Comprehensive Reduction of Risk Is What Improves Outcomes

Spanning infant mortality, chronic disease, education, employment……Wellness

What Do We Know About Risk Factors

- **Population Level Risk** – Smoking in restaurants, vegetables at the grocery

- **Most Risk Factors are at the Individual level** – Housing, access to medical care, employment, etc.

- **Some are immediate and some are upstream (preventive)** – Healthy newborn going home to a smoke filled house.

Risk Factors

10-15%

Health Care

Health Insurance
Primary Care
Specialty Care
Screenings
Child development services

Behavioral Health

Drug and ETOH
Depression
Anxiety
Domestic Violence

HEALTH

Employment

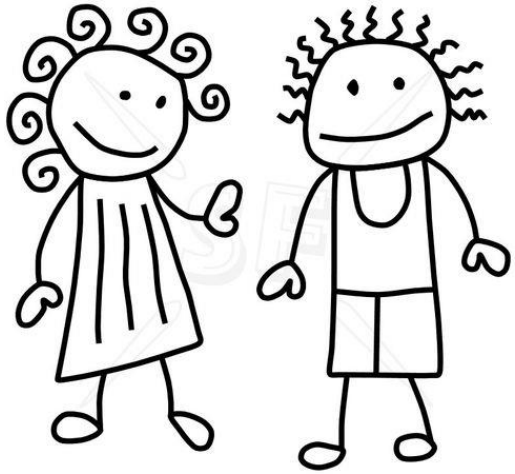
Job Readiness
Self Esteem
Clothing
Application Assist

Social Services

Food
Clothing
Housing
Heat
Electricity etc.

Education

Childhood
Adult
Personal Health
Employment



HEALTHY

Risk Reduction is Not the Work Product for Health and Social Service

- 5% of our population represents 50% of the cost and the greatest disparities in health. These individuals represent those at greatest risk.
- The US is the most expensive and least effective health and human service system (HHS) in the developed world.
- Holistic identification and reduction of risk is where the outcomes come from and that is not what our health and social system is fully and effectively focused on. Using risk reduction as the lens for our system of care the financial and programmatic premise of every funded agency within health and social service is to identify and or address key human risk factors.
- As a state service system we do not across the board document how many risk factors we are identify and how many we address. Our appeals for more resources are often based on emotion and intangible results

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“Typical” Family at Risk Today

Marisol, 21

- Pregnant
- Lost job
- No housing
- No transportation
- Depressed ?

