Unleashing the Power of Communities to Improve Health through the Pathways HUB Model

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Jan Ruma, Hospital Council of Northwest Ohio, NW Ohio Pathways HUB

Who is in the Room?

- What do you hope to learn about the *Pathways Community HUB Model* in this session?

Agenda

- Ohio Health Disparities
- Pathways Community HUB Model
- HUB Outcomes
- Strategies for integrating the HUB with Clinical Providers and Community Partners
- Contracting for Outcomes
- HUB Staffing
- Managing Data Across Systems
- Building partnerships with policy makers to address health disparities through the HUB

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

2011 Infant Mortality Rankings by State & Race

	Total	IMR		Caucasian	IMR		African American	IMR
	USA	**6.07**		**USA**	**5.12**		**USA**	**11.51**
50	Mississippi	9.38	50	Delaware	7.66	**50**	**Ohio**	**15.45**
49	Delaware	8.71	49	Indiana	7.13	49	Oklahoma	14.93
48	Louisiana	8.24	48	Maine	6.76	48	Wisconsin	14.34
47	Alabama	8.21	47	Wyoming	6.63	47	Iowa	13.85
46	**Ohio**	**7.88**	46	Mississippi	6.6	46	Kansas	13.48
45	Indiana	7.69	45	West Virginia	6.47	45	Missouri	13.45
44	South Carolina	7.42	**44**	Ohio	6.39	44	Michigan	13.36
43	Arkansas	7.39	43	Rhode Island	6.37	43	Illinois	13.14
42	Tennessee	7.39	42	Arkansas	6.22	42	Mississippi	13.1
41	North Carolina	7.23	41	Alabama	6.16	41	Alabama	13.06
40	Oklahoma	7.23	40	Tennessee	6.14	40	Colorado	12.75

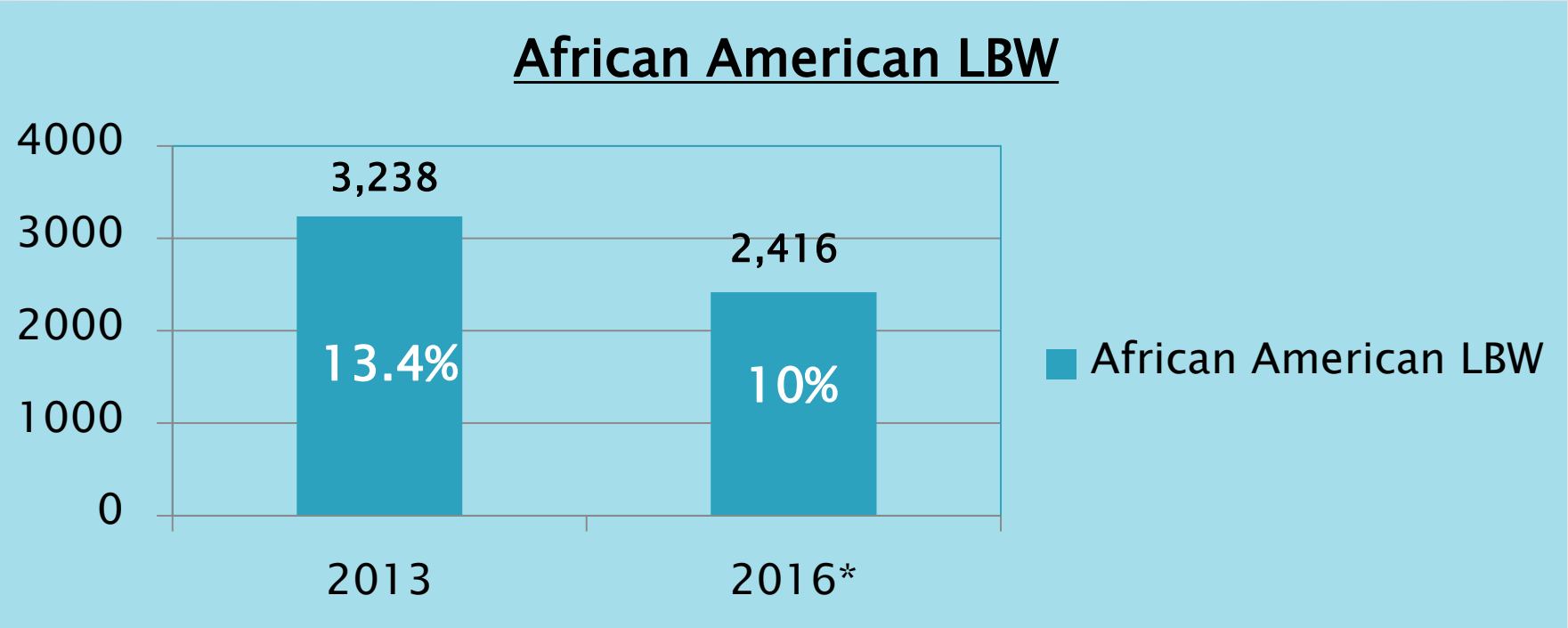
Ohio Preterm Birth Costs – 2013

- Medicaid paid for 52.4% of all Ohio births (70,479 deliveries)
- Medicaid cost for prenatal and delivery care = $596,126,541
- Preterm birth rate: Medicaid = 13.79% vs. non-Medicaid = 10.6%
- 9,719 Medicaid births were preterm (13.79%)
- Estimated 2012 preterm birth rate cost = $38,438

9,719 x $38,438 = $373,578,922
in one year

Improving Health and Reducing Cost

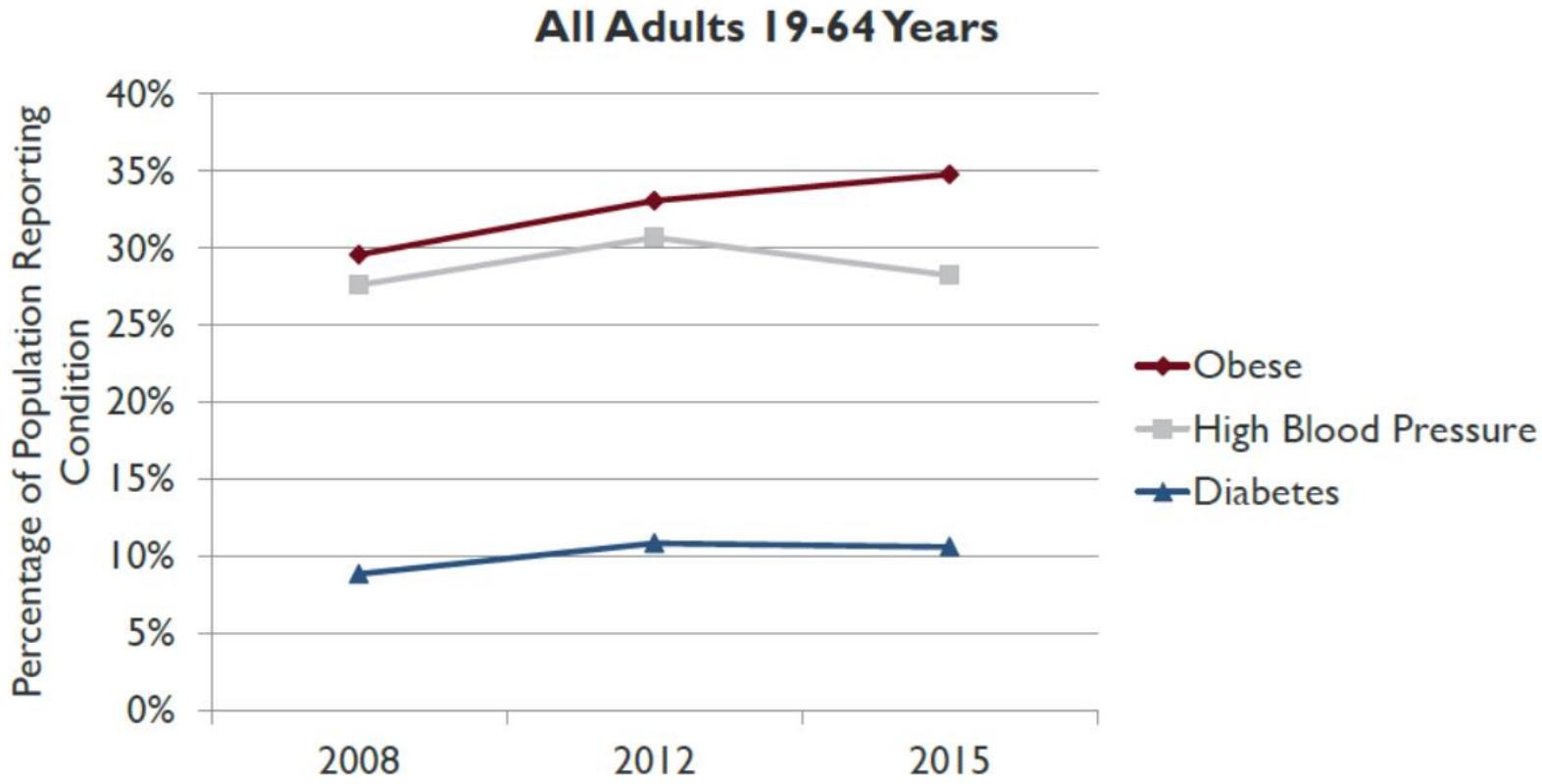
Ohio is ranked 50th in the Nation for AA Infant Mortality



