Pathways in Washington

What do you most want to know about Pathways?

- Relationship to Medicaid Demonstration Project?
- How it works?
- What training is like for the Care Coordinators?

Medicaid Transformation Project Requirements

Health Systems & Community Capacity Building

✓ These required elements are the foundation for transformation projects:

- Financial sustainability through value-based payment (VBP)
- Workforce development related to specific initiatives
- Systems for population health management

Care Delivery Redesign

✓ Required project:

Bi-directional integration of care and primary care transformation

Choose at least one:

- **Community-based care coordination**
- Transitional care
- Diversion interventions

Prevention & Health Promotion

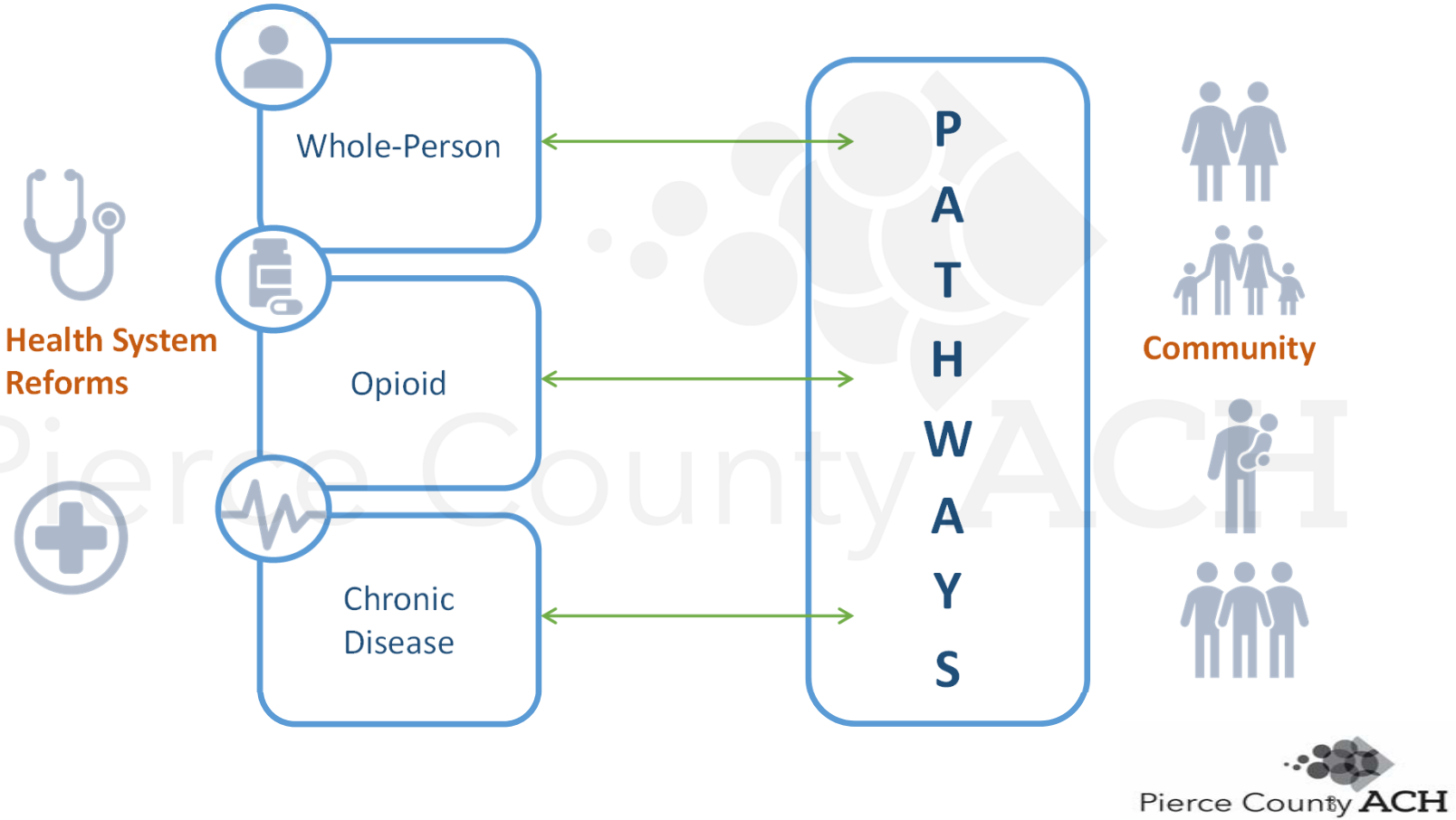
✓ Required project:

