Inclusive Alliance

CNY Pathways Community HUB (PCH)

Overview of the PCH Model & Local Planning to Date

February 15, 2023

Lauren Wetterhahn, Executive Director
Liz Crockett, Executive Director, REACH CNY
Amy Vreeland, PCHI
Heidi Arthur, HMA

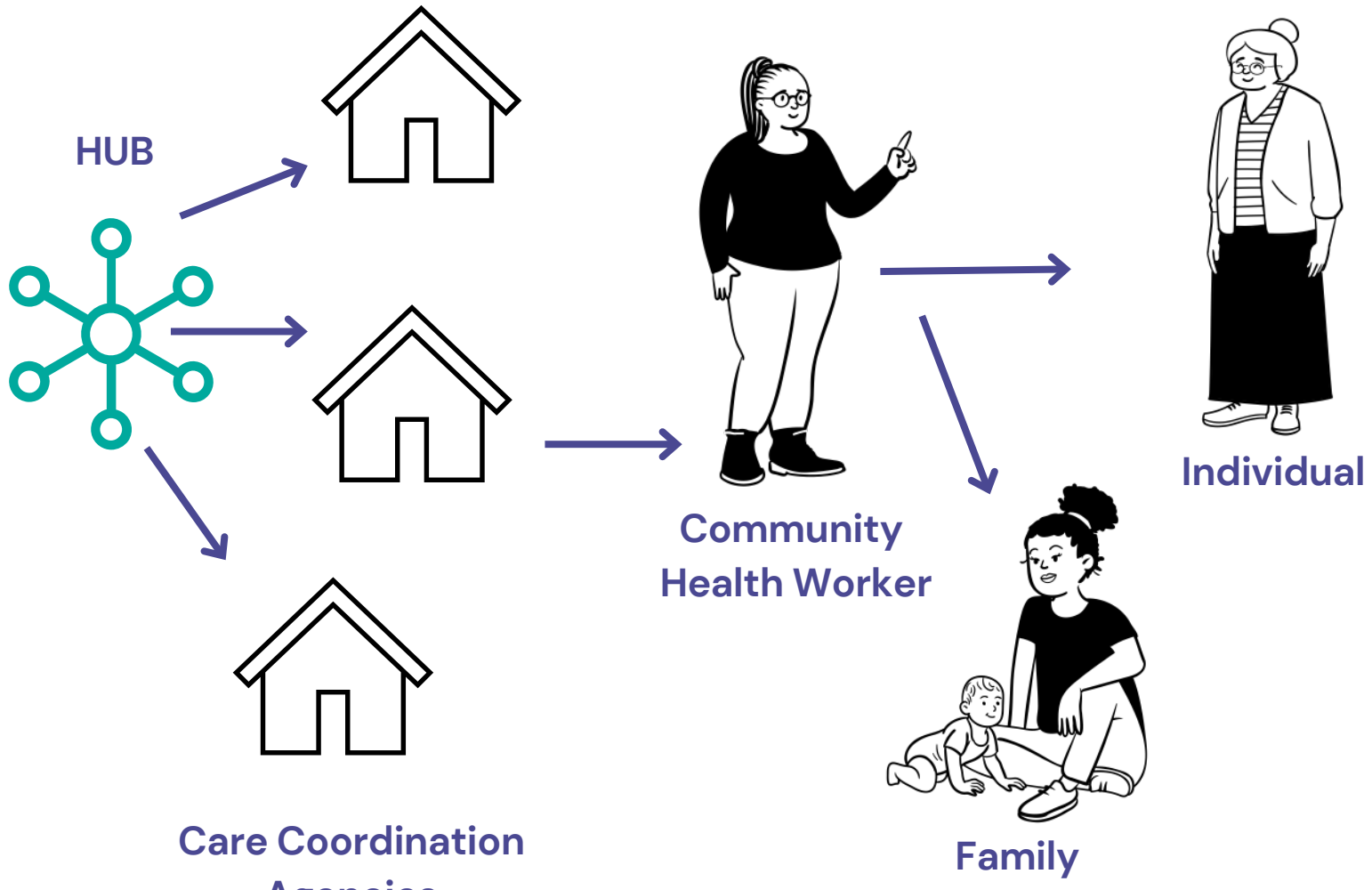
Today's Agenda

- WHAT is a Pathways Community HUB?
- WHO has a role in the Pathways Community HUB?
- WHY do we need a Pathways Community HUB in CNY?
- WHERE are there other Pathway Community HUBs?
- HOW does the Pathways Community HUB fit into the 1115 waiver?
- WHEN is this going to happen?
- HOW can my agency get involved?