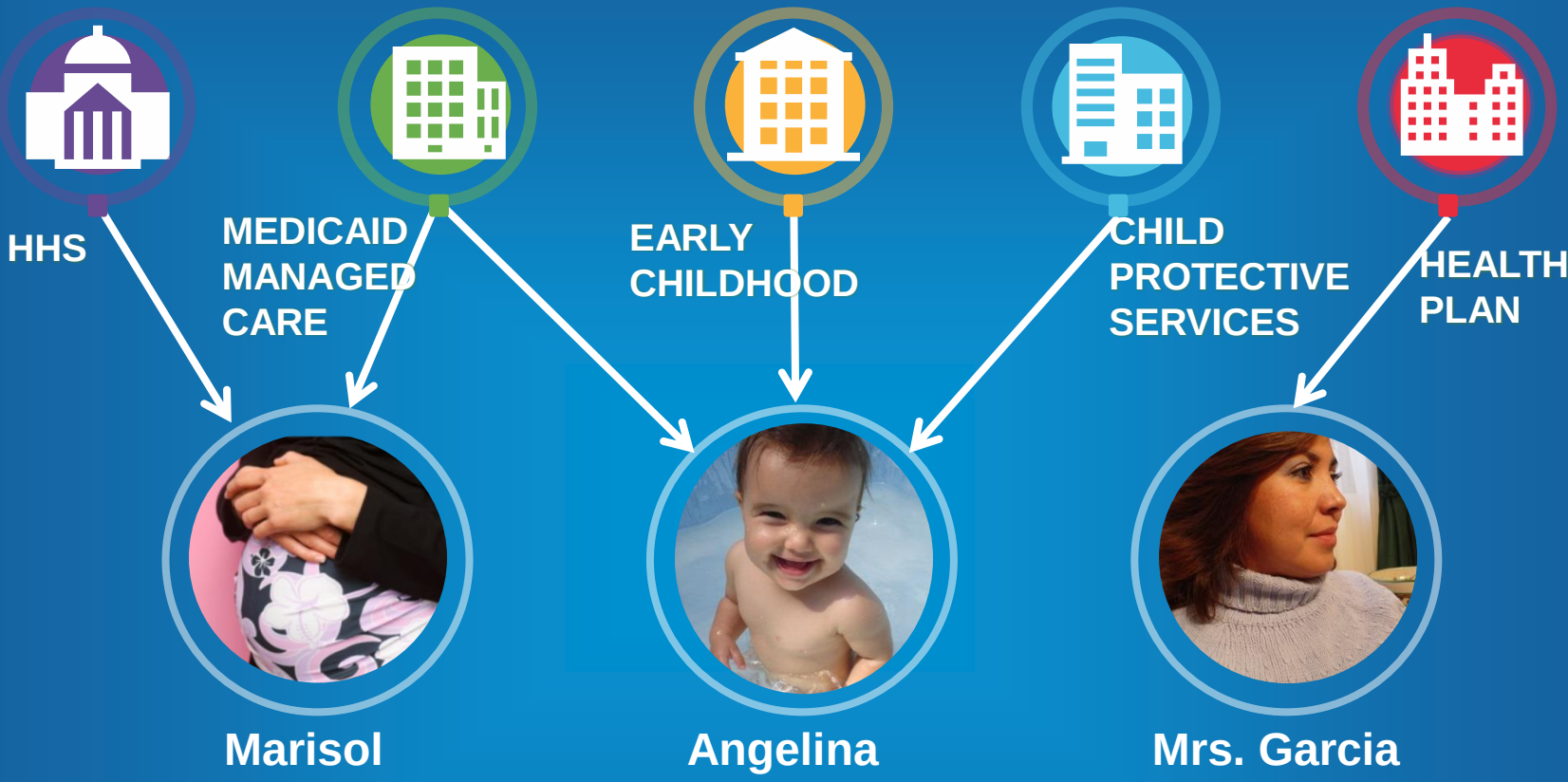
Angelina, 16 months

- Needs medical home
- Behind on imms.
- Behind on well visits
- Developmental concerns ?

Mrs. Garcia, 52

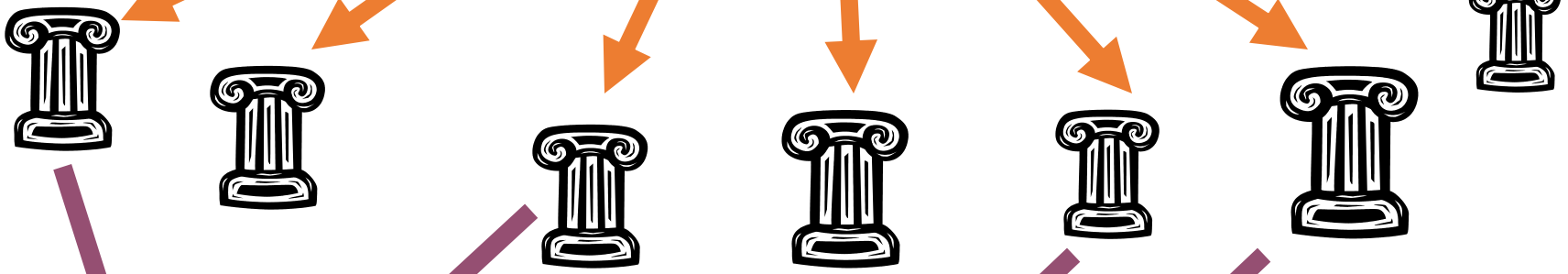
- Diabetic
- Lives in 1 bedroom apt.
- Limited income, works 32 hours
- Financial stressors ?

Care Coordination and Service Approach



Multiple agencies involved – limited communication – No effective tracking of identified and addressed risk factors

Duplication of Care Coordination



Pregnancy

One individual may have 4-15 care coordinators

Our disparity in Ohio and nationally does not lack the funding, expertise, science or capacity to address risk and improve outcomes.

We lack the community engagement and accountable business model to do the work.