Reducing the African American Low Birth Weight rate to 10% by 2017 will prevent 822 Low Birth Weight Babies and will save $28 million in healthcare costs alone.

*assumes same number of births as 2013

Trends in Chronic Conditions



OMAS
Ohio Medicaid Assessment Survey

WWW.GRC.OSU.EDU/OMAS

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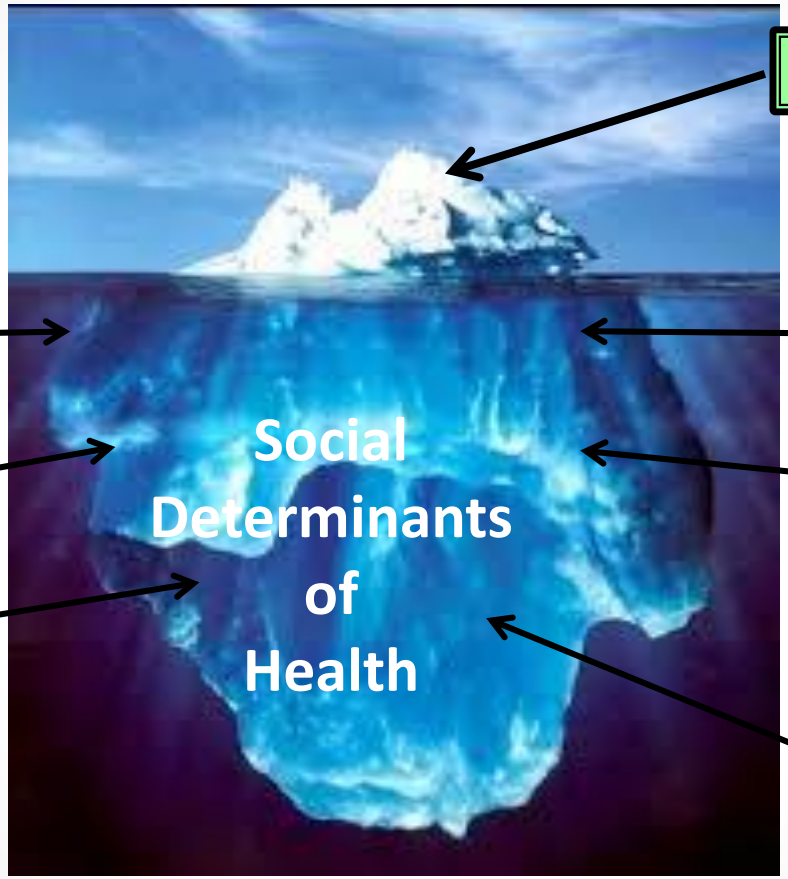
The Problem Runs Deep



10-15%

Health Care

Health Insurance
Primary Care
Specialty Care
Screenings

Behavioral Health

Substance use
Depression
Domestic Violence
Anxiety

Healthy

Employment

Job Readiness
Self Esteem
Application help
Resources

Social Services

Food
Clothing
Housing
Utilities
Transportation

Education

Childhood
Adult
Personal Health
Employment

How Can We Address Health Disparities?

- Pathways Community HUB Model

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

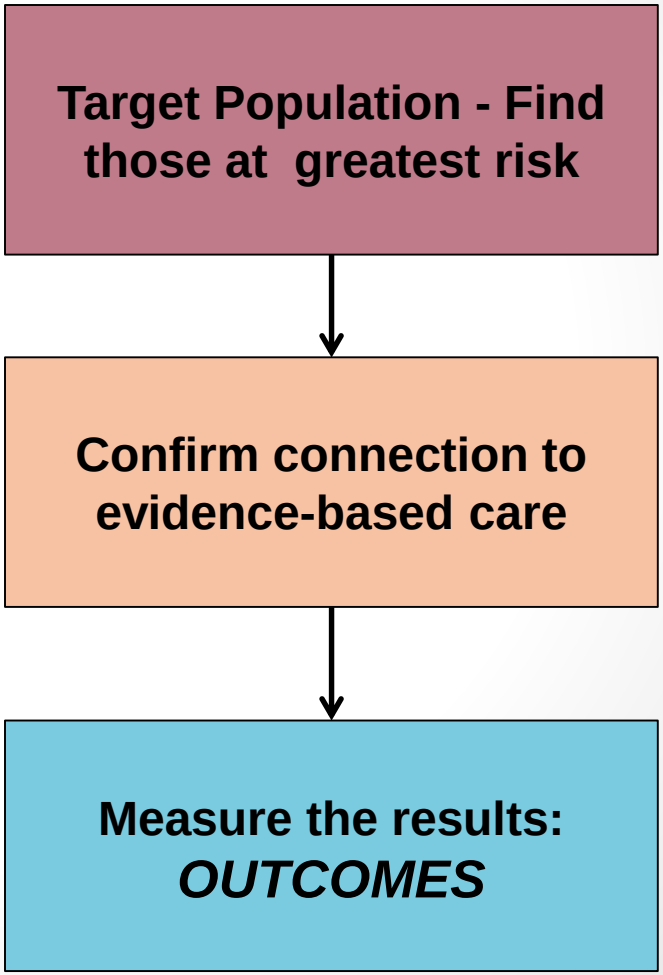
Common Goal= Reducing Health Disparities/Improve health & barriers to care