Inclusive Alliance

What Is a Pathways Community HUB (PCH)?

Both a standardized, evidence-based approach to community health work AND the central administrative infrastructure that supports CHWs to ensure services have measurable impact, are financially sustainable, & respond to community need



Inclusive Alliance

PCH Approach to Care Coordination

1

Engage client and use standardized assessment to identify modifiable individual, family, and household risk factors:

- Lack of a Medical Home
- Lack of Stable Housing
- Lack of Access to Food
- Lack of Prenatal Care
- Lack of Stable Employment
- Lack of Consistent Transportation
- Lack of Mental Health Care
- Lack of Substance Use Treatment
- + many more

2

Mitigate identified risk factors by assigning & working with client to complete standardized "Pathways" (set of action & completion steps):

- Medical Home Pathway
- Housing Pathway
- Food Security Pathway
- Pregnancy Pathway
- Employment Pathway
- Transportation Pathway
- Mental Health Pathway
- Substance Use Pathway
- +13 more

3

Track/measure outcomes

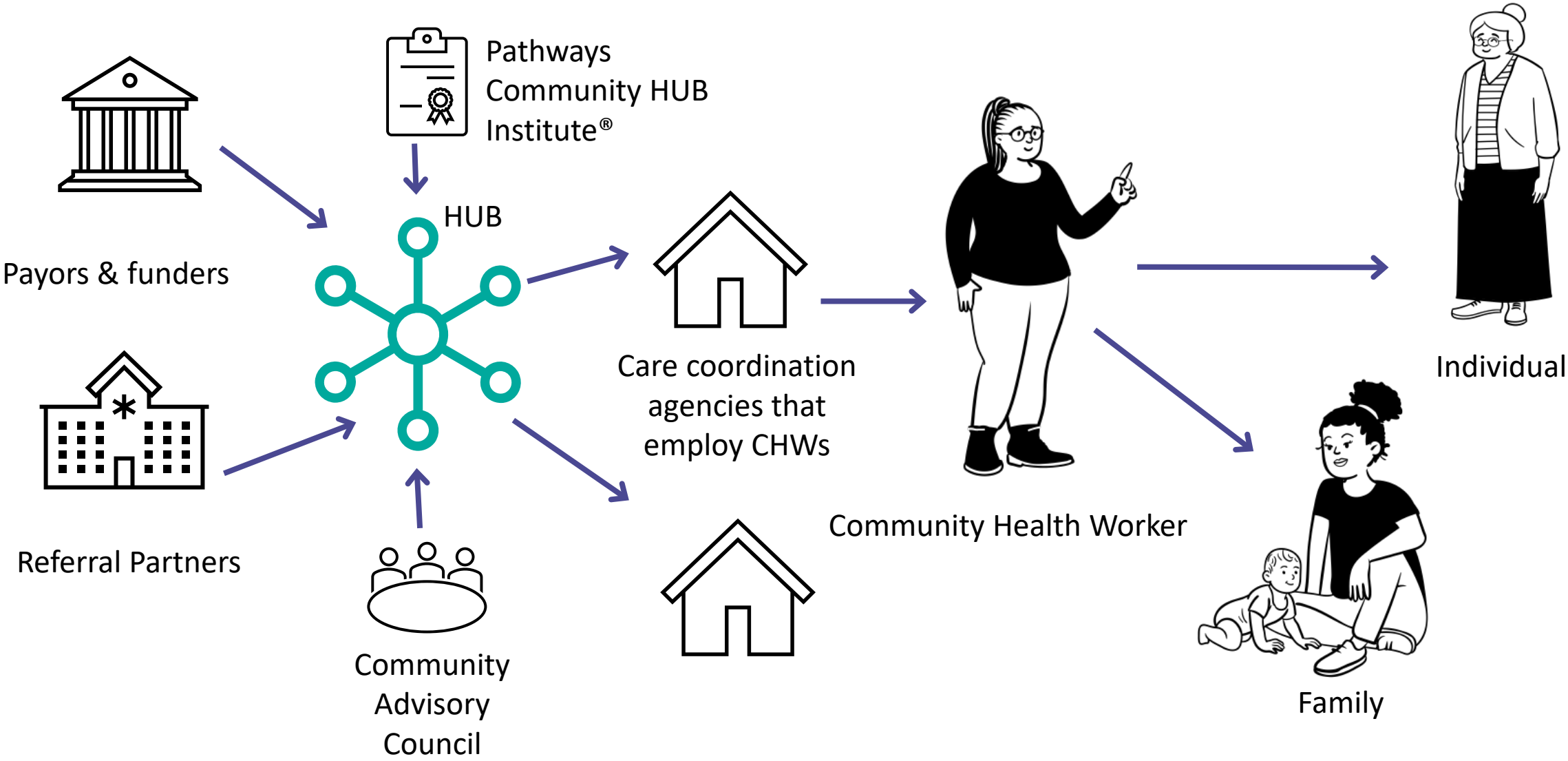
- Medical Home Established
- Housing Established
- Food Security Achieved
- Normal Birth Weight Infant
- Employment Achieved
- Transportation Established
- Mental Health Care Received
- Substance Use Treatment Received
- +13 more

