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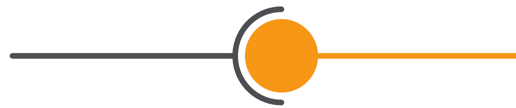


pathways **HUB**

Jan Ruma
Vice President, Hospital Council of Northwest Ohio
Director, Northwest Ohio Pathways HUB

Strategic Partnership

Stark County THRIVE
Infant Mortality Project

- Strong evidence based interventions
- Built on broad based community collaboration
- Measure results for success
- Leverage regional investments
- Develop model for sustainable interventions and funding.
- Improve infant mortality
- Eliminate disparities

Pathways Community HUB Model Endorsers

Ohio Commission On
Minority Health

Ohio
Department of
Medicaid

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

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

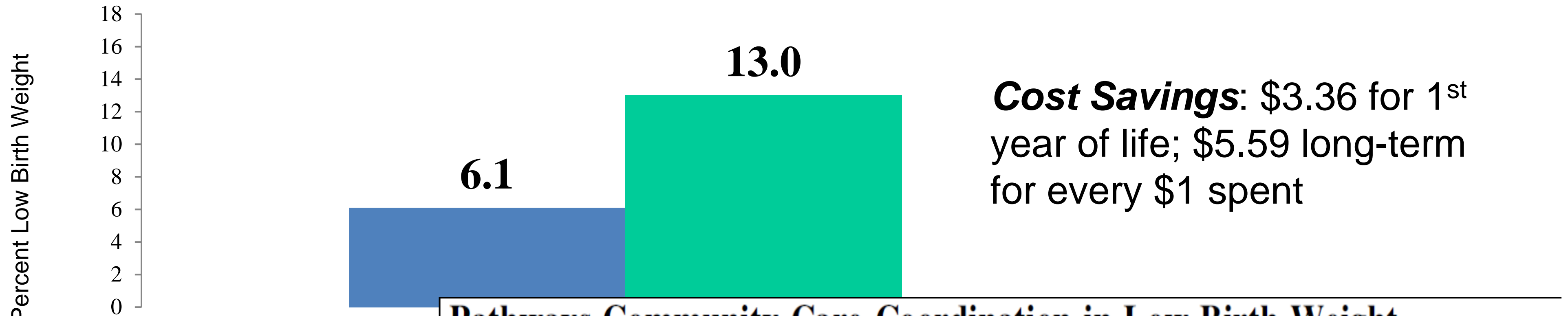
Ohio
Department of Health

National Science Foundation
WHERE DISCOVERIES BEGIN

National Institutes of Health
Turning Discovery Into Health

The CMS Innovation Center

Published Study on Results



Pathway intervention over 4 years

Pathways Community Care Coordination in Low Birth Weight Prevention

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

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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

Health Disparities: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. ***Source: CDC***

ZIP CODE
95202
Life Expectancy
73

ZIP CODE
92606
Life Expectancy
88

Your **ZIP Code** shouldn't predict **how long you'll live**, but it does.

#HealthHappensHere
www.calendow.org

#APHA12
www.apha.org

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REACHING FOR *Health Equity*

Reducing health disparities brings us closer to reaching health equity.

Programs designed to reduce health disparities

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

http://www.cdc.gov/minorityhealth/strategies2016/

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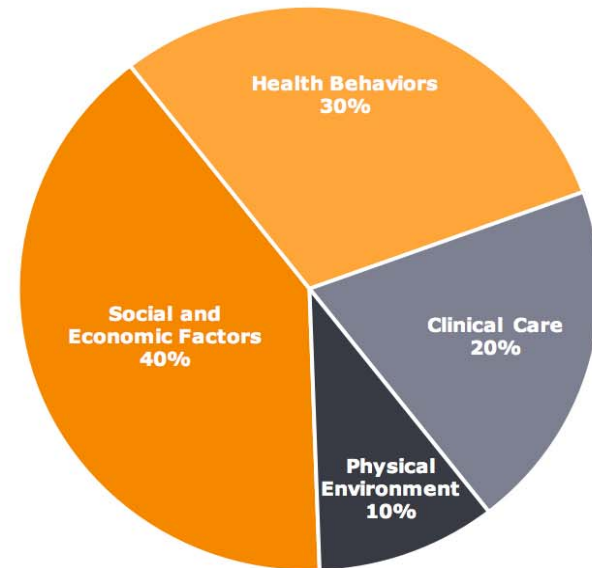
Social Determinants



Barriers to Health

The Certified Pathways Community HUB Model
is an effective way for organizations to work toward common goals.

