



PCHI® Model

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MCO Introduction to the Pathway Community HUB Institute® (PCHI) Model

- Introductions and Background
- Overview of the PCHI[®] Model
- Introduction to the Texas Pathways Community HUB (PCH) Network

Brazos Healthy Communities Harris County Pathways Community HUB Williamson County Accountable Community of Health **Grow Healthy Together**

Discussion Around MCO Contracting Options

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www.pchi-hub.org







About Us

Certification

Training

Technical Assistance

More

Log In

A Proven Model

for community-based care coordination.

The Pathways Community HUB Institute® helps communities come together to support their under-resourced residents and to improve health and well-being.

Find a PCH or PA in Your Area

PCHI Model Overview

Contact PCHI



Improve Health

Reduce Costs

Promote Health Equity

Pathways Community HUB Institute® Model



The PCHI® Model provides a transformative value-based, quality improvement framework to build a community-based care coordination network, called a Pathways Community HUB (PCH).



Leverages the skills of community health workers to find and engage residents who are under-resourced and at greatest risk for poor health outcomes.



Studies by Medicaid
Managed Care plans have
demonstrated a return on
investment and measured
health improvement for
members who received
PCHI Model care
coordination.



A certified PCH improves health, reduces costs, and promotes equity.

Evolution of the PCHI® Model









Pathways Model – CHW focus



Initial Effort:

- Developed CHW training program
- Hot-spotting in community
- High-risk pregnant women
 No significant impact -- needed a new approach!

Pathways developed (2000) to track each individually modifiable risk factor from identification to mitigation.

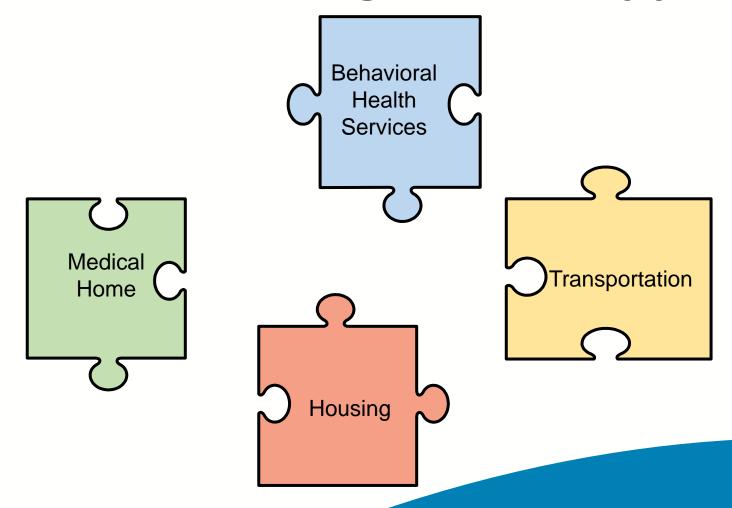
Pathways Model Demonstrates ROI

2001 - 2004: Community Health Access Project

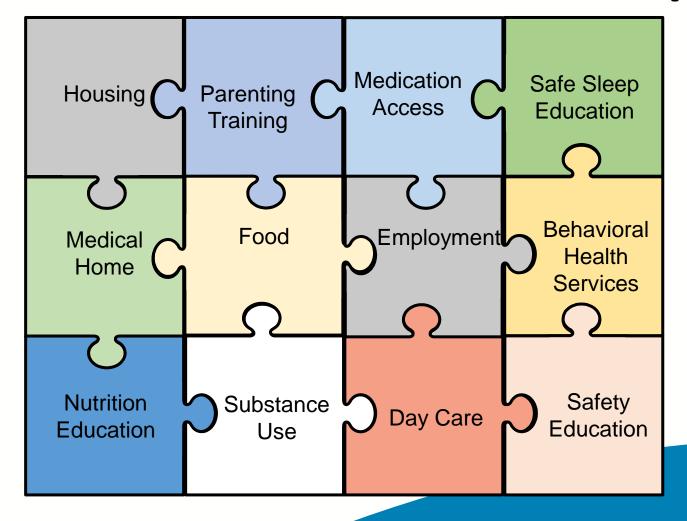
- 115 CHAP clients & 110 control births
- Decrease in low birth rate for enrolled populations of 60%
- Common non-medical Pathways initiated: Employment (52%), Adult Education (50%), Smoking Cessation (39%), Food Security (30%), and Housing (27%)
- No difference in utilization of prenatal care.

