

Early lessons and experience with the Pathways Model in Washington State

3:30 – 4:30

*Steering Toward Success: Achieving Value in Whole Person Care
September 25 and October 26, 2017*

The Healthier Washington Practice Transformation Support Hub

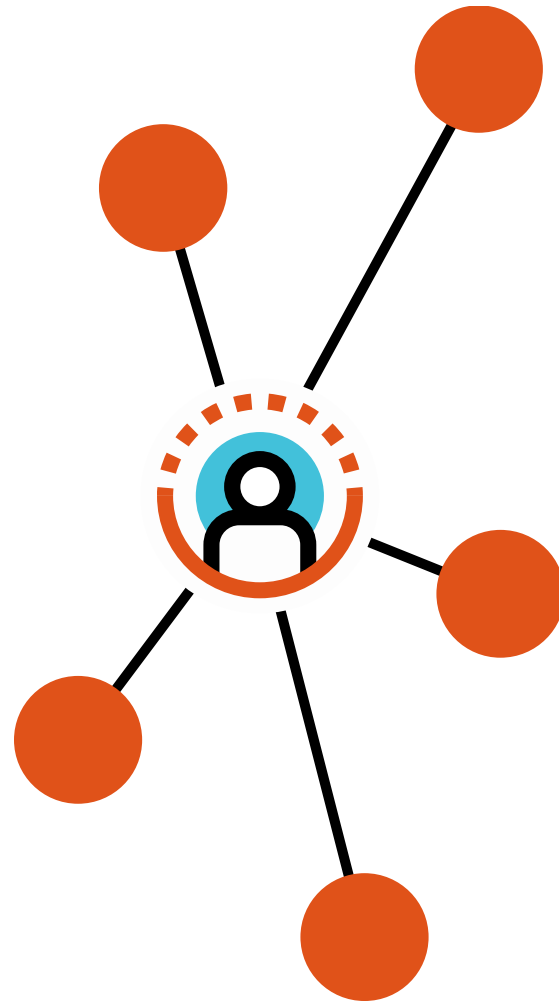




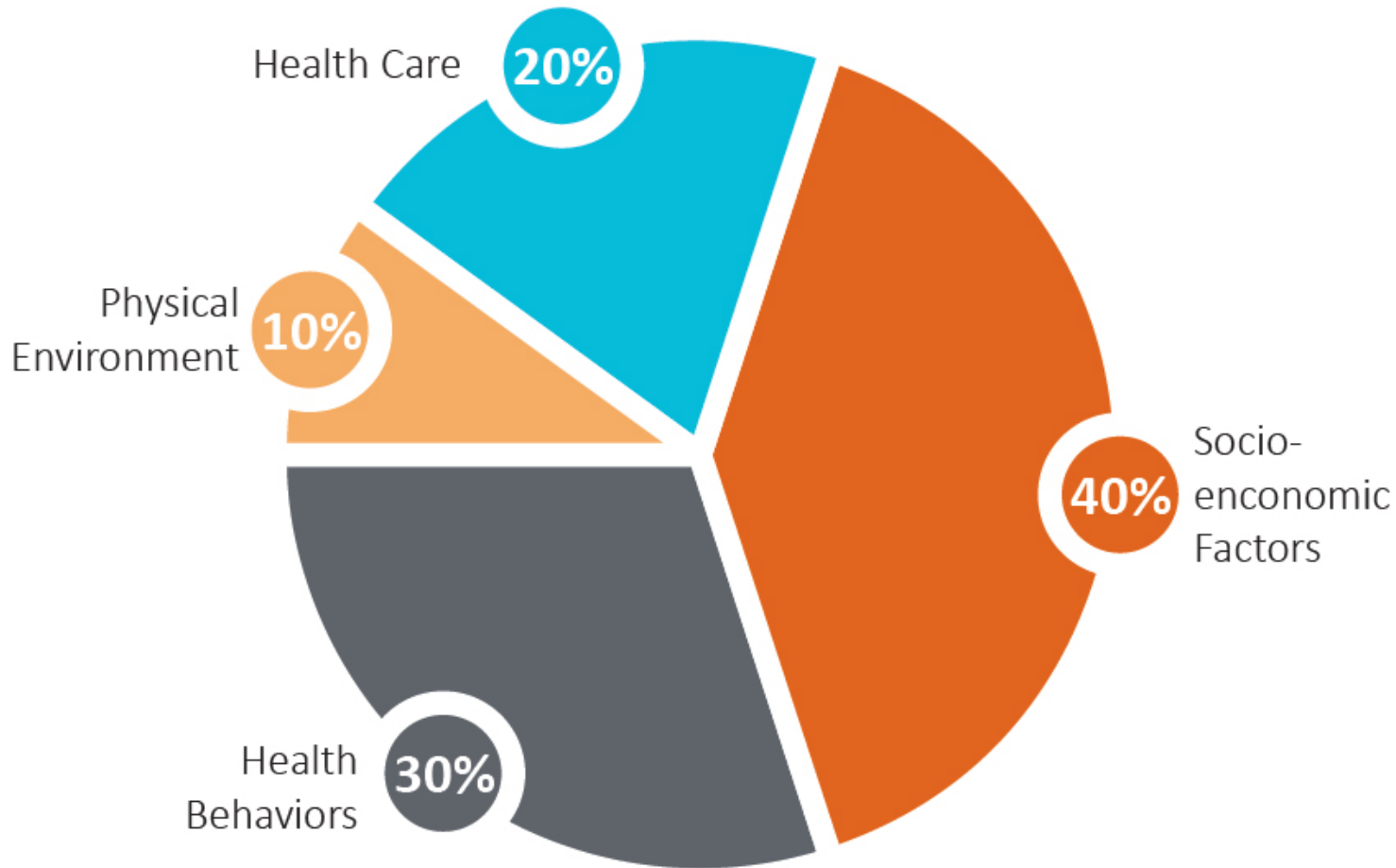
Learning Objectives

- Describe the pathways model and key considerations for implementation of the model under the Demonstration in Washington State
- Recognize opportunities and challenges likely to be encountered during implementation of the pathways model and creative solutions to support successful development of the program
- Identify community resources and provider partnerships to support success with the pathways model
- Apply lessons learned from early adopters of the pathways model in Washington State to the development of the model in other regions

Pathways Community Hub



What makes you Healthy?




Adapted from: Magnan et al. (2010). *Achieving Accountability for Health and HealthCare: A white Paper*, State Quality Improvement Institute. Minnesota.

Pathfinder Community Hub



Definition of Care Coordination



Care coordination is the **deliberate organization of patient care activities between two or more participants** (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

AHRQ Care Coordination Measures Atlas Update,
2014



Community Based Care Coordination

Care coordination provided in the community; confirms connection to health and social services.

Direct Services
=
INTERVENTION

Care Coordination
=
CLINIC BASED

Community Care
Coordination
=
HOME BASED or
COMMUNITY BASED

A Community Care Coordinator:

- Finds and engages at-risk individuals
- Performs a comprehensive risk assessment
- Confirms connection to care
- Tracks and measures results

Why do we need Community Based Care Coordination?

