Do we serve the most at-risk? Why should we?

- 5% of population uses 56% of health care resources
- 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

Pregnant Client at-risk:

Her 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 programs
Evolution of the Pathways Community HUB Model

1. Community Health Workers
2. Pathways Model
3. Community HUB
Kotzebue Alaska, Spring 1991

Model - Health Care Delivery System
To eliminate health and social disparities in our community by finding those at risk, connecting them to care, and measuring the outcomes.
Pathways

Measuring Outcomes
From the client’s perspective . . . .

social issues are just as important as health issues, and BOTH must be addressed.
Pathway Model: A Tool to Measure Outcomes

1- Find

Target Population - Find those at greatest risk

Confirm connection to evidence-based care

Measure the results

2 - Treat

3 - Measure
Pathways

- Pathways are a tool
- Shift the focus to outcomes: one outcome – one individual at a time
- Recognize the importance of social issues as well as traditional health issues
- Pathways use production based accountability measurements and quality assurance to achieve results
Protocol

Initiation/Problem

Action Step

Action Step

Action Step
More than one Pathway is usually required to improve outcomes.

<table>
<thead>
<tr>
<th>Problem List</th>
<th>Interventions</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At risk Pregnancy</td>
<td>Prenatal Care</td>
<td>Healthy Baby</td>
</tr>
<tr>
<td>2. Smoking</td>
<td>Cessation Program</td>
<td>Cut back smoking</td>
</tr>
<tr>
<td>3. Homeless</td>
<td>Housing</td>
<td>Permanent housing</td>
</tr>
<tr>
<td>4. Depression</td>
<td>Behav Health Tx</td>
<td>Score Improved</td>
</tr>
<tr>
<td>5. Needs GED</td>
<td>Education</td>
<td>Has GED</td>
</tr>
</tbody>
</table>
### Engagement of at risk client

Collect information – Initial Checklist

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td></td>
<td>Do you need a primary medical provider?</td>
</tr>
<tr>
<td>✔</td>
<td></td>
<td>Do you need health Insurance?</td>
</tr>
<tr>
<td>✔</td>
<td></td>
<td>Do you smoke cigarettes</td>
</tr>
<tr>
<td>✔</td>
<td></td>
<td>Do you need food or clothing?</td>
</tr>
</tbody>
</table>

### Assign Pathways

- **Initiation Step**
- **Action Step**
- **Completion Step**

### Track/Measure Results

(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>
</thead>
<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>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home.</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</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>
Initial Pregnancy Checklist

Checklists
Pregnancy Pathway

16 Core Pathways

Client Name __________________________
Date of Birth _________________________
Care Manager _________________________

Pregnancy Pathway

<table>
<thead>
<tr>
<th>INITIATION</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any woman confirmed to be pregnant through a pregnancy test.</td>
<td>Date education completed</td>
</tr>
<tr>
<td>Provide pregnancy education.</td>
<td>Date of 1st PN appt. – set up by</td>
</tr>
<tr>
<td>Schedule appointment with prenatal care provider:</td>
<td>Client</td>
</tr>
<tr>
<td>• Date of 1st prenatal appointment</td>
<td>Care Manager</td>
</tr>
<tr>
<td>• Date of next scheduled appointment</td>
<td></td>
</tr>
<tr>
<td>• Estimated Due Date</td>
<td></td>
</tr>
<tr>
<td>• Concerns identified</td>
<td></td>
</tr>
<tr>
<td>Check on women’s prenatal appointments at least monthly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>COMPLETION</td>
<td>Due Date</td>
</tr>
<tr>
<td>Healthy baby &gt; 5 lbs 8 ounces (2500 grams)</td>
<td>Concerns</td>
</tr>
<tr>
<td>Document baby’s birth weight, estimated age in weeks and any complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Birth Weight</td>
</tr>
</tbody>
</table>

PREG1 Initiation Date
PREG2 1st Prenatal App Date
PREG3 Rept Prenatal App Date
PREG4 Delivery Date, >2500 grams
PREG5 Delivery Date, < 2500 grams
PREG6 Finished/Incomplete

Reason: __________________________

January 11, 2011
Community Hub

Putting it all together...
Women at-risk of a poor birth outcome:

Areas of High Risk

Richland County, OH

4 years of data from vital statistics – Low Birth Weight births
Register client with the HUB

- Complete initial demographic intake and checklist
- Work with supervisor to assign Pathways
- Repeat home visits and checklists - working through Pathways
- Discharge client from care coordination
• We know where the most at-risk individuals are.

