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
Community Health Workers Bridge the Gap

Translate Systems to People and People to Systems
Referrals come from:
- Individuals
- Agencies or Clinics in B2H
- Agencies or Clinics not in B2H
- DHS/ APD
- CGCC
- Warming Shelters
- Other

Community Care Coordinators help connect to:
- Housing
- Food
- Medical/ Dental
- Transportation
- Documentation
- Legal
- Financial
- Utilities
- Many others

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 Program

Core Pathways (Needs)

- Behavioral Health/Substance Abuse
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Food
- Immunization
- Pregnancy
- Postpartum
- Employment
- Health Insurance

- Housing
- Medical and Dental Home
- Medical Referral
- Medication
- Tobacco Cessation
- Social Service Referral: transportation, debt management, utility assistance, legal, documentation, etc.
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 CCCs

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

Clients (currently Housing Challenged)
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

Pathways HUB
Bridges to Health
Evaluating our goals:

- Enable community members most in need to improve their overall health and wellbeing
- Increase collaboration of services in and out of healthcare
- Improve access to services and resources by addressing disparities
GOAL 1: Empowering community members most in need to improve their overall health and wellbeing

As Measured By:
- **Process Measures**
  - Expand # of CCC’s
  - CCC’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 (CCC based) Measures:**
  - CCCs feel supported
  - CCC’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
  - CLARA integration with Reliance
  - CLARA integration with EMR’s
- **Outcome Measures:**
  - Agency employees feel improved collaboration
  - Workforce (healthcare, CCC’s and social service) feel improved satisfaction in patient care
  - “No wrong door” is common place
<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>OUR SOLUTIONS</th>
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<tbody>
<tr>
<td><strong>HIPAA regulation and interpretation</strong> - cross sector collaboration involves HIPAA covered entities and non-covered entities</td>
<td>Data sharing agreements, providing HIPAA training and certification for those outside healthcare</td>
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<tr>
<td><strong>True COMMUNITY care coordination takes time</strong> – building relationships, trust</td>
<td>Reminder: we are DOING WORK DIFFERENTLY, INNOVATION is exciting and scary, share data on outcomes to encourage collaboration</td>
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<tr>
<td><strong>Software Challenges</strong> - Double data entry, discomfort with technology, time consuming</td>
<td>Incorporate time for data entry into the work and pay for it</td>
</tr>
<tr>
<td><strong>Healthcare is typically provided in an office</strong> - Care Coordinators are in the “office” &lt;½ the time, out in the community</td>
<td>Provide lots of opportunity for good communication - team meetings, status reports, trainings</td>
</tr>
<tr>
<td><strong>Proving program success takes time</strong> - Value qualitative data, start with process outcomes, measure success amongst all partners, plan for a three year runway</td>
<td>Leap of faith by PacificSource Community Solutions using health plan spending to commit to well being</td>
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</table>
**Bridges to Health Pathways:**

**SUCCESSES**

<table>
<thead>
<tr>
<th>Success</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Clients are met where they are most physically comfortable and</td>
<td>empowered to prioritize needs most important to them</td>
</tr>
<tr>
<td>Community Health Work aids in recognizing and eliminating disparities</td>
<td>in care</td>
</tr>
<tr>
<td>Shared data systems allow for data driven decision making approach to</td>
<td>recognizing and addressing systemic inequities and barriers to care</td>
</tr>
<tr>
<td>Cross sector partnerships break down silos, build relationships, avoid</td>
<td>duplication of services- better client experience</td>
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<td>Provides healthcare with a lens outside the walls of the system</td>
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<tr>
<td>Health plan funding is possible</td>
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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:

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

“I feel supported, someone is keeping an eye out for me”

“I 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’m not worried about insurance right now and also have help with financial assistance”

“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”

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

“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 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”

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

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

“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 feel supported, someone is keeping an eye out for me”
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 needed 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-pictures, 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 time 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.
Bridges to Health In The News

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


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
# Demographics of Current Enrollments

