



Bridges to Health Pathways Program

Original grant funding provided by:

PacificSource Community Health Excellence Grant, PacificSource Foundation, Columbia Gorge CCO-(Columbia Gorge Health Council and PacificSource Community Solutions), Meyer Memorial Trust, Oregon Community Foundation, Providence Clinical Transformation Council, Providence Hood River Memorial Hospital

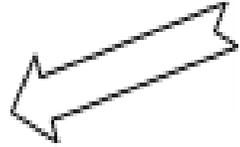
Suzanne Cross MPH, CHW – Columbia Gorge Health Council Senior Program Manager
suzanne@gorgehealthcouncil.org



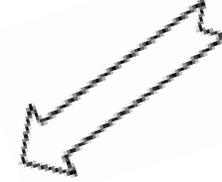
Sam is a Community Health Worker who works for Head Start and is doing a home visit on a child suspected of having developmental delays



While Sam is there he learns that the child lives in a 2 bedroom apartment with his mother and grandmother. Also living in the home is the child's aunt and her 3 children. She is a survivor of domestic violence.



Sam has concerns for the Aunt's health and for the older children. But his job description and the funding for his position only support his work with the youngest child in the household.





Clients

Agree to participate
Agree to data sharing with Hub



Community Care Coordinators (CCC/ CHW's)

Employed by own Agency
Trained as CHW's or equivalent
Find eligible clients
Track work



Funders

Contribute money
Articulate goals





Bridges to Health

Pathways HUB

Neutral Process Manager (does not provide client services)



- Training for CCCs
- Quality Improvement/ Compliance
- Operates IT Platform
- Data Collection, Reporting
- Program Evaluation
- Fiscal Responsibility
- Payments to Agencies

Empower Community Members Most in Need to Improve Overall Health and Wellbeing

- Address the needs of the household
- Engage clients where they are

Increase Collaboration of Services in and out of Healthcare

- Standardized Outcomes Based Process
- Data Driven Community Decision Making
- Address System Service Gaps

Improve Access to services/ resources by addressing disparities

- Build on Community Strengths
- Limit Duplication of Services
- Identification of Roadblocks



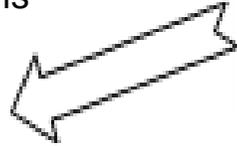
Sam is a Community Health Worker who works for Head Start and is doing a home visit on a child suspected of having developmental delays.



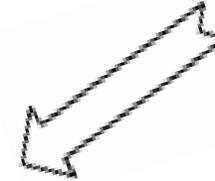
While Sam is there he learns that the child lives in a 2 bedroom apartment with his mother and grandmother. Also living in the home is the child's aunt and her 3 children. She is a survivor of domestic violence.



Sam checks CLARA and learns that no one in the household has yet been entered into the system.



Sam has concerns for the Aunt's health and for the children. He asks the Aunt if she would be interested in participating in Pathways. She is.



Sam does a Bridges to Health Pathways assessment with the Aunt and learns that she has stopped going to her counseling appointments due to lack of transportation. He also finds out that she no longer has her health insurance because of lost paperwork.



Sam and the Aunt agree to work on the Pathways that opened based on her needs:

- Social Service Referral (transportation)
- Health Insurance
- Housing
- Behavioral Health



- Sam assists the Aunt in completing and turning in her health insurance paperwork and follows up to make sure she is enrolled.
- He teaches her how to use the transportation support available to her and insures that she has gotten back to her counseling appointments and confirms that 3 appointments were attended.
- They begin the process of completing the Housing Voucher application and submit it to the Housing Authority.
- Sam will continue to follow up with the Aunt and the Housing Authority in hopes of the family finding a home.



Bridges to Health Pathways Program

Core Pathways (Needs)



- Behavioral Health
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Food
- Immunization
- Pregnancy
- Postpartum
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication
- Tobacco Cessation
- Social Service Referral (transportation, debt management, utility assistance, legal, documentation, etc.)



