PacificSource
Community Solutions

COLUMBIA GORGE
HEALTH COUNCIL

Bridges to Health Pathways Program

A cross sector collaborative approach to community care coordination

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

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https://cghealthcouncil.org/programs/bridges-to-health-pathways-program/

Community Health Workers
Bridge the Gap

Translate Systems to People and People to Systems

Find People in Need

Referrals come from:

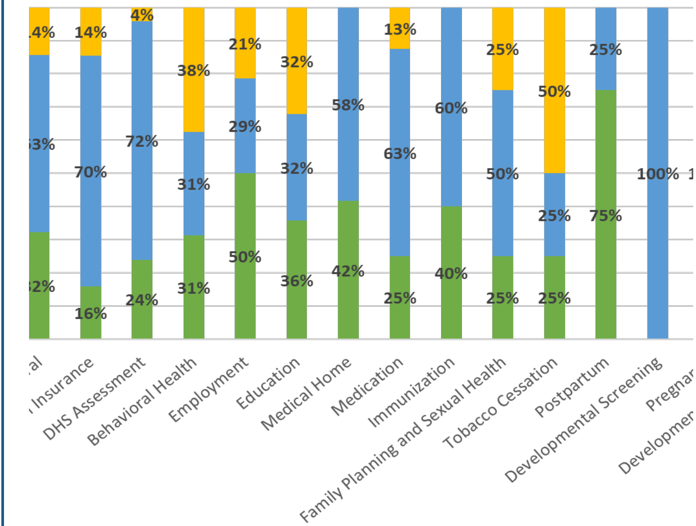
- Individuals
- Agencies or Clinics in B2H
- Agencies or Clinics not in B2H
- DHS/ APD
- CGCC
- Warming Shelters
- Other

Connect to Resources and Services

Community Care Coordinators help connect to:

- Housing
- Food
- Medical/ Dental
- Transportation
- Documentation
- Legal
- Financial
- Utilities
- Many others

Measure Outcomes

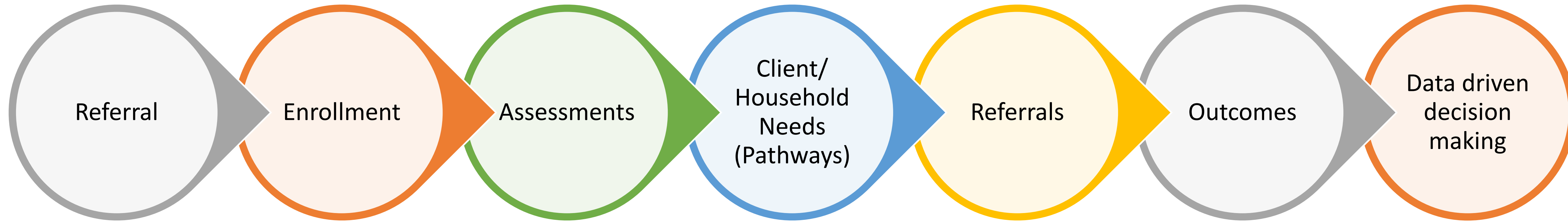


Together we track Outcomes:

- What needs do clients have?
- Do they get the services they need?
- If not, why?
- What are barriers to services?

Bridges to Health Pathways

The Bridges to Health Pathways Process



Referral
- To: B2H agency directly
- To: HUB
- From: individuals
- From: B2H agencies
- From: Other partners

Enrollment
- Consent and Auth signed
- Confirm program criteria is met
- Demographics (REALD) data collected

Assessments
- Household assessments
- Age appropriate individual assessments

Client/Household Needs (Pathways)
- Client and CHW together determine the needs to address and in which priority

Referrals
- Referrals are made

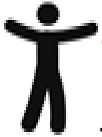
Outcomes
- Outcomes are tracked
- Barriers to services are noted

