Minnesota

Community Health Worker Alliance

MAY 2

2019

STATEWIDE CONFERENCE

Nothing about us, without us.

Pathways Community HUB Model

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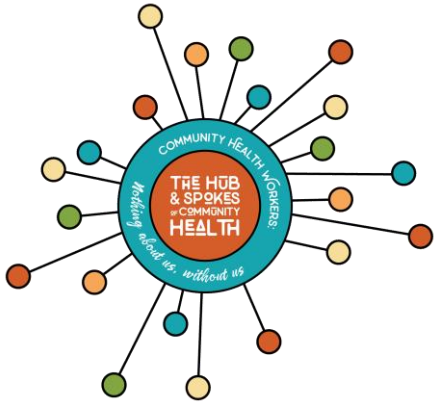
Executive Director, Pathways Community HUB Institute

PCHI

Objectives

- Understand the importance of community-based care coordination
- Understand “whole person” care coordination
- Describe the Pathways Community HUB approach
- Understand the impact of the HUB model on health outcomes and cost savings



Why do We Need a HUB?

Case for Community-Based Care Coordination

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

"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***.

Case for Community-Based Care Coordination

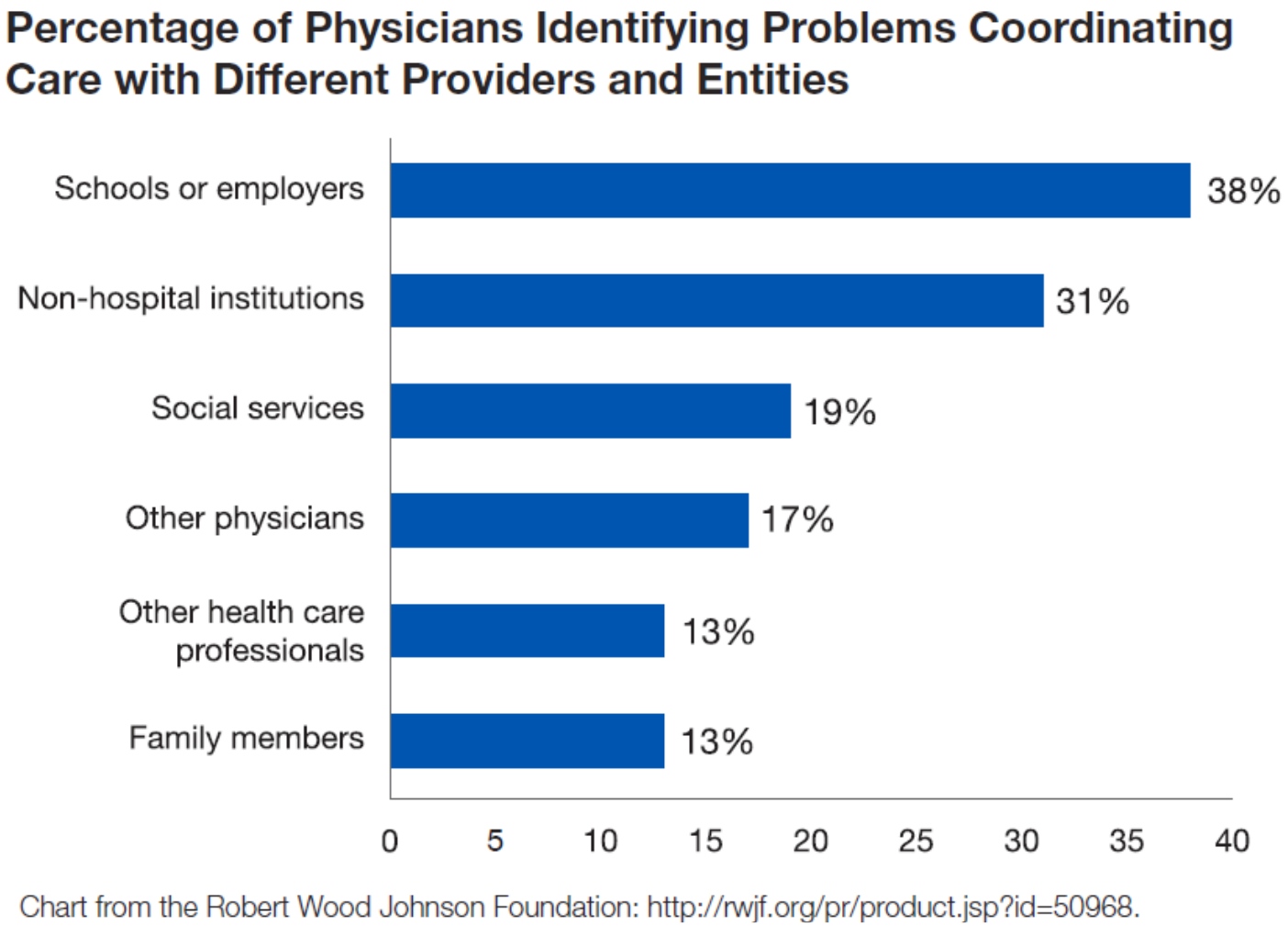


Chart from the Robert Wood Johnson Foundation: http://rwjf.org/pr/product.jsp?id=50968.

Case for Community-Based Care Coordination

- 1/2 of patients can't state their diagnosis after leaving the hospital
- 1/3 of patients can't explain their medications
- Less that 1/2 of patients saw their physician within 2 weeks of leaving the hospital
- 1 in 5 patients had an adverse event transitioning from hospital to home

  (2 out of 3 events related to prescriptions)

RWJ – Ten Things You Should Know About Care Transitions

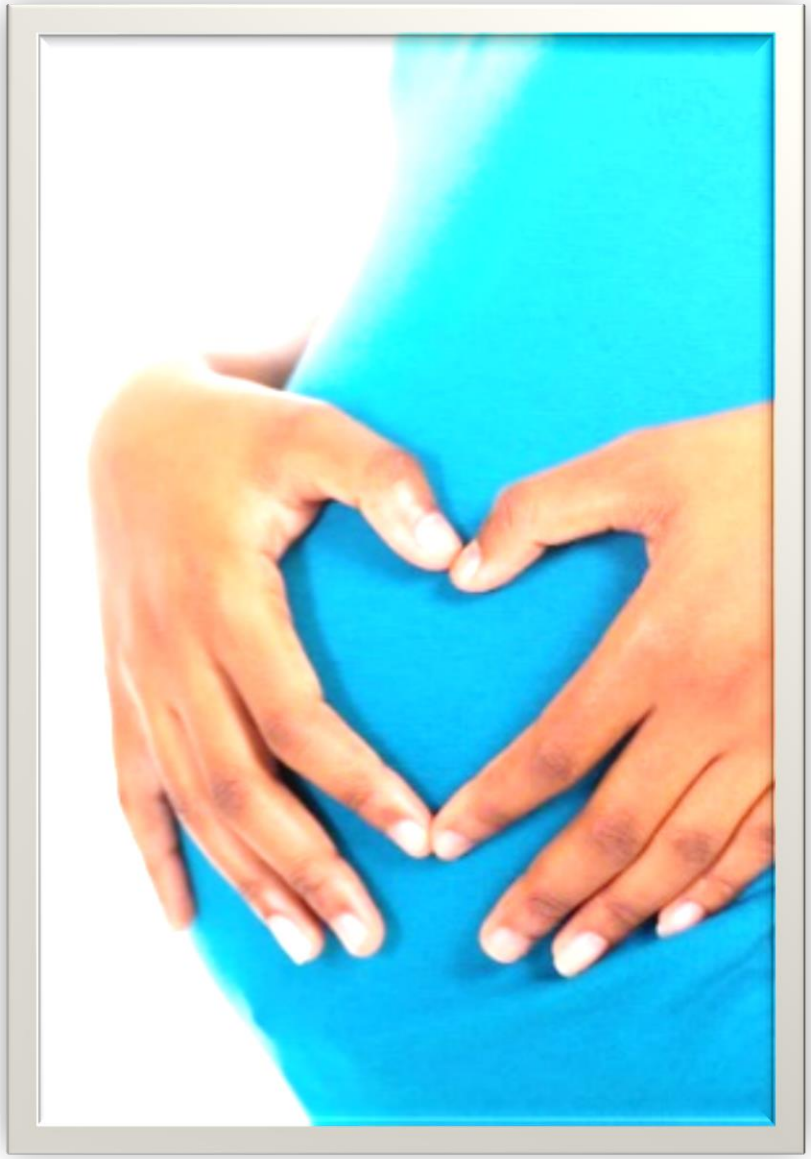
Let’s stop trying to fix people. . .

. . . and fix the system!

Relationships!

Jackie

What are Jackie's strengths?



What are Jackie's challenges?

