HCGC 2019 Monthly Meeting Series

Webinar: The Central Ohio Community Pathways HUB
January 10\textsuperscript{th}, 2019
During the Webinar:

• Please “mute” your phone and/or computer to reduce background noise.

• If you have a question please use the chat feature in Zoom or hold it until the Facilitated Community Discussion at the end of the webinar.
Our Vision
Optimal health for all people in Greater Columbus

Our Mission
is to improve the value of health care for all people in Greater Columbus by catalyzing collaboration among public and private partners: Providers, behavioral health, hospital systems, social service agencies, public and private payers, employers, government, public health and patients/consumers.

VALUE = (Quality + CONSUMER EXPERIENCE) ÷ COST

Healthcare Collaborative of Greater Columbus
Four HCGC Strategic Focus Areas

OUR WORK

- Value-Based Comprehensive Care
- Quality Improvement
- Medical Neighborhood
- Purchaser Engagement

Affiliate of:

- Columbus Medical Association
- Member of: Network for Regional Healthcare Improvement
- Healthcare Collaborative of Greater Columbus

Healthcare Collaborative of Greater Columbus
Pathways HUB 101

Jenelle Hoseus, HCGC
The Problem Runs Deep

Social Determinants of Health

- Neighborhood
- Occupation
- Education
- Race/Ethnicity
- Culture
- Socioeconomic Status/Income

Poor Health
Social Determinants

Social Determinants (food, housing, transportation)

% of Life Expectancy and Health Status Attributable to

- Health Behaviors: 30%
- Social and Economic Factors: 40%
- Clinical Care: 20%
- Physical Environment: 10%

Healthcare Collaborative of Greater Columbus
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
Barriers to Health
The Pathways Community HUB Model creates an effective way for organizations to work toward common goals.

Common Goal=Reducing Health Disparities
Find. Treat. Measure.

Step 1: Find
Comprehensive Risk Assessment

Step 2: Treat
Assign Pathways

Step 3: Measure
Track and Measure Pathways Connections to Care

Healthcare Collaborative of Greater Columbus
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
- Completes comprehensive risk assessments
- Confirms connection to care
- Tracks and measures results
Key to the system are community health workers (CHWs), who provide care coordination services and are employed by numerous medical clinics, social service agencies and other organizations throughout the community and the region.

CHWs serve as Partners, Coaches & Advocates for their Clients
CHWs canvass the community for at-risk residents and enroll them in care coordination. Healthcare providers and others also refer patients to the Pathways HUB.
CHW Certification in Ohio

• Ohio certification of CHWs began in July 2004 (legislation), law regulating CHWs signed in 2005

• Based on 6 competency areas (230 hours: 100 didactic and 130 practicum)

• “Certificate to practice”

• 15 hours of continuing education every 2 years
Enrolled clients receive a comprehensive risk assessment, and they work with their CHWs to prioritize all their health and social needs.
CHWs develop a care plan using the Pathways HUB’s online system by opening “pathways” for each unmet need, such as for health coverage, a medical home, food, housing and transportation.
CHWs work closely with their supervisors to develop these outcome-driven plans to address health, social and behavioral risk factors by opening and completing Pathways.
CHWs work closely with their supervisors to develop these outcome-driven plans to address health, social and behavioral risk factors.
Clients meet with their CHWs at least monthly to work as a team on care coordination plans, and they address each need one by one.
Pathways HUB staff tracks data to reduce duplication of services and ensure clients receive the most appropriate high-quality, evidence-based services.
Treat: Risk = Pathways (PW)

20 Standard Pathways:
• One risk factor at a time
• Outcome achieved = finished pathway & payment!
• Outcome not achieved = finished incomplete pathway
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
Certified Pathways Community HUB Model Endorsers

Ohio Commission On Minority Health

Ohio Department of Medicaid

CDC Centers for Disease Control and Prevention

Agency for Healthcare Research and Quality

HRSA

ODH | Ohio Department of Health

NSF National Science Foundation

Healthcare Collaborative of Greater Columbus

NIH National Institutes of Health

The CMS Innovation Center
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

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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 improve their health behaviors. The study utilized propensity score matching to control for differences in patient population characteristics. Logistic regression was used to examine the association of CHAP participation with decreased low birth weight.
Transition Process

Carrie Baker, HCGC
Leadership at UWCO changes led to this transition.

UWCO was never meant to house the CCN/HUB model in perpetuity.

Healthcare landscape has also evolved—healthcare providers focusing on SDOH more than ever.
HUB Transition Process Overview

- HUB Model-certification doesn’t transfer
- MCO contracts do not transfer
- Commission on Minority Health dollars do not transfer
- We are choosing to call this a transition and evolution of the HUB
Why Maintain the Model at All?

- Social Determinants of Health!
- Evidence base for better health outcomes in the literature
- High fidelity to the model among community partners
- Value based care-financial rewards for better outcomes to CCAs
- Opportunity to grow the model
Why HCGC?

• Works best with a neutral convener
• Non-profit in healthcare but not a provider, funder or public health agency
• Experience in technical assistance, coaching for quality/process improvement
• Infrastructure we have in place-experienced staff, high value reputation in the community, Board of Directors; clean, successful audits, accounting/fiscal sponsorship services/experience
Current State of Transition

- Welcome to Jenelle Hoseus, Director for the model, employed by HCGC
- David Brackett, HCGC VP of Accounting and Special Projects will be supporting
- UWCO has “ended” its role on 12/31/18
- HCGC has “begun” its role on 1/1/19
Current State of Transition

• For the HUB Administration:
  • Certification process beginning; six month process
  • Working with Hospital Council of Northwest Ohio on Managed Care Contracts and Technical Assistance
  • Securing operational funding
Current State of Transition

• For CCAs:
  • Request for Proposals out today, immediately following this webinar
  • RFP available online at www.hcgc.org; contact Jenelle@hcgc.org
  • Due January 31st; goal is to announce in February and be up and running/reimbursement in March
Current State of Transition

• For the Community:
  • Decide level of interest—are you a cheerleader, a contractor, or a CCA?
  • Continue to be educated on the HUB model
  • Think HUB anytime community health, social determinants of health and/or population health is brought up in your meetings—can the HUB be utilized to “fix” this issue? The answer is probably yes.
Hospital Council of Northwest Ohio

Jan Ruma
Additional Considerations

• How does the HUB model help public health achieve CHIP goals?
• Do commercial payers/employers see value in the HUB model enough to fund pilots?
• What data is needed to report to the community about the success of the model?
Facilitated Community Discussion

David Brackett, HCGC