Data driven decision making
- Data is reviewed in multiple venues
- Data is used to address system disparities

is our care coordination software platform

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

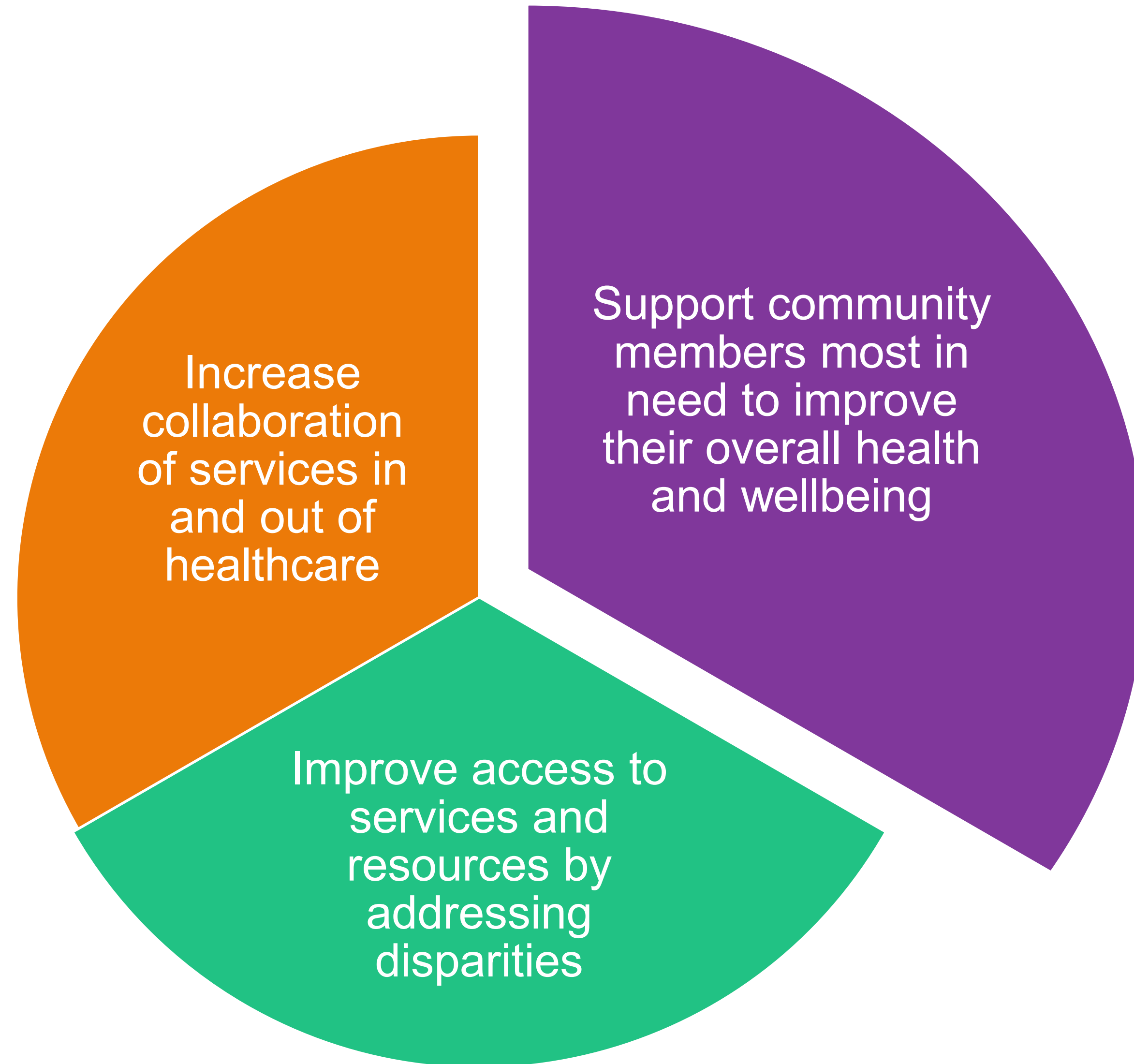
- Build on Community Strengths
- Limit Duplication of Services
- Identification of Roadblocks

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

Evaluating our goals:



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

CHALLENGES	OUR SOLUTIONS
HIPAA regulation and interpretation- cross sector collaboration involves HIPAA covered entities and non- covered entities. Information sharing needs to be smooth between healthcare and social service partners	Data sharing agreements, providing HIPAA training and certification for those outside healthcare, software provides value for all systems (in and out of 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. Insure the ‘people on the ground’ have most input on the system
Software Challenges- Double data entry, discomfort with technology, time consuming, lack of interoperability with other systems	Incorporate time for data entry into the work and pay for it, invest time into software support and constant quality improvement projects, listen to the end user to assess systems operability for programs needs
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

Bridges to Health Pathways:

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

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%

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Client Comments on program:

"Josh gives us hope! Things are getting better! We see some light at the end of the tunnel! Less depression."