If Reducting Risk is the Work Needed

- Best model for getting work done – **American Business**
- What Are the Work Products of Risk Reduction

Care Coordination – To identify the risk factors and coordinate connection to intervention

Direct Service – Intervention proven to address the risk factor

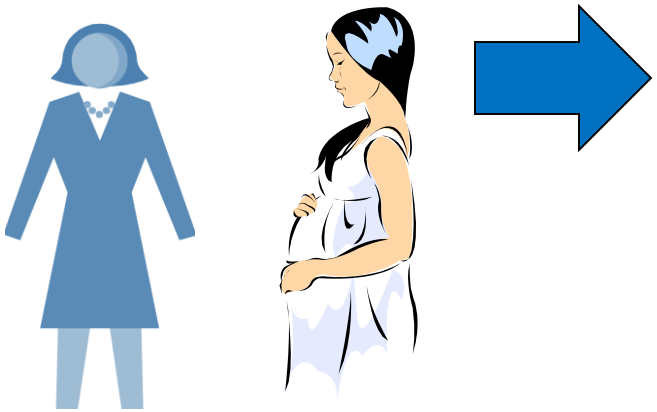
Community Delivery System

- We know where the most at-risk individuals are.
- We have the interventions that can help them.
- **We need a community delivery system that will make sure they connect to preventive care!**

Risk Factors Assigned to Pathways

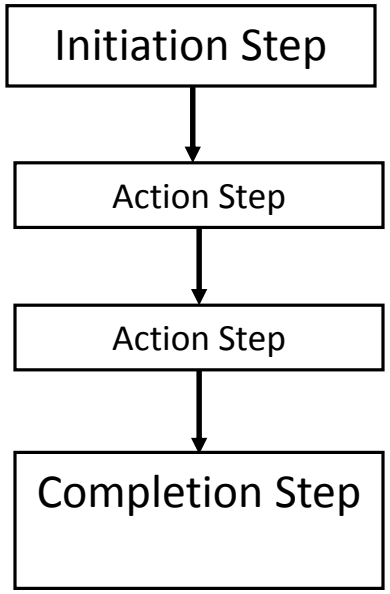
Engagement of at risk client

Initial Checklist – Captures Comprehensive Risk Issues



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



Track/Measure Results (Connections to Care)

By: Care Coordinator
Agency
Region

Name	Medical Home	Pregnancy	Social Service
CHW A	5	2	10
CHW B	1	3	4
CHW C	9	15	18

Site	Medical Home	Pregnancy	Social Service
Agency A	50	25	22
Agency B	64	17	35
Agency C	40	32	19

Example - Pregnancy Pathway

Risk Factor Identified

Initiation Step

Defined "at risk" pregnant woman engaged and enrolled in care coordination

Determine and document barriers:

1. Insurance Status
2. Transportation
3. Importance of Prenatal Care

Evidence based Intervention

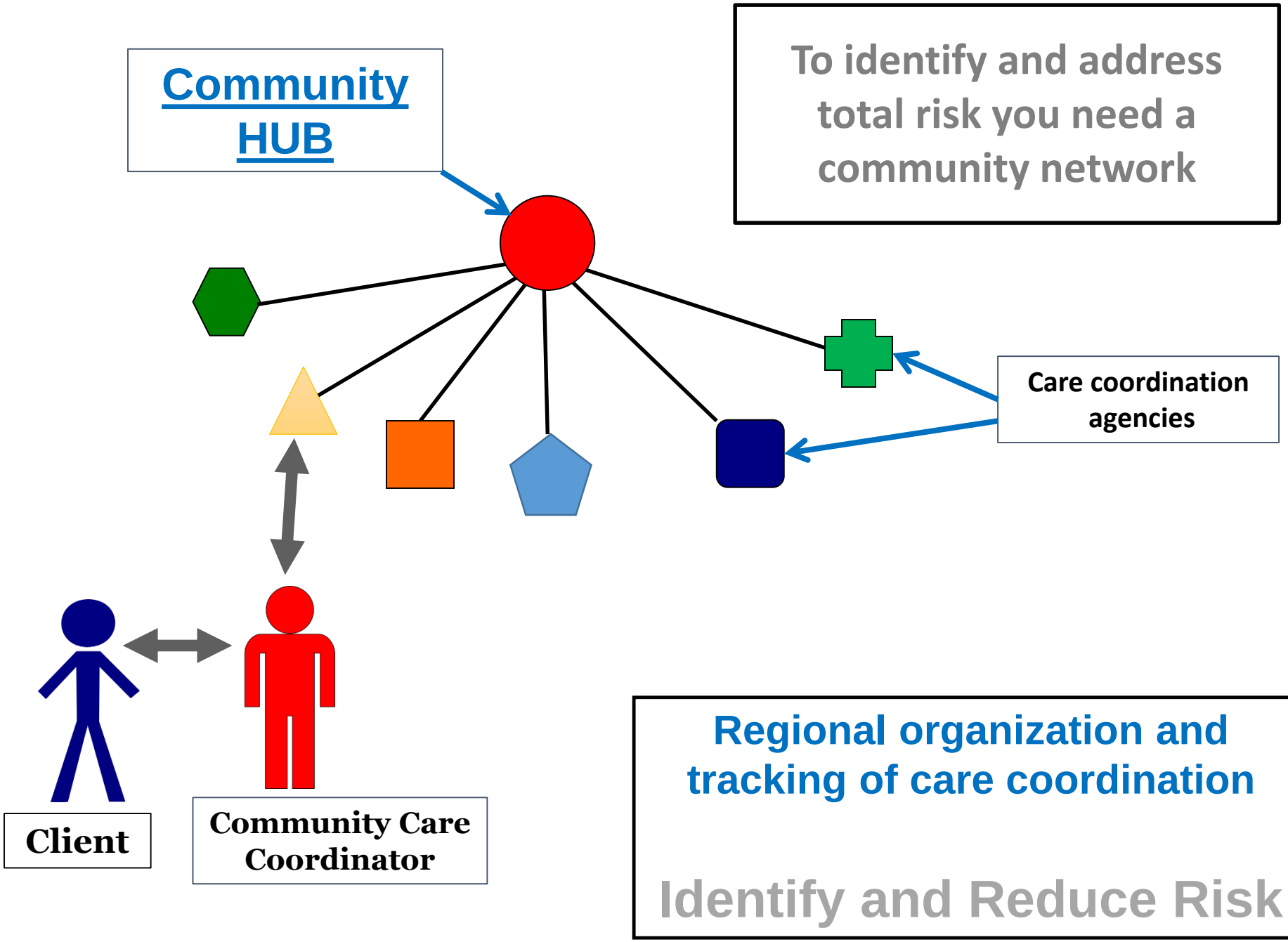
Prenatal care provider established

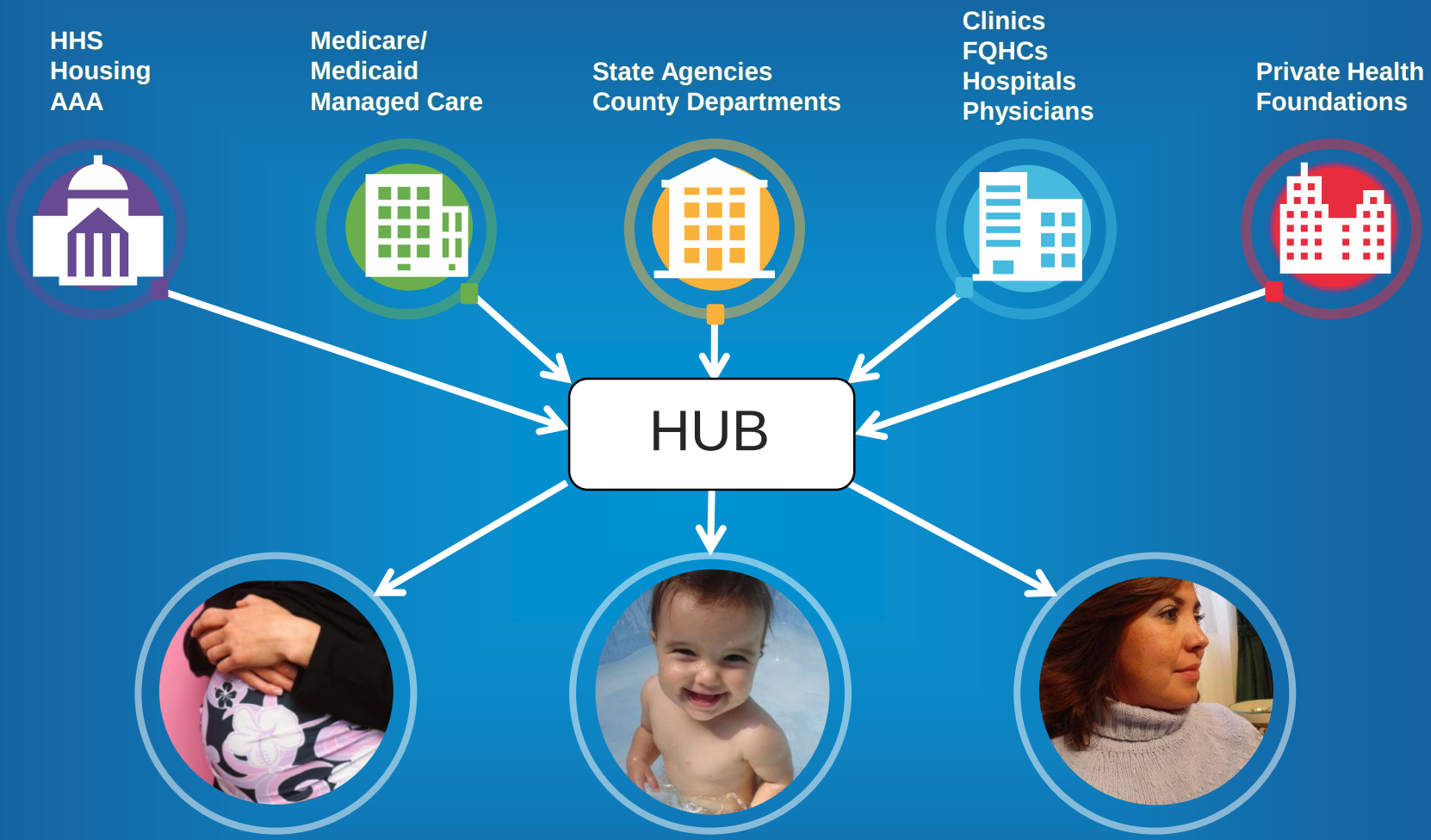
First and ongoing visits confirmed

Outcome
Risk Factor Confirmed Addressed

Completion Step

Healthy baby > 5 lbs 8 ounces (2500 grams)


Community HUB
To identify and address total risk you need a community network
Care coordination agencies
Client
Community Care Coordinator
Regional organization and tracking of care coordination
Identify and Reduce Risk



One Care Coordinator for the Entire Family

One Care Coordinator for the Entire Family

Marisol

- Pregnancy PW
- Employment PW
- Housing PW
- Medical Referral PW
- Social Service Referral PW
- Education PW – prenatal, parenting

Angelina

- Medical Home PW
- Immunization Referral PW
- Medical Referral PW
- Developmental Screening PW

Mrs. Garcia

- Medical Referral PW – primary & specialty
- Housing PW
- Social Service Referral PW
- Education PW - diabetes

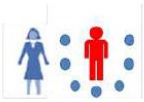
Community Care Coordinator Risk Management Navigation: Family-Centered Network Assistance

Top 5% of Population that has most risks are identified by the CCC

Care Plan with Specialty Providers

Specialty Providers: Case Managers, Social Workers

Direct Hand off from Inpatient Care Coordinators to Outpatient