Whole Person Care

Health Care

Health Insurance
Primary Care
Specialty Care
Screenings
Child development

Behavioral Health

Drug & Alcohol Use
Depression
Anxiety
PTSD

Education Employment

Job Readiness
Financial Aid
Clothing
Applications

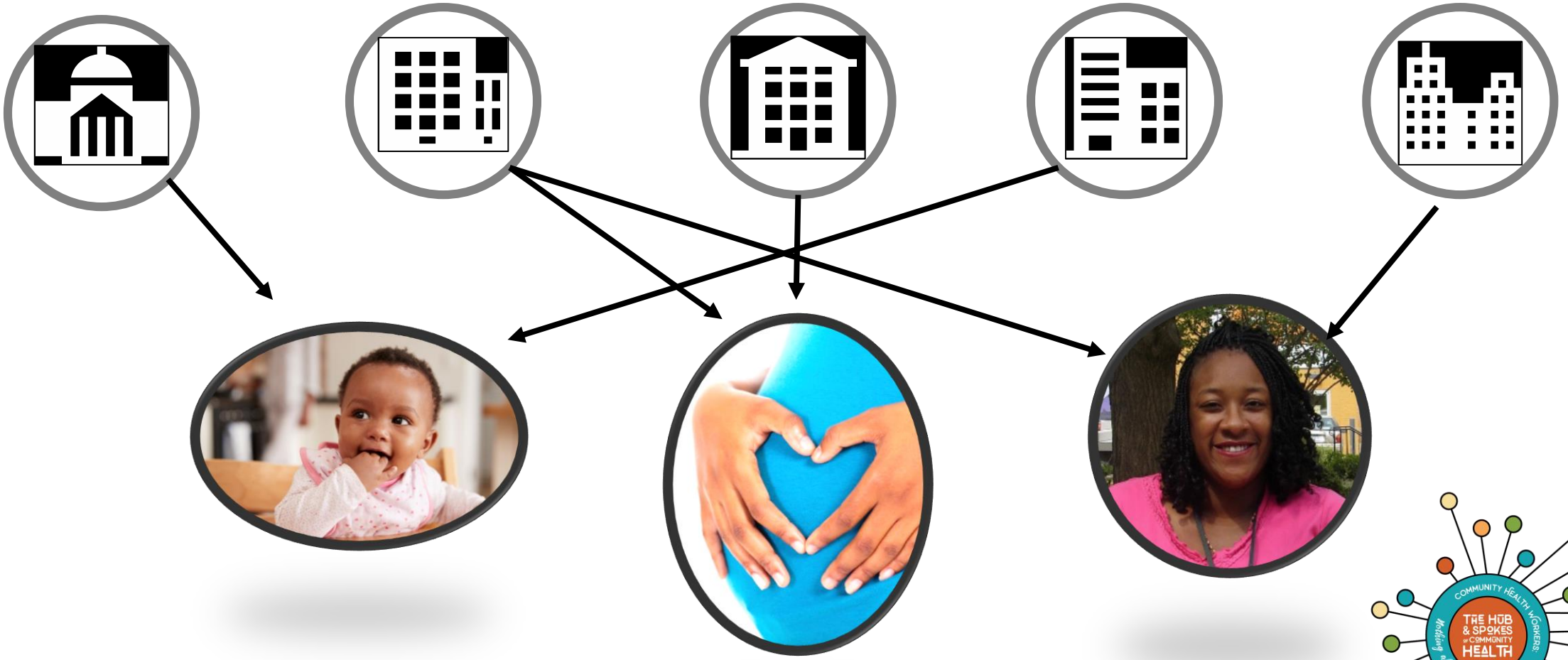
Social

Food
Clothing
Housing
Utilities

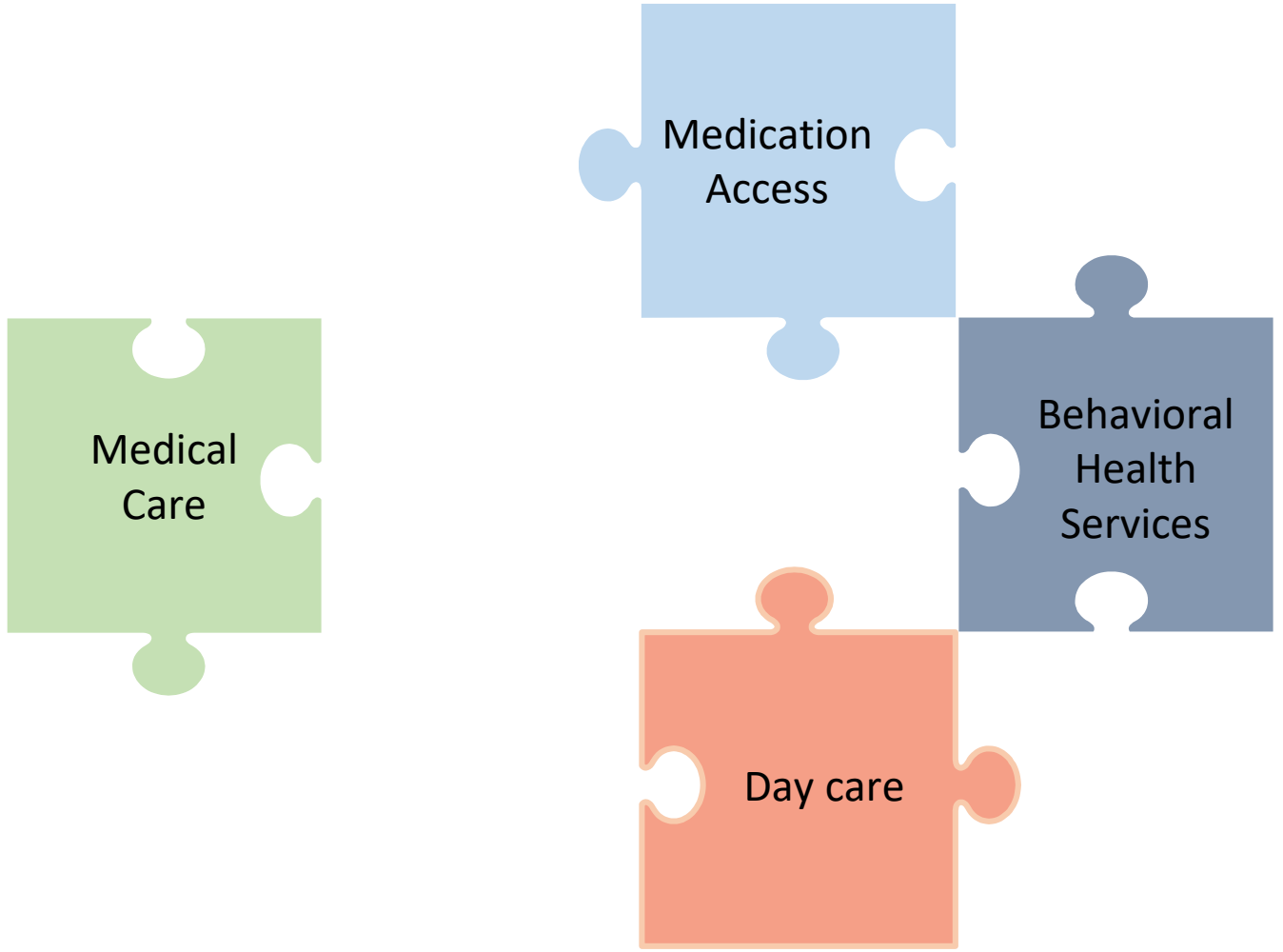
Safety

Care Coordination Today. . .

