Pathways to Better Health Overview

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Serving Pathways to Better Health | Community Access to Home Visiting | Children’s Health Access Program
Overview/history of implementation

• MPHI, in partnership with MDHHS and multiple agencies and organizations in Saginaw, Muskegon, and Ingham Counties, received a Health Care Innovations Award from CMS to implement the Pathways Community HUB model in three Michigan counties

• 19 counties served by 3 HUBs

• Based on Dr. Sarah and Mark Redding’s work
Project Goals & Target Population

• Aligns with three-part aim:
  – Better care for patients
  – Better health for communities
  – Lower costs through health care system improvement

• Pathways to Better Health focuses on
  – Decreasing primary sensitive ED visits & inpatient admissions
  – Increasing utilization of primary care
  – Addressing social determinants of health
  – Integration of health care and social services

• Targets at-risk population
  – Adults with two or more chronic conditions
  – Enrolled in or eligible for Medicaid and/or Medicare
  – Frequent utilizers of emergency services or at-risk
Pathways Community HUB Model

1. **Find**
   - Target Population - Find those at greatest risk

2. **Treat**
   - Confirm connection to evidence-based care

3. **Measure**
   - Measure the results
Roles within Pathways Community HUB Model

• **HUB** – A central point of entry that links participants with needed community services; evaluates participants’ needs & assigns to the appropriate CCA

• **Care Coordination Agency (CCA)** – Accepts assignments from HUB; recruits, hires, manages, & deploys CHWs; Clinical Supervision provided by registered nurse or licensed social worker

• **Community Health Worker (CHW)** – Provides peer support & serves as a care manager extender; meets with clients in their homes & coordinates with case managers from other agencies (e.g. physician practices, Medicaid Health Plans)
Roles of a Community HUB

- Acts as an information clearinghouse with a centralized client registry to avoid duplication of services
  - Receives referrals, screens for eligibility and assigns to trained community health workers; Provides the vehicle for bi-directional communication with referral entities

- Provides a single point of entry or the “no wrong door” approach to patients, ensuring the referral will best meet their needs

- Performance monitoring and QA functions for all aspects of the program.
  - Delivers consistency – responsible for training, monitors activity for quality and productivity and provides program oversight
  - National standards from Pathways Community HUB Certification Program promotes accountability for quality care coordination services

- Provides a single point for contracting arrangements to reduce administrative costs.

- Reports outcomes to the community

- IT Infrastructure
COMMUNITY HEALTH WORKER ROLES

- Engage eligible clients in the Pathways to Better Health Program

- Assess eligible clients’ health and social needs as identified by client priorities (using a person-centered planning approach). Assess client’s stage of change and educate appropriate to that stage in order to promote healthy behaviors.

- Connect clients to needed medical and social services; assist in making appointments and assuring client participation; follow up to assure that services are available and meeting the client’s needs.

- Document services provided to eligible clients and collect client data using standardized Checklists and evidence-based Pathways and Tools.

- Communicate and serve as a liaison between providers, community agencies and health plan and the client.
  - Coordinate client care with a team of health care and social service provide

- Provide peer support to clients and reinforce health education and preventive measures.
- Help clients navigate care transitions through all systems of services and foster independence.
- Advocate for clients within the health and social service systems.
Pathways

• Document steps toward an outcome – PCP appointment kept, health education received, etc.
• 20 standardized/nationally recognized Pathways
• Focus on progress & outcomes/achievement of client’s health goals
  – In order for a Pathway to be closed complete CHW must document & verify the service was received by the client
  – Lends itself to value-based reimbursement
    • Payment for engagement of high risk clients, retention & completed Pathways
Examples of Pathways and Tools

- Social Service Referral
- Medical Referral
- Tobacco Cessation
- Medication Assessment
- Medication Management
- Medical Home
- Health Insurance
- Chronic Disease Education
- Pregnancy
- Postpartum
- Family Planning
- Healthy Changes Plan
- Healthy Homes Checklist
- PHQ-9 Screening
- Fall Prevention
- CAGE-AID
- Health Risk Assessment
Pathways Community HUB Model of Care Coordination
2016 Referral sources BY TYPE

- 211 Referral Service
- Ambulance Service
- Area Agency on Aging
- Community Health Worker
- Community Mental Health
- Community Organization
- County Human Services Office
- Emergency Department
- Hospital
- Home Health Agency
- Health Plan
- Primary Care Practice
- Specialty Care Practice
- Self-Referral
- Other

Top Referral Reasons:

1. Access to Community Resources
2. Chronic Health Conditions
3. Access to Medical Care
Top Social Service Needs

- Food
- Clothing
- Housing

Top Medical Needs

1. Primary Care
2. Specialty Care
3. Medication Assessment
4. Mental Health
5. Dental
Top 10 chronic conditions self-reported by client

1. Depression
2. Anxiety
3. Hypertension
4. Arthritis
5. Tobacco Use
6. Back Pain
7. Chronic Pain
8. Vision Loss
9. Diabetes
10. Asthma
Data Analysis of Pathways CMS Project

• To analyze healthcare utilization cost over time, Medicaid & Medicare claims data were processed to identify key utilization categories (i.e. inpatient hospitalizations & ED visits) & actual paid amounts, which were then summed on a quarterly basis for **2 years before & 1 year after enrollment**

• Medicaid & Medicare eligibility information was processed during the same time period to determine # of months each participant was covered within each quarter

• Total quarterly costs were then divided by # of eligible months within each quarter to obtain PMPM costs across quarters
  
  – Converting total costs into a PMPM format provides a method of standardizing costs over time & prevents variability in the # of months participants were enrolled in Medicaid/Medicare from unduly impacting results of the analysis
Average Quarterly PMPM Medicaid & Medicare Costs

Orange line is point of Enrollment in Pathways
ED Use per 1000 Member Months

Orange line is point of Enrollment in Pathways
# of Inpatient Hospitalizations per 1,000 Members

Orange line is point of Enrollment in Pathways
# of 30-day All Cause Readmissions

Orange line is point of Enrollment in Pathways
Client Satisfaction

Overall Satisfaction with CHW Services

Survey Quarter

Satisfied with services (%)

Happy
Would Recommend
Self-Efficacy

Overall Felt Empowerment and Health Impact

- Self Empowerment: 93.72%
- Health Improvement: 56.42%
Patient Activation

Client-Felt Empowerment to Meet Needs

- Doctor appointments: 94.81%
- Medication list: 92.31%
- Appointment transportation: 89.55%
- Self Management Info: 86.08%
- Medication taking problems: 85.71%
- Healthy eating and exercise: 84.62%
- Housing food and clothing: 83.75%
- Finding Services: 80.72%
- Tobacco use cessation: 76.92%
Support for the model

- State Innovations Model (SIM)
- Other State Implementation (OH, NM, OR, WA, WI, MN, NY, SC, CT)

Support for CHWs

- Medicaid Managed Care Plans
- State Plan Amendment (SPA)
- Training & Certification Program
- Care Team Members
Questions,
Comments,
Clarifications?