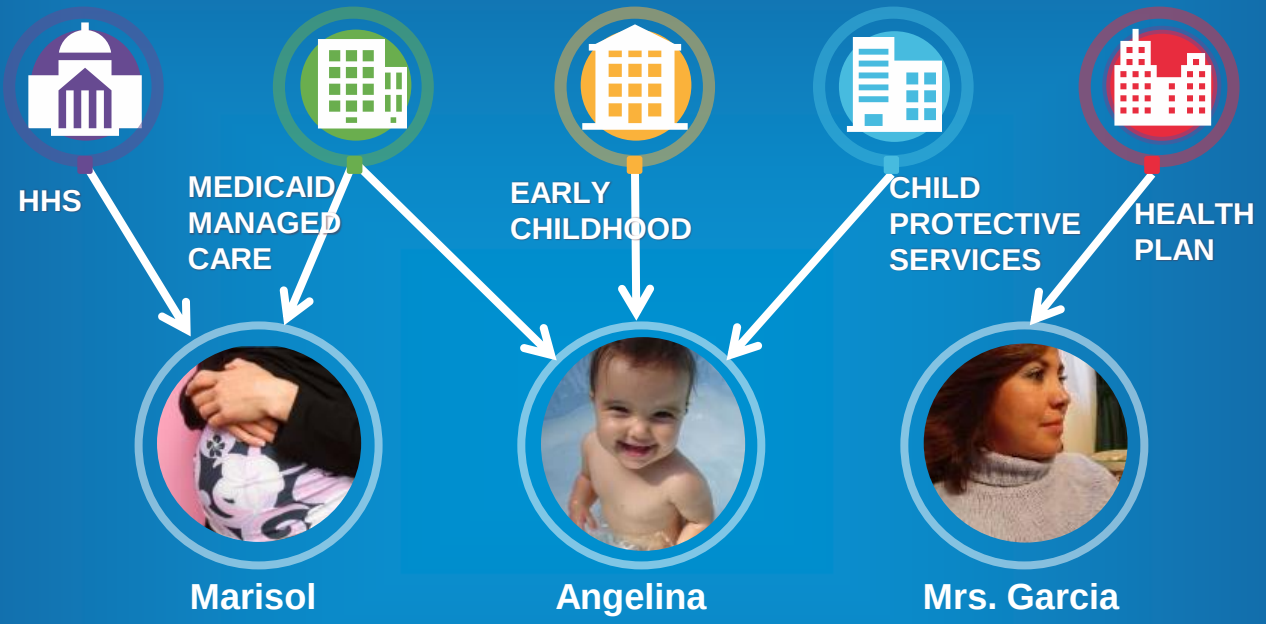


Orange – Active HUBs
Ohio, Michigan, Washington, Oregon, Texas, New Mexico, Wisconsin, Minnesota

Pink – Developing HUBs and Pathways Programs
Pennsylvania, New York, North Carolina, South Carolina, Connecticut Virginia