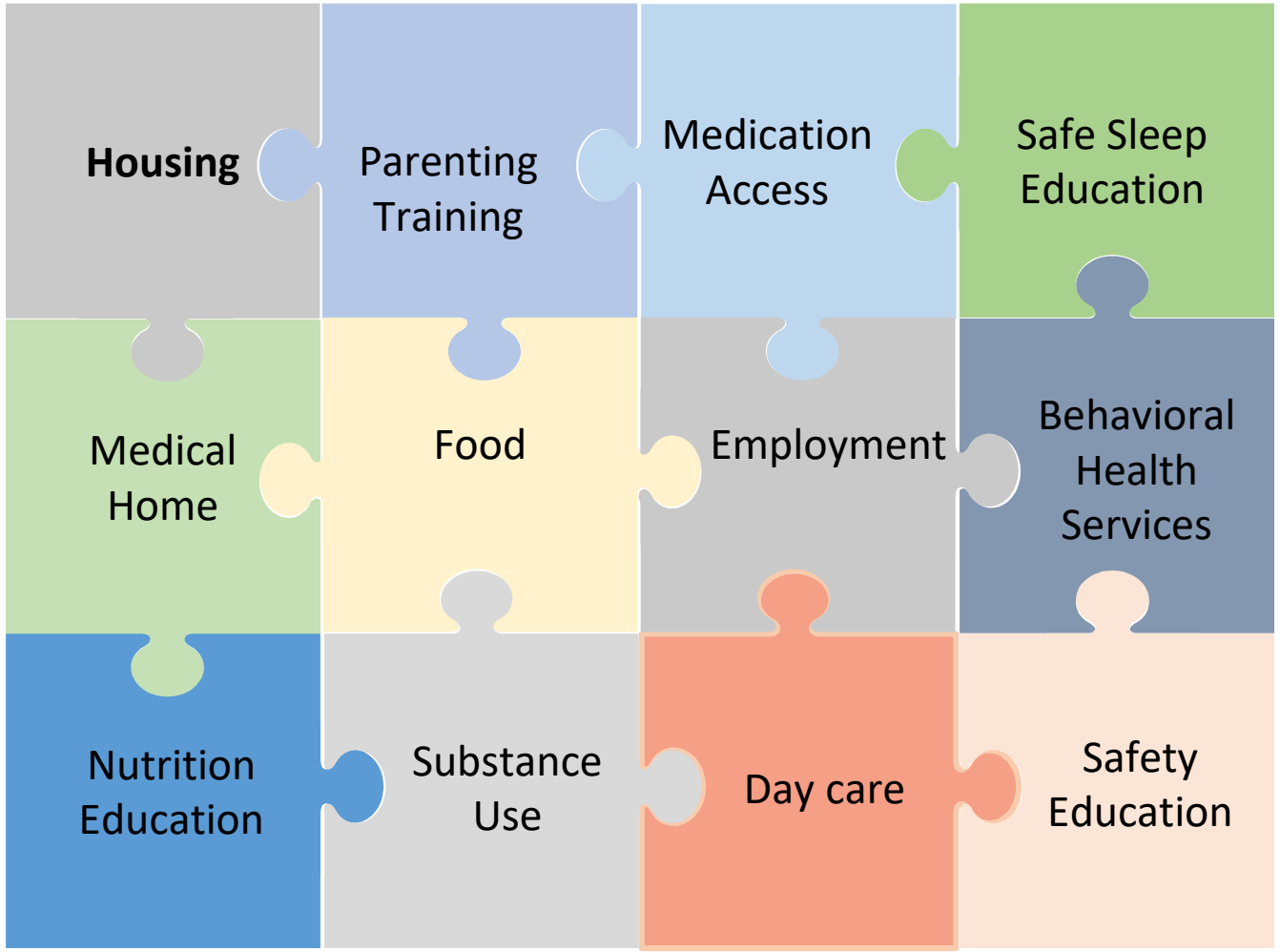
Care Coordination Today. . .



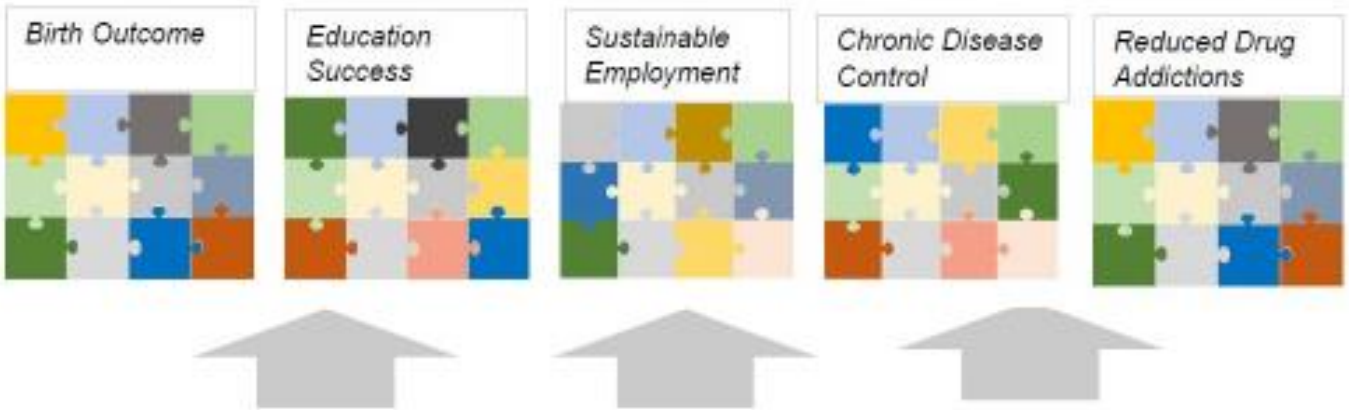
Fragmented Approach

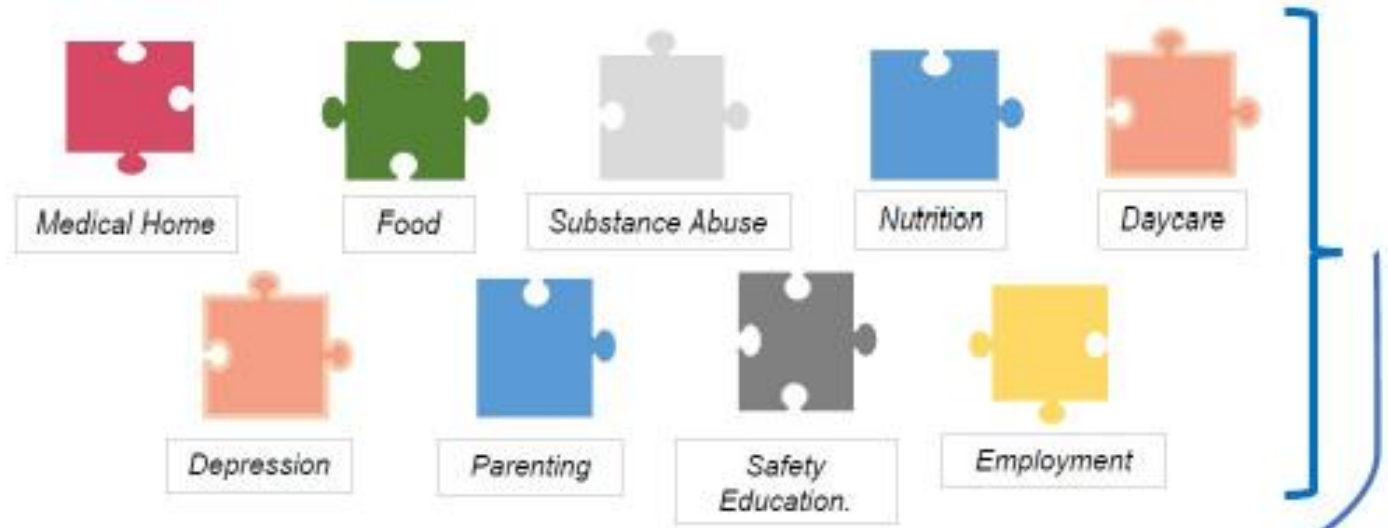


Whole Person Care



Major Outcomes





Foundational /Intermediate Outcomes

How did the HUB Model Begin?


Kotzebue Alaska, Spring 1991

Community Health Workers

CHAP
COMMUNITY HEALTH ACCESS PROJECT

What is a HUB?


COMMUNITY HEALTH WORKERS
THE HUB & SPOKES OF COMMUNITY HEALTH
Meeting need us, without us

Foundation of the HUB Model

Step 1: Find

Comprehensive Risk Assessment

Step 2: Treat

Assign Pathways

Step 3: Measure

Track/Measure Results (Connections to Care)

FIND: Comprehensive Risk Assessment

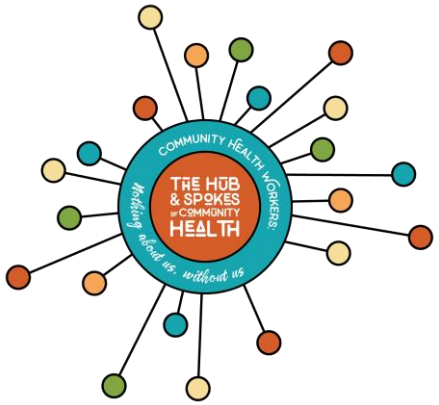
Client Request Form

Name: _____ Date: _____ Visit Location: _____

What could you use help with today? Please answer all that apply. Household Lead ☐ Yes ☐ No

