AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS
Innovation Station
Sharing Best Practices in Maternal & Child Health

Pathways Community HUB

Location: Ohio
Date Submitted: 5/2016
Category: **Promising Practice**

TITLE V/MCH BLOCK GRANT MEASURES ADDRESSED

#01: Percent of women with a past year preventive visit
#03: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
#11: Percent of children with and without special health care needs having a medical home

BACKGROUND

The United States spends significantly more money per capita on health care services than any other nation in the world and lags behind most other developed countries in key outcome measures. The primary sources of these adverse health and social outcomes are risk factors.
To address risk factors communities need to develop standardized, organized and effective care coordination networks focused on the comprehensive identification and reduction of risk. The purpose of the HUB is to provide an organized, evidence based approach for a network of agencies to identify the populations most at risk within a community.
Finding the specific individuals within communities who are most likely to have a poor health outcome, addressing their specific needs, and accountably measuring their results will influence the overall health of the individual and the community. The first community that piloted the HUB model demonstrated with peer reviewed publication a significant improvement in low birthweight for individuals enrolled as well as a countywide reduction in low birth weight

PROGRAM OBJECTIVES

Within an organized multiagency network of community care coordination,

a. Accomplish outcome improvement through identifying at risk individuals, and assuring their health, behavioral health and social service risk factors are identified and addressed.
b. Support a model certification structure for community networks that utilize a standardized approach for reaching out to those at greatest risk, and assure identified risk factors are addressed using Standardized Pathways. Health, social and behavioral health risk factor reduction is the focus achieving individual and population based outcome improvements.
c. Provide an accountable framework for communities who want to build an effective network.
d. Provide standardized mechanisms for data reporting and continual quality improvement.
e. Provide community networks an evidence based approach that they can utilize to collaborate effectively and market to funders for sustainability.
f. Provide funders and policy makers assurance that community networks have met specific operational, health outcome and cost of care improvement benchmarks.

TARGET POPULATION SERVED

The model is being utilized in all age groups with an emphasis on maternal and child health.

PROGRAM ACTIVITIES

The Community HUB provides an organized, evidence based approach for a community based network to identify the individuals most at risk and connect them to the interventions needed to address risk factors such as adverse health and social outcomes. To influence the overall health of an individual and community, HUB works with individuals within communities who are most likely to have a poor health outcomes and addresses their specific risk factors.

The basic framework of the model involves the comprehensive identification and reduction of risk factors tracked within a pay for performance approach. The HUB Model,

- Focuses on those at greatest risk
- Assures health social and behavioral health risk factors are assessed
- Assures each risk factor identified is addressed with standardized checklists and standardized Pathways.

Identified risk factors are assigned a quality assurance, pay for performance accountability tool called a Pathway. Pathways have been nationally standardized to address health, social and behavioral health risk factors.

The Care coordinator and their program are accountable to complete each Pathway and with each completion must document that the risk factor identified has been addressed.

An individual needing housing, adult education and a medical home will have specific Pathways assigned for each of these risk factors. The program can then bill for the service when the client has been assured to reside in safe housing, has enrolled and is receiving adult education and has been confirmed to attend their first Medical Home visit.

Instead of only tracking chart notes and caseloads, the identification of risk factors and methods in which they are addressed are also carefully tracked. The comprehensive approach across health, social and behavioral health is critical to achieving the best results. Single individuals have been identified to have as many as 30 Pathways/risk factors. Most at risk individuals have 4-5 Pathways in progress.

Agencies that hire Community Health Workers within a HUB network report back to a central HUB. The HUB is a separate standalone agency that does not have its own care coordinators. It serves as the central quality control, tracking, duplication reduction, client and Pathway tracking center. Most of the care coordination contracts come through the HUB. The HUB provides support in the areas of quality improvement, tracking, reporting, contracting with Payers, training and IT.

The "care coordination agencies" that do hire the care coordinators and serve within the HUB are required at the time of enrolling a new client to check in with the HUB to assure the client is eligible for service and that the service is not in duplication.

A fully operational Pathways Community HUB can,

- Serve all age groups
- Has a strong variety of payment sources to support a diverse service population
- Eliminates unnecessary service duplication
- Assures the focus on the most at risk populations
- Coordinates multiple care coordination agencies to work as a team to identify and address risk factors in a comprehensive and payment for outcomes focused approach

Critical to the model is following the national standards of Certification. Many years of work by CHAP, AHRQ, the Rockville Institute and a related Kresge Foundation Grant have gone into the careful determination of standards which must be met to achieve similar outcomes. The National Standards for Community HUBs allow flexibility and variation across urban and rural service environments and recognize cultural competence and related community based variations is need and approach. More information related to the Certification standards is available at: https://pchcp.rockvilleinstitute.org/

More details related to the model are available at https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

PROGRAM OUTCOMES/EVALUATION DATA

Our recent article in the Journal of Maternal and Child Health demonstrated statistically significant improvement in LBW of more than 60% in the impact group versus control with a 500 percent long term return on investment. Additional outcomes in cost savings, outcome improvement, duplication elimination and improved documentation and effective data entry have also been studied and reported.

PROGRAM COST

Cost varies substantially based on the size of the HUB and the population that is served. The budget for a HUB supports several individuals who serve at the central HUB as well as support for the Community Health Workers and related care coordinators that serve at multiple agencies though out the community. The national standards require that at least %50 of the total HUB budget is directly tied to outcomes. Many of the outcomes the dollars are tied to represent confirmed reduction in risk factors as outlined above. Some HUBs have additional payments tied to other higher level performance outcomes such as the percentage of women receiving postpartum care etc.