Common Goal=Reducing Health Disparities

HUB=Collective Impact

The 5 Conditions of Collective Impact

1 Common Agenda

- **Common understanding** of the problem
- **Shared vision** for change

2 Shared Measurement

- **Collecting data** and **measuring results**
- Focus on **performance management**
- **Shared accountability**

3 Mutually Reinforcing Activities

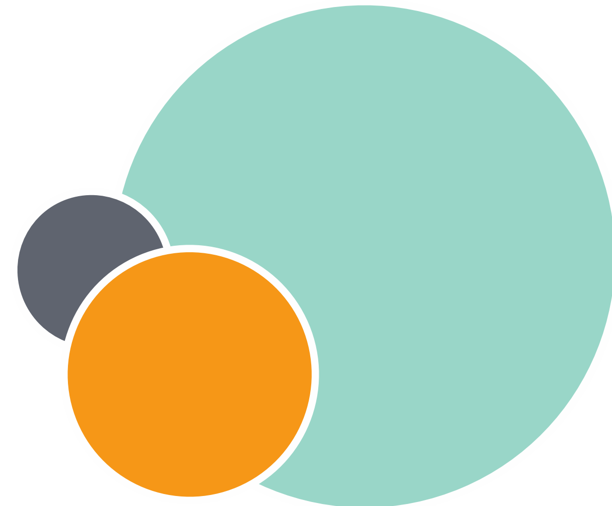
- **Differentiated approaches**
- **Coordination** through joint plan of action

4 Continuous Communication

- **Consistent** and **open communication**
- Focus on **building trust**

5 Backbone Support

- Separate organization(s) with **staff**
- Resources and skills to **convene** and **coordinate** participating organizations



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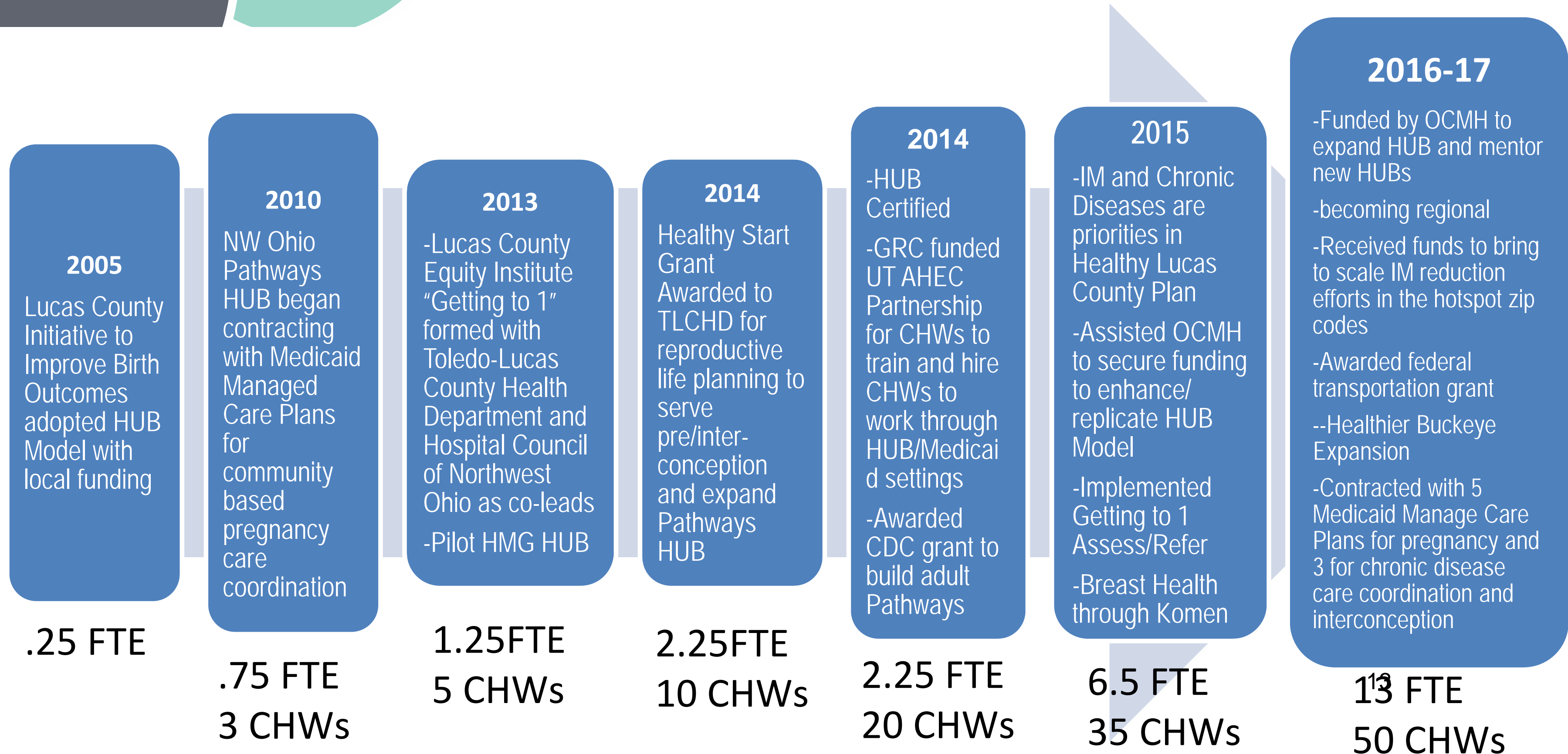
Milestones to Reduce Health Disparities