Evaluating our goals:



Empowering community members most in need to improve their overall health and wellbeing

- **Process**

- Expand # of CCC's
- CCC's maintain caseloads
- Collect and share data re: clients needs

- **Outcome (client based)**

- Improve health
- Improve self-efficacy
- Improve quality of life
- Improve social support
- Improve connection to resources/ services
- Decrease stress

- **Outcome (CCC based)**

- CCCs feel supported
- CCC's feel job satisfaction

Improve access to services and resources by addressing disparities

- **Process**

- Data is shared with agencies about Pathways CLOSED INCOMPLETE
- Identify gaps in systems/ services with data
- Measure cost prevention

- **Outcome**

- Decrease % of Pathways CLOSED INCOMPLETE
- Costs of high care services decrease
- Costs of prevented services increase

Increase collaboration of services in and out of healthcare

- **Process**

- Sign contracts with key agencies (healthcare and social service)
- CLARA integration with Reliance
- CLARA integration with EMR's

- **Outcome**

- Agency employees feel improved collaboration
- Workforce (healthcare, CCC's and social service) feel improved satisfaction in patient care
- "No wrong door" is common place



CHALLENGES

OUR SOLUTIONS

HIPAA regulation and interpretation- cross sector collaboration involves HIPAA covered entities and non-covered entities

Data sharing agreements, providing HIPAA training and certification for those outside healthcare

True COMMUNITY care coordination takes time – building relationships, trust

Reminder: we are DOING WORK DIFFERENTLY, INNOVATION is exciting and scary, share data on outcomes to encourage collaboration

Software Challenges-
Double data entry, discomfort with technology, time consuming

Incorporate time for data entry into the work and pay for it

Healthcare is typically provided in an office- Care Coordinators are in the “office” $\frac{1}{2}$ the time, out in the community

Provide lots of opportunity for good communication- team meetings, status reports, trainings

Proving program success takes time-
Value qualitative data, start with process outcomes, measure success amongst all partners, plan for a three year runway

Leap of faith by PacificSource Community Solutions using health plan spending to commit to well being



Bridges to Health Pathways:



SUCCESSSES

Clients are met where they are most physically comfortable and empowered to prioritize needs most important to them

Community Health Work aids in recognizing and eliminating disparities in care

Shared data systems allow for data driven decision making approach to recognizing and addressing systemic inequities and barriers to care

Cross sector partnerships break down silos, build relationships, avoid duplication of services- better client experience

Provides healthcare with a lens outside the walls of the system

Health plan funding is possible



Client Outcomes after 4 months in the program

- ❖ Feel better connected to services: 84%
- ❖ Feel in good health: 52%
- ❖ Feel in fair health: 48%
- ❖ Health has gotten better: 32%
- ❖ Health has stayed the same: 42%
- ❖ Health has gotten worse: 26%
- ❖ Quality of life has improved: 74%
- ❖ Feel more confident in managing health and health needs: 50%



Client Comments on program:



“I feel more stable, some attention can be directed at me”

❖ “I feel supported and have some financial relief”

“Not worried about insurance right now and also have help with financial assistance”

“My care coordinator has helped me understand about my disease”

“Feel supported, someone is keeping at eye out for me”

“Have insurance and medical care”

“Advocacy, having other support”

“Advocacy, help with resources”

“I was able to get help with my diabetes- an elliptical, measuring cups, and little books. Logs, that she made for me. I wouldn't be able to do this or pay for these on my own”

“I appreciate the help and support with all the paperwork and phone calls- it's daunting for me to try to deal with these things”

“Advocacy help with gas, kept employed and help looking for housing”

“I know who to call to point me in the right direction”

“Help with Resources, Services, keeps me more active”