	FAMILY – Complete if you are the Household Lead		INDIVIDUAL
	(Complete if you're the main contact for your household or if you live alone)		
	Housing		**Completing forms** (reading them, understanding them, filling them out)
	Safe (not living in a safe place)		**Medical home** (place to go for regular health care)
	Stable (need permanent place to live)		**Health insurance** (payment for health care)
	Food		**Healthcare** (family doctor, specialist)
	WIC/SNAP/Food Stamps		**Immunizations** (shots)
	Not enough food		**Dental care** (teeth or gums)
	Hard to get healthy food (overweight or underweight)		**Family planning** (birth control, family spacing)
	Utilities		**Medication problems** (taking medications, getting medications, side effects)
	Don't have		**Vision** (eye sight)
	Will be turned off		**Feeling sad, depressed, angry, stressed, worried** (behavioral health issues)
	Financial		**Substance use** (alcohol, tobacco, marijuana, other drugs)
	Need help with applying for SSI/SSDI		**Pregnancy** (pregnant now, trying to get pregnant)
	Can't pay medical bills		**Chronic disease** (diabetes, heart disease, cancer, asthma, other diseases)
	Can't pay bills		**Behavioral problems with child** (anger, acting out, temper tantrums)
	No Phone		**Development concerns about child** (delay with walking, talking)
	No Internet		**Employment** (getting a job, finding a better job)
	Transportation		**Education** (completing school, GED, training program, college)
	No transportation		**Legal help** (housing, identification paperwork, parole status, citizenship)
	Car needs repairs		**Getting along with partner or others in my home** (fighting, abuse or any kind)
	Child Care (day care)		**Child(ren)s connection to family member** (mom, dad, sibling, grandparent)
	Respite Care (support for caregiver)		**Help with everyday activities** (bathing, getting dressed, making meals)
	Household items		**Safety** (feeling safe in my home, neighborhood, work)
	Guardianship/Custody		**Clothing and personal items**

Are any of these issues urgent? ___ Yes ___ No



FIND: Comprehensive Risk Assessment

Strengths I bring:

_____

_____

Other things I want to talk about today:

_____

_____

_____

Care coordinator's notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Next Home Visit Date: _____

Goals for Next Home Visit:

_____

_____

_____

_____ _____ _____

Client's Signature **Date** **Care Coordinator's Signature**

Care Coordination Plan

Care Coordination Plan

Care Coordinator _____

First Name	
Last Name	
Maiden Name	
Contact Phone	
Emergency	
Contact Name	
Phone	

Visit Dates				

Insurance	
Insurance #	
Address	

Race	
Ethnicity	
Marital Status	
Education Status	
Employment	

Providers

Primary	
Specialty	
Behavioral	
Prenatal	
Dental	

Individual Risk Factors	Start	Complete
Medical Home		
Medical Referral		
Primary Care		
Specialty Care		
Dental		
Behavioral Health		
Substance Use		
Prenatal Care		
Postpartum Care		
Family Planning		
Hearing		
Vision		
Other		
Immunization Referral		
Developmental Referral		
Medication Assessment		
Medication Referral		
Insurance		
Adult Learning		
Employment		
Social Service Referral		
Identification documents		
Citizenship		
Legal Aide		
Prison/Parole		
Safety		

Only Complete Household Risks if Client is Household Lead

Family/Household Risks	Start	Complete
Housing		
Social Service Referral		
Food		
WIC		
SNAP/Food Stamps		
Not Enough Food		
Healthy Food		
Utilities – Don't have		
Will be Stopped		
Financial – SSI/SSDI		
Medical Dept		
Can't Pay Bills		
No Phone		
No Internet		
Transportation - none		
Needs Repairs		
Child Care		
Respite Care		
Equipment – Household		
Medical Related		

Hospital Admissions			
ED Visits			

Household Members

First	Last	Role	Birthdate

Screenings	Date	Result	Intervention/ Pathway
Depression			
Development			
Immunization			
Lead			
Wellness			
ACEs			
Asthma			

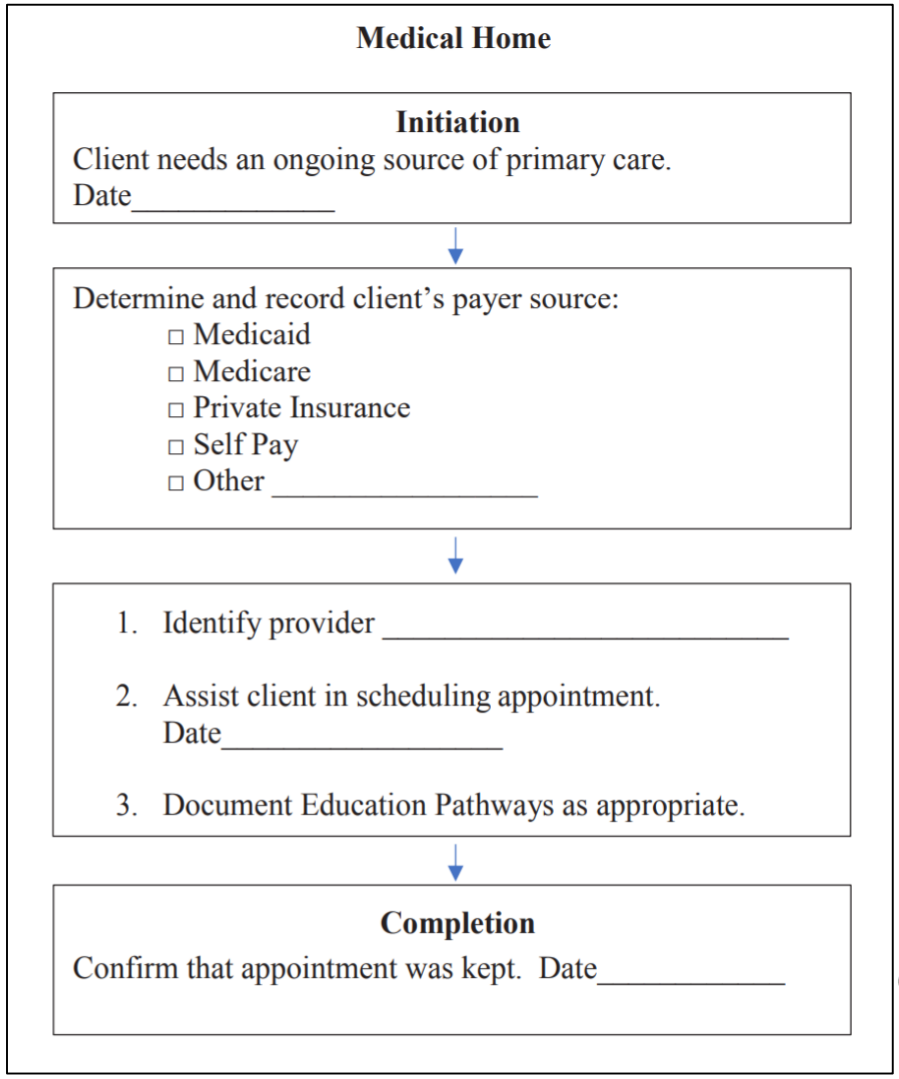
Successfully completed program	
Discharged – did not complete program	
Completed school/training program	
Completed college	
Birth	
Death	

TREAT: Each Risk Factor = Pathway

20 Standard Pathways

- One risk factor at a time
- Completion = Payment
- Finished Incomplete

  Pathway = Gaps



Medical Home

Initiation
Client needs an ongoing source of primary care.
Date_____

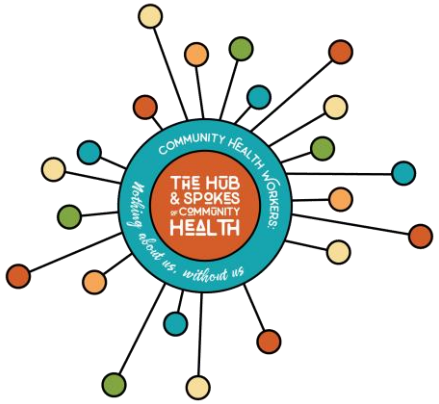
Determine and record client's payer source:
- □ Medicaid
- □ Medicare
- □ Private Insurance
- □ Self Pay
- □ Other _____

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

Completion
Confirm that appointment was kept. Date_____

20 Standard 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



MEASURE: Track Progress with Pathways

Pathway	Initiated	Completed	Median Duration - Days	# Clients with PW	% Clients with PW
Medical Referral	2456	1750	19	762	36.2
Social Service Referral	2561	1672	9	709	33.68
Education	3109	2934	1	725	34.44
Developmental Screening	446	344	1	223	10.59
Immunization Screening	506	390	22	291	13.82
Pregnancy	370	226	107	359	17.05
Medical Home	443	234	14	416	19.76
Family Planning	242	122	50	222	10.55
Postpartum	258	167	48	245	11.64
Medication Assessment	289	190	4	223	10.59
Tobacco Cessation	198	6	108	191	9.07
Employment	184	63	93	169	8.03
Health Insurance	199	128	14	188	8.93
Lead	68	30	22	60	2.85
Housing	146	41	102	137	6.51
Behavioral Health	180	51	76	172	8.17
Immunization Referral	87	49	36	70	3.33
Adult Learning	112	27	91	102	4.85
Developmental Referral	21	11	25	21	1
Medication Management	9	2	92	9	0.43

Fix the System!