Addressing the opioid use public health crisis

Choose at least one:

- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control

Pathways as an Anchor Strategy



Endorsers of the Pathways Community HUB Model

Ohio Commission On Minority Health

Institute *for* Healthcare Improvement

Ohio Department of Medicaid

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

Ohio Department of Health

The CMS Innovation Center

NIH National Institutes of Health
Turning Discovery Into Health

NSF National Science Foundation
WHERE DISCOVERIES BEGIN

Community Care Coordination – care coordination provided in the community; confirms connection to health and social services.

A Community Care Coordinator:

- Finds and engages at-risk individuals
- Comprehensive risk assessment
- Confirms connection to care
- Tracks and measures results

Family at Risk

Marisol, 28

- Pregnant
- Lost job
- Can't pay rent

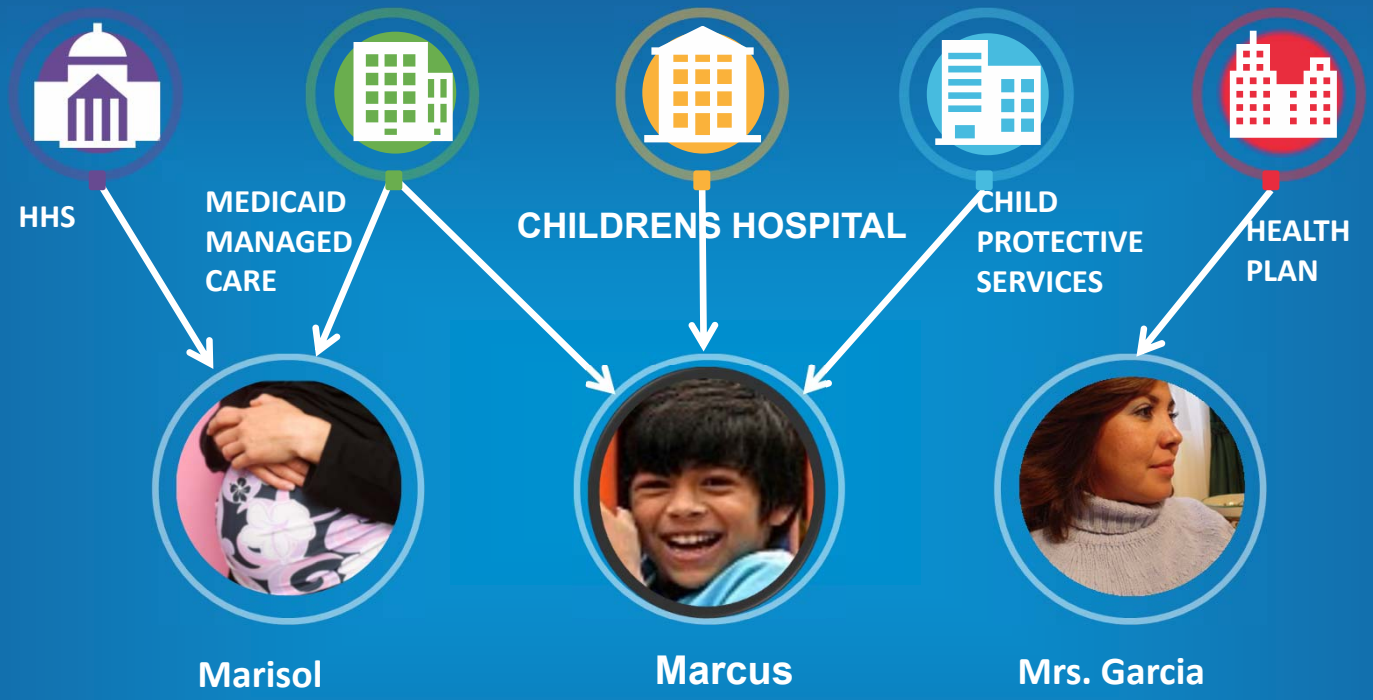
Marcus, 6

- 2 ED visits this month
- No asthma action plan
- Struggling at school

Mrs. Garcia, 50

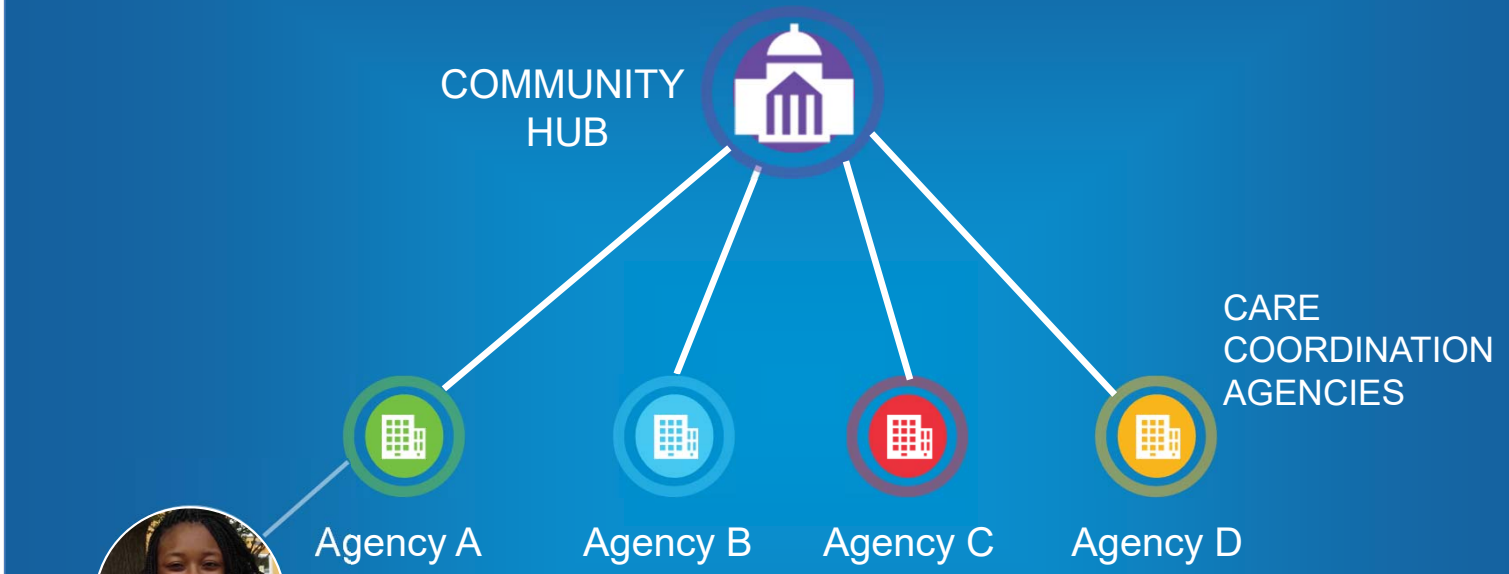
- One bedroom apartment
- Type 2 Diabetes
- 1 ½ ppd Smoker