Risk Reduction

Once all risk factors met

Patient Risks Identified, enters Network with the CCC

Community Care Worker works with family, patient to identify risks, create plan

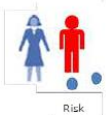
Risk Reduction

Community Resources: Non-Profit and Fundraising organizations to assist with food, clothing, housing, behavioral health needs including substance abuse

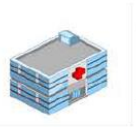
Insurance: PA, DME, Transportation (Medicaid), Insurance Acceptance, Transitions from Medicaid to Medicare

Risk Reduction

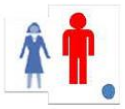
Government Resources: CSB, Waiver, BCMH, School (IEP, Nursing)



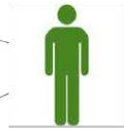
Risk Reduction



Children's Hospital: Inpatient/ED Case Managers/Social Workers

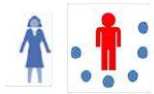


Risk Reduction



Over-all health well-being: Physical, Behavioral, Economical, Social Health

Once all risk factors met



Risk Reduction

Care Plan with Primary Care Providers

Primary Care Offices: CCC Base of Operations

Direct Hand off from Inpatient Care Coordinators to Outpatient

Akron Children's Hospital

Rebecca D. Considine Research Institute Center for Childhood Lifestyles and Population Health

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20 Core Pathways – National Certification