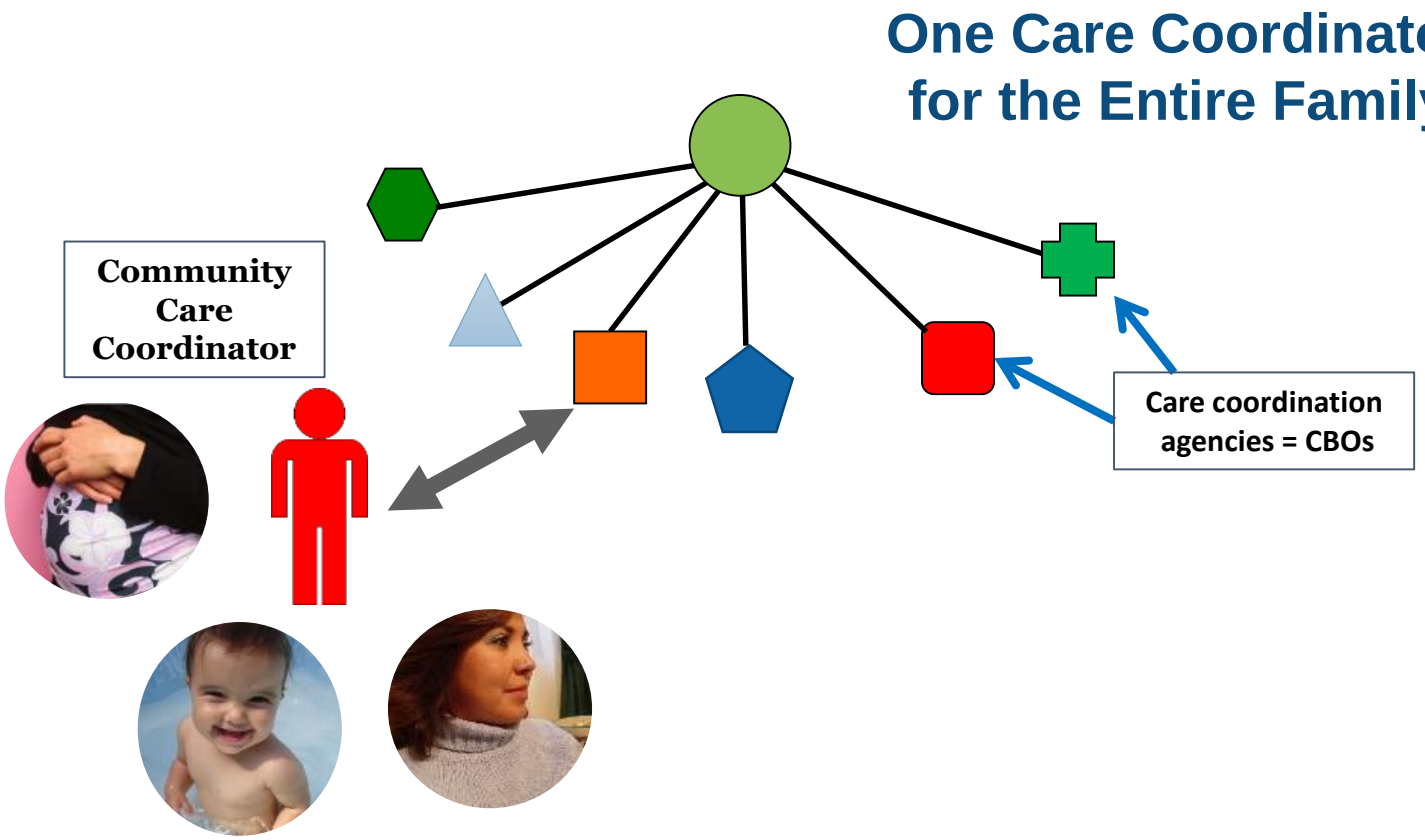
There are 4-5 other states in an exploratory Phase

CARE COORDINATION AND SERVICE APPROACH



Multiple agencies involved – limited communication – No effective tracking of identified and addressed risk factors

COMMUNITY HUB



RISK FACTORS

Health Care

Health Insurance
Primary Care
Specialty Care
Screenings
Child development

Behavioral Health

Drug and ETOH
Depression
Anxiety
Domestic Violence

Education Employment

Job Readiness
Self Esteem
Clothing
Application Assist

Social

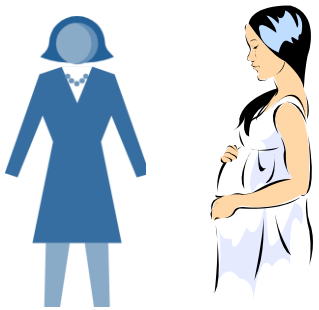
Food
Clothing
Housing
Heat
Electricity etc.

Safety

PATHWAYS COMMUNITY HUB

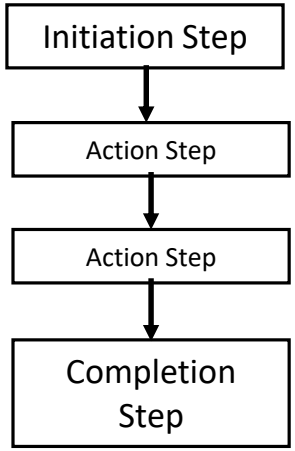
Engagement of at risk client – Assess Risk

Initial Checklist – Captures Comprehensive Risk Issues



Yes	No	Question
✔		Do you need a primary medical provider?
	✔	Do you need health Insurance?
	✔	Do you smoke cigarettes
✔		Do you need food or clothing?