MORE THAN $\frac{1}{2}$ of patients

can't state their diagnosis when leaving the hospital

MORE THAN $\frac{1}{3}$ of patients

can't explain their medications

LESS THAN $\frac{1}{2}$ of patients

saw a primary care physician within 2 weeks of leaving the hospital

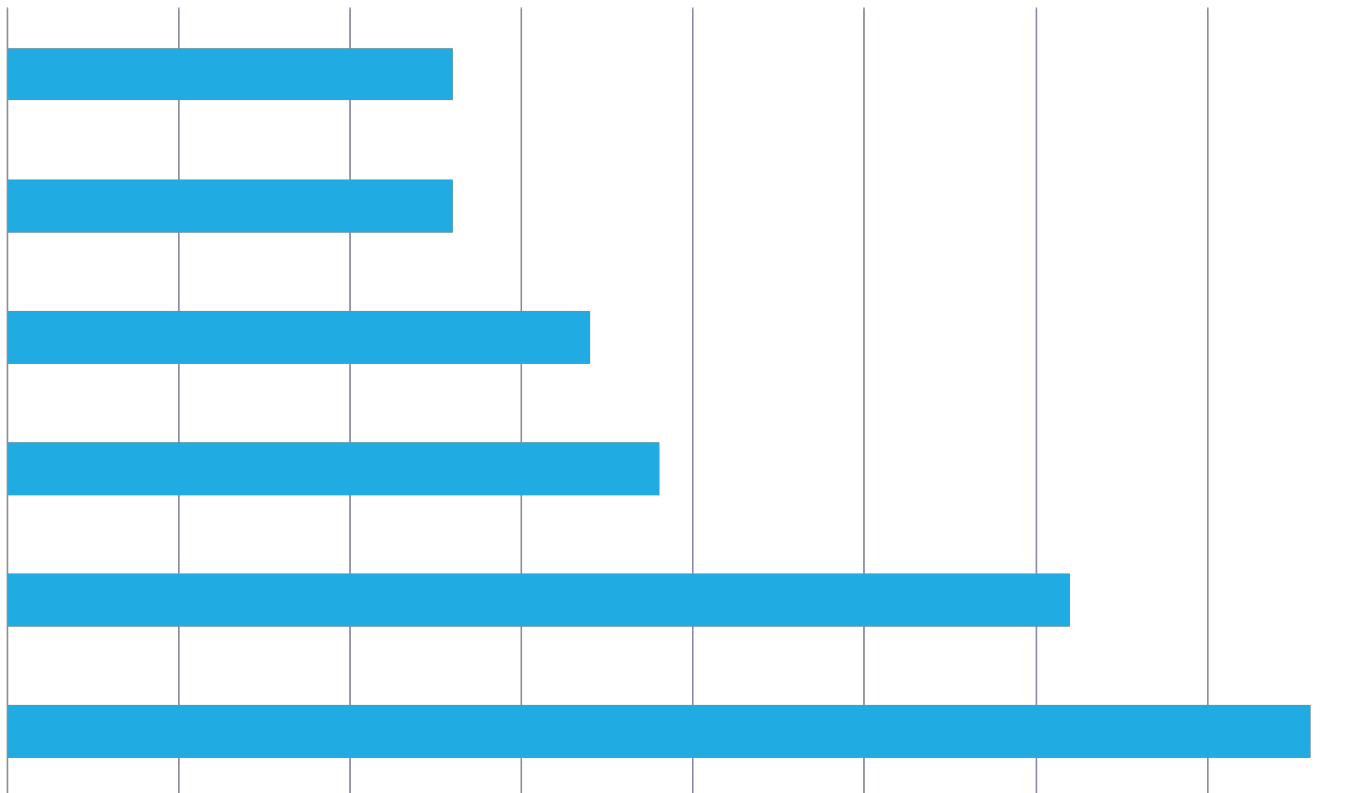
1 IN 5 patients

has an adverse event transitioning from hospital to home

Robert Wood Johnson Foundation Study

It's a well known problem

Percentage of physicians identifying problems coordinating care with different providers and entities



Pathways as a Proven Solution



Evidenced Based Practice
New England Journal of Medicine

Matern Child Health J (2015) 19:643–650
DOI 10.1007/s10995-014-1554-4

Pathways Community Care Coordination in Low Birth Weight Prevention

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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, and track each identified health or social issue to a measurable completion. CHWs are trained individuals from the same highest risk communities. The CHAP Pathways Model is used to track each maternal health and social service need to resolution and CHWs are paid based upon outcomes. We evaluated the impact of the CHAP Pathways program on LBW in an urban Ohio community.

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 with LBW while controlling for risk factors for LBW. We identified 115 CHAP clients and 115 control births. Among the intervention group there were seven LBW births (6.1 %) compared with 15 (13.0 %) among non-CHAP clients. The adjusted odds ratio for LBW was 0.35 (95 % confidence interval, 0.12–0.96) among CHAP clients. This study provides evidence that structured community care coordination coupled with tracking and payment for outcomes may reduce LBW birth among high-risk women.

Keywords Low birth weight prevention · Community health worker · Community care coordination · Social determinants of health · Pay for performance · Home visiting

Introduction

Infant mortality rates are used as an indicator for the health of a community. To prevent infant deaths, mothers need to be healthy, live in a safe environment, and have access to quality care. Reducing low birth weight (LBW) and premature births has been identified as a key strategy to decrease infant mortality [1]. While infant mortality rates in the US have improved over the past decades, they have been stagnant in Ohio. In fact, Ohio ranked second worst for black infant mortality among all states, and fourth worst for overall infant mortality in 2010 [2, 3]. Nationally, despite overall improvements, the 2011 Centers for Disease

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Pierce County **ACH**

Pathways Community HUB

What now?

- Many people have seen presentations, had conversations, gone into depth on the materials.
- So, where do we start? What steps do we take to engage the community and start the process of operationalizing a new HUB?



Implementation in Phases

- Based on my experience, we get this done in phases or co-occurring steps.
- The following slides will show the different steps Pierce County ACH is currently engaging in.



Identification of a Target Population

- A HUB is not meant to serve all people.
- So who should the HUB serve?
- Considerations:
 - Where is there need?
 - Where is there energy?
 - Where are there some resources?
 - Medicaid Transformation?