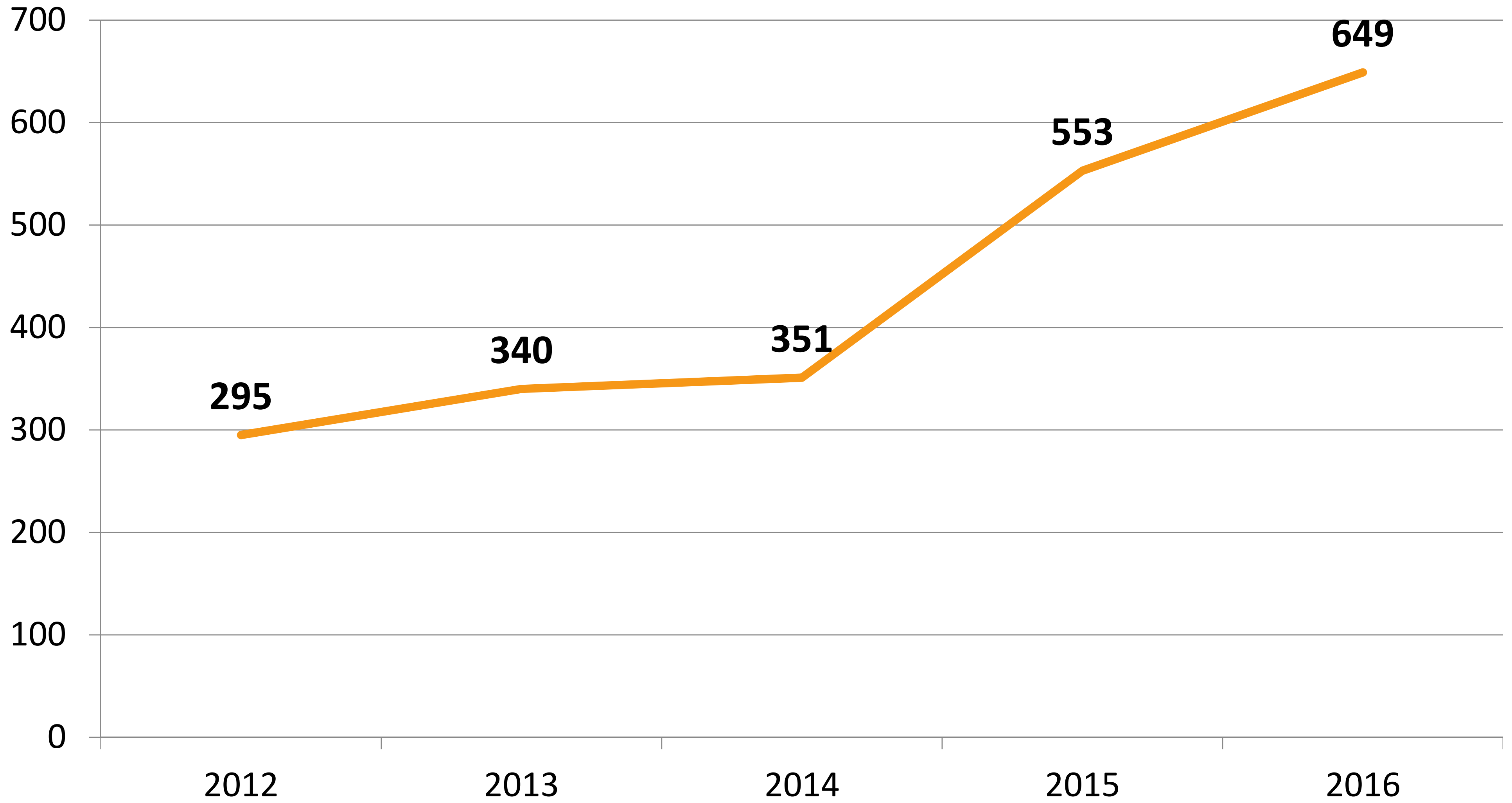


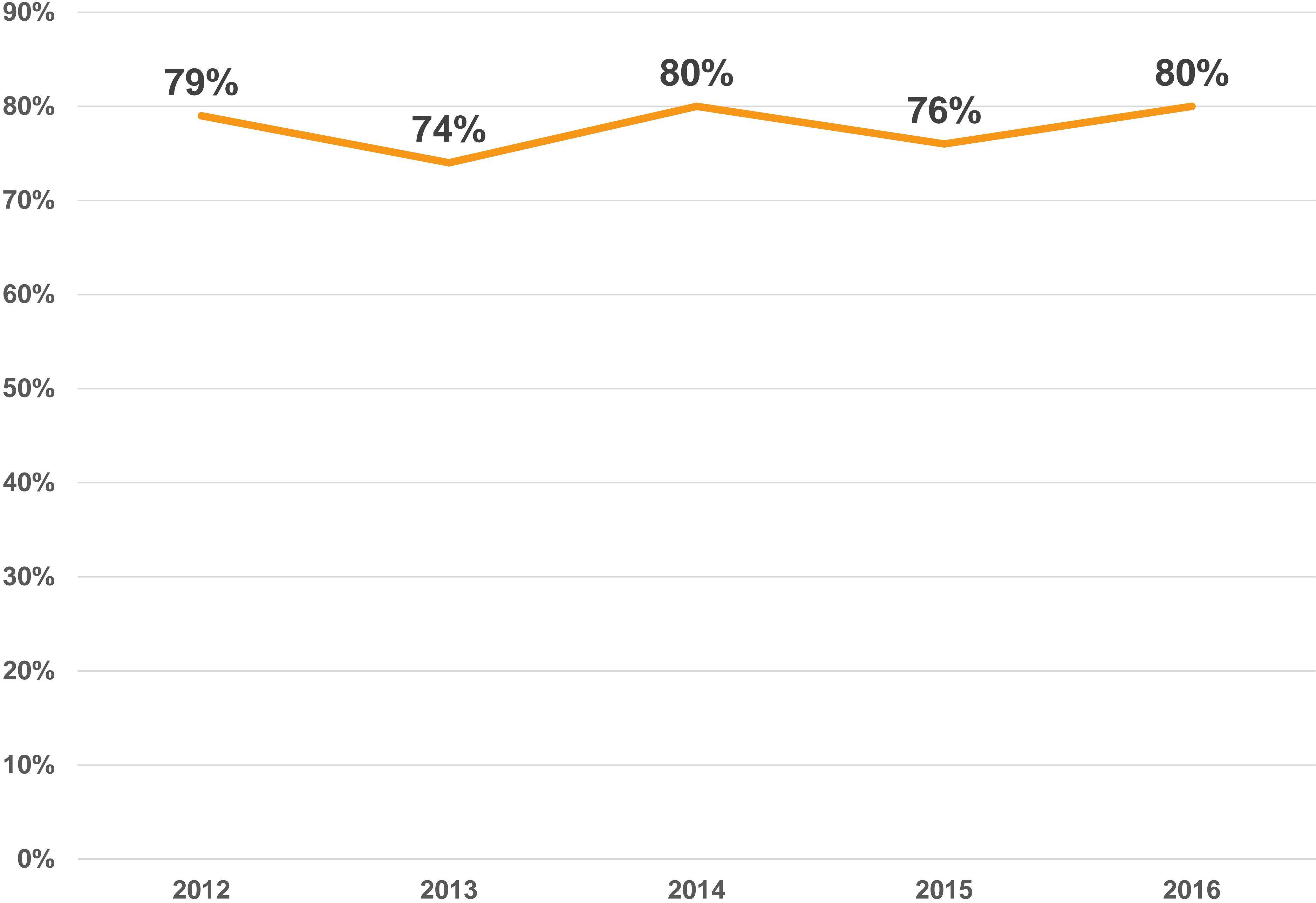
Medicaid Managed Care Plan Partners

Baby Pathways

Adult Pathways

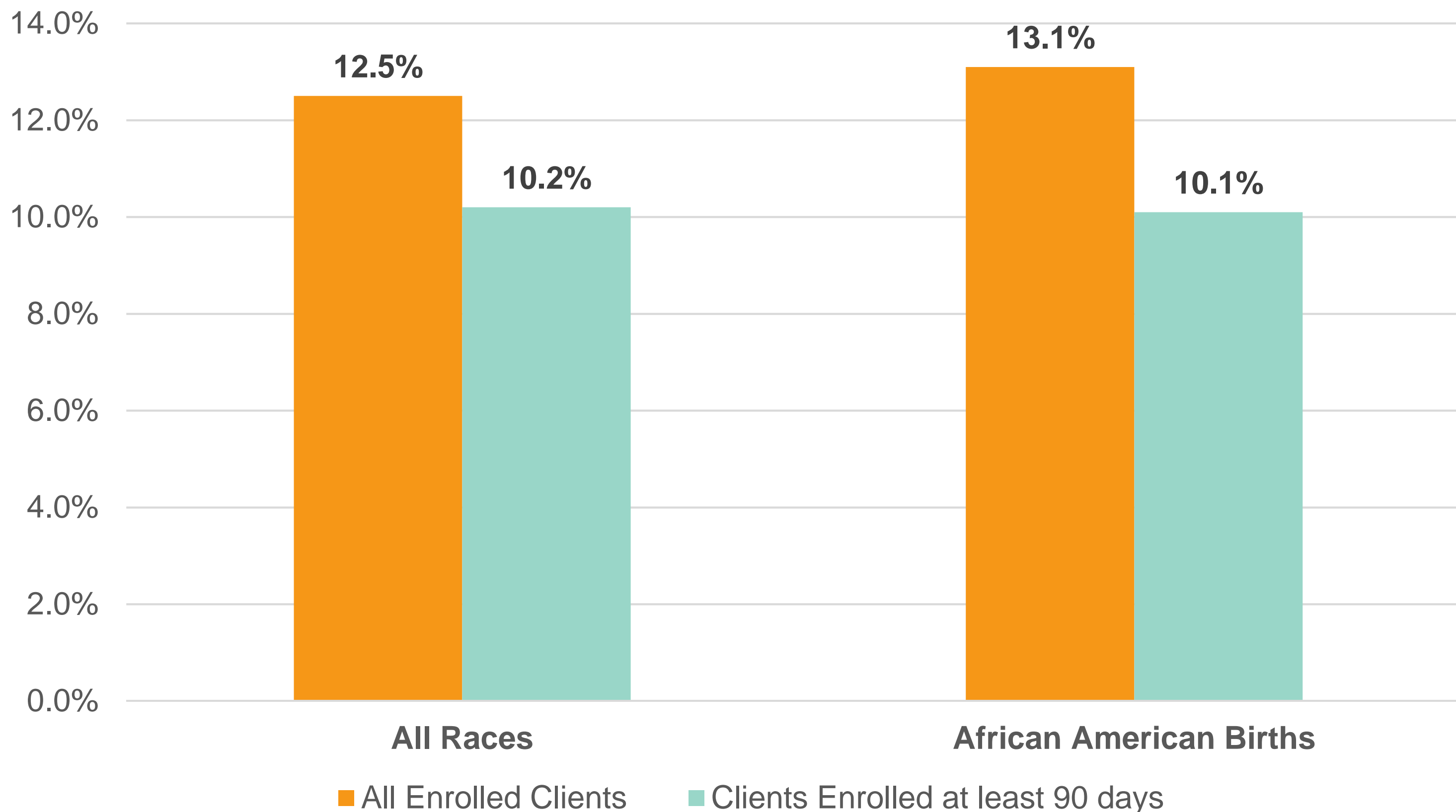
Overall Prenatal Enrollments

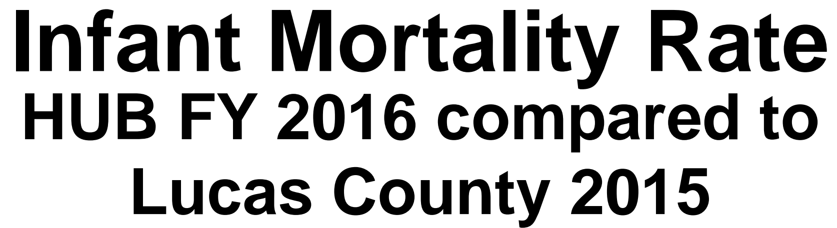



Overall Postpartum Rates
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
79%
74%
80%
76%
80%
2012
2013
2014
2015
2016

Low Birth Weight Rates
2013-2016

Lucas County 2015
African American– 16%
All Races – 9.6%





African American Infant Mortality Rate

	Infant Mortality Rate
Pathways HUB	5.3
Lucas County	16.8

Certified Pathways Community HUB Model

Pathways

Step 1: Find

Comprehensive Risk Assessment

Step 2: Treat

Assign Pathways

Step 3: Measure

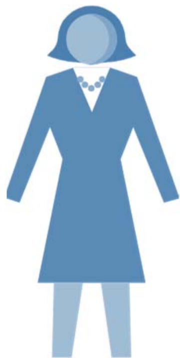
Track and Measure Pathways Connections to Care