Current *Community* Care Coordination

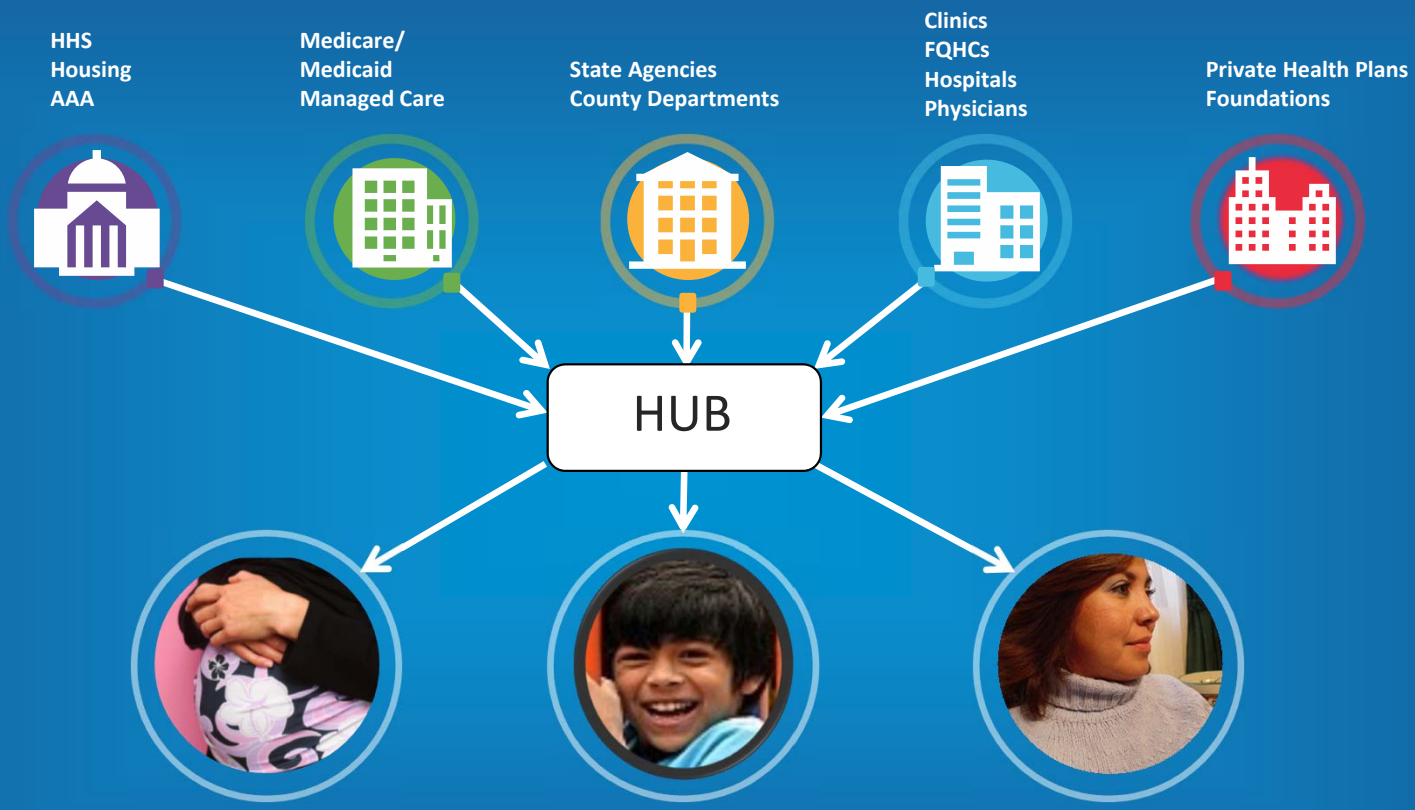


Multiple care coordinators involved – limited communication

Regional Organization and Tracking of Care Coordination



- Demographic Intake
- Initial Checklist -- assign Pathways
- Regular home visits – Checklists and Pathways completed
- Discharge when Pathways completed (no issues)