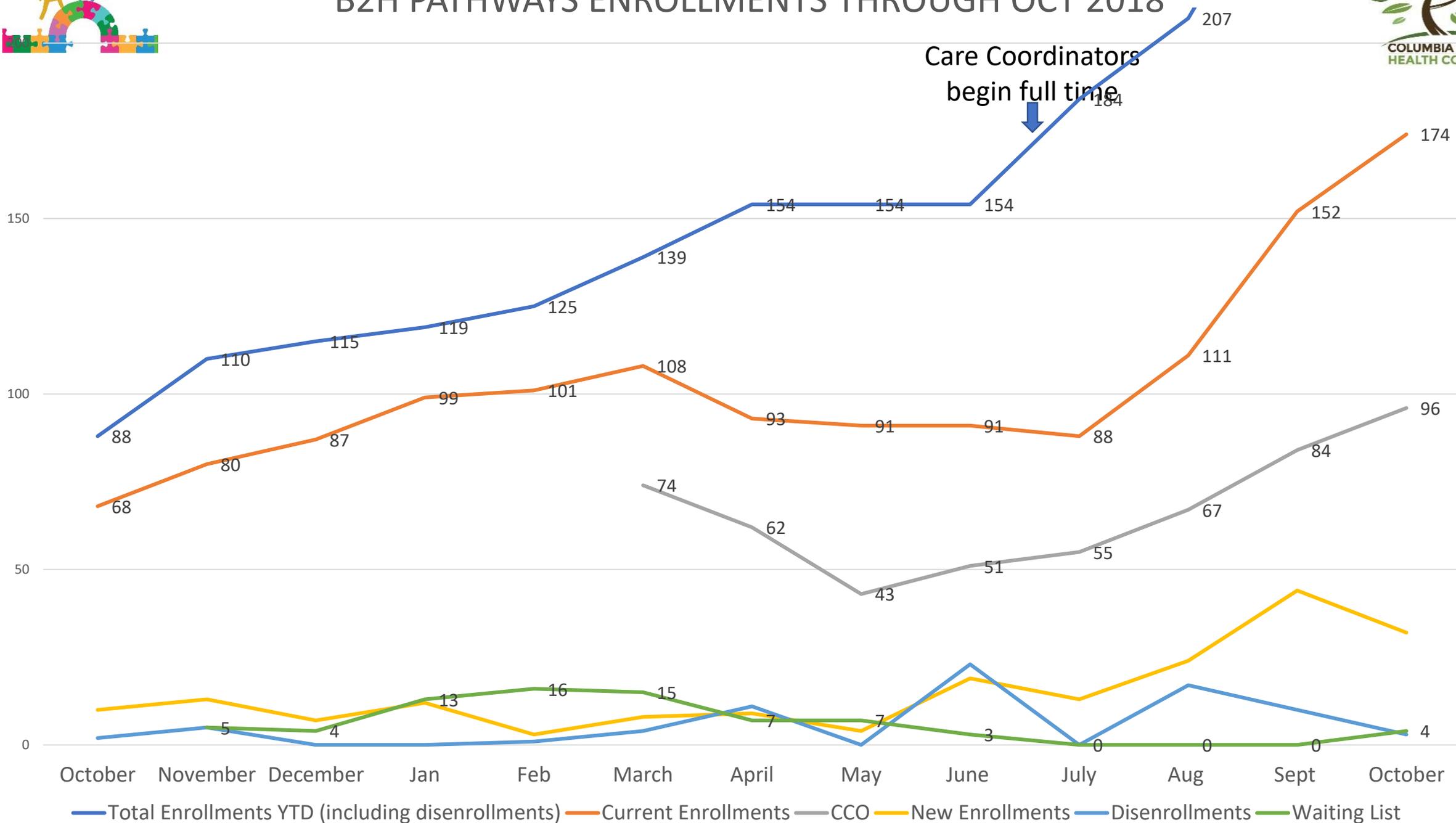
Stories:



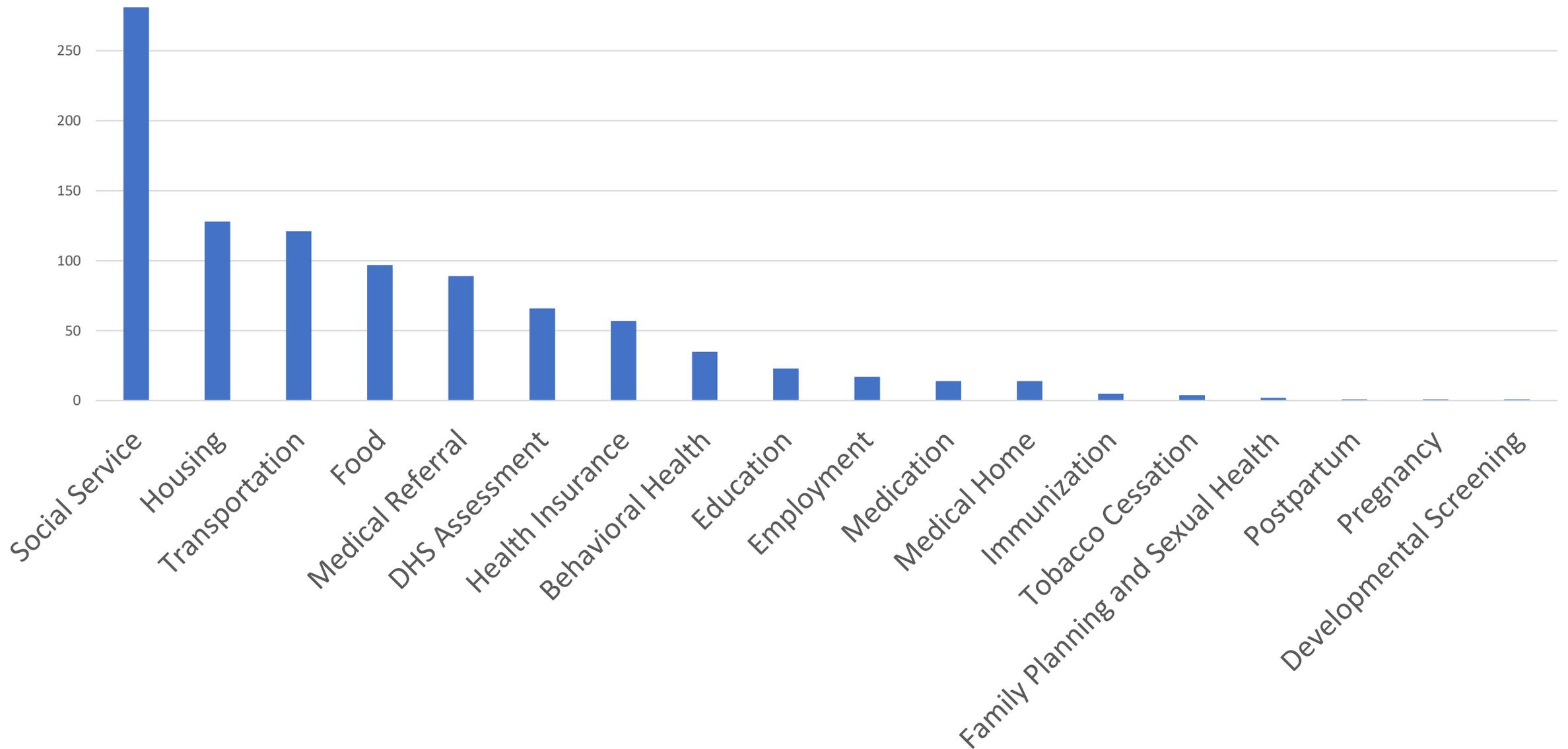
- Client with low literacy struggling to understand her diabetes diagnosis and all that comes with it A1C, diet, glucose checks, etc. The Community Care Coordinator (CCC) working with the client was able to devote the time need to help the client have a better understanding of her disease. The CCC provided 1:1 home visits to go over all provider and nutritionists orders and dietary recommendations using pictures and hands-on examples. This included taking instructions from provider and dietician and converting them to an all picture, laminated document for the client to be able to follow instructions and track outcomes using a dry erase marker. As a result, client has maintained control of her diabetes and was able to travel outside the US safely for the first in a long time.
- Single mother of ill young baby seen in the Emergency Department (ED) multiple times for illness. ED recognized the living conditions were not adequate for the infant and likely contributing to illness as they were living without heat, electricity and running water. Social worker was unsuccessful in tracking down family and called in CCC. CCC had built relationships with the community and was able to gain access to location of mother through a trusted member. Because the CCC had become a trusted person she was able to work with mother. In the short term mother obtained WIC, a heat and electrical source, warm clothing and blankets, dependable transportation and a relationship with a primary care provider for a well child check and for herself. Long term, she was able to get into her own apartment, apply for a job and get herself regular health and dental care. Baby is thriving.



