Linking to Care and Services through a Community Coordinated Model

Michigan Primary Care Association
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Learning Objectives

1. Understand the concept of a community "hub"
2. Learn about the implementation of different hub models in Michigan communities
3. Understand the involvement of FQHCs in local hub models.

What are we talking about?

Linking the Clinical Setting to Community Resources

What are we talking about?

- Outreach to the most at-risk
- Patient navigation
- Care coordination
- Addressing social determinants of health

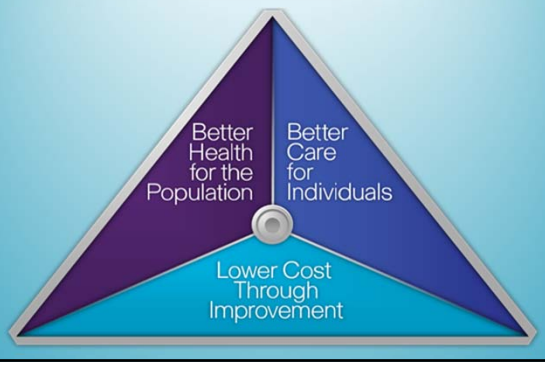
What are we talking about?

- Health education
- Advocacy
- Data collection, outcome analysis, reporting
- Neutral convening

Why are we talking about it?

Value of Organizing Communities to Partner with Healthcare Systems

Triple Aim



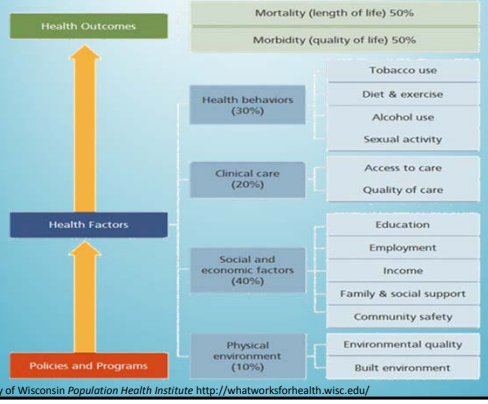
Patient Centered Medical Home

Michigan Primary Care Transformation Project
Advancing Population Management

	PCMH Services	*PCMH Infrastructure*
Complex Care Management *Functional Tier 4*	All Tier 1-2-3 services plus: • Home care team • Comprehensive care plan • Palliative and end-of life care	**Health IT** - Registry / EHR registry functionality * - Care management documentation * - E-prescribing (optional) - Patient portal (advanced/optional) - Community portal/HIE (adv/optional) - Home monitoring (advanced/optional) **Patient Access** • 24/7 access to decision-maker * - 30% open access slots * - Extended hours * - Group visits (advanced/optional) - Electronic visits (advanced/optional) **Infrastructure Support** - PO/PHO and practice determine optimal balance of shared support - Patient risk assessment - Population stratification - Clinical metrics reporting *denotes requirement by end of year 1
Care Management *Functional Tier 3*	All Tier 1-2 services plus: • Planned visits to optimize chronic conditions • Self-management support • Patient education • Advance directives	
Transition Care *Functional Tier 2*	All Tier 1 services plus: • Notification of admit/discharge • PCP and/or specialist follow-up • Medication reconciliation	
Navigating the Medical Neighborhood *Functional Tier 1*	• Optimize relationships with specialists and hospitals • Coordinate referrals and tests • Link to community resources	
Prepared Proactive Healthcare Team Engaging, Informing and Activating Patients		