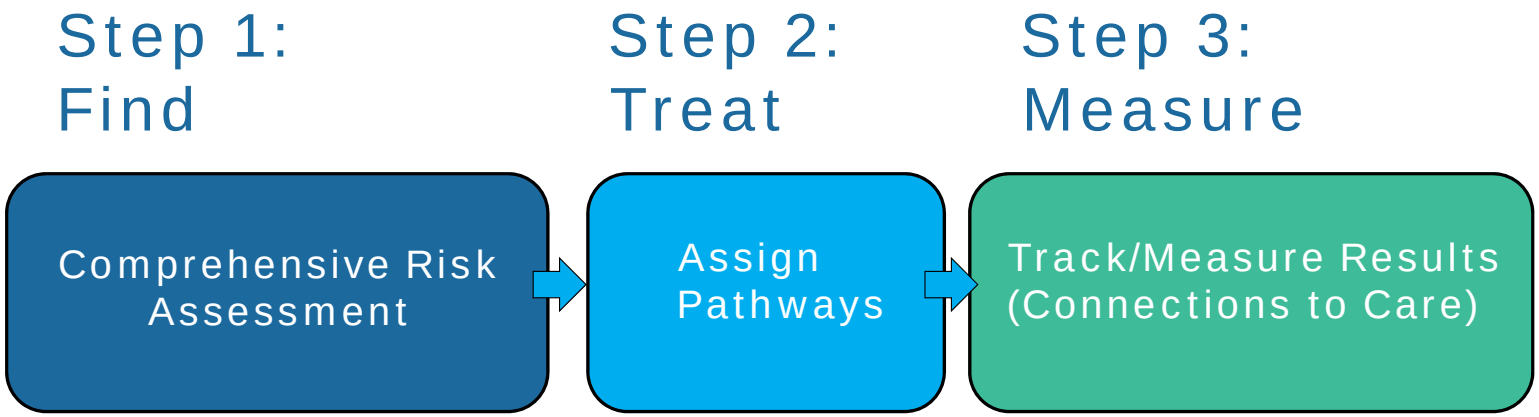


One Care Coordinator for the Entire Family

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

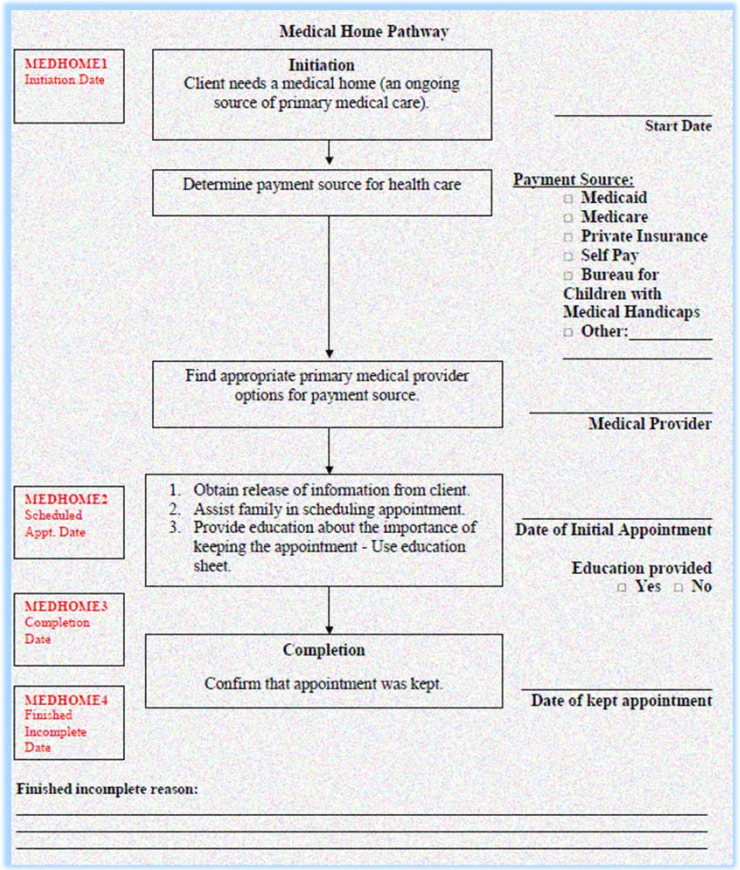
Foundation of the Model