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum

System of Pathway Billing Codes Used Used in Ohio

		Normal Risk	High Risk	Modifier
Checklists				
Initial Pregnancy Checklist	Completed one time at Member enrollment, 1st trimester engagement	G9001	G9003	R1
	Completed one time at Member enrollment, 2nd trimester engagement	G9001	G9003	R2
	Completed one time at Member enrollment, 3rd trimester engagement	G9001	G9003	R3
Pregnancy Checklist	Completed at each face-to-face encounter with Member	G9005	G9010	R
Pathways				
Behavioral Health	Kept three scheduled behavioral health appointments	G9002	G9009	RB
Education	Educational module delivered.	G9002	G9009	RE
Family Planning	LARC (long-acting, reversible) or permanent method	G9002	G9009	G1
Family Planning	All other family planning methods	G9002	G9009	G2
Housing	Residing in affordable & suitable housing for 2 months.	G9002	G9009	RI

Define Our Work Products
Evaluate the Cost
Use Every Available Business Innovation
To Identify and Address Risk


OCIE HILL
NEIGHBORHOOD CENTER

Risk Reduction Reports Now Live in 6 HUBs

HUB : CHAP

Pathway	Initiated	Open Pathways To Date	Completed	Finished Incomplete	Median Duration Days	% Finished Incomplete	% Completed To Date
Social Service Referral	361	109	151	125	19	31.9	42.6
Medical Referral	314	49	227	45	27	15.6	69.9
Education	167	42	112	13	1	7.8	67.1
Pregnancy	121	45	51	34	101	24.0	45.2
Family Planning	90	49	22	32	75	32.4	23.4
Postpartum	70	35	29	9	54	13.1	45.2
Medical Home	72	21	34	21	10	30.4	43.0
Immunization Screening	58	19	34	5	44	8.5	59.3
Medication Assessment	53	8	41	8	13	13.8	72.4
Developmental Screening	45	17	19	9	39	19.1	44.7
Smoking Cessation	40	16	3	26	112	58.7	6.5
Housing	30	14	4	13	63	38.2	20.6
Behavioral	30	8	6	19	76	55.9	20.6
Employment	25	12	1	15	86	50.0	12.5
Adult Education	28	15	2	14	88	45.2	6.5
Health Insurance	21	6	7	8	28	36.4	36.4
Immunization Referral	5	3	2	0	49	0.0	40.0
Lead	1	1	0	0	29	0.0	50.0
Medication Management	1	0	1	0	182	0.0	100.0
	1532	**469**	**746**	**396**			

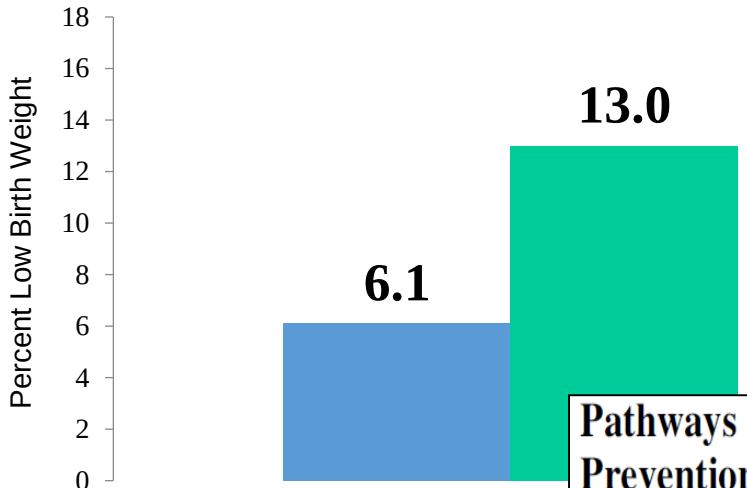
Health

Behavioral Health

Social

Family & Personal Health Management

Published Study on Results



Pathway intervention over 4 years

Cost Savings: $3.36 for 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social

Women participating in CHAP and having a live birth in 2001 through 2004 constituted the intervention group. Using birth certificate records, each CHAP birth was matched through propensity score to a control birth from the same census tract and year. Logistic regression was used to examine the association of CHAP participation