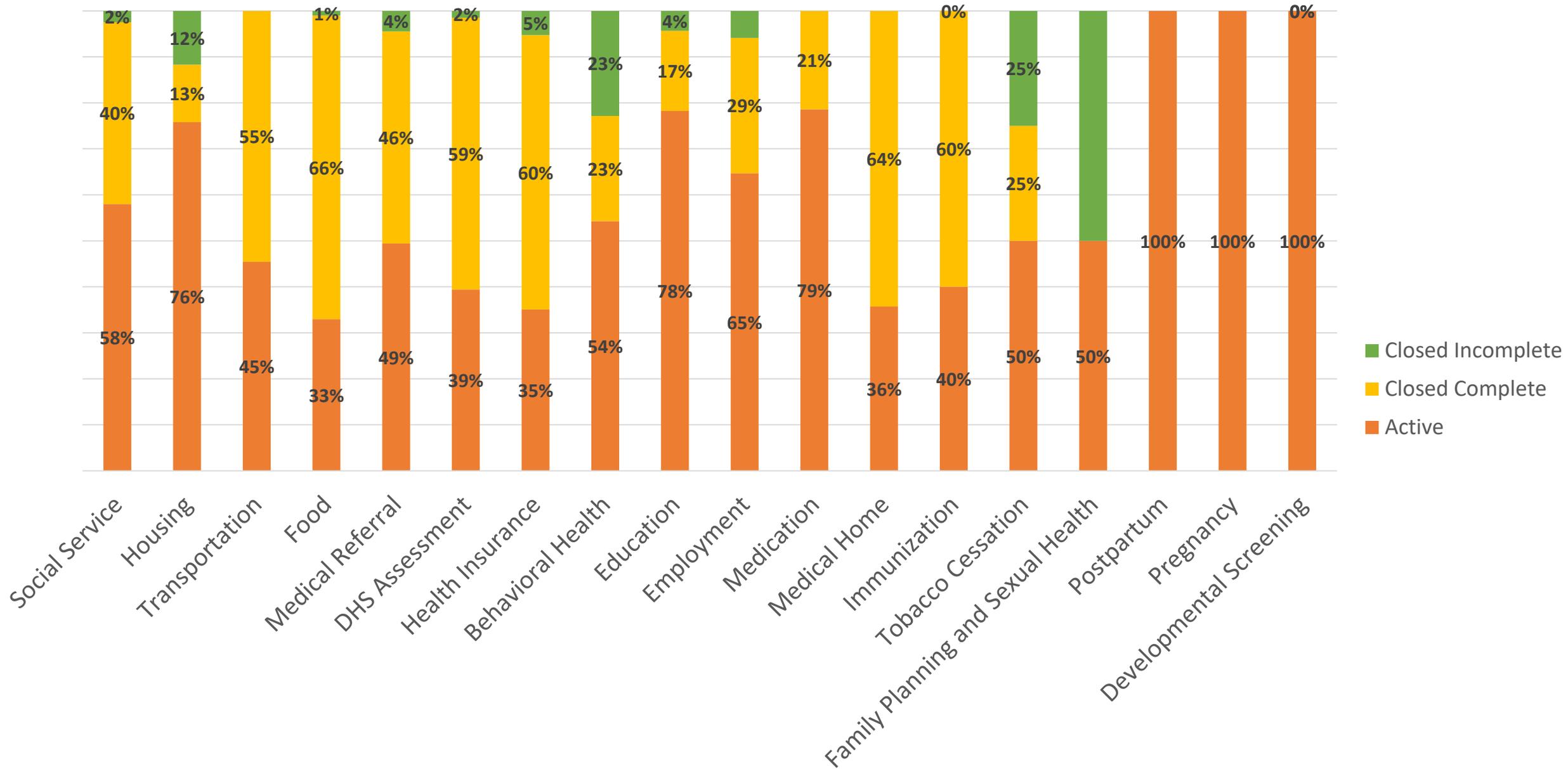
B2H PATHWAYS ENROLLMENTS THROUGH OCT 2018