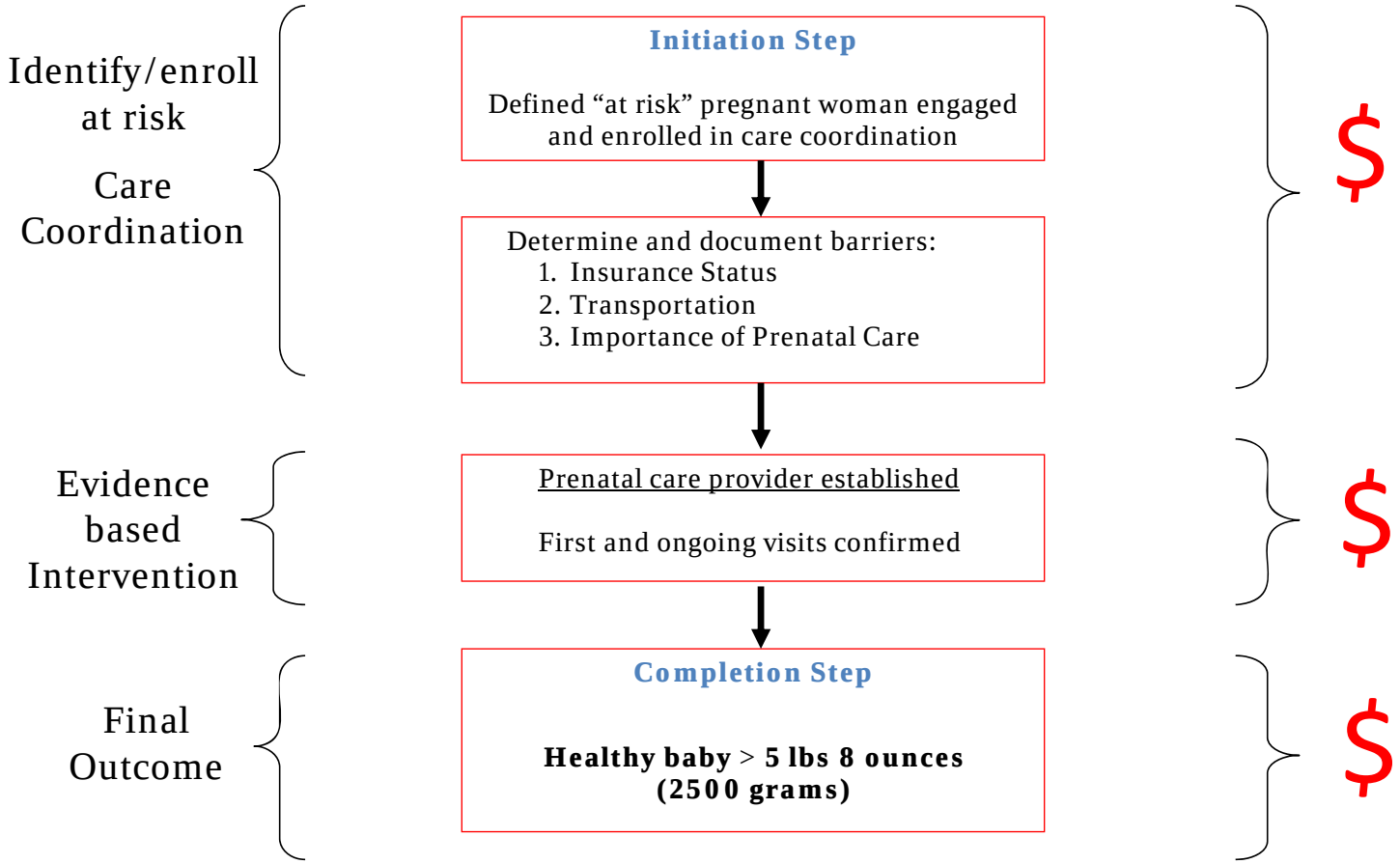
Treat: Risk = Pathways (PW)

20 Standard Pathways:

- One risk factor at a time
- Outcome achieved = finished PW & Payment!
- Outcome not achieved = finished incomplete PW