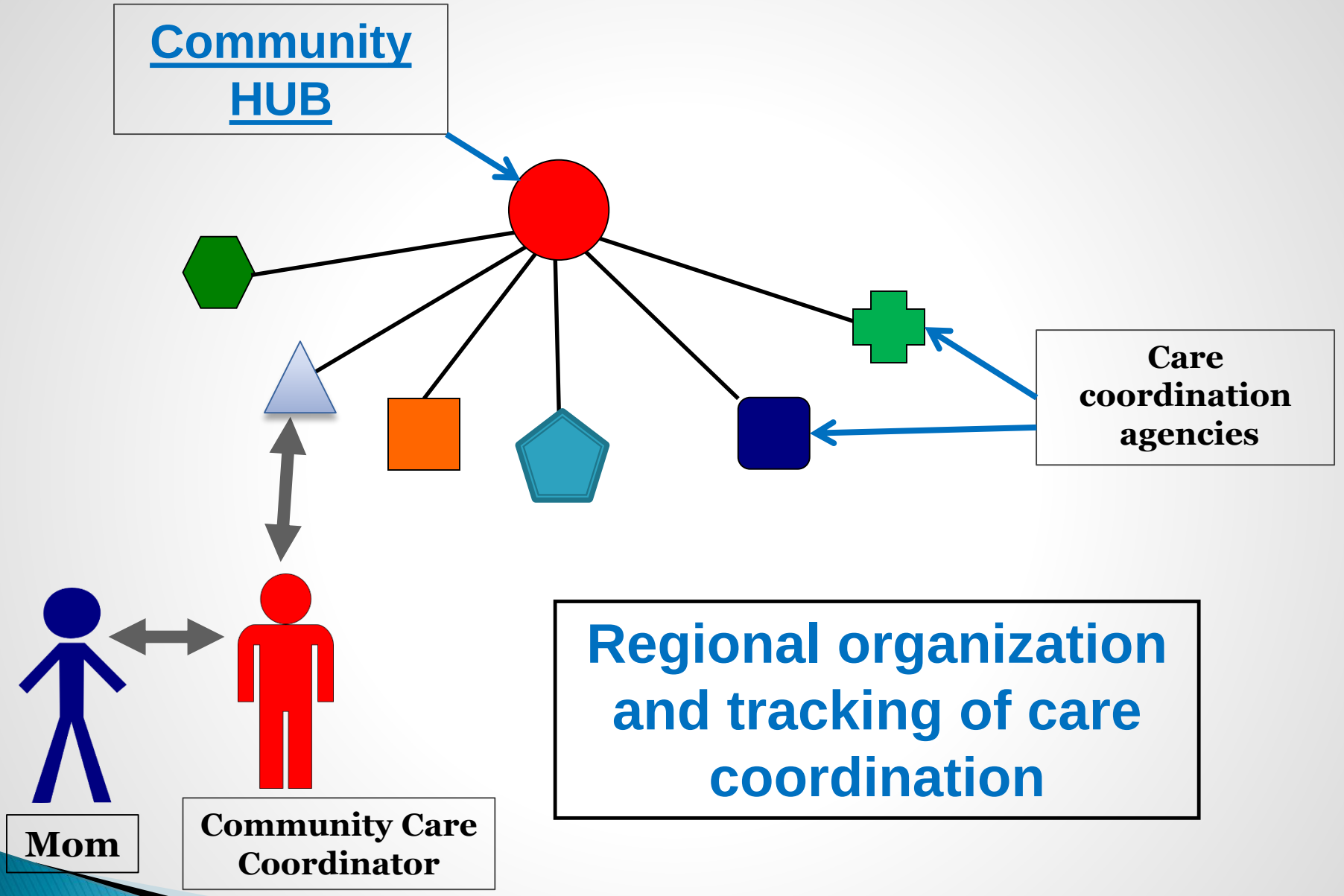
Pathways Model:
A Tool to Measure Outcomes

1- Find

2 - Treat

3 - Measure





Regional organization and tracking of care coordination

The Role of the HUB

- **Neutral Forum and Facilitator**
- **Grant & Contract Management**
  - Medicaid Managed Care
  - Grants
  - Care Coordinating Agency Contracts
- **Service Development & Implementation**
  - Manage outcomes and payments
  - Facilitate Care Coordinators and Advisory Committee
  - Link between Medicaid Managed Care and Care Coordination Agencies
- **Building CHW Workforce**
- **Evaluation and Quality Assurance**

National Certification

Form B: Certification Standards
Rockville Institute,
Kresge Grant: 245873

HUB Certification Pre-requisites & Standards

Pre-requisites

1) The Pathways Community HUB (HUB) must be an established community-based organization.
2) The HUB has utilized the HUB model for a minimum of six months.
3) The HUB is the only HUB in its regional service area.
4) The HUB has documentation of coordinating a network of agencies, comprised of a minimum of two agencies, each having at least one care coordinator with assigned caseloads of active at-risk clients identified within the agency's respective service area.
5) The HUB is able to contract with more than one payer on behalf of participating agencies.
6) The HUB is tracking outcomes using standard Pathways.
7) The HUB ties measured outcomes and results to dollars within financial contracts with payers.
8) The HUB has written program requirements and documentation to include client eligibility for services.
9) The HUB has written policies to ensure HIPAA-compliant client privacy and personal health information protections.
10) The HUB is an independent legal entity or an affiliated component of a legal entity.
11) The HUB is free of actual and perceived conflicts of interest (e.g., the HUB cannot employ care coordinators).

HUB Standards

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

Pathways Community HUB Model

- Removes “silos” and fragmentation
- Uses existing community resources efficiently and effectively
- Focuses on common metrics to identify & track risks (risk reduction)
- Holistic community care coordination
- Pays for outcomes – sustainable
- Owned by the community/region