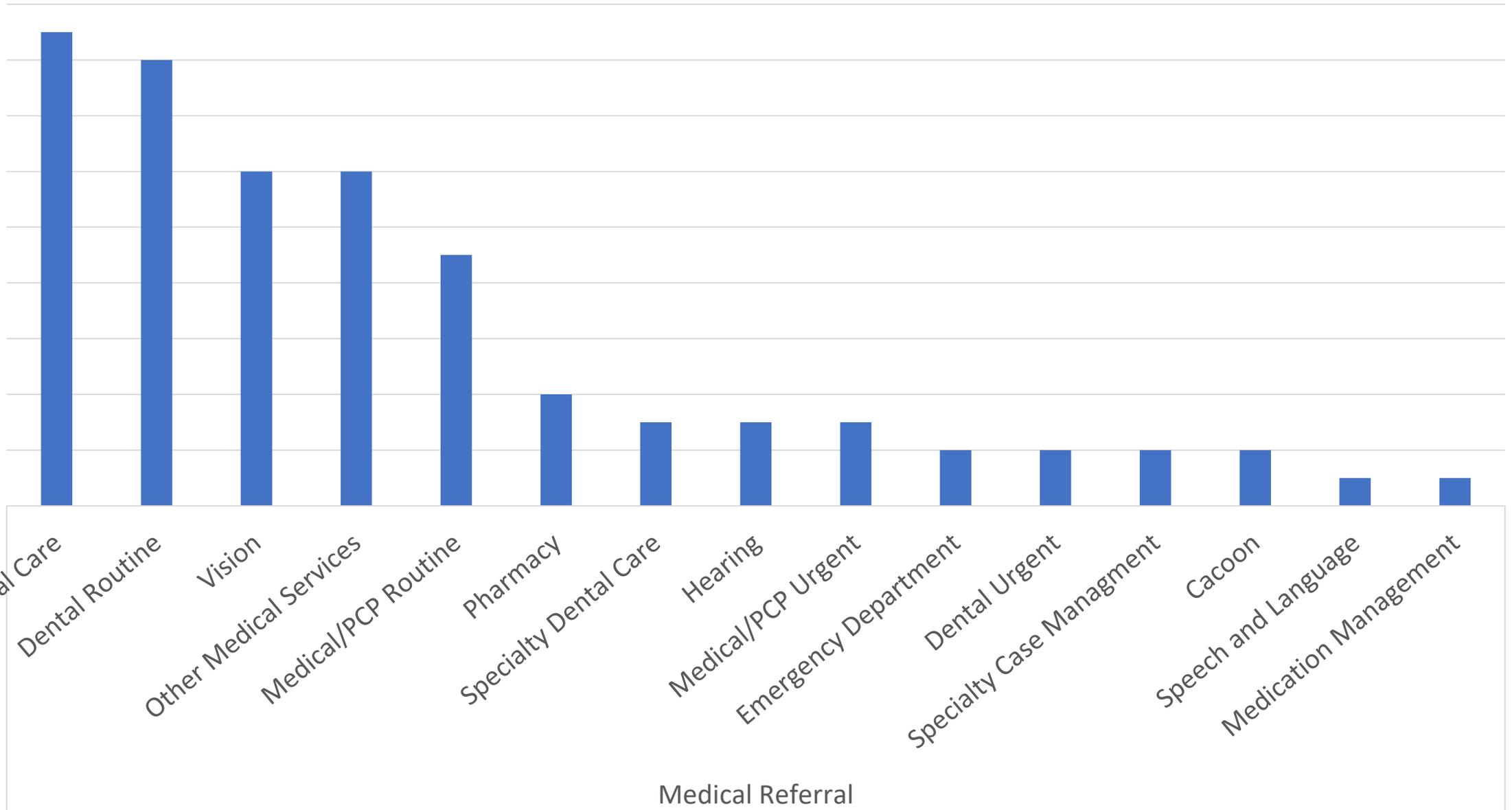
Pathways through Oct 2018



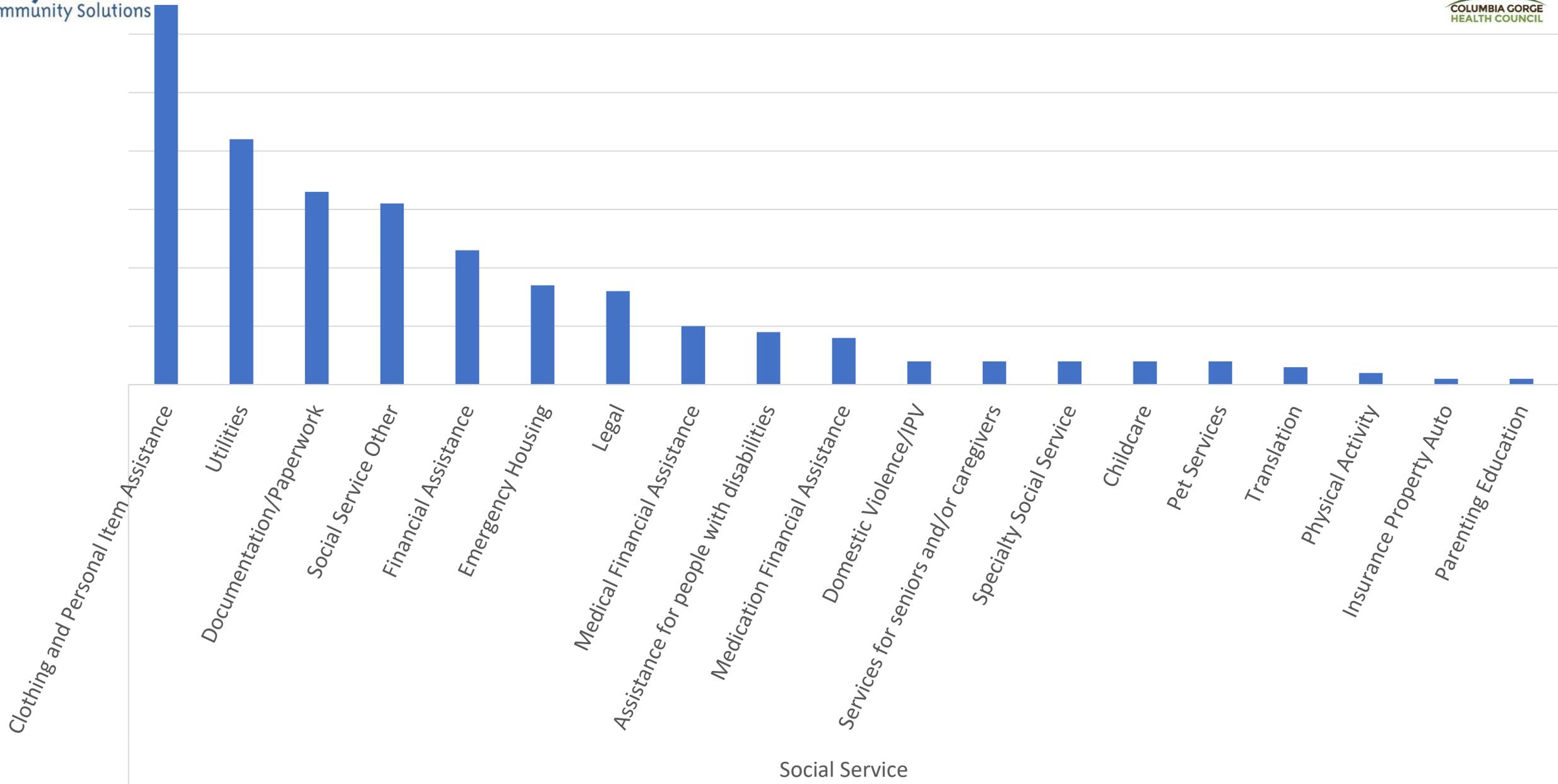
Pathways Status through Oct 2018



Medical Referral Needs Broken Out through Oct 2018



Social Service Needs Broken Out through Oct 2018



How CCO's can pay for Community Care Coordination

Type of SDOH Services	Applicable Federal Regulations and Guidelines	Financial Implications
<p>Community Care Coordination Services</p> <p>An MCO's contractual responsibility to identify and coordinate community based, non-medical services that are related to meeting a patient's health needs, with medical services.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Coordinate the transition between settings of care • Coordinate services enrollee receives from community and social support providers 	<p>"Coordination and Continuity of Care" provision: 42 C.F.R. § 438.20(b)(2)(iv)</p> <p>Medical loss implications: 42 C.F.R. § 438.3(e)(1), (e)(2)(i)(A) (referring to direct claims paid to providers for services covered under the contract)</p> <p>42 C.F.R. § 438.3(e)(1), (e)(3)(i), (referring to activities that improve health care quality)</p> <p>45 C.F.R. § 158.15(b)(2)(i)(A)(1) (listing care coordination as an activity that improves health care quality)</p> <p>Calculation of capitation rate: 42 C.F.R. § 438.4(b)(3)</p>	<p>May be considered in the numerator of the medical loss ratio for the MCO as a standard contract requirement for all MCOs and an activity that improves health care quality</p> <p>Must be considered for MCO capitation rate setting purposes</p>