Community Engagement

- With setting up a HUB under Medicaid Transformation, not a typical process
- Easier and harder because of that
 - Easier:
 - + People want to be involved
 - + \$\$\$
 - Harder:
 - + Not quite the organic process it has been in other places
 - + Making sure you have the right engagement, which could include people/organizations who have not yet engaged in this process at all



Identification of CCAs

- First, you have to know the target population.
- Second, some considerations include:
 - trusted by the target population
 - geographic spread
 - experience with care coordination
 - size

Necessary Resources

Opportunity for up-front investment in:

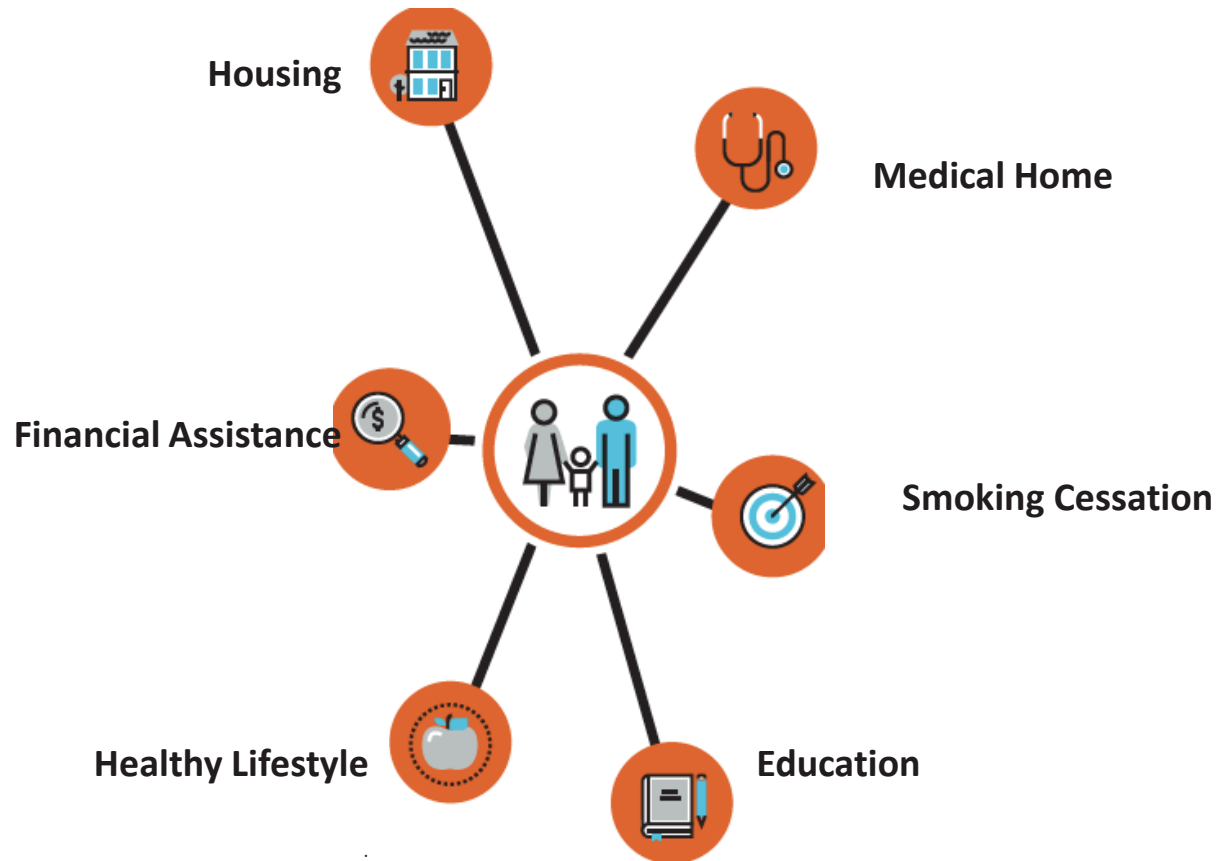
- Technology platform
- Workforce development



Specific Considerations

- Equitable approach
- Overlap and consideration of interaction with the Project Toolkit
- Health Systems Transformation

ACH Project: Pathfinder Community Hub



Ferry County Jail Transition Pilot

Long Term Outcomes by December 2018:

(Ferry County Pilot)

Recidivism

- Reduction in recidivism in Ferry County Jail by 20% by December 2018 Ferry County recidivism rate is 62% (Ferry County data 2015) National statistics show that 43% of all inmates return to prison within three years of their release (Pew, 2011) Ferry County is 274% higher incarcerated than Washington State average (Vera.org, 2013)

Cost

- Reduction in cost of providing jail health services in Ferry County by 20% by December 2018 Annual County Budget \$2million / Annual Jail Budget \$800,000 / Annual Jail Health Services \$45,000 (Ferry County data 2015)