Pathways Community HUB Model Endorsers

Ohio Commission On Minority Health

Institute *for* Healthcare Improvement

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

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

HRSA

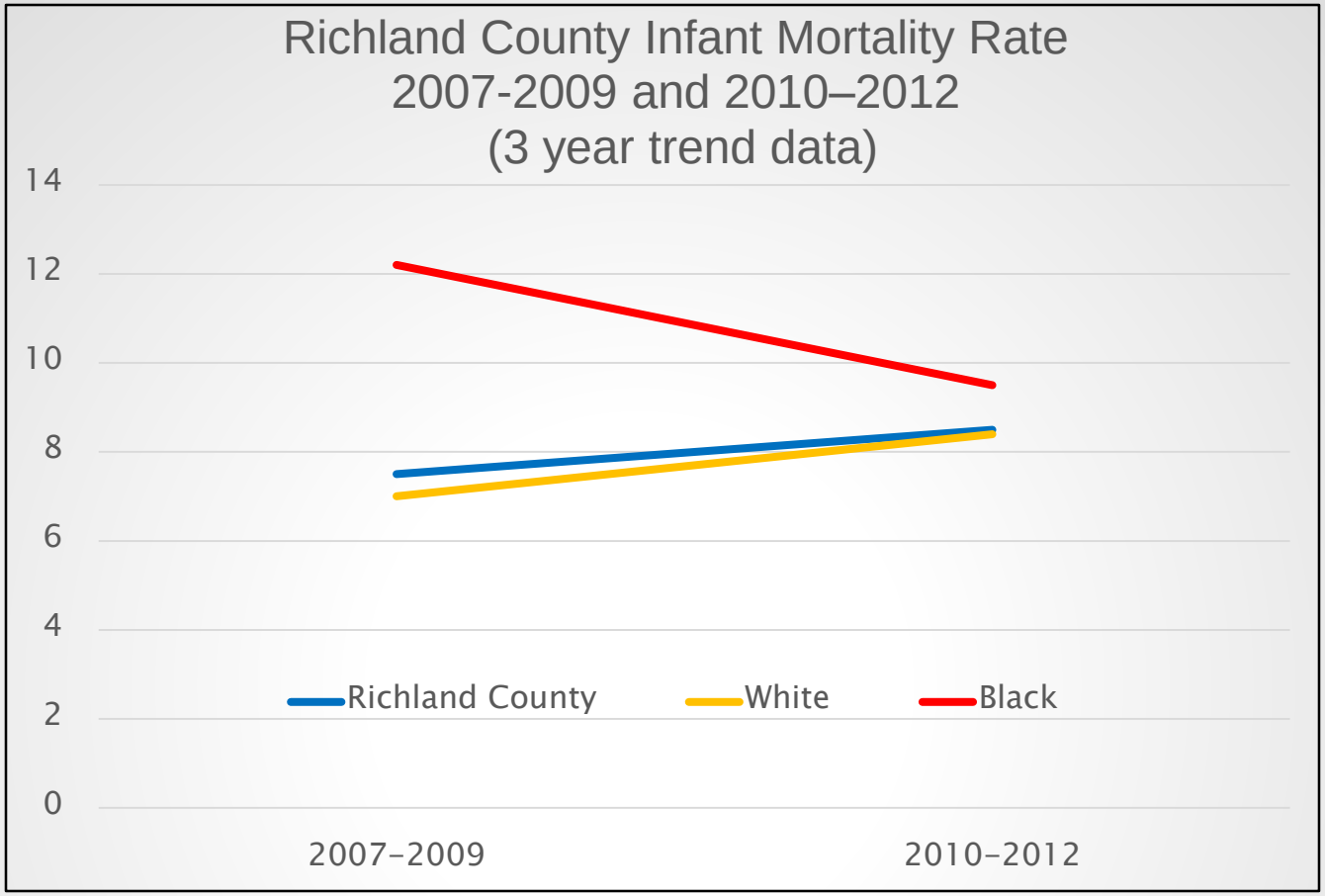
ODH Ohio Department of Health

NSF National Science Foundation
WHERE DISCOVERIES BEGIN

NIH National Institutes of Health
Turning Discovery Into Health

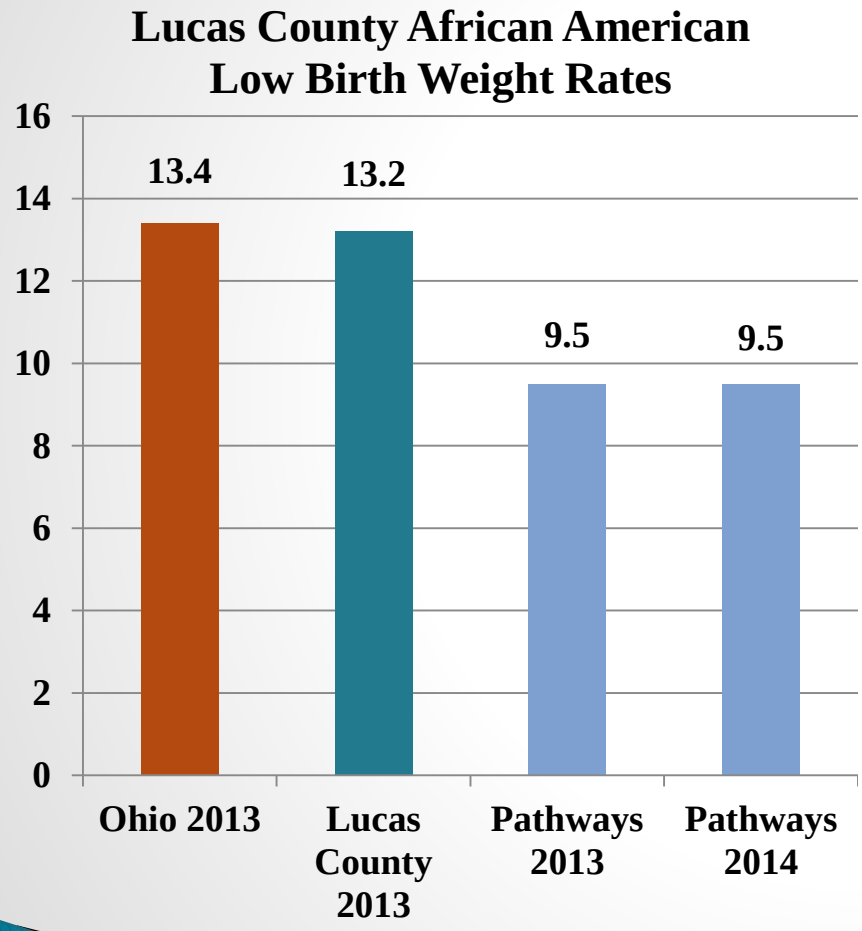
The CMS Innovation Center

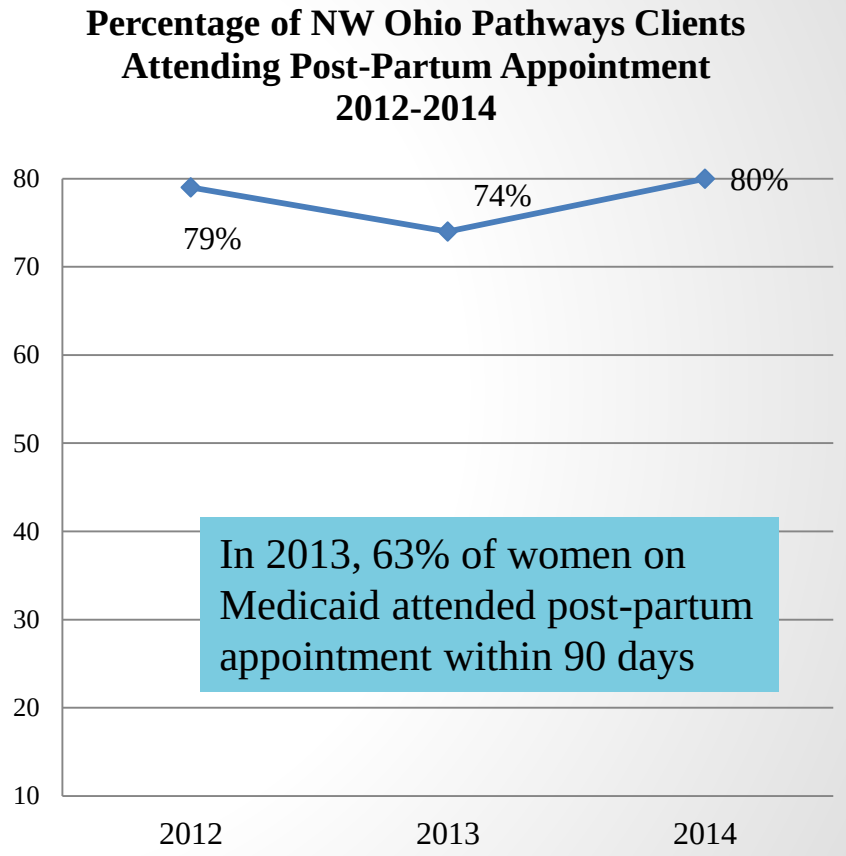
HUB Outcomes



	2007	2008	2009	2010	2011	2012
Infant Deaths Total	15	6	14	15	14	6
White Deaths	11	6	12	13	13	5
Black Deaths	4	0	2	2	1	1
Births, Total**	1,606	1,523	1,517	1,339	1,353	1,410
White Births	1,436	1,365	1,353	1,199	1,220	1,260
Black Births	170	158	164	140	133	150

northwest ohio pathways HUB





Pathways Pregnancy Outcomes (2007-14)

- 64% of clients from high risk neighborhoods
- Average number of prenatal visits – 7.6
- 87% delivered a full term baby (excluding twins)
- 89% delivered a healthy birth weight baby (excluding twins)
- 28% enrolled in 1st trimester; 52% enrolled in 2nd trimester
- Upward trend of a completed postpartum visit – 57% . . .