Example - Pregnancy Pathway



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

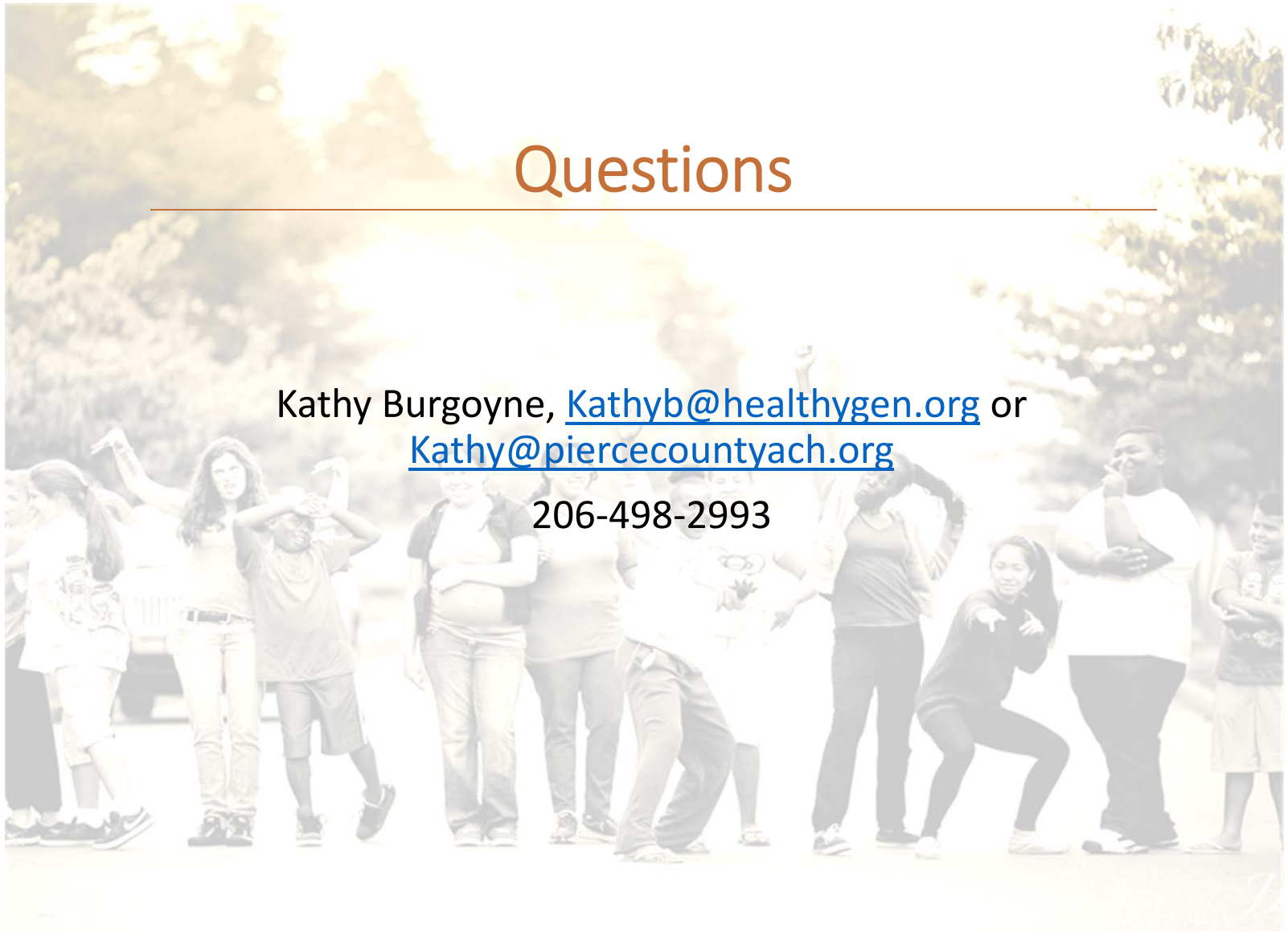
- **Care Coordinator**
- **Agency**
- **HUB**
- **Community**
- **Region**
- **Etc…**

Community Care Coordination

Benefits:

- Designed to use CHWs as Care Coordinators
- Has a payment model attached to it (value based payment from MCOs+ others), hence creating more sustainability for CHW work force

- Training is extensive: 5 days in person, on-line, practicum, 4-5 days in person
- Provides information on community need



