Columbia Gorge Health Council
Bridges to Health Pathways Program
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Bridges to Health Pathways Program Project Evaluation Summary:

Bridges to Health began as a 2014 OHA Transformation Grant funded project to "develop coordinate and connect a region-wide infrastructure of front-line Community Health Workers", embedded across multiple (>10) agencies in our region, across which multiple health outcomes can be pursued.

The short-term goals (<2 yrs.) were:

1. Experience of improved coordination between social service, early childhood, home visiting and health care services.
2. Simplified and coordinated referrals to resources "upstream" of health care.
3. Initial outcomes and pathways identified and implemented.

Success was to be measured by:

1. Declaration of Cooperation signed with hub criteria.
2. At least 4 agencies contracted to participate in the network this year.
3. Additional sources of operational funding identified and committed

CURRENT Goals/Metrics/Progress: With all above success measurements met- goals, metrics & progress has evolved over time and currently looks like:

GOAL 1: Support community members most in need to improve their overall health and wellbeing

As Measured By:

- **Process Measures**
  - Expand # of CHW's
  - CHW's maintain caseloads
  - Collect and share data re: clients needs
- **Outcome (client based) Measures:**
  - Improve health
  - Improve self -efficacy
  - Improve quality of life
  - Improve connection to resources/ services
  - Decrease stress
- **Outcome (CHW based) Measures:**
  - CHWs feel supported
  - CHW's feel job satisfaction

GOAL 2: Improve access to services and resources by addressing disparities

As Measured By:

- **Process Measures:**
  - Data is shared with agencies about Pathways CLOSED INCOMPLETE
  - Identify gaps in systems/ services with data
  - Measure cost prevention
- **Outcome Measures:**
  - # Pathways Opened
  - # Pathways Closed
  - Tracking and deeper dive into Pathways Closed Incomplete
  - Costs of high care services decrease
  - Costs of prevented services increase

GOAL 3: Increase collaboration of services in and out of healthcare

As Measured By:

- **Process Measures:**
  - Sign contracts with key agencies (healthcare and social service)
  - Referrals made into the program from multiple sectors
  - Activate Care integration with Reliance and Unite Us
  - Activate Care integration with EMR's
- **Outcome Measures:**
  - Agency employees feel improved collaboration
  - Workforce (healthcare, CHW's and social service) feel improved satisfaction in patient care
  - "No wrong door" is common place

An overview of the current B2H Pathways HUB model and responsibilities of who is involved:

Clients (currently Housing Challenged)
Agree to participate
Agree to data sharing with Hub

Community Health Workers (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)

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

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 and Resources by Addressing Disparities

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

Bridges to Health Pathways Program

Core Pathways (Needs)

- Behavioral Health
- Covid- 19 Immunization
- Developmental Screening
- Developmental Referral
- Education
- Employment
- Family Planning
- Food
- Health Insurance
- Housing
- Immunization
- Medical/ Dental Referral
- Health Insurance
- Medication
- Pregnancy
- Postpartum
- Social Service Referral (debt management, utility assistance, legal, documentation, etc.)
- Tobacco Cessation
- Transportation

Demographics of Current Enrollments

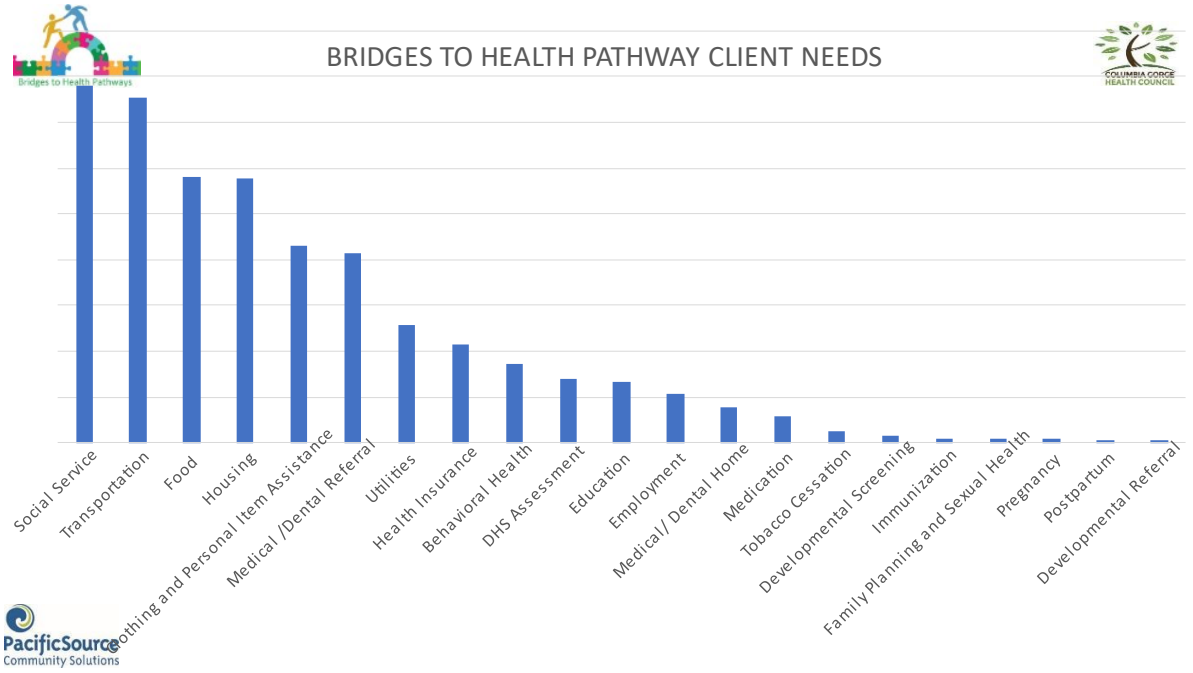
	Gender
Female	56%
Male	43%
Unknown	1%

	Ethnicity
Hispanic / Latino	29%
Non Hispanic / Latino	63%
Unknown	7%

	Race
American Indian	2%
Asian	1%
Black or African American	1%
Other	12%
White	85%