  80% in 2014
- Low birth weight deliveries trending downward – 11%

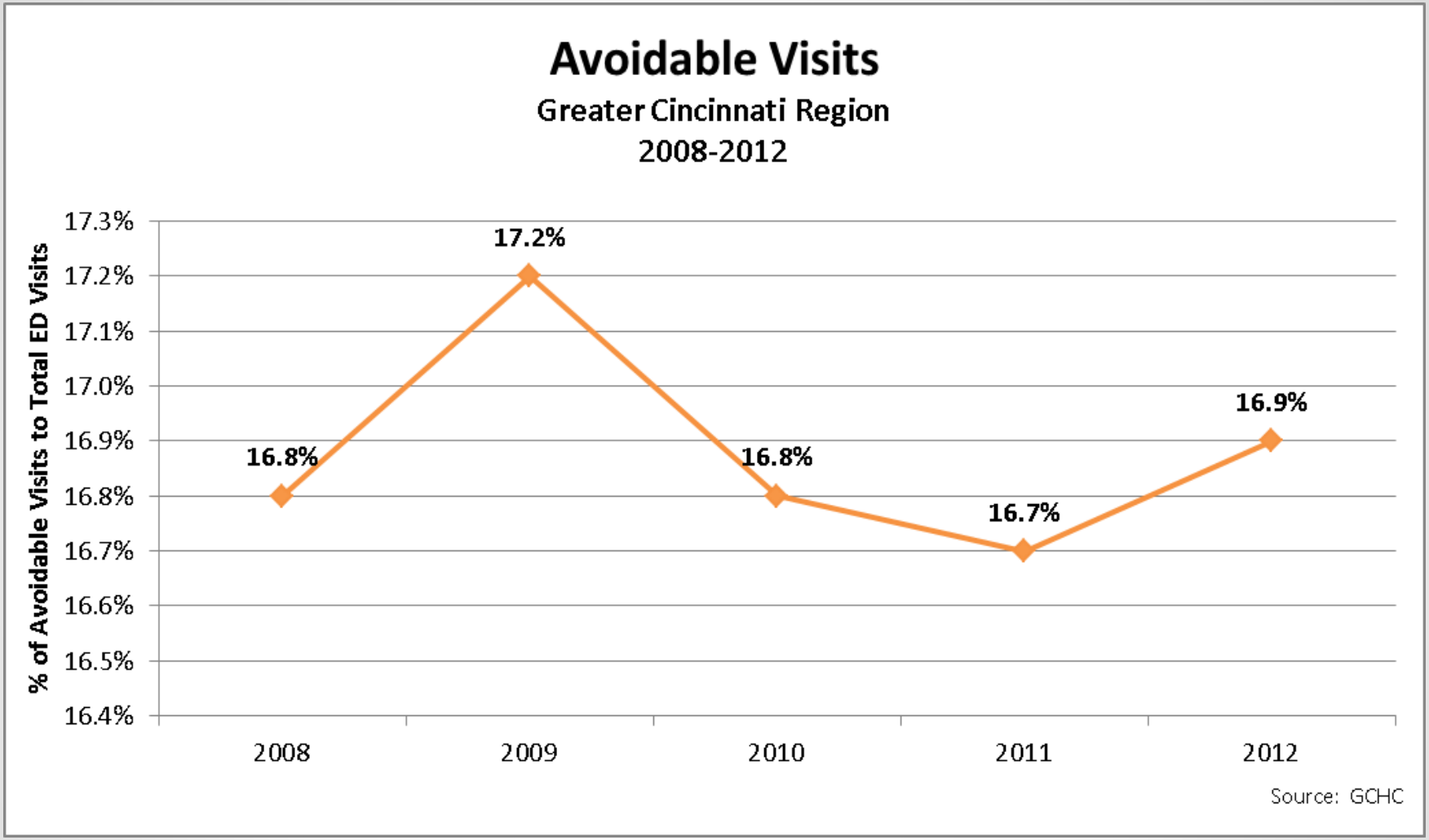
northwest ohio pathways HUB

Pregnancy Pathway Outcomes (2010-2013)

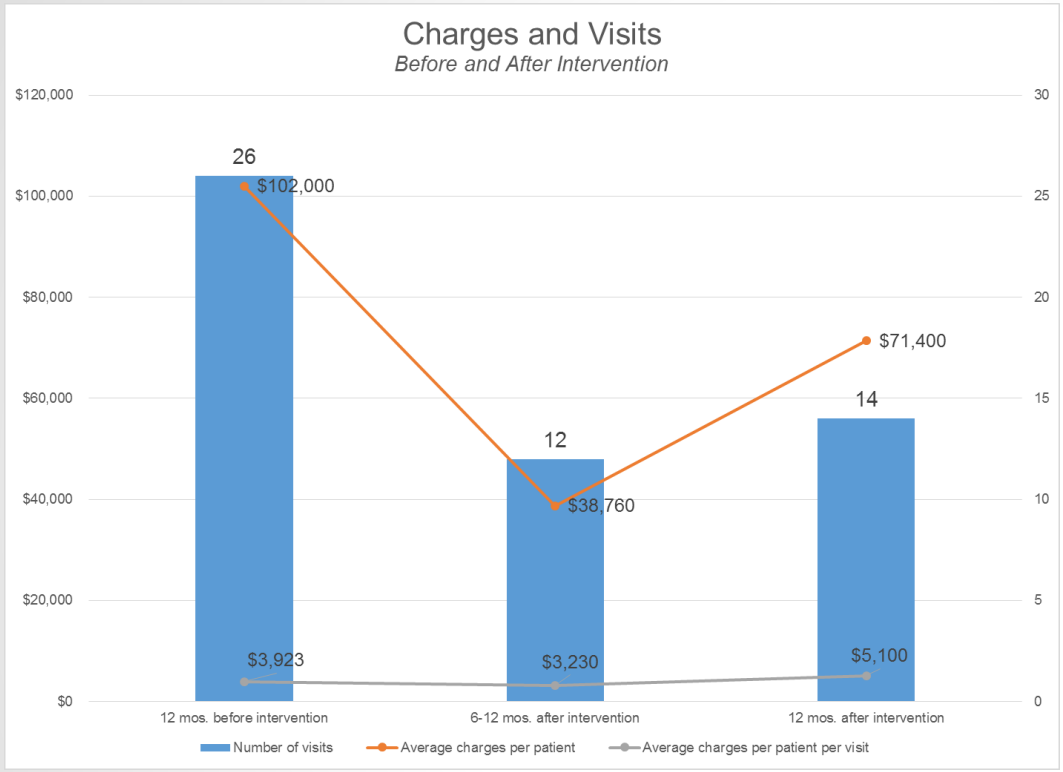
- 70% of clients come from high-risk neighborhoods (IMR – 5.8%)
- Average number of prenatal visits – 9.5 prenatal visits
- 83% delivered full term babies with birth weight >2500 gms.
- 40% enrolled in 1st trimester; 45% enrolled in 2nd trimester
- Trend of successful completion of postpartum visit rates – 58% of Moms completed in 2013
- Low birth weight deliveries trending downward: 11.9% (2010) – 9.7% (2013)

Health Care Access Now™

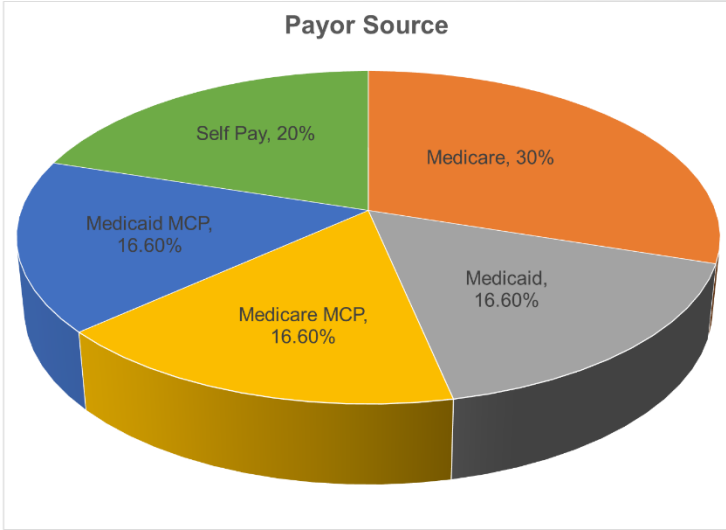
Building partnerships that improve access to health care in Greater Cincinnati