\$3.36 short term and \$5.59 long term return on investment

Care Coordination: Fragmented Approach



Care Coordination: Whole Person Approach

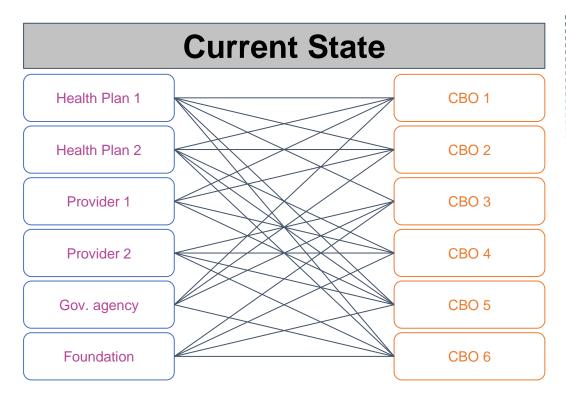


Pathways Community HUB Approach

- American Academy of Pediatrics (CATCH grant)
 Supported the development of the pilot PCH in Richland County, OH (2005), connected payments to Pathway completion
- Ohio Department of Health (HRSA grant)
 6 Pathways Developed and piloted at several Ohio sites: Immunizations, Lead, Medical Home, Health/Social Service, Pregnancy, Tobacco Cessation
- Agency for Healthcare Research and Quality

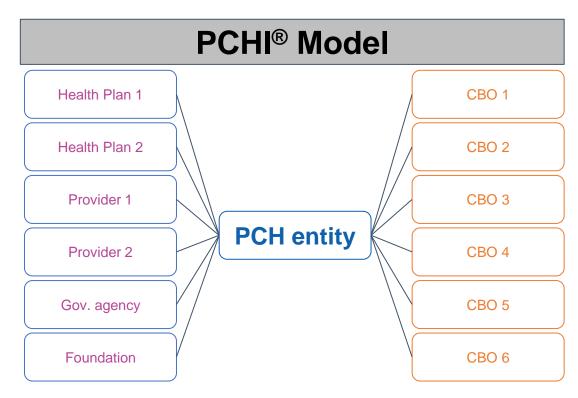
First model selected under the national Innovations Exchange

Community Based Care Coordination



Challenges

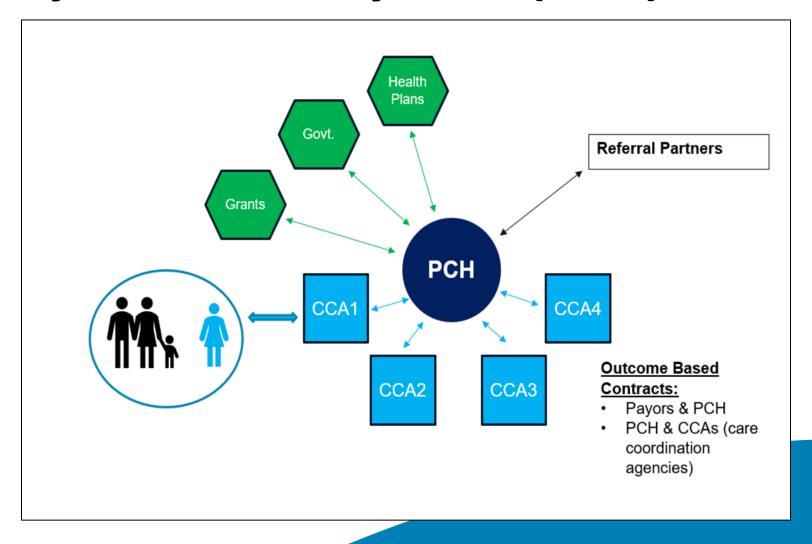
- -Different contracts with multiple organizations
- -Duplicated efforts
- -Siloed CHW outreach process
- -Inability for CBOs to contract with different health entities



Benefits of the Model

- -Pay for outcomes & braided funding creates sustainability
- -PCH Entity creates structure, governance oversight, standardized data and reporting, quality assurance, and contracting as a trusted neutral convener.