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<tr>
<th>Gender</th>
<th>Ethnicity</th>
<th>Race</th>
<th>Age</th>
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<tbody>
<tr>
<td>Female</td>
<td>Hispanic / Latino</td>
<td>American Indian</td>
<td>0-5</td>
</tr>
<tr>
<td></td>
<td>Non Hispanic / Latino</td>
<td>Asian</td>
<td>6-18</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>Black or African</td>
<td>19-55</td>
</tr>
<tr>
<td></td>
<td></td>
<td>American</td>
<td>56-65</td>
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<tr>
<td></td>
<td></td>
<td>Other</td>
<td>65+</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>White</td>
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<tr>
<td>Unknown</td>
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<tr>
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<tbody>
<tr>
<td></td>
<td>Female</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>1%</td>
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</tbody>
</table>

- Hispanic / Latino: 29%
- Non Hispanic / Latino: 63%
- Unknown: 7%
- American Indian: 2%
- Asian: 1%
- Black or African American: 1%
- Other: 12%
- White: 85%
- 0-5: 18%
- 6-18: 18%
- 19-55: 46%
- 56-65: 11%
- 65+: 7%
Bridges to Health Pathways Enrollments by Quarter

Care Coordinators begin full time

- Total Enrollments YTD (including disenrollments)
- Current Enrollments
- CCO
- Waiting List
# Pathway Outcomes:

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>Client has had THREE appointments with behavioral/mental health provider</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>Confirm that Developmental Screening and Well Child Visit (to discuss results) are on track with Bright Futures timeline</td>
</tr>
<tr>
<td>DHS Assessment</td>
<td>Client has had an appointment with provider</td>
</tr>
<tr>
<td>Developmental Referral</td>
<td>Confirmation that appointments with PCP and Early Intervention were completed</td>
</tr>
<tr>
<td>Education</td>
<td>Confirm that client successfully completes stated educational goal</td>
</tr>
<tr>
<td>Family Planning and Sexual Health</td>
<td>After 30 days, client is confirmed to be satisfied with contraception method, pre-conception or sexual health options chosen and are using those methods</td>
</tr>
<tr>
<td>Food</td>
<td>Client has successfully accessed food resources</td>
</tr>
<tr>
<td>Immunization</td>
<td>Clients immunization record reviewed and VERIFIED to be up to date. Verify through Alert IIS IMM ALERT system or other verification from appointment</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Pregnant woman's pregnancy is complete (delivered, still birth, aborted, therapeutic abortion) and she received dental visit during pregnancy</td>
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<thead>
<tr>
<th>Pathway</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Postpartum</td>
<td>Client has been referred to Our Family Network. Client has kept postpartum appointment. Discuss whether family planning pathway needs to be opened</td>
</tr>
<tr>
<td>Employment</td>
<td>Client has found consistent source(s) of steady income and is employed for more than 30 days</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>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</td>
</tr>
<tr>
<td>Housing</td>
<td>Confirm Housing - client and/or family has remained in an affordable and suitable housing unit for a minimum of 2 months</td>
</tr>
<tr>
<td>Medical/Dental Home</td>
<td>Client has kept at least one appointment with medical or dental provider.</td>
</tr>
<tr>
<td>Medical Referral</td>
<td>Confirmation that appointment was completed</td>
</tr>
<tr>
<td>Medication</td>
<td>Verify with Primary Care Provider that client is taking medications as prescribed</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>Client reports having stopped smoking / using tobacco products for a period of at least 60 days</td>
</tr>
<tr>
<td>Social Service</td>
<td>Confirmation that client kept scheduled appointment and/or received services</td>
</tr>
</tbody>
</table>
BRIDGES TO HEALTH PATHWAYS UTILIZED

MOST FREQUENTLY USED

LEAST FREQUENTLY USED
Medical Referral Needs Broken Out

- Health Insurance
- 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
- Cocoon
- Sexual Health
- Home Health
Social Service Pathway Data
BRIDGES TO HEALTH PATHWAYS IMPACT ON EMERGENCY DEPARTMENT VISITS