Avoidable Visits
Greater Cincinnati Region
2008-2012
% of Avoidable Visits to Total ED Visits
17.3%
17.2%
17.1%
17.0%
16.9%
16.8%
16.7%
16.6%
16.5%
16.4%
16.8%
17.2%
16.8%
16.7%
16.9%
2008
2009
2010
2011
2012
Source: GCHC

HCAN ED Super Utilizer Results – 2014
(n=30)



The average charge per visit suggests that visits that were reduced (or avoided) may have been lower acuity and therefore avoidable. The increase in the average charge after 12 months suggests that the intensity of services for those visits was higher; making it more likely that it was an appropriate ED visit. Further data analyses are needed to explore these assumptions.



Source: Health Care Access Now, 2014

Pre/Post Intervention Utilization

Average Client Prior to Intervention:

- 22 ED Visits in 12 months, total charges ~$147,000

Results

- After 6 months of Enrollment
- Reduced ED Visits by **52%**
- Reduced charges by **54%**
- After 12 months of Enrollment
- Reduced ED Visits by **40%**
- Reduced charges by **7%** (if two non-compliant clients removed, charges reduced by **29%**)

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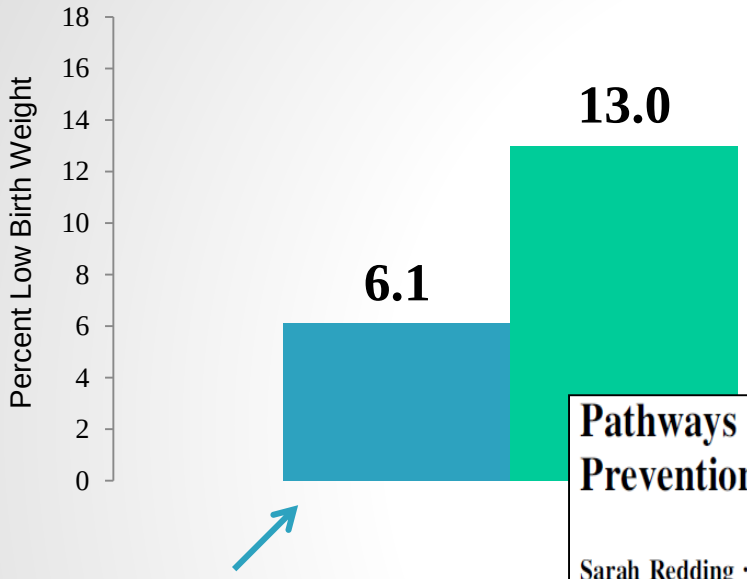
Published Study on Results



Pathway intervention over 4 years

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

Strategies for integrating HUB with Clinical Providers and Community Partners

Patient Centered Medical Homes

- Developing interdisciplinary/multilevel teams in outpatient clinics and PCP sites
- Community care coordination to provide the social connectedness and filling gaps in case management
- Support care transition services – better match between the level of service needed (non clinical care)

HUB Referrals

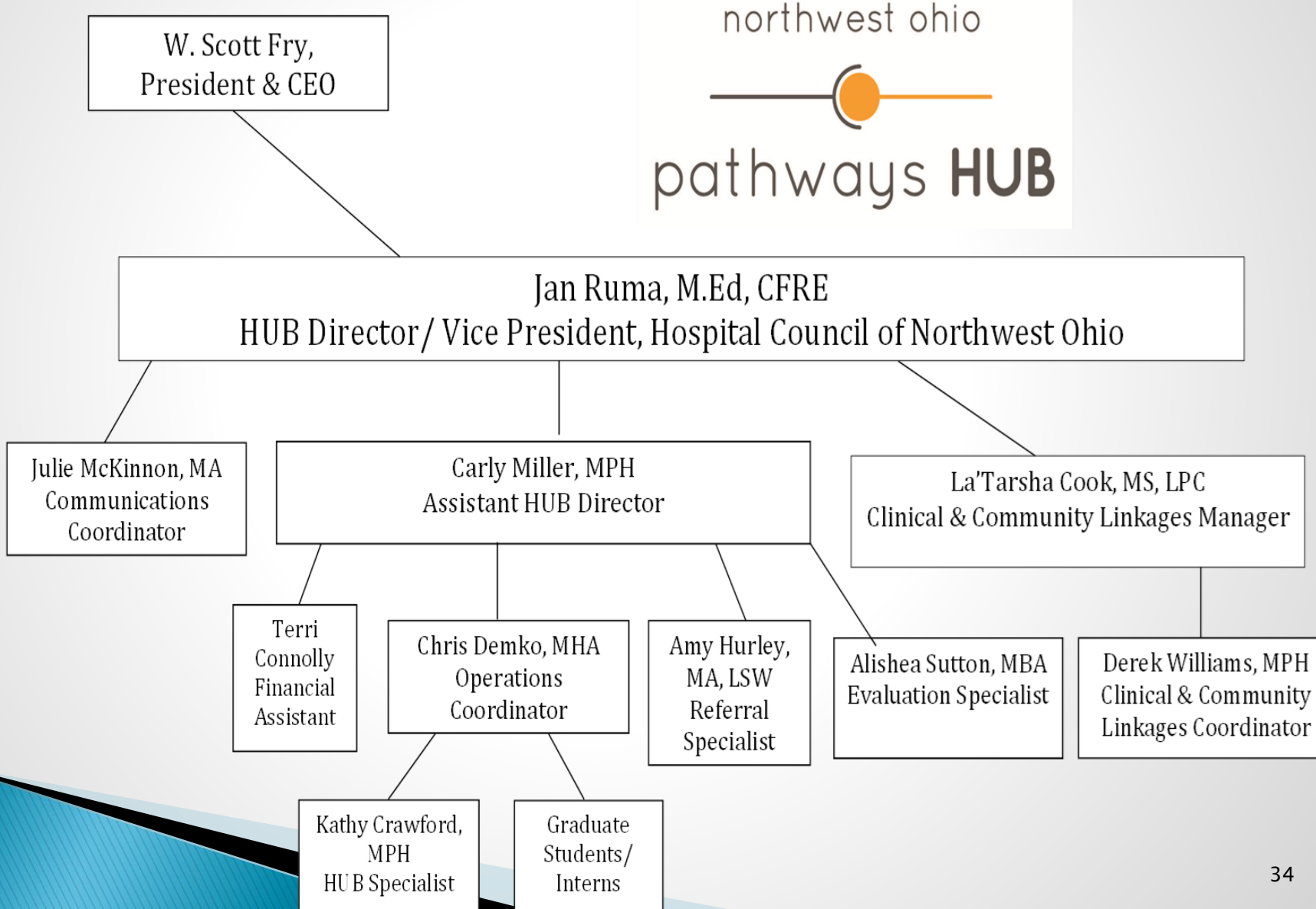
- Getting to 1: Assessment & Referral
- Embed social determinant questions in electronic health record
- Health plans
- Canvassing neighborhoods

HUB Staffing & Contracts

Workforce Development Opportunities & Challenges

- Community health worker career path
- Community Health Worker Certification
- CHW Job Coaching