ED Diversion

- Reduction of emergency department utilization for ambulatory sensitive conditions in target population in Ferry County from 20% to 16% of all ED visits by December 2018 (both inmates and their families) National emergency department overuse is \$38 billion in wasteful health care spending; 56% or roughly 67 million visits, are potentially avoidable. Significant Savings, average cost of an ED visit is \$580 more than the cost of an office health care visit (National Quality Forum, 2016)

Pathways:

- Adult Education
- Behavioral Health
- Developmental Screening Pathway
- Education Pathway
- Employment Pathway
- Family Planning Pathway
- Health Insurance Pathway
- Housing Pathway
- Immunization Referral Pathway
- Medical Home Pathway
- Medical Referral Pathway
- Medication Management Pathway
- Smoking Cessation Pathway
- Social Service Referral Pathway

Pathfinder Community Hub



Theory of Action

TRANSFORM COMMUNITY HEALTH

Create robust linkages between health care and social determinants of health to improve population health outcomes and accelerate transition to value based payment



5 YEAR DEMONSTRATION PERIOD TARGETED POPULATIONS & OUTCOMES

- ★ People transitioning out of jail*
- ★ People with chronic conditions (diabetes, asthma, hypertension, & cardiovascular disease)
- ★ Women of child bearing age & children
- ★ Kids in foster care & aging out*
- ★ Addressing opioid use*

*Expected to affect the number of people experiencing homelessness, dual eligibles

MEASUREMENTS

- 90% of state payment tied to value by 2021
- Implement full integration of Medicaid payments and delivery system by 2020
- Implement Fully Integrated Managed Care as a mid-Adopter by 2019
- Demonstrate multi-sector savings and creating shared savings models to invest in upstream prevention
- TBD measurement to demonstrate integrated care delivery
- TBD measurement around data sharing
- Increase primary care capacity by x%
- Increase rural health capacity by x%
- Increase Medicaid accepting Oral Health providers by x%
- Increase behavioral health capacity by x%
- Increase utilization of community-based care coordinators by x%
- 100% of eligible community members have health insurance

PAY FOR VALUE

Pay for outcomes in the health care and in social determinants of health systems

- Implement robust data management mechanisms throughout the region
- Encourage Value Based Care models

WHOLE PERSON HEALTH IN ALL POLICIES

Everyone has the right level of culturally appropriate care in the best setting.

- Retain 95% insurance rates
- Increase and sustain health workforce capacity
- Use data to form fact-based arguments for policy change

ALIGN COMMUNITY STRATEGIES

Create integrated community based plans to improve population health outcomes throughout the region.

- Population Health Strategy Maps
- Social Determinants of Health Strategy Maps

Medicaid Transformation Tool Kit



OPTIONAL

DOMAIN 2- Community Based Care Coordination

Rationale: Care coordination is essential for ensuring that children and adults with complex health service needs are connected to the evidence-based interventions and services that will improve their outcomes. Appropriately coordinated care is especially important for high-risk populations, such as those living with chronic conditions, those impacted by the social determinants of health such as unstable housing and/or food insecurity, the aging community, and those dependent on institutionalized settings.

Approaches:

- Utilize [Pathways Model](#) or other evidenced based community care coordination
- Assess current community capacity based on workforce, technology, partners and financial sustainability aligned with Domain 1 plans
- Develop HUB Implementation Plan

System wide Metrics: • Inpatient Utilization per 1,000 Medicaid Member Months • Outpatient Emergency Department • Visits per 1000 Member Months • Plan All-Cause Readmission Rate (30 Days) • **Percent Homeless (Narrow Definition)** • **Percent Employed (Medicaid)** • Home and Community-Based Long Term Services and Supports Use • Mental Health Treatment Penetration (Broad Version) • Substance Use Disorder Treatment Penetration

Project-Level Metrics: To be determined based on approval of region-specific target populations and selected interventions.

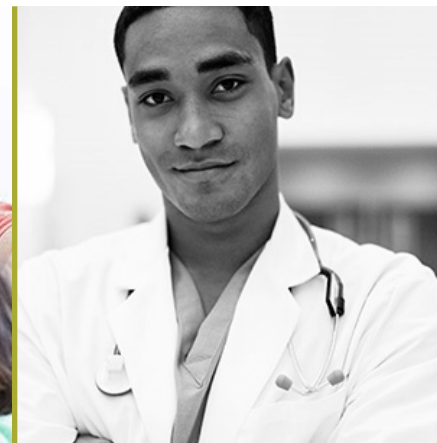
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Q & A



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