Pathways Community HUB (PCH)



CHWs Serve as Partners, Coaches, and Advocates



Key to the Pathways Community HUB Institute® Model are community health workers (CHWs), who provide community-based care coordination services and are employed by community-based organizations, clinics, social service agencies, and other organizations.

Pathways Community HUB (PCH)

Neutral, transparent, and accountable

- Based in the community/region served
- Only one PCH in a community/region
- Develops a care coordination network
- Does NOT employ community health workers
- Uses outcome-based contracting
- Community Advisory Council
- Uses PCHI® Model standardized data collection tools



PCHI® Model Components

- Standard forms for collecting information on participants (Demographic Form, Visit Form, Progress Form) across all contracted agencies
- 2. 21 Pathways
- 3. 60+ Evidence based Learning Modules
- 4. Standard Outcome and engagement-based billing (50% linked to confirmed outcomes/Pathways)
- 5. Quality Benchmark Report

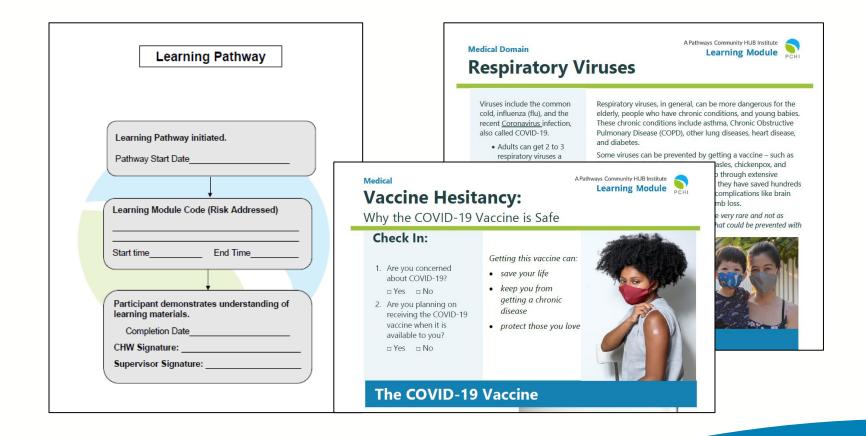
21 Standard Pathways

Adult Education Developmental Referral **Employment** Family Planning **Food Security** Healthcare Coverage Housing Immunization Referral 60+ **Learning** -Learning **Modules** Medical Home **Medical Referral** 24 types of referrals

Medication Adherence Medication Reconciliation **Medication Screening** Mental Health Oral Health Postpartum Pregnancy 31 types of **Social Service Referral** referrals Substance Use

Transportation

Learning Pathway & Learning Modules



Eliminating Risk

Identify and Address Individually Modifiable Risk Factors



Completed Pathways = Outcomes/Risks Mitigated



Larger Scale Outcomes From Multiple Risks Being Addressed

- Food
- Clothing
- Housing
- Parenting Education
- Depression
- Substance use
- Access to a Medical Home
- Education
- Employment
- Car Seat Safety
- Safe Sleep
- Nutrition

- Connection To Medical Home
- Housing Established
- Food Security
- Normal Birth Weight Infant
- School Attendance
- Employment Established
- Transportation
 Established

- Improved Birth Outcomes
- Reduced ED Visits
- Cost Savings
- More Preventive Care

PCHI® Model Payment Strategy

Braided funding

- Grants
- Philanthropy
- Payer Contract



Value-based Contracting

- At least 50% of payment is tied to outcomes or completed Pathways.
- The other 50% is tied to confirmed engagement, measured by completed Visit Forms documenting home visits.
- If a participant is not engaged and Pathways are not completed, there is no payment.