2 Missed Appointments

HUB Referral

CHW Assigned

Health Care

Resources & Education

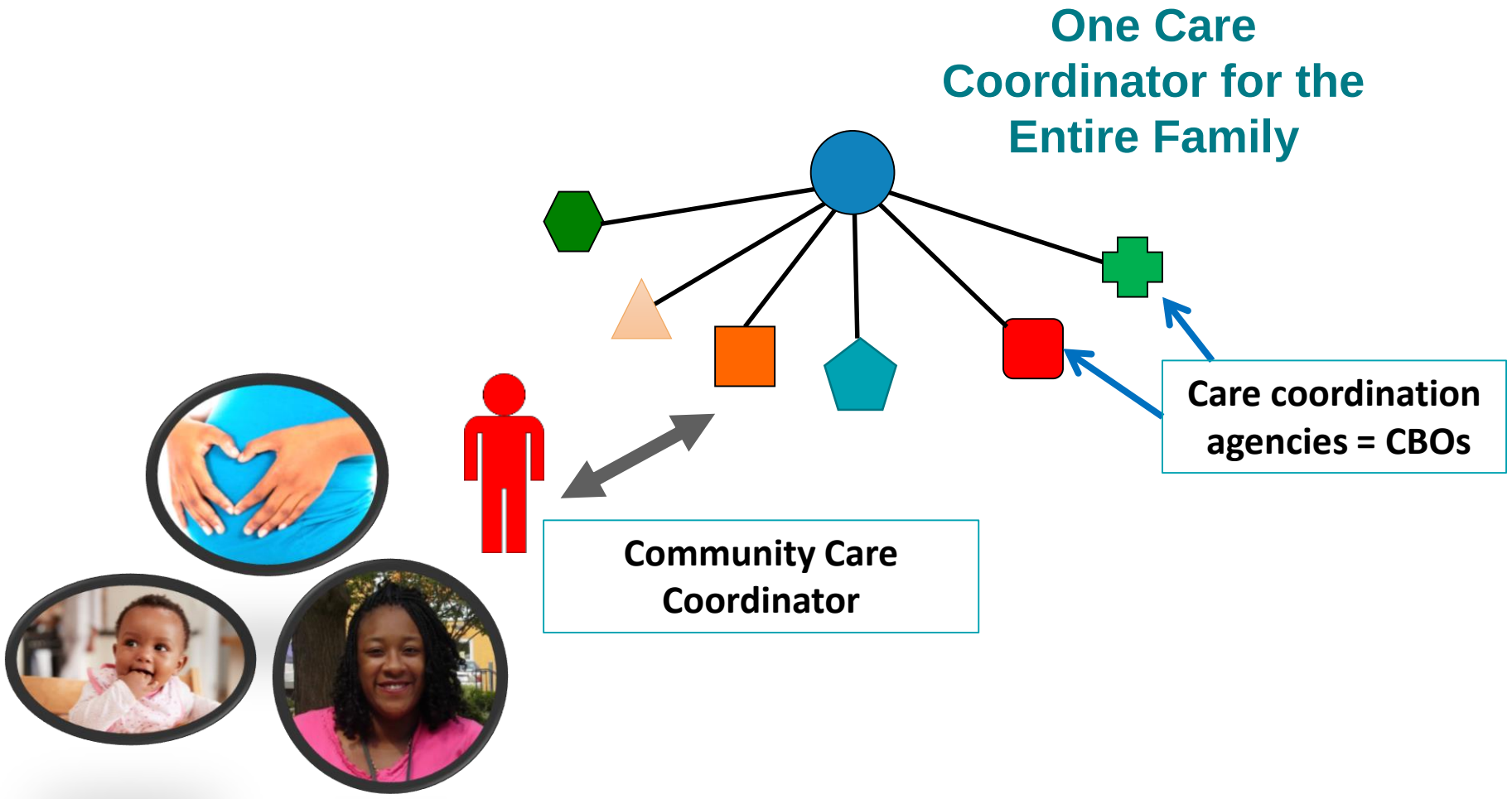
Whole Family Care Coordination

Medical Home PW
Immunization Referral PW
Developmental Referral PW
Lead PW

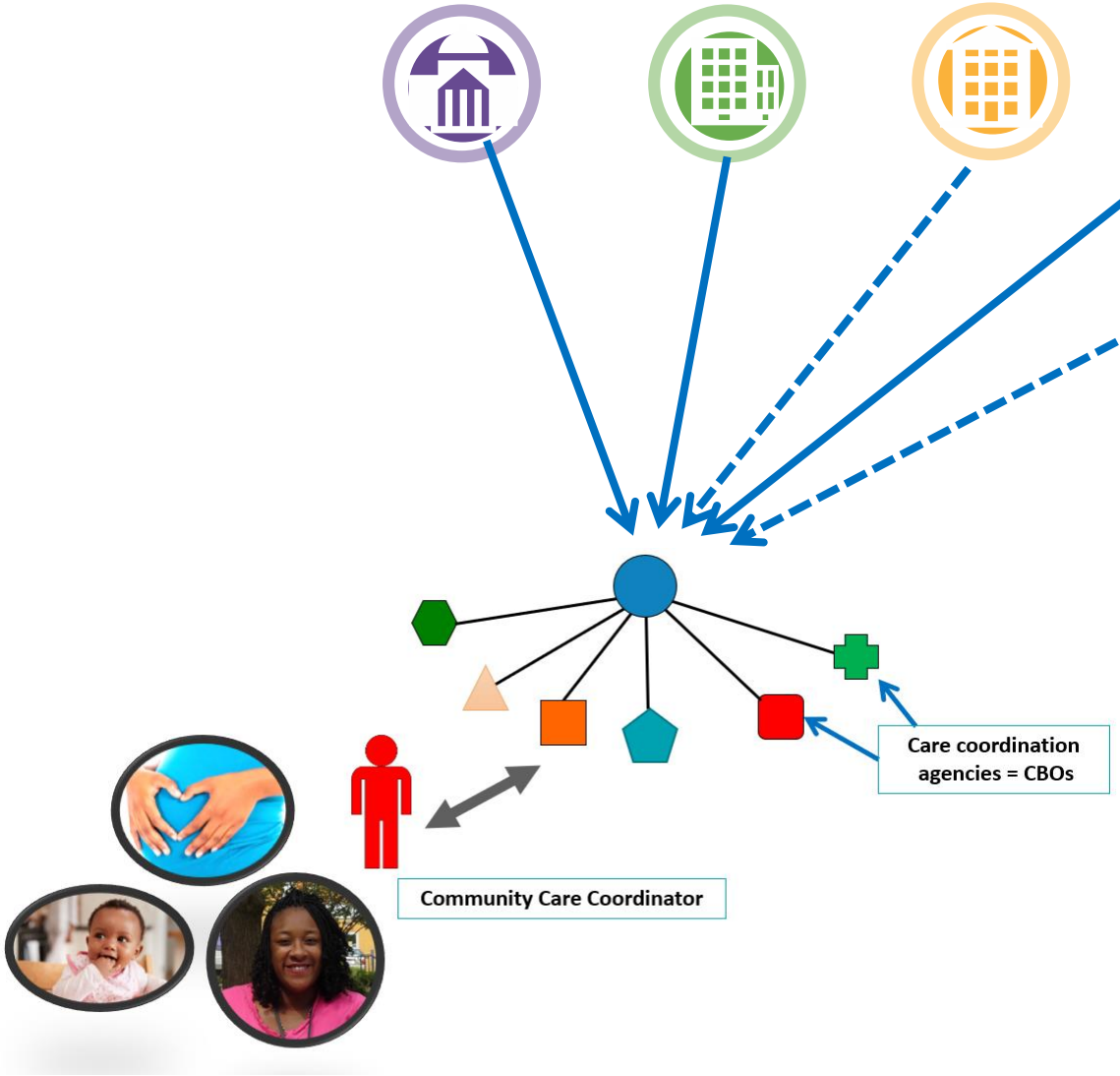
Pregnancy PW
Medical Referral PW – counseling
Health Insurance PW
Employment PW
Housing PW
Education PW
pregnancy, nutrition,

Medical Referral PW – DPP
Medical Referral PW – primary care
Tobacco Cessation PW
Medication Assessment PW
Education PW – diabetes, nutrition, smoking , high blood pressure

Community HUB



Community HUB and Funders



Health and other initiatives can contract or collaborate with CBOs through the Pathways Community HUB

Contracts based on OBUs

If one Outcome-Based Unit (OBU) = $30

High Risk:

Initial Adult Checklist = $210

Health Insurance = $150

Employment = $210

Very High Risk:

Initial Adult Checklist = $270

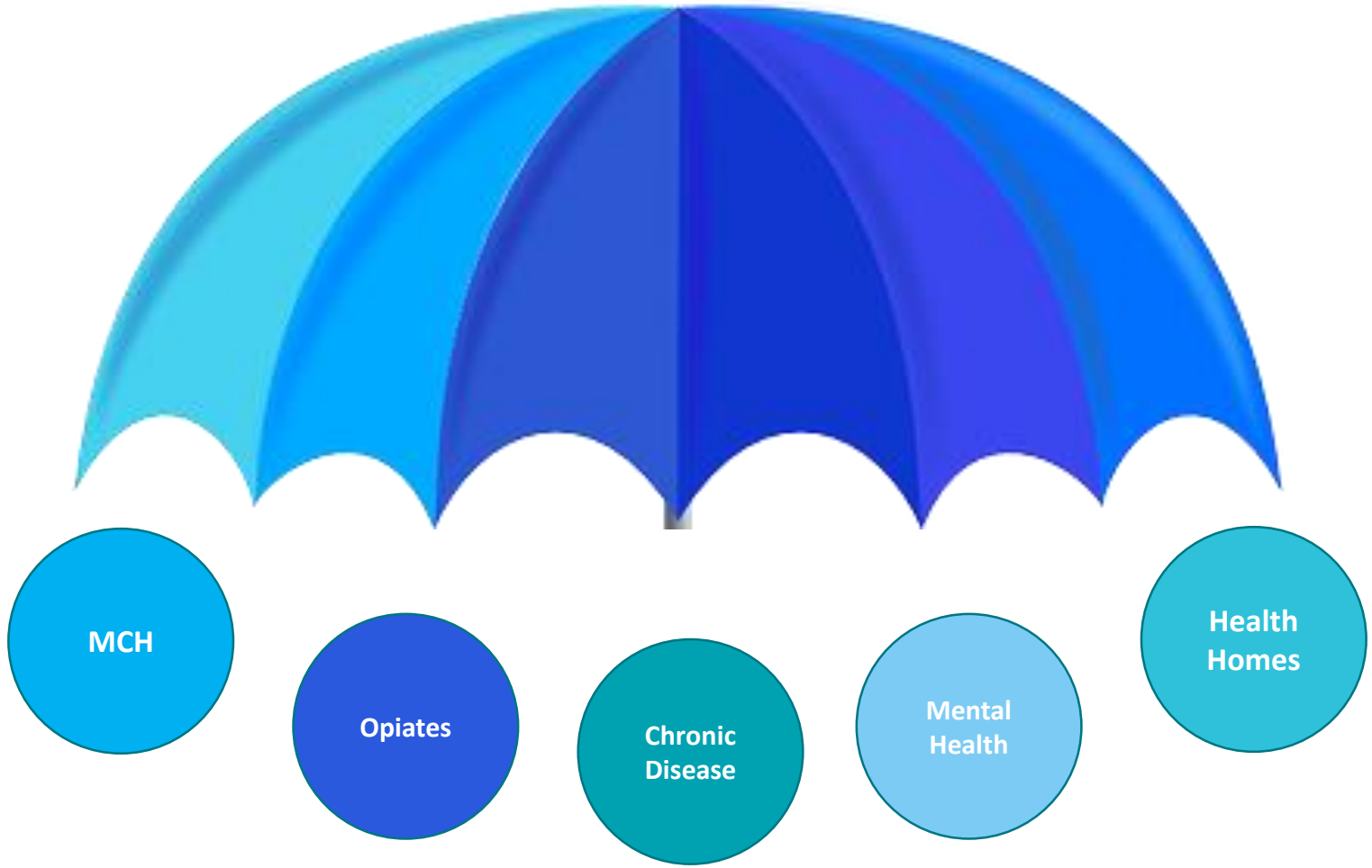
Health Insurance = $180

Employment = $240

Adult Member:

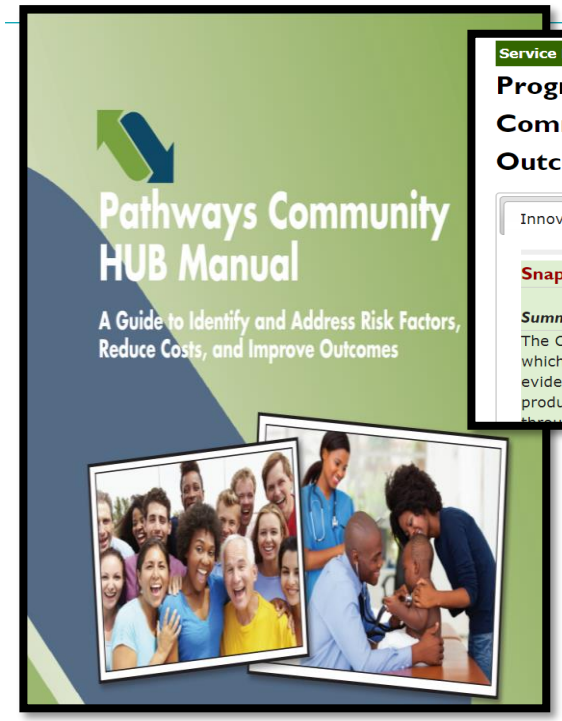
		High Risk	OBU	Very High Risk	OBU	Modifier
Checklists						
Initial Adult Checklist	Completed one time at enrollment	G9001	7	G9003	9	A1
Adult Checklist	Completed at each face-to-face encounter	G9005	1	G9010	1.5	A1
Pathways						
Adult Learning	Confirm that client successfully completes stated education goal	G9002	6	G9009	7	AA
Behavioral Health	Kept three scheduled behavioral health appointments	G9002	4	G9009	5	AB
Education	All required education components are completed and documented	G9002	1	G9009	1	AE
Employment	Consistent source of steady income and is employed more than 30 days from date of hire	G9002	7	G9009	8	AF
Family Planning	Tubal ligation, vasectomy, IUD, implant, shot or other form of long-acting reversible contraceptive (LARC) is obtained	G9002	5	G9009	6	G1
Family Planning	Method other than a permanent method or LARC chosen & client has successfully used the method for more than 30 days from the start date	G9002	4	G9009	5	G2
Health Insurance	Received health insurance – document plan and insurance number	G9002	5	G9009	6	AH

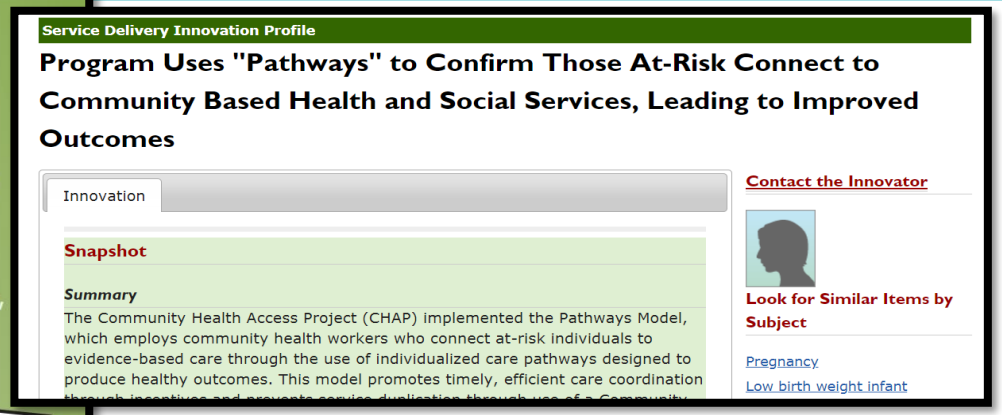
HUBs work with any population:



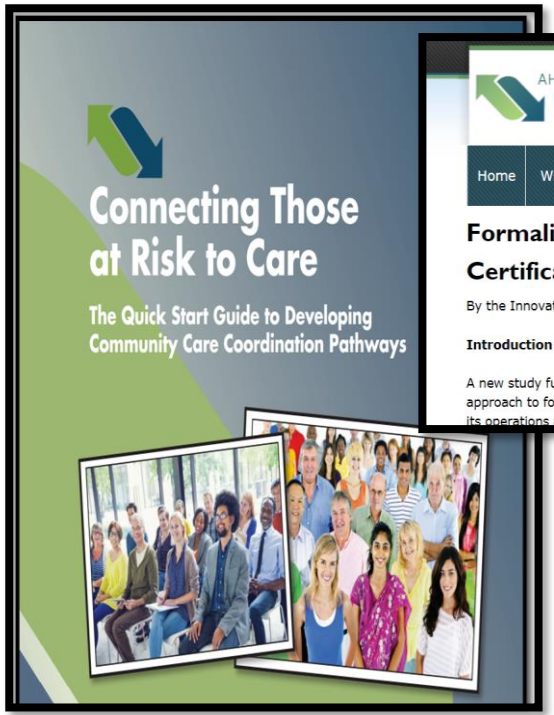
Does a HUB make a difference?