New CHWs from Medicaid funded training at the University of Toledo 2015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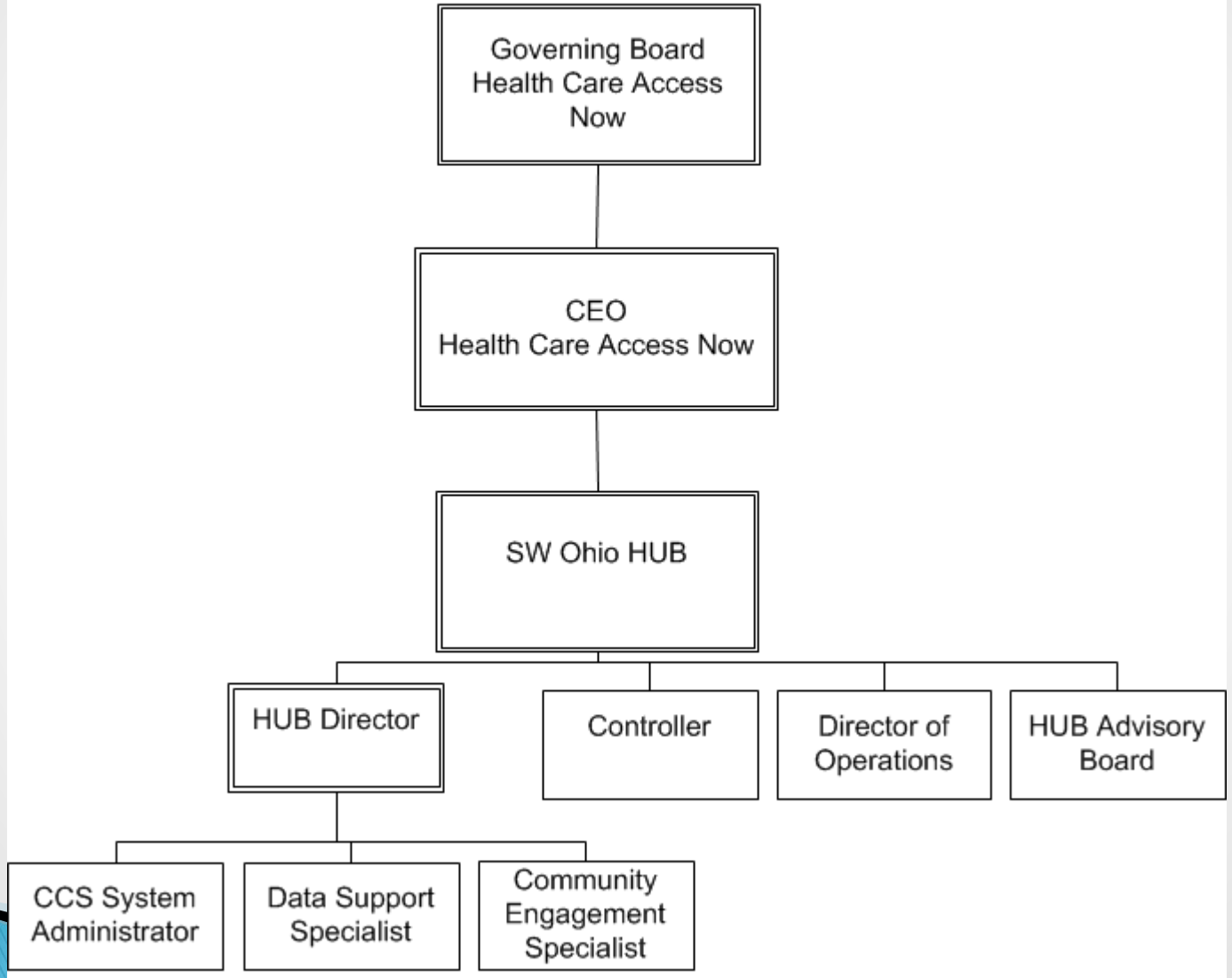
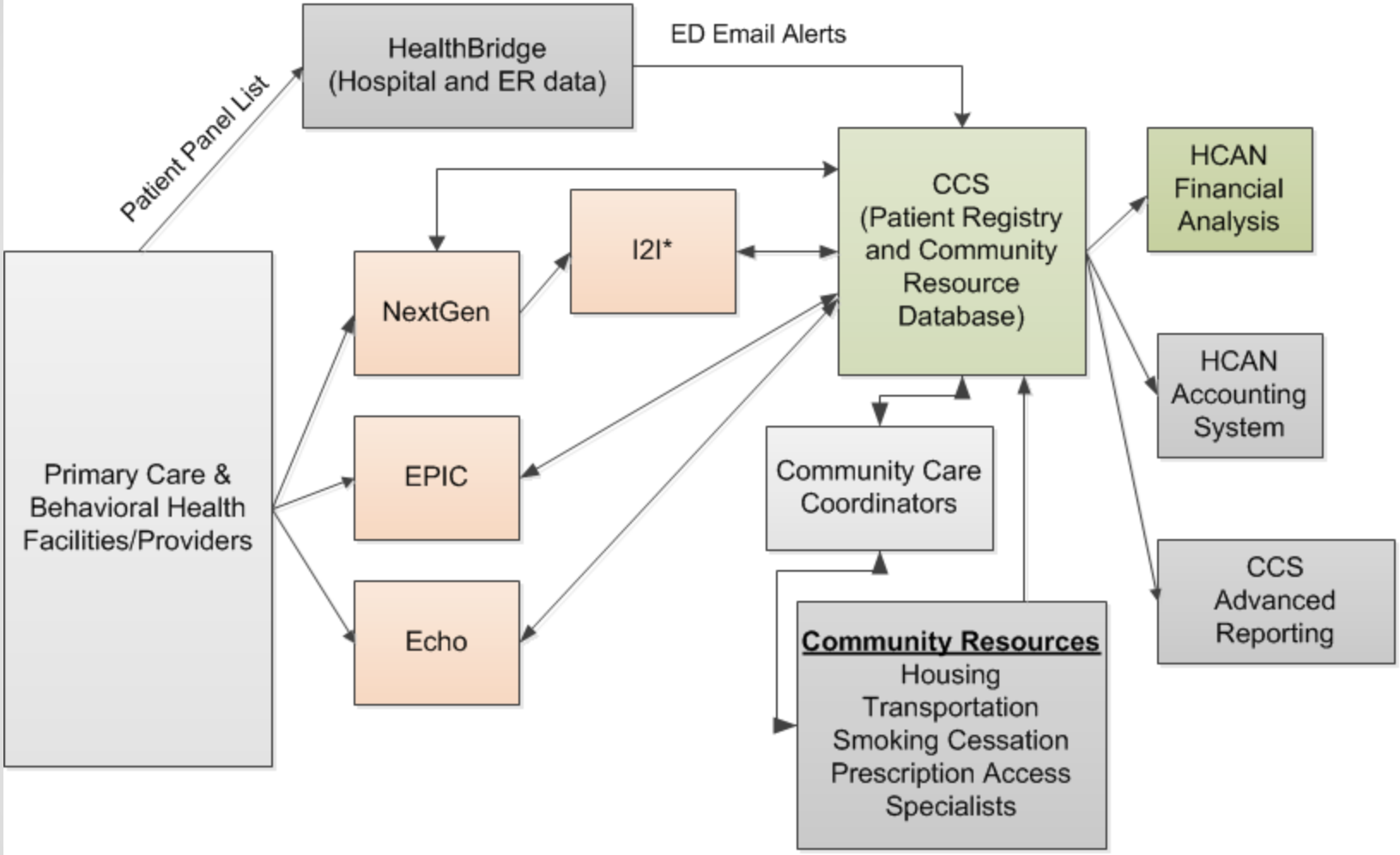