	Age
0-5	18%
6-18	18%
19-45	30%
46-65	27%
65+	7%

	Insurance
Medicaid - PacificSource	68%
Medicare	12%
Medicaid- Open Card	5%
Medicaid- Other	4%
Medicaid - CAWEM	3%
No Insurance	2%
Commercial	2%
Insurance Pending	2%
GAP - sliding fee scale	1%
Veterans Benefits	1%



What has worked and not worked and what has been learned?

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" <½ 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

What are additional outcomes not directly associated with the Program's objectives?

SUCCESSES
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

2019 Evaluation Metrics and Outcomes

GOAL 1: Empowering community members most in need to improve their overall health and wellbeing	
Measures	**Outcomes**
Process Measures:	**Process Outcome:**
•Expand # of CHW's	Expanded from 1.5 FTE (March "17) to 12.5 FTE
•CCC's maintain caseloads	April average caseload was 25. Challenges still exist keeping down waiting list while maintaining caseload for CCC's with stricter criteria
•Collect and share data re: clients needs	CLARA is functioning and about to go through new User Interface (spring '19) for improved user experience and efficiency
Client Based Outcome Measures:	**Client Based Outcome (based on survey of clients after 4 months in the program):**
•Improve health	32% of clients feel their health has improved
•Improve self-efficacy	65% feel more confident managing their health and health needs
•Improve quality of life	78% feel their quality of life has improved since being in the B2H Program
•Improve connection to resources/ services	84% feel better connected to services and resources
•Decrease stress	Not asked specifically in an evaluation question but 10% of clients wrote of decreased stress in their evaluation comments
CCC Based Outcome Measures:	**CCC Based Outcome:**
Initial early program evaluation was performed between March 2017- Jan 2018. Data collected recommended increased FTE was needed to be successful doing the work, placement of CCCs in ED's, and placement of CCC's in agencies without case management or home visiting programs. The responses below are also based on that early evaluation but an updated evaluation of satisfaction is needed since CCC's became Full Time in August 2018	
•CCCs feel supported	80% of CCCs and supervisors had a good understanding of pathways felt adequately trained and in a timely manner. 100% felt concerns about responsiveness of the CLARA system to issues.
•CCC's feel job satisfaction	80% of CCCs and supervisors felt heard by HUB staff, felt they were responsive to their needs and felt comfortable voicing concerns.

GOAL 2: Improve access to services and resources by addressing disparities	
Measures	**Outcomes**
Process Measures:	**Process Outcome:**
•Data is shared with agencies about Pathways CLOSED INCOMPLETE	Monthly data is shared between contracted partners in B2H as well as other partners on the SIT (systems integration team) B2H advisory group email list.
•Identify gaps in systems/ services with data- looking deeper at barriers experienced by clients when accessing resources	Gaps are identified by Pathways Closed Incomplete as well as Qualitative stories from client experiences. Data has been used to discuss changes in the housing application process. Data will be used by the dental access workgroup. Data is also being reviewed amongst CCC group and will be part of the CHA/CHIP process regionally.
•Measure cost prevention	This needs to be done as part of an updated Program Evaluation. Program Manager was waiting until at least 1 year of CCCs working full time to begin process (August 2019 will be 1 year). Funding for evaluation assistance is needed (PS data analyst, claims data, program data analyst, etc.)
Outcome Measures:	**Outcomes:**
•# Pathways Opened	1850 Pathways (needs) have been opened. 3.5 Pathways per client.
•# Pathways Closed	63% of total Pathways have been closed complete (outcome met)
•Tracking and deeper dive into Pathways Closed Incomplete	See comment above on "Identify Gaps in Systems"
•Costs of high care services decrease	Not yet evaluated, however, MCMC has shown 17% decrease in ED utilization rates since start of B2H CCC's in ED and primary care clinics
•Costs of prevented services increase	Not yet evaluated

GOAL 3: Increase collaboration of services in and out of healthcare	
Measures	**Outcomes**
Process Measures:	**Process Outcome:**
•Sign contracts with key agencies (healthcare and social service)	Started in March 2017 with 3 agencies. Currently contracts are signed with 8.
•Referrals made into the program from multiple sectors	Referrals come from (in order of frequency) the Contracted B2H Agencies themselves, Primary Care, DHS, Self Referred, Warming Shelters, Schools, APD
•CLARA integration with Reliance	A single-sign on has been developed between CLARA and Reliance and is in testing phase
•CLARA integration with EMR's	Not yet started
Outcome Measures:	**Outcomes:**
•Agency employees feel improved collaboration	Collected last between March '17-Jan '18. 80% of supervisors felt supported by B2H program and comments collected stated B2H improved services and made a difference for their clients. Updated direct agency comments can be found on B2H Quarterly Report from April 2019.
•Workforce (healthcare, CCC's and social service) feel improved satisfaction in patient care	See above
•"No wrong door" is common place: system is connected such that client data is shared	Not yet started. Need to define better what "no wrong door" means and how we would measure it.