PCHI Payment Model Example

Pathway/ Engagement	Completion	OBU	OBU Value	\$
Housing	Maintained safe and stable housing for 30 days from move-in date.	15	\$40*	\$600
Mental Health	Kept 3 scheduled mental health appointments.	8	\$40*	\$320
Engagement Fee	Monthly documented visit with client – includes support for PCH, QI, invoicing, training, etc.			\$240

^{*}For illustration purposes only. Each PCH negotiates the Outcome Based Unit (OBU) rate.

PCHI[®] Model Activity in 17 States



Ohio's Experience

PCH pilot in 2004-2005 (CHAP)

MCO contracts

- 2007 with Centene, 2008 with UnitedHealthcare, others followed
- No direct involvement with Ohio Department of Medicaid until 2017
- Today -- all Medicaid MCOs contract with Ohio's 11 Certified Pathways Community HUBs (CareSource, Centene, Molina, Paramount, UnitedHealthcare)

Commission on Minority Health

- Funded CHAP and some other PCHs (one at a time)
- Became the "champion" at the state level
- Biennial budget \$ to replicate and expand PCHs



Demonstrated Outcomes

The Northwest Ohio Pathways Community HUB (Centene Ohio Plan), demonstrated that **high-risk mothers** without PCH intervention were **1.6x** more likely to deliver a baby needing special care.



For every \$ spent on PCH for Centene members there was a savings of \$2.36.



Newborns born to mothers at high risk enrolled in the PCH have a **PMPM cost** savings of \$403 during the first year of life compared to those born to mothers not enrolled in the PCH at delivery.



Workforce Development

Pathways HUBs in Ohio:



There are
192 CHWs
serving HUB
clients in Ohio



Member HUBs are partnered with 65 community agercies that employ CHWs



Member HUB CHWs served **4,036 clients** in 2020



The Ohio Network of Certified Pathways Community HUBs work to improve the health outcomes of our communities. During the COVID-19 pandemic we have each responded in our communities by steadfastly providing service to our clients.

On average, member HUBs provided 2,397 educations related to COVID-19 for their clients in 2020 including:



Personal Hygiene



Mask Wearing & Physical Distancing



a Testing Site



Vaccine Education



Statewide Community Health Worker Day

Community Action Akron Summit celebrated the accomplishments and achievements of the Community Action Akron Summit Pathway HUB Community Health Workers (CHWs) along with the Care Coordinating Agencies and Supervisors during the statewide Community Health Worker Day, June 6, 2022.

Introduction to the 4 Pathways Community HUBs in Texas:

Brazos Healthy Communities
Harris County Pathways Community HUB
Williamson County Accountable Communities of Health
Grow Healthy Together Pathways HUB (Level 1 PCHI® Certified)

Brazos Healthy Communities

PCH Director: Olga Rodriguez (Texas A&M University Health Science Center)/ Jeannie Mansill (Project Unity)

Service Area: Brazos County

Target Population: Pregnant Women with anxiety and/or mild depression

PCH Network Description: Initially, targeting community organizations who see pregnant women with multiple pregnancies.

Contracted CCAs: None to date.

Number of CHWs: None to date.

Launch Date: December 2022

Funders: Episcopal Health Foundation, CommonSpirit

Harris County Pathways Community HUB

PCH Director: LaToya Shields, BSW, MPA

Service Area: Harris County, TX

Target Population:

Current Medicaid recipients or Medicaid-eligible adults who:

- Are pregnant and have behavioral health risk factors;
- Have a mental illness; or
- Have a substance use disorder

Harris County Pathways Community HUB

PCH Network Description:

- The Network of Behavioral Health Providers (NBHP), which will lead the Harris County Pathways Community HUB, is a 501(c) (3) collaborative of the leadership of more than 40 mental health and substance use treatment providers in greater Houston.
- The PCH has engaged NBHP's 40+ member organizations as well as dozens of other community-based medical, behavioral health and social organizations in Harris County - who will work collaboratively to meet the needs of the high-risk target population.