<p>Value-added Services</p> <p>Additional services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Assessing the home for asthma triggers • Medication compliance initiatives • Identifying and addressing ethnic, cultural, or racial disparities • Mosquito repellent to prevent Zika transmission 	<p>"Value-added Services" provision: 42 C.F.R. § 438.3(e)(1)(i)</p> <p>Medical loss implications: 42 C.F.R. § 438.3(e)(1), (e)(2)(i)(A) (referring to incurred claims and services under 42 C.F.R. § 438.3(e))</p> <p>42 C.F.R. § 438.3(e)(1), (e)(3)(i)</p> <p>45 C.F.R. § 158.15(b) (referring to activities that improve health care quality)</p> <p>Calculation of capitation rate: 42 C.F.R. § 438.3(e)(1)(i)</p> <p>Referred to as Value-added Services Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.</p>	<p>May be considered in the numerator of the medical loss ratio for the MCO as "incurred claims" or "activities that improve health care quality."</p> <p>May not be considered for MCO capitation rate setting purposes.</p>

ⁱ D. Bachrach, J. Guyer, and A. Levin. "Medicaid Coverage of Social Interventions: A Road Map for States." Manatt Health, July 2016. Available at: http://www.milbank.org/uploads/documents/medicaid_coverage_of_social_interventions_a_road_map_for_states.pdf. Although value-added services may not be included in developing capitation rates, these services can be included as incurred claims in the numerator for the medical loss ratio calculation. Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.

Find

- People at risk or in need ← **Coordinated Care Organization Members**
- In the community and through agencies

Treat

- Behavioral Health Referral
- Dental Referral
- Developmental Screening
- Developmental Referral
- Education
- Employment
- Family Planning
- Food
- ~~Health Insurance~~
- Housing
- Immunization
- Pregnancy
- Postpartum
- Medical Home
- ~~Smoking Cessation~~ ← **Can navigate TO cessation but not provide it**
- Social Service Referral

Measure

- Individual Outcomes
- Community Resource Gaps ← **Priority to address with Shared Savings from CCO**

Resources

- Coordinated Care Organizations: <http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx>
- Oregon Solutions: <http://orsolutions.org/>
- Pathways HUB Manual, Agency for Healthcare Research and Quality: <https://innovations.ahrq.gov/qualitytools/connecting-those-risk-care-quick-start-guide-developing-community-care-coordination>
- Collective Impact: https://ssir.org/articles/entry/collective_impact
- Collective Impact Health Specialist: https://www.ruralhealthinfo.org/community-health/project-examples/957?utm_source=racupdate&utm_medium=email&utm_campaign=update060717