Rockville Institute

Pathways

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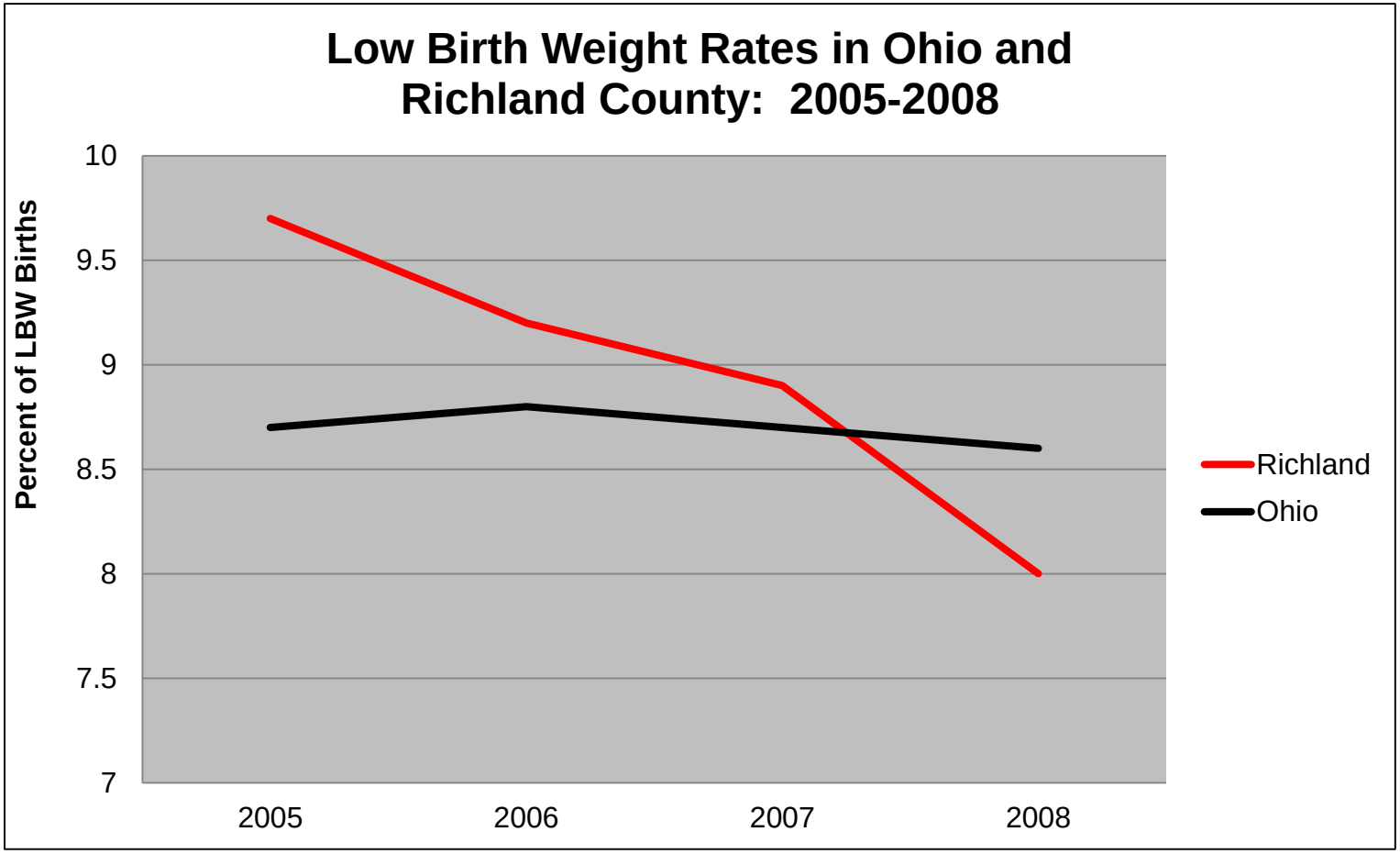
HOME