Harris County Pathways Community HUB

(3) Contracted CCAs:

- Santa Maria Hostel
- The Council on Recovery
- City of Houston Health Department

Number of CHWs: 5 Full Time State Certified CHWs

Proposed Launch Date: November 1, 2022

Current Funders: Episcopal Health Foundation

Williamson County Accountable Communities of Health

PCH Director: Dorothy Light, United Way of Greater Austin

Service Area: Williamson County, focus on <u>Health Equity Zones</u>

Target Population: Pregnant Moms, Families with young children

PCH Network Description: Partnering with Health District, Lone Star Circle of Care, Georgetown Health Foundation, and Ascension-Seton to build network of trusted care coordination agencies across the county

Contracted CCAs: Currently talking with interested agencies in Southeast Georgetown before moving to Taylor

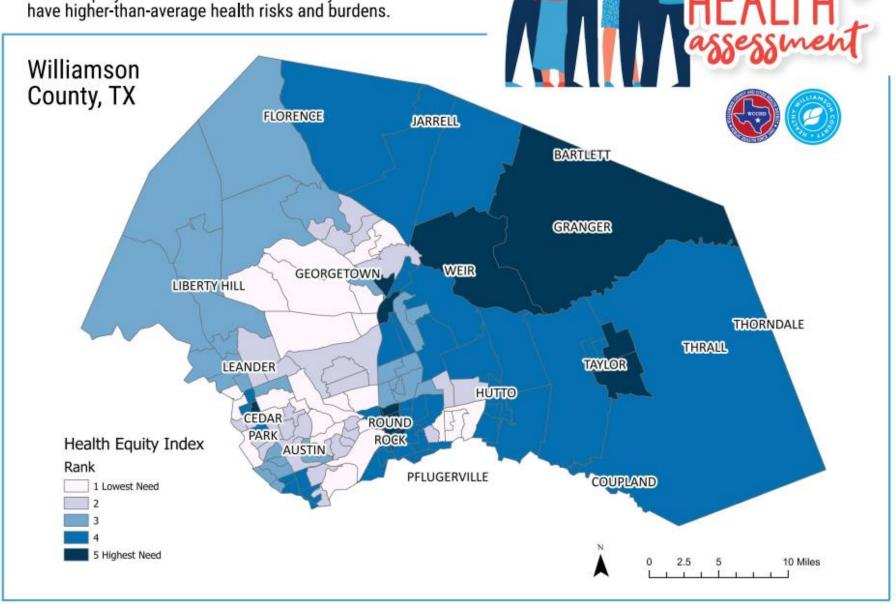
Number of CHWs: Goal is 4 CHWs by March 2023

Launch Date: March 2023

Funders: Episcopal Health Foundation, St. David's Foundation

Health Equity Zones

Health equity zones are areas in the county that tend to have higher-than-average health risks and burdens.



Grow Healthy Together Pathways HUB

PCH Director: Derek Anderson, DrPH

Service Area: Bexar County

Target Population: All underserved community

PCH Network Description: The Grow Healthy Together Pathways Community HUB is an initiative of The Health Collaborative; a 25-year 501 c 3 Nonprofit organization whose mission is to improve the health of the community through collaborative means. The Grow Healthy Together Pathways Community HUB increases access to integrated health care for central and south Texas residents by identifying system gaps, facilitating community-developed solutions, and advocating for health policy change.