• We have the interventions that can help them.

• We don’t have the community delivery system that will make sure they connect to care!
Regional organization and tracking of care coordination

- Focus on at-risk
- Eliminate duplication
- Benchmarks – confirmed connection to care

Regional HUB System

Public-Private Partnership
Who is the primary purchaser of the services (Pathways)?

Any health, behavioral health or social service provider purchasing community care coordination
What is the value to the purchaser?

- Completed work units (Pathways) that are meaningful to the individual served.
- The ability to focus services on those who need them the most.
- The tools to improve efficiency over time – increased efficiency; more results for less money.
- Pay for your part and look to others to pay for their part(s).
Example - Pregnancy Pathway

Identify/enroll at risk

Care Coordination

Determine and document barriers:
1. Insurance Status
2. Transportation
3. Importance of Prenatal Care

Initiation Step

Defined “at risk” pregnant woman engaged and enrolled in care coordination

Completion Step

Healthy baby > 5 lbs 8 ounces (2500 grams)

Evidence based Intervention

Prenatal care provider established
First and ongoing visits confirmed

Final Outcome
Richland Help Me Grow – Pregnancy Pathways Contracting
Seven Care Coordination Agencies Serving Richland County

2004-2005
Contracting for Process
19 At Risk Served

2005-2006 –
Dollars tied to Performance
Duplication Removed
146 At Risk Served
“Where we focus on is the trend, our costs from 2007 to 2009 have only increased $.05 which I wish we could say that about all of our other medical costs, the trend over that two year period is much more than the insignificant $.05 that Richland County (OH) trended upward.” (NICU costs)

- - CFO, UnitedHealthcare Community Plan of Ohio
Caseload and Pathway Production

- One care coordinator can serve 30-60 clients
- One client may have 4-10 Pathways, both health and social
- One supervisor may have 4-6 CHWs in the field
- One agency may have as many as 20 care coordinators

Care coordinators may be CHWs, social workers, mental health case managers, nurses or other trained professionals.
results

Does this work?
Results: Low Birth Weight Richland County (OH)

Percent Low Birth Weight

Richland

6.1

13.0

CHAP
Pathways Birth Outcomes 2007–2011
Toledo, Ohio

Healthy  Low  Very Low

2007  4  2  0
2008  133  23  2
2009  186  30  8
2010  51  3  1
2011  70  4  1

33% LBW  13% LBW  6.6% LBW  7% LBW  15% LBW
Successful HUB Implementation

- **Collaborative Team**
  - All Medicaid managed care organizations in a community and other funders
  - All agencies and providers that interact with at-risk individuals

- **Standardized Data Collection:**
  - Demographic intake
  - Home visiting checklists
  - Core Pathways
  - Reports – multiple levels
  - Invoices – payment for outcomes / Pathway completion

- **Data System** – web based, user friendly, secure

- **Contracting Strategies**

- **Continuous Quality Improvement & Research**
Only one Community HUB in a region!

HUB:
- is neutral - not a provider of care coordination services; not a payer
- negotiates contracts with payers
- subcontracts with local agencies that can do the care coordination work
- has strong leadership and management skills
How to Make it Work

- Fidelity to the Pathways Community HUB Model; certification principles
- Keep it simple!
- Engage local community as a critical designer to drive the process
- Don’t expect immediate change . . . It takes time and this is hard work!
- Do the research
health care transformation “won’t yield to a massive top-down national project. . . Successful redesign of health care is a community by community task”.

– Don Berwick, M.D.
Resources

AHRQ –Connecting Those at Risk to Care

Quickstart Guide

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