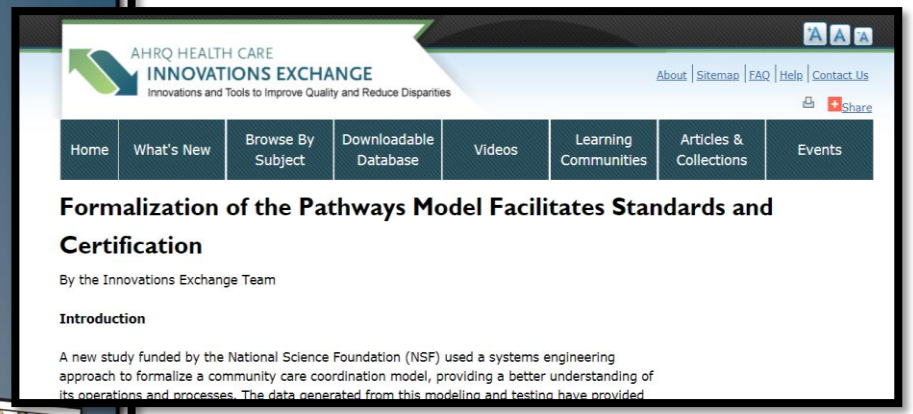
AHRQ Partnership





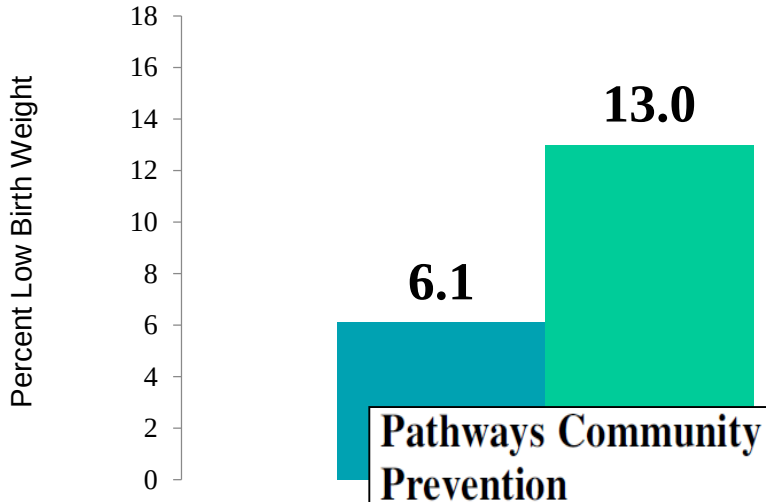
AHRQ Publication No 09(10)-0088
September 2010, replaced by AHRQ Publication No 15(16)-0070EF, January 2016





AHRQ Publication No 15(16)-0070-1-EF
January 2016

Published Results



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

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

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

Ohio – Buckeye Health Plan

Improved Birth Outcomes through Health Plan and Community Hub Partnership

Authored by: Dr. Brad Lucas ▪ Amber Detty, MA, CHDA

BACKGROUND

The impact of non-clinical barriers to care on direct medical costs should be accepted as a major impediment to our ability to impact major determinants of community vitality such as Infant Mortality.

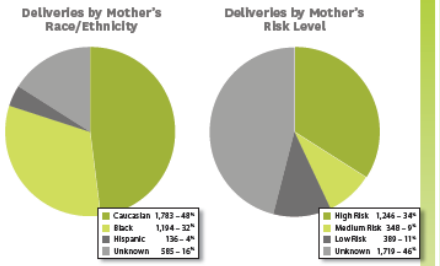
- Community hubs use community care coordinators—mostly licensed community health workers to find at risk individuals, assess and lower risk, find and remove barriers to clinical care and then connect to effective clinical care.
- Buckeye Health Plan has long partnered with Community Hubs to help reduce our members' non-clinical/social determinant barriers.
- We have shown previously that participation in health plan pregnancy management programs improves birth outcomes in women who are at risk for low birthweight deliveries.[1]
- This additional care is a natural extension of the care management work that occurs in the world of Medicaid managed care.

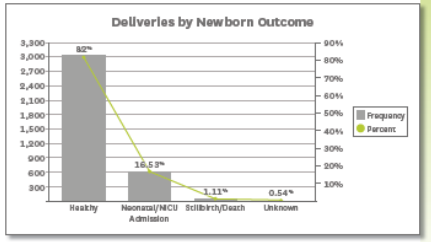
We asked ourselves whether this partnership made a measurable and statistically significant difference in outcomes.

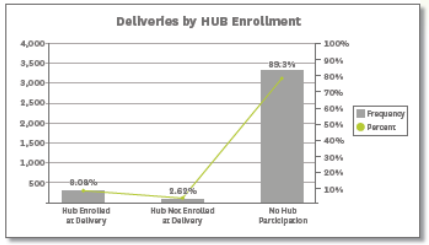
[1]Management of Pregnancy In a Medicaid Population. Mason, Lucas et al. Managed Care, March 2011.

ANALYSIS AND METHODS

- A retrospective cohort study of 3,702 deliveries in the footprint of our busiest Community Hub (Health Council of Northwest Ohio). All deliveries in these areas between March 2013-February 2017 included.
- Analysis included the mother's age, race/ethnicity, gestational age, birthweight, and whether the baby needed neonatal care.
- 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.







Lower First Year of Life Costs for Babies through Health Plan and Community Hub Partnership

Authored by: Dr. Brad Lucas ▪ Amber Detty, MA, CHDA

BACKGROUND

The impact of non-clinical barriers to care on direct medical costs should be accepted as a major impediment to our ability to impact major determinants of community vitality such as Infant Mortality.

Buckeye Health Plan has long partnered with Community Hubs to help reduce our members' non-clinical/social determinant barriers. We have shown that the combination of community coordination of social services and health plan care management improves birth outcomes in high risk pregnant members.*

We asked whether health plan investment in reduction of non-clinical barriers could lead to healthcare savings... it does.

*See our poster on the success of Community Hub Partnerships for more information.

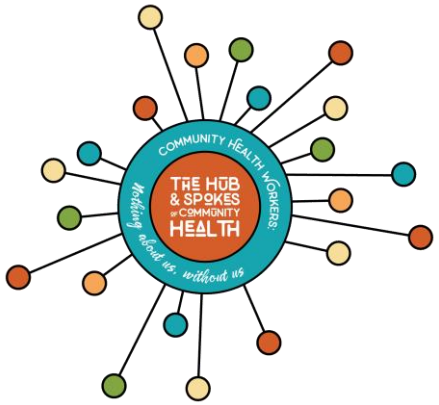
METHODS

- A retrospective cohort study of 3,702 deliveries in the footprint of our busiest Community Hub (Health Council of Northwest Ohio). All deliveries in these areas between March 2013-February 2017 included.
- Analysis included the mother's age, race/ethnicity, gestational age, birthweight, and whether the baby needed neonatal care.
- 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.
- Total paid amounts (medical and pharmacy) for baby's cost of care in their first year of life were calculated to best determine any savings. Babies whose mothers were enrolled with a Community Hub through delivery were compared to babies whose mothers who did not have care through a Community Hub.

Buckeye Newborns:
Inpatient Cost Through First Year of Life When Enrolled with Start Smart and Hub Enrollment at Delivery, 2013-2016

Risk Level	Hub Group	Newborn Inpatient PMPM Through 1st Birthday	Enrolled with Hub at Delivery Inpatient PMPM Savings*
High Risk	Enrolled with Hub at Delivery	$301.38	$378.72
	Participated in the Hub, but not through delivery	$186.34	
	Not Enrolled with Hub	$680.10	
High Risk Total		$596.44	
Medium Risk	Enrolled with Hub at Delivery	$192.67	$209.13
	Participated in the Hub, but not through delivery	$102.84	
	Not Enrolled with Hub	$401.80	
Medium Risk Total		$386.60	
Low Risk	Enrolled with Hub at Delivery	$101.81	$161.87
	Participated in the Hub, but not through delivery	$54.54	
	Not Enrolled with Hub	$263.68	
Low Risk Total		$257.04	
Unknown Risk (Not Enrolled in Start Smart)	Enrolled with Hub at Delivery	$483.25	$131.78
	Participated in the Hub, but not through delivery	$1,261.39	
	Not Enrolled with Hub	$615.04	
Unknown Risk Total		$616.78	
Total		$551.60	