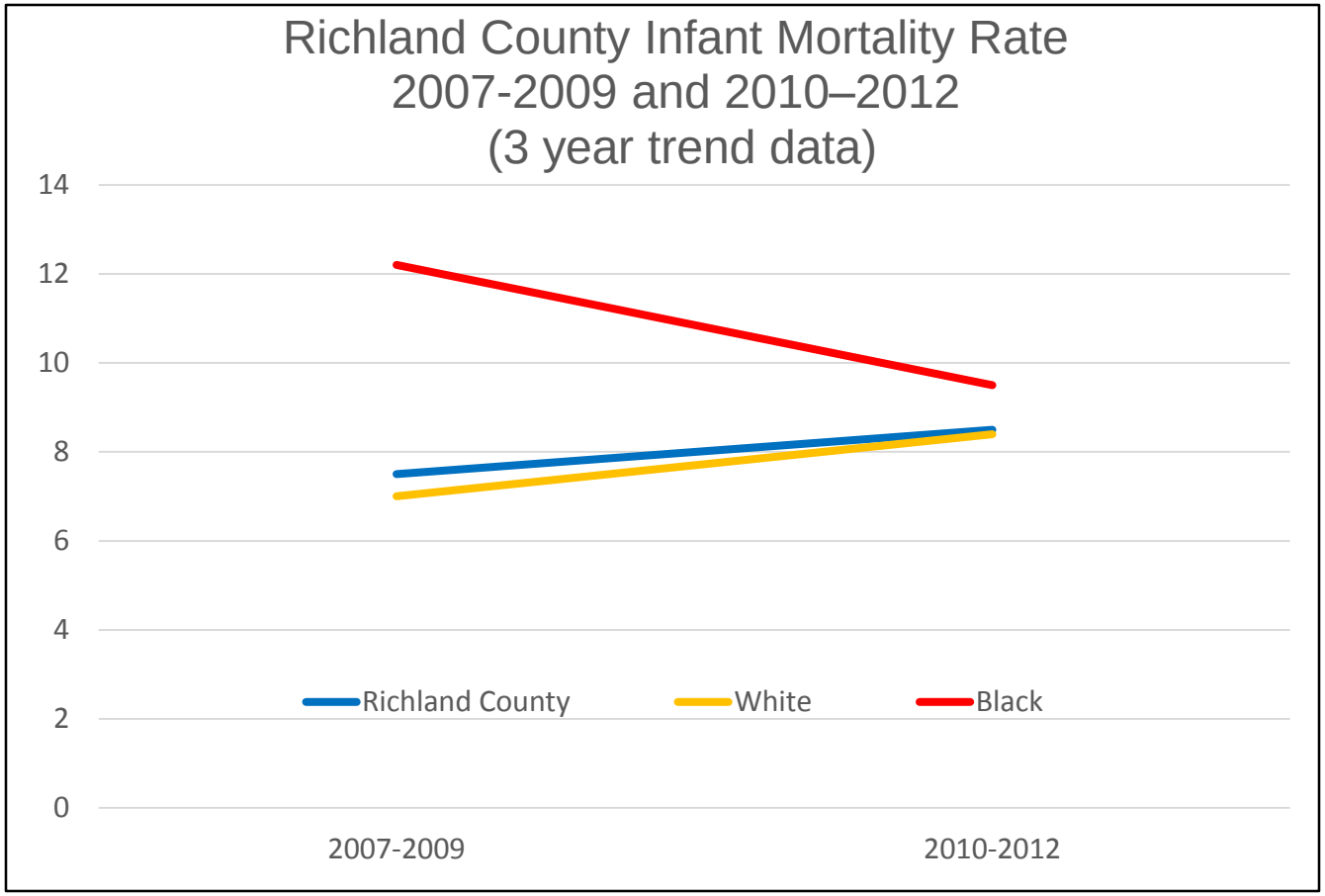
ACHIEVING BETTER CARE, BETTER OUTCOMES AT LOWER COST

HUB Model Community Benefit

- Evidence based improvements in outcomes and reduction in cost.
- The highest level of pay for performance and the closest modeling to American Business in the health and human service industry
- The model sends the training, jobs and economic mobiity right were it is needed the most. Some of the best CWs started firs as clients.

LBW in Richland County





	2007	2008	2009	2010	2011	2012
Infant Deaths Total	15	6	14	15	14	6
White Deaths	11	6	12	13	13	5
Black Deaths	4	0	2	2	1	1
Births, Total**	1,606	1,523	1,517	1,339	1,353	1,410
White Births	1,436	1,365	1,353	1,199	1,220	1,260
Black Births	170	158	164	140	133	150

Resources

Scientific Publication Journal of Mat and Child Health – 60% reduction in low birth weight and %500 return on investment
http://link.springer.com/article/10.1007/s10995-014-1554-4

AHRQ – Pathways Manual, Connecting Those at Risk to Care, and other supporting network publications.
http://www.innovations.ahrq.gov

Voices for Ohio's Children
Medicaid Braided Funding Policy Brief, Nov 2013
http://www.raiseyourvoiceforkids.org/Media/Documents/Policy%20Briefs/MedicaidBraided_Brief%20FINAL.pdf

NQF - Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination
https://www.qualityforum.org/Publications/2014/08/Priority_Setting_for_Healthcare_Performance_Measurement__Addressing_Performance_Measure_Gaps_in_Care_Coordination.aspx

AHRQ Publication Discussing Risk Scoring
http://www.innovations.ahrq.gov/content.aspx?id=3991&tab=2

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