Questions

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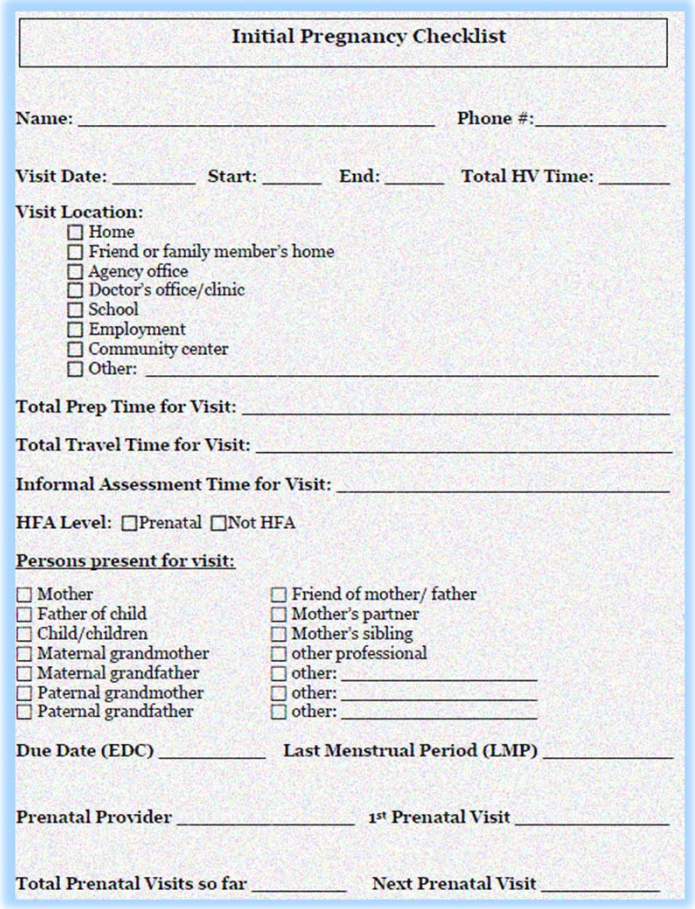
206-498-2993

Find: Comprehensive Risk Assessment

Standard Data Collection:

- Release of Information (ROI)
- Client Intake
- Initial Checklist (enrollment)
- Ongoing Checklist at each face-to-face visit



Initial Pregnancy Checklist

Name: _____ Phone #:_____

Visit Date: _____ Start: _____ End: _____ Total HV Time: _____

Visit Location:
- ☐ Home
- ☐ Friend or family member's home
- ☐ Agency office
- ☐ Doctor's office/clinic
- ☐ School
- ☐ Employment
- ☐ Community center
- ☐ Other: _____

Total Prep Time for Visit: _____

Total Travel Time for Visit: _____

Informal Assessment Time for Visit: _____

HFA Level: ☐Prenatal ☐Not HFA

Persons present for visit:

- ☐ Mother
- ☐ Father of child
- ☐ Child/children
- ☐ Maternal grandmother
- ☐ Maternal grandfather
- ☐ Paternal grandmother
- ☐ Paternal grandfather
- ☐ Friend of mother/ father
- ☐ Mother's partner
- ☐ Mother's sibling
- ☐ other professional
- ☐ other: _____
- ☐ other: _____
- ☐ other: _____

Due Date (EDC) _____ Last Menstrual Period (LMP) _____

Prenatal Provider _____ 1st Prenatal Visit _____

Total Prenatal Visits so far _____ Next Prenatal Visit _____

Distinctions between Pathways & HUB

Pathways

- Patient-centered, care coordination tool
- Identifies and “translates” patient risks
- Measured outcomes
- Payments for measured Pathway outcomes

Community HUB

- Tracks Pathways (outcomes) across agencies
- Eliminates duplication
- Streamlines referrals
- Provide infrastructure for community-based care coordination
- Involve braided funding – Pathways can be purchased by different funders

Key Points in Building a HUB

- The HUB must be a neutral entity in the community and cannot employ its own care coordinators.
- There is only one Pathways Community HUB in a community or region.
- The HUB must be an independent legal entity or an affiliated component of a legal entity.
- The HUB must be based in the community or region it serves.
- There must be a Community Advisory Board made up of members reflecting the community or region the HUB serves.