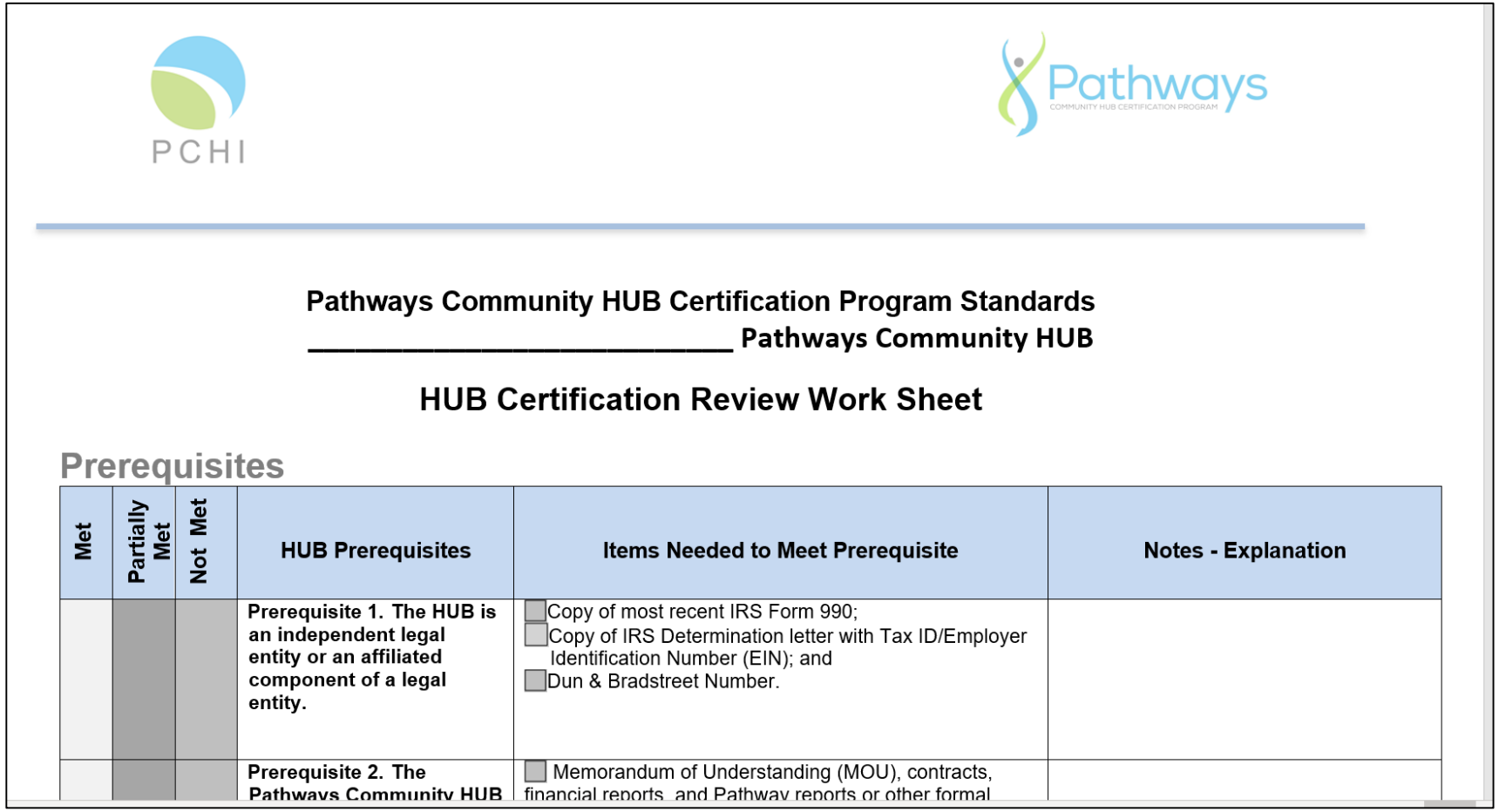
*Compared to Not Enrolled with Hub



Expansion of the HUB Model

Pathways Community HUB Institute

Certification Process for HUBs



PCHI

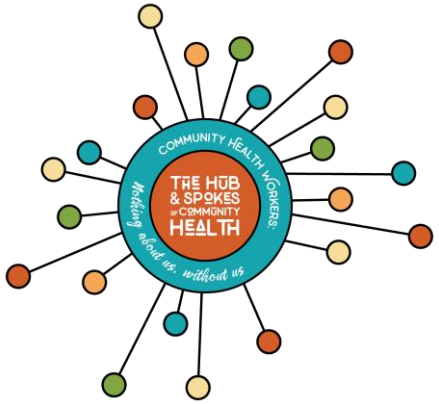
Pathways
COMMUNITY HUB CERTIFICATION PROGRAM

Pathways Community HUB Certification Program Standards
_____ Pathways Community HUB

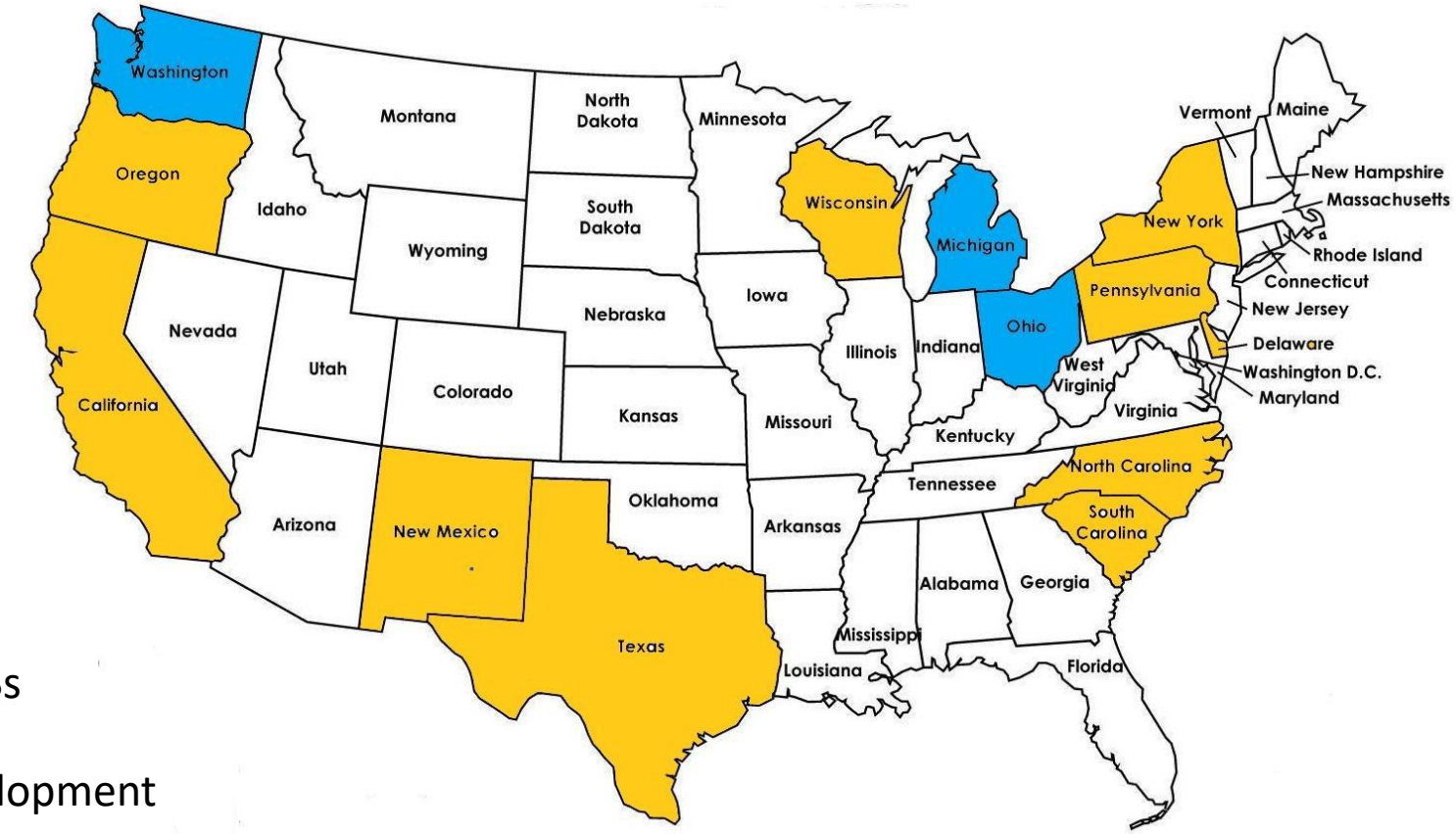
HUB Certification Review Work Sheet

Prerequisites

Met	Partially Met	Not Met	HUB Prerequisites	Items Needed to Meet Prerequisite	Notes - Explanation
			Prerequisite 1. The HUB is an independent legal entity or an affiliated component of a legal entity.	☐ Copy of most recent IRS Form 990; ☐ Copy of IRS Determination letter with Tax ID/Employer Identification Number (EIN); and ☐ Dun & Bradstreet Number.	
			Prerequisite 2. The Pathways Community HUB	☐ Memorandum of Understanding (MOU), contracts, financial reports, and Pathway reports or other formal	



HUB Expansion



Certified HUBs

HUBs in development

Benefits of the Pathways Community HUB

- Removes “siloes” and fragmentation
- Uses existing community resources efficiently & effectively
- Common metrics (Pathways) to identify and track risks
- Whole person community care coordination
- Payment for outcomes
- Owned by the community


COMMUNITY HEALTH WORKERS:
Nothing about us, without us
THE HUB & SPOKES OF COMMUNITY HEALTH

QUESTIONS?

Thank You!

For More Information Contact:

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Minnesota

Community Health Worker

Alliance