Direct Services = <u>Intervention</u>

Care Coordination = clinic based

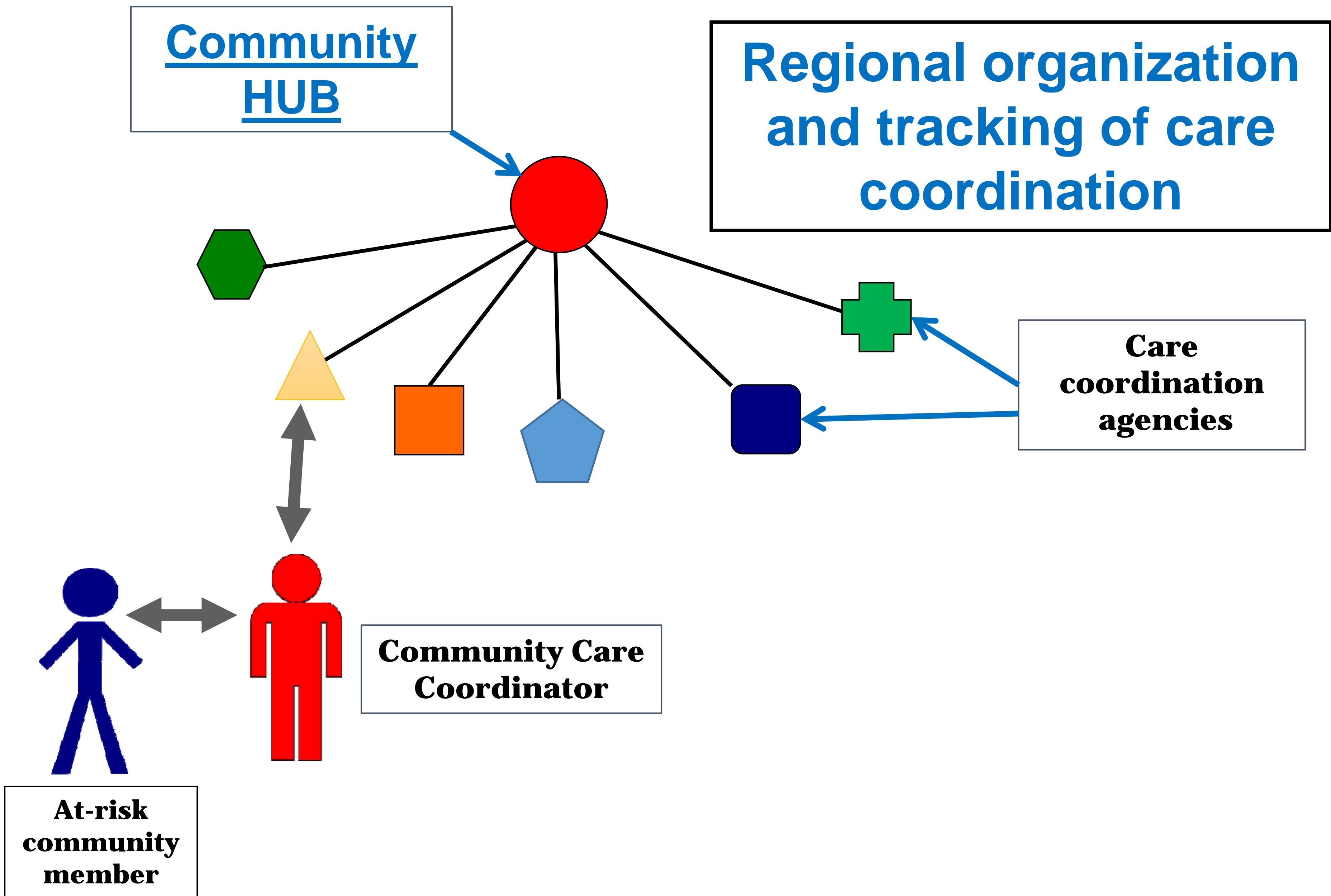
Community Care Coordination = home based

Community Care Coordination – care coordination provided *<u>in the community</u>*; confirms connection to health and social services.



A Community Care Coordinator:

- Finds and engages at-risk individuals
- Completes comprehensive risk assessments
- Confirms connection to care
- Tracks and measures results


Community HUB
Regional organization and tracking of care coordination
Care coordination agencies
Community Care Coordinator
At-risk community member

Community-Wide System to Address Disparities and Improve Population Health

Referrals and Assessments by Medical Professionals

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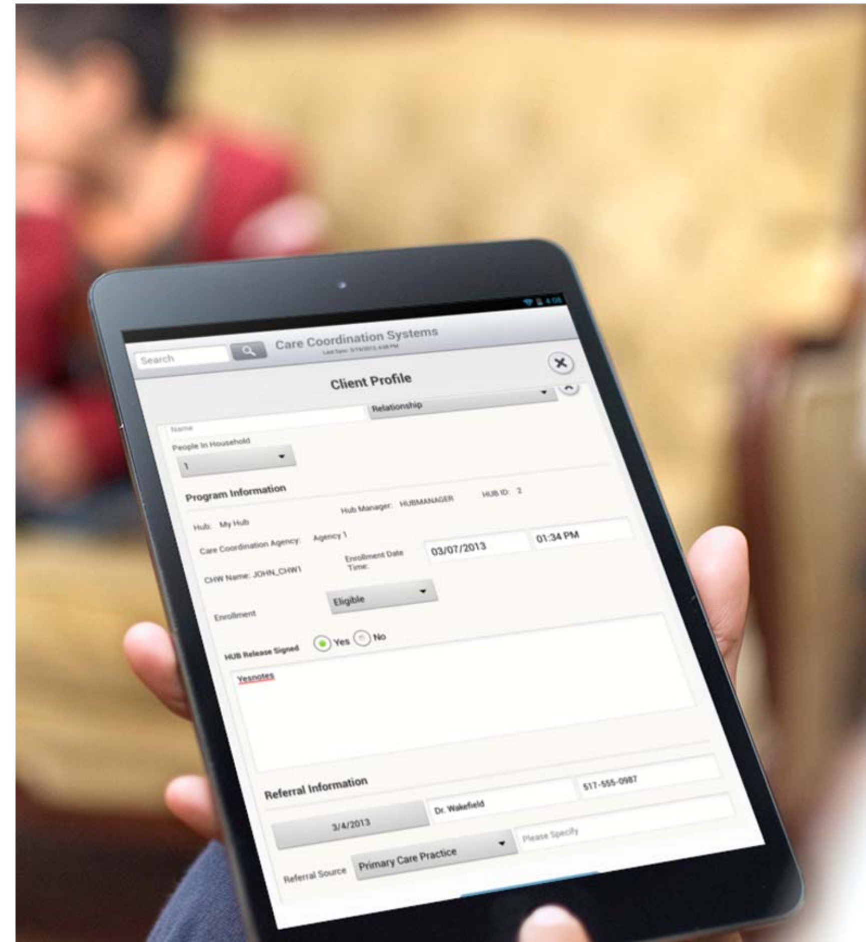
Neutral Forum
Track Data
Measures Outcomes/QI
Provide Training
Eliminate Duplication
Identify & Address Gaps
Community Outreach