Assign Pathways



Track/Measure Risk Factors Addressed (Connections to Care)

By: Care Coordinator
Agency
Region

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

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

MEDICAL HOME PATHWAY

Risk Factor Identified

Initiation

Client needs an ongoing source of primary care.
Date_____

Barriers Identified and Overcome

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
Risk Factor Confirmed Addressed

Completion

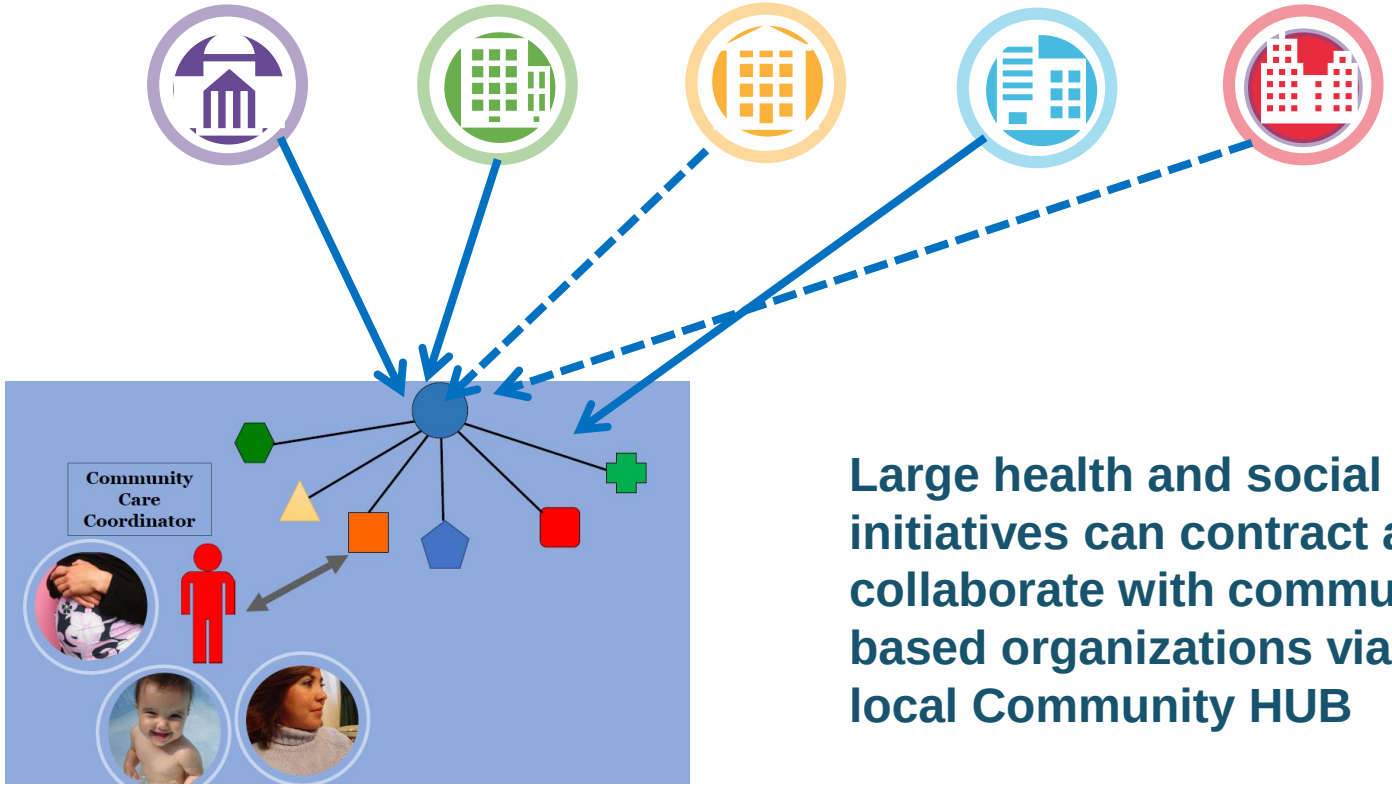
Confirm that appointment was kept. Date_____