"I'm not worried about insurance right now and also have help with financial assistance"

"I have asked for help three times—and got help three times…They helped me when I was desperate and hopeless. I got money for rental application fees and gas money"

"I feel supported, someone is keeping at eye out for me"

"They have helped me achieve housing stability. I have children and it means a lot. It helps keep us together. "

"My care coordinator has helped me understand about my disease"

"Getting housing; very grateful, able to cook and feel I have a sense of belonging. Able to have more networking with resources. Taking steps on getting proper care"

"I know who to call to point me in the right direction"

"Advocacy, help with gas, kept employed and help looking for housing"

"Got a new roof, stalled a foreclosure and kept from losing my home and went to the doctor for the first time in 15 years. Learned about resources. Can call for support. Got homeowners insurance"

"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"

"I got help with resources, services, keeps me more active "

"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"

Stories:

- Client with low literacy struggling to understand her diabetes diagnosis and all that comes with it A1C, diet, glucose checks, etc. The Community Health Worker (CHW) working with the client was able to devote the time need to help the client have a better understanding of her disease. The CHW 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 CHW. CHW had built relationships with the community and was able to gain access to location of mother through a trusted member. Because the CHW 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.

Bridges to Health In The News

Our website: https://www.cghealthcouncil.org/bridges-to-health

COVID Support Stories:

- Bridges' Avila Provides Crucial Link to Recovery
- Community Health Worker, Josh, highlighted for his work
- Bridges to Health Adapts to Support The Gorge
- The Daily Yonder: In The Columbia Gorge

OHA Stories: http://www.oregonhealthstories.com/bridges-health-pathways-provides-community-care-coordination/

Building Bridges to Better Health: https://www.ruralite.com/building-bridges-to-better-health/

OHA Care Coordination: https://www.youtube.com/watch?v=ggBpXO8E20U&feature=youtu.be

Bridges to Health Pathways

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%
19-55	46%
56-65	11%
65+	7%

BRIDGES TO HEALTH PATHWAY CLIENT NEEDS

Social Service
Transportation
Food
Housing
Clothing and Personal Item Assistance
Medical /Dental Referral
Utilities
Health Insurance
Behavioral Health
DHS Assessment
Education
Employment
Medical/ Dental Home
Medication
Tobacco Cessation
Developmental Screening
Immunization
Family Planning and Sexual Health
Pregnancy
Postpartum
Developmental Referral

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Pathway Outcomes:

Pathway	Outcome
Behavioral Health	Client has had THREE appointments with behavioral/ mental health provider
Developmental Screening	Confirm that Developmental Screening and Well Child Visit (to discuss results) are on track with Bright Futures timeline
DHS Assessment	Client has had an appointment with provider
Developmental Referral	Confirmation that appointments with PCP and Early Intervention were completed
Education	Confirm that client successfully completes stated educational goal
Family Planning and Sexual Health	After 30 days, client is confirmed to be satisfied with contraception method, pre-conception or sexual health options chosen and are using those methods
Food	Client has successfully accessed food resources
Immunization	Clients immunization record reviewed and VERIFIED to be up to date. Verify through Alert IIS IMM ALERT system or other verification from appointment
Pregnancy	Pregnant woman's pregnancy is complete (delivered, still birth, aborted, therapeutic abortion) and she received dental visit during pregnancy

Pathway	Outcome
Postpartum	Client has been referred to Our Family Network. Client has kept postpartum appointment. Discuss whether family planning pathway needs to be opened
Employment	Client has found consistent source(s) of steady income and is employed for more than 30 days
Health Insurance	Client received insurance and/or referral if ineligible. a) Client understands how to use health insurance to access healthcare b) insurance info is recorded in client record
Housing	Confirm Housing- client and/or family has remained in an affordable and suitable housing unit for a minimum of 2 months
Medical/ Dental Home	Client has kept at least one appointment with medical or dental provider.
Medical Referral	Confirmation that appointment was completed
Medication	Verify with Primary Care Provider that client is taking medications as prescribed
Tobacco Cessation	Client reports having stopped smoking / using tobacco products for a period of at least 60 days
Social Service	Confirmation that client kept scheduled appointment and/or received services