Outcome Payments from Medicaid Managed Care and Grant Funding

Find: Comprehensive Risk Assessment

Standard Data Collection:

- Client Profile
- Initial Checklist (enrollment)
- Ongoing Checklist at each face-to-face 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

Medical Home Pathway

MEDHOME1
Initiation Date

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

Start Date

Determine payment source for health care

Payment Source:
- ☐ Medicaid
- ☐ Medicare
- ☐ Private Insurance
- ☐ Self Pay
- ☐ Bureau for Children with Medical Handicaps
- ☐ Other: ________

Find appropriate primary medical provider options for payment source.

Medical Provider

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.

Date of Initial Appointment

Education provided ☐ Yes ☐ No

MEDHOME3
Completion Date

Completion
Confirm that appointment was kept.

Date of kept appointment

MEDHOME4
Finished Incomplete Date

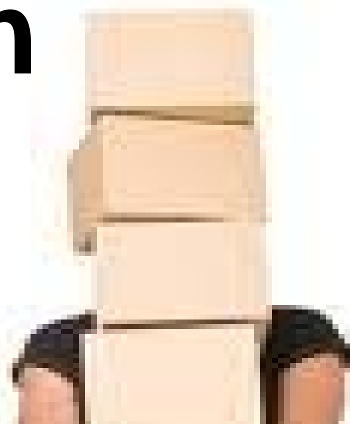
Finished incomplete reason:

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

Risk Assessment and Risk Reduction

Community Based Care Coordination



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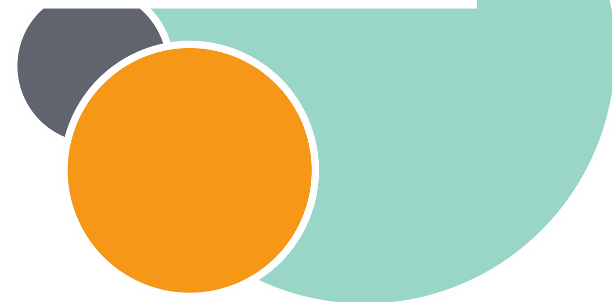
WHAT IS A CERTIFIED COMMUNITY HEALTH WORKER?

The Northwest Ohio Pathways HUB system relies on certified community health workers (CHWs), who help connect low-income residents to needed medical care and social services. Who are CHWs, and what can they do for you?

CHWs
Serve as partners & coaches
to help people take charge of their health.



Connect people to health insurance, a primary care provider and medical services.

Educate people about their conditions, and provide referrals to community resources.

Ensure people are able to get food, housing, clothing, diapers and other **basic needs.**

Work at physician offices, clinics, agencies and other places **throughout the community.**

Evidence Base for CHW Strategy

- CHWs provide outreach, education, referral and follow-up, case management, advocacy, and home visiting services.
- Rated expected beneficial outcomes include Increased patient knowledge; access to care; healthy behaviors and preventive care.*
- ***strong evidence*** of effectiveness: interventions that engage CHWs in a team-based care model to improve blood pressure and cholesterol in patients at increased risk for CVD
- ***sufficient evidence*** of effectiveness: interventions that engage CHWs for health education, and as outreach, enrollment, and information agents to increase self-reported health behaviors (physical activity, healthful eating habits, and smoking cessation) in patients at increased risk for CVD.**

* County Health Rankings & Roadmaps

** The Guide to Community Preventive Services Task Force

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…**

Risk

It is a Systems Issue …

Are we serving the most at risk?

- **5% of population uses 56% of health care resources** (Ohio Medicaid data)
- Most at-risk are often the hardest to serve → no incentive to serve them
- Access for all (insured and un-insured) has gotten worse over the past 10 years

Low Income Resident. . .

