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


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

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.

Notes: GDP refers to gross domestic product.
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”

- Range of existing relationships
- Known and unknown players vary
- Local safety net system varies
- Payer and HCO needs vary
- State Medicaid plans vary
- Existing networks and alliances vary

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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

- Standardized Risk Assessment approach
- Standardized documentation
- Standardized performance metrics
- Centralized contracting & administration infrastructure
- Coordinated CBO engagement
- Standardized P4P approach
HUB facilitates contracting with multiple payers; braids and blends funds from an array of sources.
THE HUB:
INFRASTRUCTURE FOR CBO COORDINATION & QUALITY MANAGEMENT

- Coordinates CBOs
- Trains and assigns CHWs
- Shared metrics and quality management
- Identify gaps related to SDOH
- Centralized collective planning
PATHWAYS: P4P METHODOLOGY BASED ON RISK REDUCTION

Outreach to the highest risk individuals and support the whole family

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

Home visits and relationship building in community settings (wherever and whenever)

Payment for Pathways, once risks are mitigated, which trigger payment and collect data
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
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

<table>
<thead>
<tr>
<th>HIGH RISK PREGNANCY</th>
<th>ALL RISK LEVELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly less chance of neonatal admission</td>
<td>Approached significance in reduced chance of neonatal admission</td>
</tr>
</tbody>
</table>

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

ROI: 236%


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
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 services.

First Published Study on Results

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

Pathway intervention over 4 years

Percent Low Birth Weight

0 2 4 6 8 10 12 14 16 18

6.1

13.0

Baseline

Pathway intervention over 4 years
PHUB RECOGNITION

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

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

NIH
National Institutes of Health
Turning Discovery Into Health

NSF
National Science Foundation
WHERE DISCOVERIES BEGIN

HRSA
Institute for Healthcare Improvement
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
Multiple agencies involved – limited communication – No effective tracking of identified and addressed risk factors
COMMUNITY HUB

One Care Coordinator for the Entire Family

Community Care Coordinator

Care coordination agencies = CBOs
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
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

Initiation Step

Action Step

Completion Step

Track/Measure Risk Factors Addressed (Connections to Care)
By: Care Coordinator
Agency Region

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
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<tbody>
<tr>
<td>CHW A</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>CHW B</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CHW C</td>
<td>9</td>
<td>15</td>
<td>18</td>
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<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
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</thead>
<tbody>
<tr>
<td>Agency A</td>
<td>50</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Agency B</td>
<td>64</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Agency C</td>
<td>40</td>
<td>32</td>
<td>19</td>
</tr>
</tbody>
</table>
**Initiation**

Client needs an ongoing source of primary care.

Date

**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.**

**Completion**

Confirm that appointment was kept. Date
### Risk Reduction Reports Now Live in 6 Ohio Hubs

Sample represents 1 Hub brief period of data.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th># Found</th>
<th># Addressed</th>
<th># Not Addressed</th>
<th>Average Time days</th>
<th>Cost per Addressed $25-$250</th>
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<tbody>
<tr>
<td>Medical Home</td>
<td>55</td>
<td>44</td>
<td>11</td>
<td>10</td>
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</tr>
<tr>
<td>Medical Referral</td>
<td>272</td>
<td>227</td>
<td>45</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Medication Assessment</td>
<td>49</td>
<td>41</td>
<td>8</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>85</td>
<td>71</td>
<td>14</td>
<td>101</td>
<td></td>
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<tr>
<td>Family Planning</td>
<td>57</td>
<td>42</td>
<td>12</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Post Partum</td>
<td>59</td>
<td>48</td>
<td>10</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Social Service Referral</td>
<td>276</td>
<td>201</td>
<td>75</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>45</td>
<td>43</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td>28</td>
<td>22</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>52</td>
<td>25</td>
<td>27</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>30</td>
<td>4</td>
<td>13</td>
<td>63</td>
<td></td>
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<tr>
<td>Behavioral Health</td>
<td>35</td>
<td>14</td>
<td>21</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>40</td>
<td>3</td>
<td>26</td>
<td>112</td>
<td></td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Pathways</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Education</td>
</tr>
<tr>
<td>Employment</td>
</tr>
<tr>
<td>Health Insurance</td>
</tr>
<tr>
<td>Housing</td>
</tr>
<tr>
<td>Medical Home</td>
</tr>
<tr>
<td>Medical Referral</td>
</tr>
<tr>
<td>Medication Assessment</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td>Smoking Cessation</td>
</tr>
<tr>
<td>Social Service Referral</td>
</tr>
<tr>
<td>Behavioral Referral</td>
</tr>
<tr>
<td>Developmental Screening</td>
</tr>
<tr>
<td>Developmental Referral</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Family Planning</td>
</tr>
<tr>
<td>Immunization Screening</td>
</tr>
<tr>
<td>Immunization Referral</td>
</tr>
<tr>
<td>Lead Screening</td>
</tr>
<tr>
<td>Pregnancy</td>
</tr>
<tr>
<td>Postpartum</td>
</tr>
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</table>
## SYSTEM OF PATHWAY BILLING USED IN OHIO

<table>
<thead>
<tr>
<th>Checklists</th>
<th>Normal Risk</th>
<th>High Risk</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Pregnancy Checklist</td>
<td>Completed one time at Member enrollment, 1&lt;sup&gt;st&lt;/sup&gt; trimester engagement</td>
<td>G9001</td>
<td>G9003</td>
</tr>
<tr>
<td></td>
<td>Completed one time at Member enrollment, 2&lt;sup&gt;nd&lt;/sup&gt; trimester engagement</td>
<td>G9001</td>
<td>G9003</td>
</tr>
<tr>
<td></td>
<td>Completed one time at Member enrollment, 3&lt;sup&gt;rd&lt;/sup&gt; trimester engagement</td>
<td>G9001</td>
<td>G9003</td>
</tr>
<tr>
<td>Pregnancy Checklist</td>
<td>Completed at each face-to-face encounter with Member</td>
<td>G9005</td>
<td>G9010</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Pathways</th>
<th>Normal Risk</th>
<th>High Risk</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Kept three scheduled behavioral health appointments</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td>Education</td>
<td>Educational module delivered.</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td>Family Planning</td>
<td>LARC (long-acting, reversible) or permanent method</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td>Family Planning</td>
<td>All other family planning methods</td>
<td>G9002</td>
<td>G9009</td>
</tr>
<tr>
<td>Housing</td>
<td>Residing in affordable &amp; suitable housing for 2 months.</td>
<td>G9002</td>
<td>G9009</td>
</tr>
</tbody>
</table>
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.

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

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

NQF
Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination

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
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
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

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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

Figure 1. Five Key Lessons from NYC CBOs

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

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 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.