The current range in HUBs varies from a few hundred thousand dollars to several million dollars per year. The average cost per person served over one-year time and involving many home visits and evaluations varies from $1000-3000 dollars per year. In the most recent publication more than 5 dollars in long term savings was achieved for each dollar invested.

ASSETS & CHALLENGES

Assets
Cultural competence - Focus on Community Health Workers and or other care coordinators with experience and connection with the community.
Risk Factors Assessed and Addressed – Organized approach to identify and address health, social and behavioral health risk factors
Coordination Across the Community – The HUB coordinates multiple agencies across the community to work as a team to assess and address risk factors. Data collection and related informative results help to identify best practice and guide the community to address challenges.
Pay for Performance – With more than 50% of all dollars going into a HUB being required to tie to specific outcomes

and results the model uses American business innovation to leverage dollars towards better outcomes and health.
More than one risk factor and more than one outcome – In order to improve infant mortality, individuals and families at risk must have more than one risk factor identified and addressed. The latest data confirms that housing, food, behavioral health and direct medical care all represent risk factors that can dramatically affect outcomes. This is not only true for Infant mortality but also true for school performance, employment, economic success and overall childhood and adult health. Initiatives that effectively serve the whole person have the best change to truly bend the curve to achieve better outcomes. The HUB model requires a comprehensive approach to the identification and mitigation of risk.

Challenges
The current health and social service system is built within isolated silos of care that are not effective in collaborating within comprehensive approaches to improving health. Some communities do not work well across health, social and behavioral health service structures. The current funding models of care do not incentivize or promote collaboration. The infrastructure to start a HUB and build a collaboration of agencies is often a challenging first step even if sustainable funding is available for a fully implemented HUB. Fortunately, there are some communities with a highly collaborative structure willing to pilot the way forward. Startup funding and support is needed to help get HUBs started and to incentivize local agencies to get involved.

LESSONS LEARNED

Having an effective central community leader "Community Change agent is critical to brining the agencies and funders together in a common mission to build the local HUB. Following the National Standards for Community HUBs is very important to achieve the outcomes and related cost effectiveness. Programs that have carefully followed the national standards have been very successful. There have been a number of programs who have not focused on the basic Standards of the model and have not been successful or sustainable.

FUTURE STEPS

There is a national learning network for Community HUBs. Research, payment strategies, programmatic approaches and related issues are all part of a national quality improvement focused initiative. Conferences and related events are bringing together new communities and expanded strategies to grow and improve the model.

Nationally, the goal is to become strong as a national network focused on comprehensively assessing and addressing risk factors with populations most at risk.

Growing the research and the HUB sites implementing the certified model can help.

COLLABORATIONS

The Rockville Institute – Pathways Community HUB Certification Program Westat, Communities Joined in Action, HRSA, CHAP and the IHI 100 Million Healthier Lives Initiative.

PEER REVIEW & REPLICATION

There are now more than 20 established or in development HUBs across the United States. Ohio, Michigan, New Mexico and Oregon have specifically focused on HUB model development.

Peer reviewed and related publications are provided below:

1. Redding S, Conrey E, Porter K, et al. Pathways community care coordination in low birth weight prevention. Matern Child Health J 2015;19:643-50. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4326650/

2. Dawn E. Alley, Ph.D., Chisara N. Asomugha, M.D., Patrick H. Conway, M.D., and Darshak M. Sanghavi, M.D. Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid N Engl J Med 2016; 374:8-11, January 7, 2016, DOI: 10.1056/NEJMp1512532

3. Pathways Community HUB Manual A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes. Agency for Healthcare Quality and Research, 2016 - https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

4. Alley D.E.Asomugha C.N.Conway P.H.Sanghavi D.M.Accountable Health Communities — Addressing Social Needs through Medicare and Medicaid - January 7, 2016, N Engl J Med 2016; 374:8-11

5. Connecting Those at Risk to Care – The Quick Start Guide to Developing Community Care Coordination Pathways, Agency for Healthcare Quality and Research, 2016 https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

6. National Quality Forum. Priority setting for healthcare

performance measurement. Addressing performance measure gaps in care coordination. Final report. (Prepared under Department of Health and Human Services Contract No. HHSM-500-2012-00009I, Task 5). Washington, DC: NQF; August 2014. https://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Care_Coordination.aspx.

7. Zeigler BP, Carter EL, Redding SA, et al.. Care coordination: formalization of pathways for standardization and certification. National Science Foundation Grant Award No. CMMI-1235364. Rockville, MD: Rockville Institute; 2014. https://www.rockvilleinstitute.org/files/Care_Coordination_Formalization_of_Pathways_for_Standardization_and_Certification.pdf. Accessed November 4, 2015.

8. Panovksa A, Scales B, Oxley S, et al. Medicaid braided funding policy brief. Columbus: Voices for Ohio's Children; 2013. http://www.raiseyourvoiceforkids.org/Media/Documents/Policy%20Briefs/MedicaidBraided_Brief%20FINAL.pdf.

Key words:
Low birth weight prevention, Community health worker, Community care coordination, Social determinants of health, Pay for performance, Home visiting, Community Care Coordination

For more information about this program please contact: Mark or Sarah Redding at
mreddinghub@gmail.com
sredding@att.net