Individual issues cross multiple agencies that function as silos:

- Health care
- Insurance
- Housing
- Education / Employment
- Mental health

. . . . and no one is **measuring the system**
→ only the individual agencies

Health-Related
Care Coordination Partners

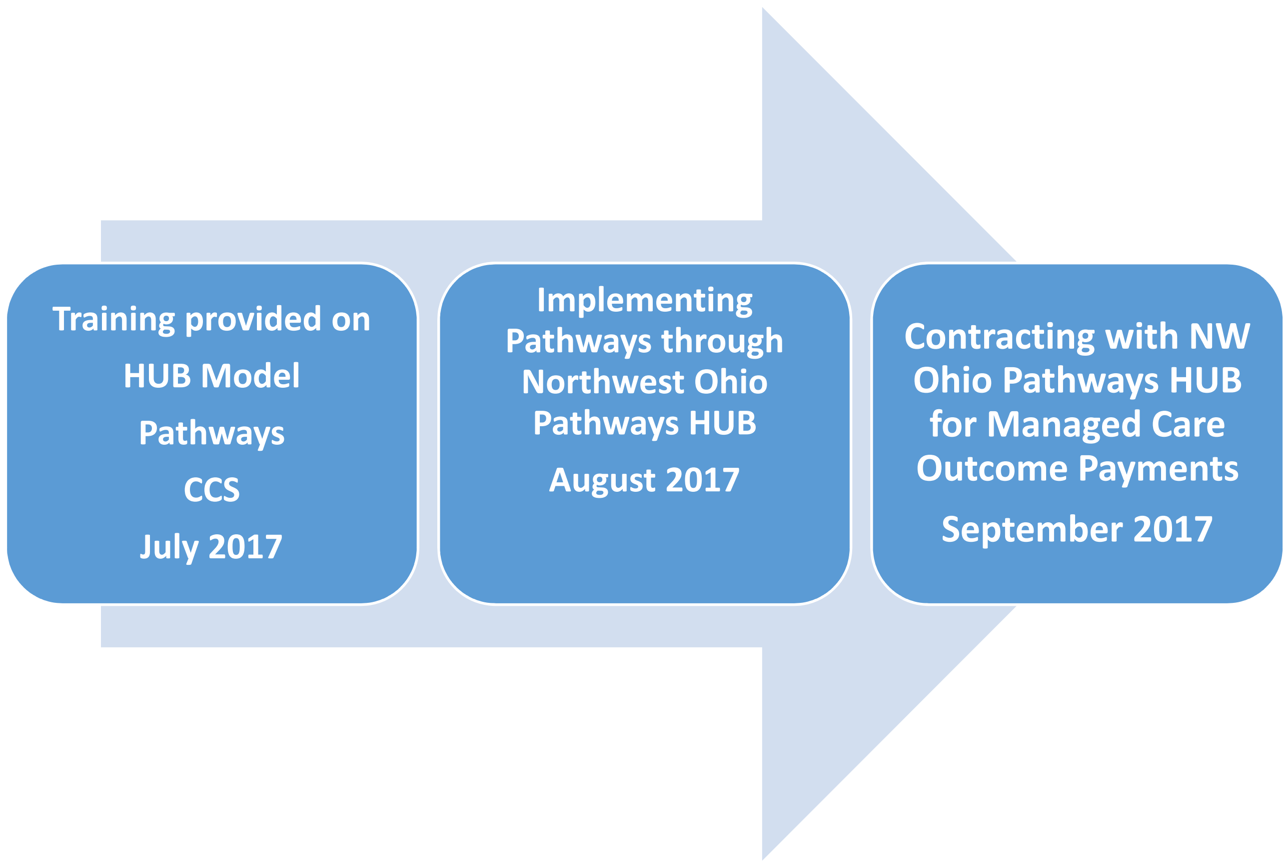
dentalcenter
of northwest ohio

Community-Based Care Coordination Partners

HUB Services Provided to Canton-Stark County THRIVE

- **Training**
  - THRIVE staff to manage the collaboration of care coordinating organizations utilizing the HUB Model;
  - Community health workers (CHW) and supervisors to work through the HUB model to achieve positive health and social outcomes.
  - Provide technical assistance to work in partnership with the managed care plans and earn payment for positive outcomes by expanding our existing contracts.
- **Operations**
  - Provide ongoing data quality services and billing Ohio Medicaid Managed Care Plans for completed Pathways.
  - Provide ongoing technical assistance for quality improvement to achieve the desired outcomes.

STRIVE HUB Services Time Line



Northwest Ohio Pathways HUB

STRIVE TEAM

- Jan Ruma, HUB Director and Vice President of HCNO
- Carly Salamone, Assistant Director
- Chris Demko, Operations Manager
- Michelle Smith-Wojnowski, Clinical-Community Linkages Specialist
- Kailyn Kabat, Training and Data Coordinator
- Alayna Cavanaugh, Graduate Assistant

YOUR Connection to a

Healthier Life

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For more information about the Pathways HUB, call the Hospital Council of Northwest Ohio at **419-842-0800**

Made possible with funding from the Centers for Disease Control and Prevention.

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LAMAR