RISK REDUCTION REPORTS NOW LIVE IN 6 OHIO HUBS

SAMPLE REPRESENTS 1 HUB BRIEF PERIOD OF DATA

Risk Factor	# Found	# Addressed	# Not Addressed	Average Time days	Cost per Addressed $25-$250
Medical Home	55	44	11	10	
Medical Referral	272	227	45	27	
Medication Assessment	49	41	8	13	
Pregnancy	85	71	14	101	
Family Planning	57	42	12	75	
Post Partum	59	48	10	49	
Social Service Referral	276	201	75	19	
Food	45	43	2	5	
Clothing	28	22	6	4	
Legal Assistance	52	25	27	42	
Housing	30	4	13	63	
Behavioral Health	35	14	21	58	
Smoking Cessation	40	3	26	112	

COMMUNITY HUB AND FUNDERS



Large health and social initiatives can contract and or collaborate with community based organizations via their local Community HUB

One Care Coordinator for the Family

Marisol

- Pregnancy PW
- Employment PW
- Housing PW
- Medical Referral PW
- Social Service Referral PW
- Education PW – prenatal, parenting

Angelina

- Medical Home PW
- Immunization Referral PW
- Medical Referral PW
- Developmental Screening PW

Mrs. Garcia

- Medical Referral PW – primary & specialty
- Housing PW
- Social Service Referral PW
- Education PW - diabetes

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

SYSTEM OF PATHWAY BILLING USED IN OHIO

		Normal Risk	High Risk	Modifier
Checklists		**Billing #**	**Billing #**	
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

COMMUNITY HUB RESOURCES

Evidence and Related Publications
https://pchi-hub.com/publications

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.
https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

AHRQ
Connecting Those at Risk to Care – The Quick Start Guide
https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

National Certification
Pathways Community HUB – Rockville Institute
https://pchcp.rockvilleinstitute.org/

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

Association of Maternal and Child Health Programs (AMCHP)
http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Pathways%20Community%20HUB.pdf

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HOW TO IMPLEMENT

IMPLEMENTING A HUB

Identify a core team of local champions

- 5-10 diverse community representatives
- May be community members, community-based organizations that employ care coordinators, faith-based organizations, healthcare systems, providers, social service agencies, policy makers, legislators, payers and funders

Identify Funding

- Grants and/or State, County, Medicaid plans, delivery systems, private foundations, and more

Customize the plan

- **Identify target population to start with**
  May be SUD/SMI population, Maternal and Child Health, Children in Foster Care, Re-entry population, or other
- Identify a HUB lead and participating care coordination agencies