Contracted CCAs: 5

Number of CHWs: 14

Grow Healthy Together Pathways HUB

Launch Date: July 1, 2018

Funders: Community First Health Plan

Superior Health Plan

San Antonio Metro Health District (Contract)

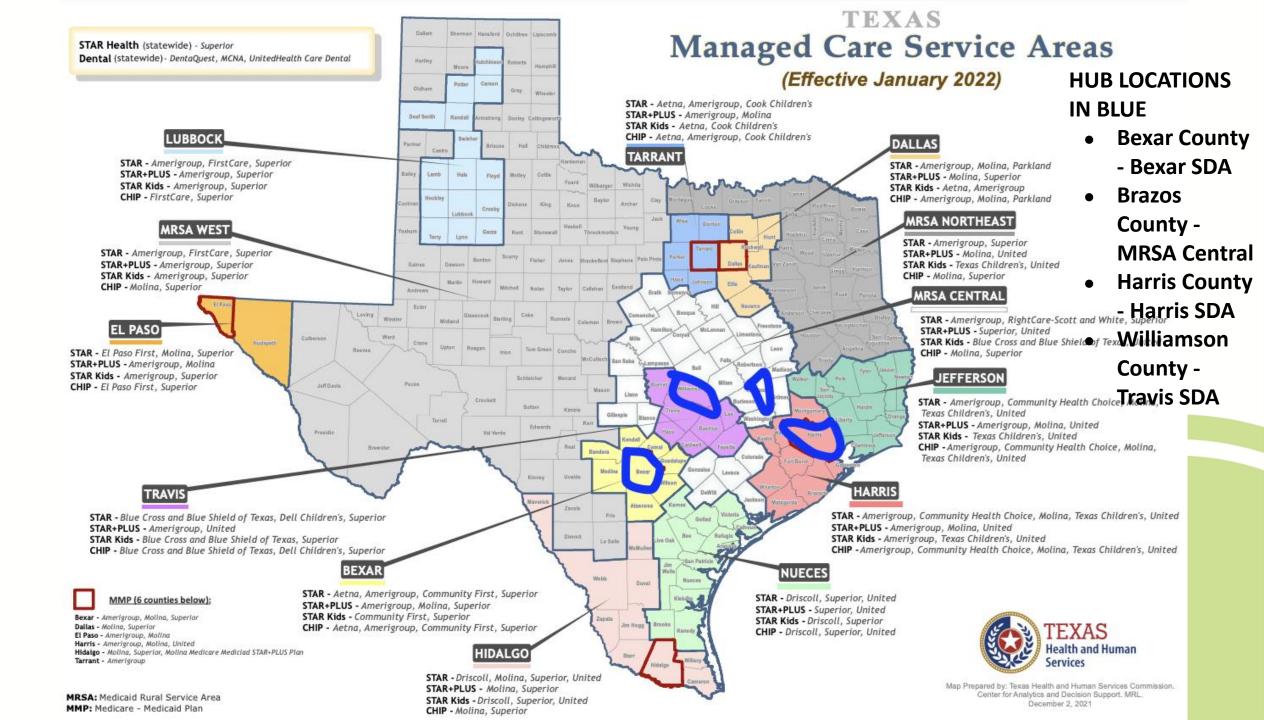
Bexar County Commissioners (Contract)

Methodist Healthcare Ministries of South Texas Inc. (Grant)

United Way (Grant)

Blue Cross and Blue Shield of Texas (Grant)

Humana (Grant)



Discussion

- What has been Superior and CFHP experience contracting with Grow Healthy Together?
- What are contracting options?
 - Value-added Services
 - Admin/Service Coordination or Case Management
 - Quality Improvement
 - Others?
- Quality Improvement activities must:
 - Be designed to improve health quality;
 - Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
 - Be directed toward either individuals or segments of enrollee populations, or provide health improvements to the population beyond those enrolled without additional costs for the nonmembers; and
 - Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by accreditation bodies, recognized professional medical associations, government agencies, or other national health care quality organizations.

Next Steps

- Do the MCOs have any concerns or questions?
- Would the MCOs be open to a follow-up meeting for MCOs in each SDA and corresponding Pathways Community HUB to further explore contracting options?
- Are there concerns with the development of a standard contract for the 4 PCHs to help reduce administrative burden?