POPULATION MANAGEMENT

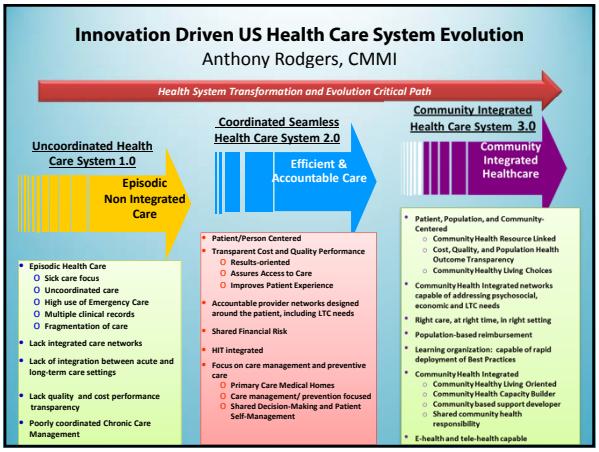
Health Determinants

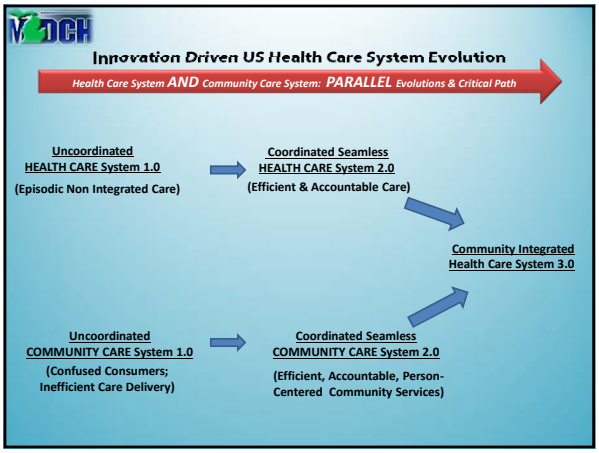


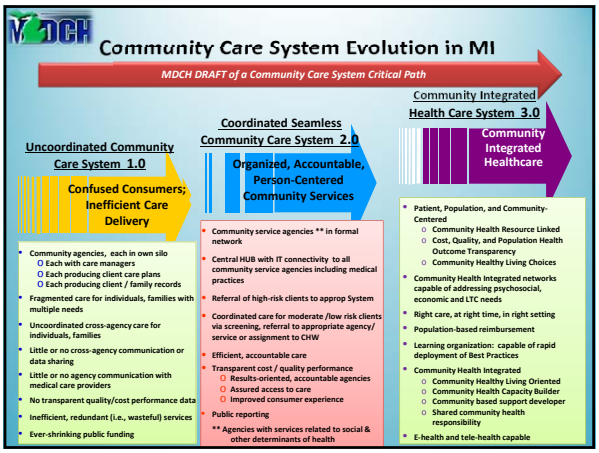
University of Wisconsin *Population Health Institute* http://whatworksforhealth.wisc.edu/

The State's Vision

- Innovation Driven Healthcare & Community System Evolution
- State Innovations Grant







What is Kent County Doing?

- Children's Healthcare Access Program (CHAP)
- Results
- Plans moving forward

Kent County Children's Healthcare Access Program (CHAP)

- Referrals of patients from participating PCPs
  - Need for community resources
  - No-shows for appointments
  - Behind on well child, immunizations, lead testing
  - Inappropriate ED use
  - Need for system navigation (particularly behavioral health)
  - Need for asthma case management
  - Need for transportation
- CHAP team provides services and feedback to PCP
  - Multidisciplinary team of RN, MSW, CHW, asthma educators
  - Services/education provided via phone and/or home visit as appropriate

CHAP Results

- 3 year pilot showed significant Triple Aim improvements:
  - 35% decrease in ED use
  - 24% increase in children up to date on well child exams
  - Improvements in asthma and obesity care at the pediatric practices
  - Social cost-benefit over 2 years = $1.53 return for every $1 invested

How is Cherry Street Health Services involved?

- Referrals
  - Since start of program in August 2008, CSHS has referred more than 4,000 patients to CHAP
- Provider Perspective
- Patient Perspective

Kent County's Vision

- Currently planning the expansion of CHAP services into the adult population, beginning with Medicaid and uninsured
- Developing a Kent County Community Healthcare Hub with multiple community partners
  - 2-1-1 as major gateway
  - Partnering with 3 area hospitals & largest Medicaid health plans
  - Outreach via community-based agencies into highest needs neighborhood
  - Robust data collection and reporting system

What are Ingham, Muskegon, and Saginaw Counties doing?

- Michigan Pathways to Better Health (MPBH)
- Results so far

CMS Health Care Innovation Award (HCIA) Round 1

Michigan Pathways to Better Health (MPBH) Demonstration Project

Award:	MPHI, 3-year cooperative agreement
Duration:	July 2012 through June 2015; Hubs were functional and serving clients by end of January, 2013
Impetus:	If left unaddressed, social determinants of health will prevent people from getting and staying healthy
Objective:	Demonstrate whether the Pathways Community HUB model improves outcomes and reduces costs
Target: Population	Adults with Medicaid and/or Medicare insurance, and 2+ Chronic Condition Diagnoses.