HMA/HMA-CS
CBO ENGAGEMENT TOOLKIT

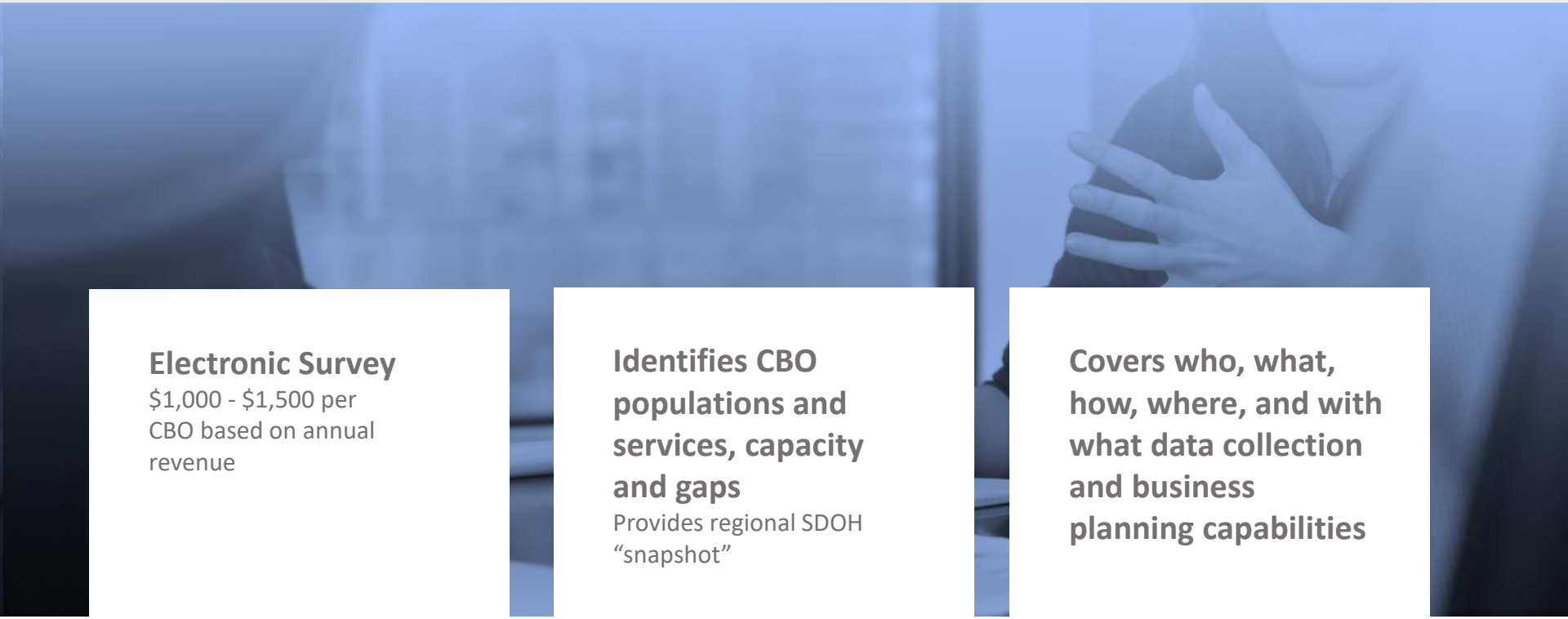
Community programs and model design, development, implementation

Readiness Assessment Tool
TA, Training, Tools for CBOs to use

Analytics, Participatory Evaluation

Rate development
VBP contracting
ROI Analysis

HMA'S CBO CAPACITY ASSESSMENT TOOL



Electronic Survey
$1,000 - $1,500 per CBO based on annual revenue

Identifies CBO populations and services, capacity and gaps
Provides regional SDOH "snapshot"

Covers who, what, how, where, and with what data collection and business planning capabilities

TA AND TRAINING

Developing the CBO Value Proposition

Performance Outcome Measurement to Achieve Return on Investment (ROI)

Information Technology and Data Planning

Business Development, Financing, and Budget Development

THANK YOU

Hot off the press

Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program

AcademyHealth in partnership with Health Management Associates (HMA) and the Disability Policy Consortium (DPC)

Authors: Ellen Breslin, MPP (HMA), Heidi Arthur, LMSW (HMA), Dennis Heaphy, MPH (DPC)

Contributors: Denise Soffel, PhD, (HMA), Susan Kennedy, MPP/MSW, (AcademyHealth), and Sunita Krishnan, MPH, (AcademyHealth)

HMA DPC

Figure 1. Five Key Lessons from NYC CBOs

Lesson 2. Bridging the Cultural Gap Between Health Care Organizations (HCOs) and Community-Based Organizations (CBOs) Requires A Paradigm Shift.

Lesson 3. Successful Reform Requires Engagement and Expertise from Community-Based Organizations that Represent their Communities.

Lesson 1. Delivery System Reform Must Be Rooted in Health Equity and Wellness Goals.

Lesson 4. Community-Based Organizations Must Build Capacity to Level the Playing Field.

Lesson 5. Community-Based Organizations Must Come Together as a Collective to Participate in Delivery Reform.

CONTACT US

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