Health Care Access Now Organizational Chart - 2015

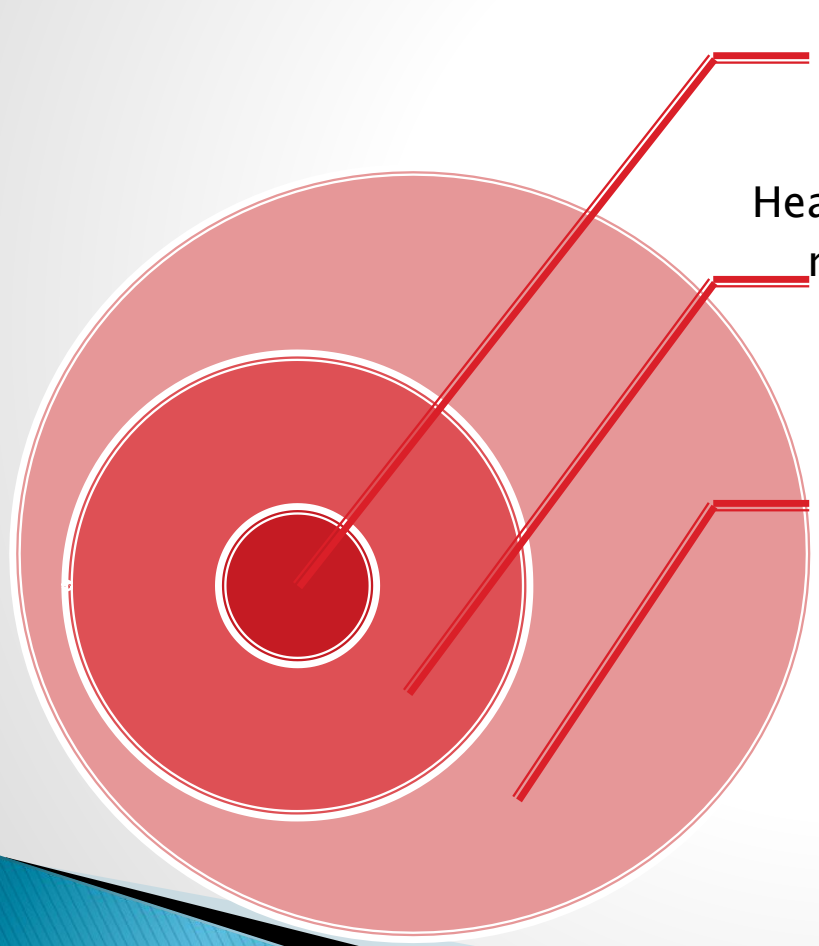
Managing Data Across Systems

Health Care Access Now
Care Coordination System (CCS) Architecture



Health Care Access Now

Care Coordination Options



Health Care Access Now™
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Braided Funding Model

- “Pay for performance” funding model--Care Coordinating agencies are paid strictly on achievement of positive outcomes
- Stipends are used to help organizations hire CHWs/care coordinators
- Grant funding provides seed dollars or subsidy for uninsured or clients pending enrollment.
- Medicaid Managed Care Plans or contracts with health systems provide earned revenue

Building Partnerships with Policy Makers

Proposed distribution of Ohio HUBs

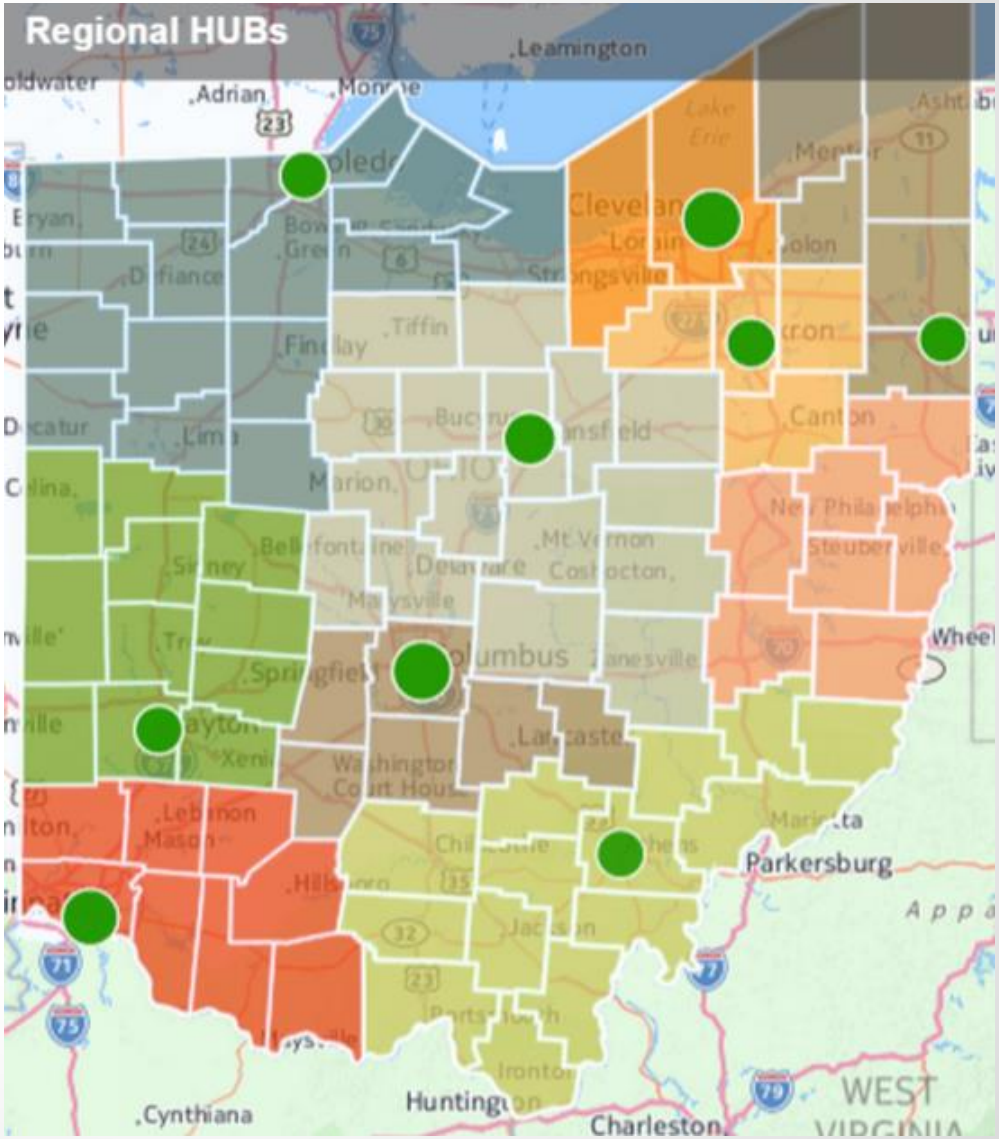
Existing HUBs:

1. Central Ohio (Richland County)
2. Northwest Ohio
3. SW Ohio (Hamilton, Butler & Clermont County)

Opportunity for HUBs*:

1. Cleveland
2. Columbus
3. Youngstown
4. Akron
5. Southeast
6. Dayton

*Funding will allow for the start-up of 3 additional HUBS



OCMH Grant Application Criteria

- Applicants must be certified HUBs, in the process of certification, or agree to begin the certification process within 6 months of funding.
- Applicants must demonstrate 20% match.
- Applicants must demonstrate support from
  - prospective community based organizations to provide care coordinators/Community Health Workers.
  - prospective payers, such as Medicaid Managed Care indicating interest in contracting for outcomes.
- Applicants must budget for a HUB Director and staffing.
- Applicants must agree to participate in statewide sponsored training and technical assistance.

Questions?