**Emergency Dept Visits by Location of Provider**

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</tr>
</thead>
<tbody>
<tr>
<td>Sum of FM</td>
<td>258</td>
<td>220</td>
<td>261</td>
<td>240</td>
<td>252</td>
<td>234</td>
<td>259</td>
<td>233</td>
<td>200</td>
<td>230</td>
<td>198</td>
<td>250</td>
<td>237</td>
<td>205</td>
</tr>
<tr>
<td>Sum of IM</td>
<td>295</td>
<td>246</td>
<td>228</td>
<td>257</td>
<td>287</td>
<td>231</td>
<td>258</td>
<td>239</td>
<td>219</td>
<td>245</td>
<td>244</td>
<td>257</td>
<td>253</td>
<td>185</td>
</tr>
<tr>
<td>Sum of No PCP</td>
<td>224</td>
<td>185</td>
<td>233</td>
<td>205</td>
<td>243</td>
<td>339</td>
<td>341</td>
<td>269</td>
<td>241</td>
<td>235</td>
<td>211</td>
<td>210</td>
<td>251</td>
<td>215</td>
</tr>
<tr>
<td>Sum of Non MCMC</td>
<td>526</td>
<td>428</td>
<td>471</td>
<td>425</td>
<td>456</td>
<td>475</td>
<td>479</td>
<td>430</td>
<td>435</td>
<td>403</td>
<td>386</td>
<td>361</td>
<td>381</td>
<td>321</td>
</tr>
<tr>
<td>Sum of PEDS</td>
<td>119</td>
<td>87</td>
<td>94</td>
<td>96</td>
<td>96</td>
<td>69</td>
<td>53</td>
<td>53</td>
<td>60</td>
<td>71</td>
<td>80</td>
<td>64</td>
<td>83</td>
<td>73</td>
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</tbody>
</table>

Full time B2H CCC started in ED

Full time B2H CCC started in clinics
<table>
<thead>
<tr>
<th>Type of SDOH Services</th>
<th>Applicable Federal Regulations and Guidelines</th>
<th>Financial Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Care Coordination Services</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>“Coordination and Continuity of Care” provision: 42 C.F.R. § 438.20(b)(2)(iv) Medical loss implications: 42 C.F.R. § 438.4(e)(1), (e)(2)(i)(A) (referring to activities that improve health care quality) 45 C.F.R. § 158.15(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)</td>
<td>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</td>
</tr>
<tr>
<td><strong>Value-added Services</strong></td>
<td>“Value-added Services” provision: 42 C.F.R. § 438.4(e)(1)(i) Medical loss implications: 42 C.F.R. § 438.4(e)(1), (e)(2)(i)(A) (referring to incurred claims and services under42 C.F.R. § 438.4(e)) 42 C.F.R. § 438.4(e)(1), (e)(3)(i) 45 C.F.R. § 158.15(b) (referring to activities that improve health care quality) Calculation of capitation rate: 42 C.F.R. § 438.4(e)(1)(i) Referred to as Value-added Services Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.</td>
<td>May be considered in the numerator of the medical loss ratio for the MCO as &quot;incurred claims&quot; or &quot;activities that improve health care quality.&quot; May not be considered for MCO capitation rate setting purposes.</td>
</tr>
</tbody>
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Examples:  
- Coordinate the transition between settings of care  
- Coordinate services enrolled receives from community and social support providers

Examples:  
- Assessing the home for asthma triggers  
- Medication compliance initiatives  
- Identifying and addressing ethnic, cultural, or racial disparities  
- Mosquito repellent to prevent Zika transmission

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Find

- People at risk or in need
- 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
- Social Service Referral

Measure

- Individual Outcomes
- Community Resource Gaps

Coordinated Care Organization Members

Priority to address with Shared Savings from CCO

Can navigate TO cessation but not provide it
Resources

- Coordinated Care Organizations: [http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx](http://www.oregon.gov/oha/HPA/Pages/CCOs-Oregon.aspx)
- Collective Impact: [https://ssir.org/articles/entry/collective_impact](https://ssir.org/articles/entry/collective_impact)