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Michigan Pathways to Better Health

Pathways Community HUB Model Components

- Community Health Workers
- Care Coordination Agencies
- RN or SW Clinical Supervisors
- Pathways
- Community HUB
- Neutral Convener

Pathways Model: A Tool to Measure Outcomes

1- Find — Target Population - Find those at greatest risk

2 - Treat — Confirm connection to evidence-based care

3 - Measure — Measure the results *OUTCOMES*

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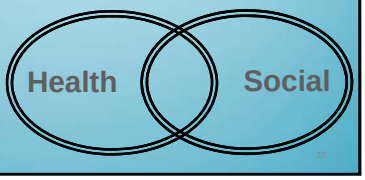
Pathways

- Social Service Referral
- Medication Assessment
- Medication Management
- Medical Referral
- Medical Home
- Health Insurance



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Work Flow

Find the right person

Collect information – Initial Checklist

Yes	No	Question
✔		Do you need a primary medical provider?
	✔	Do you need health Insurance?
	✔	Do you smoke cigarettes
✔		Do you need food or clothing?

Assign Pathways

Initiation Step → Action Step → Action Step → Completion Step

Measure Results (Connections to Care)

Care Coordinator	Medical Home	Preg.	Social Service
A	5	2	10
B	1	3	4
C	9	15	18

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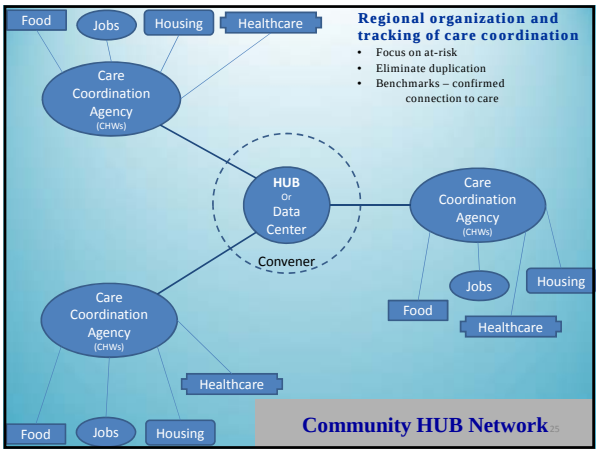

MPBH Pilot Sites

- **Ingham County – Lead is Ingham County Health Dept. (ICHD)**
  - Hub – Ingham Health Plan
  - CHW deployment – ICHD (partnership with 8 different agencies)
  - Convener – Power of We Consortium
- **Saginaw County – Lead is Saginaw Community Mental Health (CMH)**
  - Hub – Saginaw CMH
  - CHW deployment – 3 agencies (2 of which are hospitals)
  - Convener – Mich. Health Info. Alliance (MiHIA) & ALIGNMENT Saginaw
- **Muskegon County – Lead is Muskegon Community Health Proj. (MCHP)**
  - Hub – Muskegon County Government
  - CHW deployment – MCHP ~ Trinity Health System
  - Convener – MCHP

MPBH Year 1 Accomplishments

- Established Lead Agencies & HUBs in Ingham, Muskegon and Saginaw counties
  - Employed 42 CHWs and a total of 68 staff
  - Served 929 clients
  - Provided 5,810 encounters
- Provided client support and referrals for insurance, primary care, medication reconciliation, prescription assistance, mental health/substance abuse and social services

MPBH Year 1 Accomplishments

- Launched Education Pathway and Healthy Changes Plan for Hypertension
  - Additional funding by the Centers for Disease Control through the Michigan Department of Community Health
  - CHWs and Clinical Supervisors attended training provided by Dr. Sarah Redding
  - Clients are using the Pathway and Plan with clients
  - Other chronic conditions will be added in Year 2

MPBH Year 2 Goals

- Outreach to physician practices, hospitals, clinics, social service agencies, and other referral organizations will be essential!
- Measurement of client clinical outcomes
- Hire 18 additional CHWs
- Establish minimum of 2 Clinical Supervisors (preferably one RN and one SW) per site

Plans for Sustainability

- HUB Certification
- CCA Performance Measurement
  - Pay for enrollment
  - Pay for partial/completed Pathways
  - Incentivize HUB tracking/invoicing system
- Potential contracting with Medicaid Managed Care payers

Conclusions

Thank You!

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