BRIDGES TO HEALTH PATHWAYS UTILIZED

MOST FREQUENTLY USED LEAST FREQUENTLY USED

Pathway	Active	Closed Complete	Closed Incomplete
Social Service	22%	66%	12%
Transportation	12%	85%	4%
Food	11%	85%	4%
Housing	50%	30%	20%
Clothing and Personal Item Assistance	25%	67%	7%
Medical /Dental Referral	29%	57%	14%
Utilities	22%	71%	7%
Health Insurance	13%	76%	11%
Behavioral Health	45%	28%	27%
DHS Assessment	14%	81%	4%
Education	52%	31%	16%
Employment	51%	36%	13%
Medical/ Dental Home	33%	56%	10%
Medication	28%	66%	7%
Tobacco Cessation	31%	38%	31%
Developmental Screening	29%	71%	
Immunization			
Family Planning and Sexual Health		75%	25%
Pregnancy	75%	25%	
Postpartum			
Developmental Referral			

Active · Closed Complete · Closed Incomplete

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Medical Referral Needs Broken Out

- Health Insurance
- Medical PCP home/routine/urgent
- Dental
- Behavioral Health
- Medication Management
- Vision
- Other Medical Services
- Specialty Medical Care
- Stress Management
- Medication Financial Assistance
- Medical Financial Assistance
- Tobacco Cessation
- Substance Abuse
- Immunization
- Pregnancy
- Speech and Language
- Emergency Department
- Postpartum
- Hospice
- Cacoon
- Sexual Health
- Home Health

Social Service Pathway Data

Transportation
Housing
Food
Clothing and Personal Item Assistance
Utilities
Documentation/Paperwork
Employment
Legal
Social Service Other
Long Term Education
Short Term Education
Assistance for people with disabilities
Physical Activity
Services for seniors and/or caregivers
Pet Services
Domestic Violence/IPV
Childcare
Parenting Education
Specialty Social Service
Translation
Insurance Property Auto

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BRIDGES TO HEALTH PATHWAYS IMPACT ON EMERGENCY DEPARTMENT VISITS

Emergency Dept Visits by Location of Provider

of Visits

Full time B2H CCC started in ED

Full time B2H CCC started in clinics

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	2018												2019	
Sum of FM	268	220	261	240	252	234	259	233	200	230	198	250	237	205
Sum of IM	295	246	228	257	287	231	258	239	219	245	244	257	253	185
Sum of No PCP	224	185	233	205	243	339	341	269	241	235	211	210	251	215
Sum of Non MCMC	526	428	471	425	456	475	479	430	435	403	386	361	381	321
Sum of PEDS	119	87	94	96	96	69	53	53	60	71	80	64	83	73

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How CCO's can pay for Community Care Coordination

Type of SDOH Services	Applicable Federal Regulations and Guidelines	Financial Implications
Community Care Coordination Services 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. Examples: • Coordinate the transition between settings of care • Coordinate services enrollee receives from community and social support providers	"Coordination and Continuity of Care" provision: 42 C.F.R. § 438.208(b)(2)(iv) Medical loss implications: 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (referring to direct claims paid to providers for services covered under the contract) 42 C.F.R. § 438.8(e)(1), (e)(3)(i), (referring to activities that improve health care quality) 45 C.F.R. § 158.150(b)(2)(i)(A)(1) (listing care coordination as an activity that improves health care quality) Calculation of capitation rate: 42 C.F.R. § 438.4(b)(3)	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 Must be considered for MCO capitation rate setting purposes
Value-added Services 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[i]. Examples: • Assessing the home for asthma triggers • Medication compliance initiatives • Identifying and addressing ethnic, cultural, or racial disparities • Mosquito repellant to prevent Zika transmission	"Value-added Services" provision: 42 C.F.R. § 438.3(e)(1)(i) Medical loss implications: 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (referring to incurred claims and services under 42 C.F.R. § 438.3(e)) 42 C.F.R. § 438.8(e)(1), (e)(3)(i) 45 C.F.R. § 158.150(b) (referring to activities that improve health care quality) Calculation of capitation rate: 42 C.F.R. § 438.3(e)(1)(i) Referred to as Value-added Services *Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.*	May be considered in the numerator of the medical loss ratio for the MCO as "incurred claims" or "activities that improve health care quality." May not be considered for MCO capitation rate setting purposes.

Take from: "Innovations in Addressing Social Determinants: How Columbia Gorge is Building and Sustaining a Pathways HUB Program" – CHCS, Center For Health Care Strategies, Supported by the Robert Wood Johnson Foundation, AcademyHealth, and the Nemours Children's Health System

[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.

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Resources

- Coordinated Care Organizations: http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx
- Oregon Solutions: http://orsolutions.org/
- Pathways Community HUB Institute: https://pchi-hub.com/
- 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