Attribution: Pathways Community HUB Institute®

Inclusive Alliance

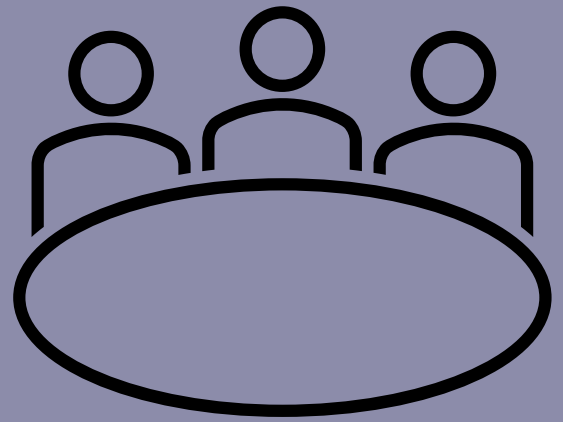
Who Has a Role in the PCH?

Inclusive Alliance



Community Advisory Council

- Representation from key stakeholder groups:
  - Community members (participants and others)
  - Care coordination agency staff (including CHWs and supervisors)
  - Other CBOs and providers that serve as referral partners
  - Payors & funders
- Oversee PCH operations & review quarterly PCH service data
- Raise issues of community concern & advises the HUB
- Provide community ownership of the PCH



Attribution: Pathways Community HUB Institute®

Inclusive Alliance

PCH Participants

Participants are at the CENTER of the PCH

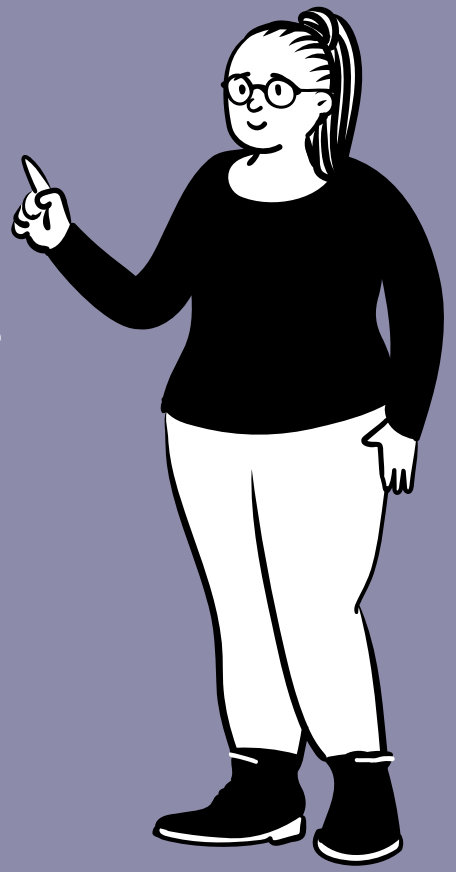
- Participants have choice in care coordination agency/CHW
- Engage with CHWs to complete Pathways
- Relationship with CHW may last for months
- Participant priorities guide which Pathways are completed first
- Represented on the Community Advisory Council

Inclusive Alliance

Community Health Workers

Community health workers (CHWs) are KEY to the PCH model

- Job titles include but are not limited to: promotores/promotoras, navigators, care coordinators, care connectors, referral coordinators, peers, health coaches, etc.
- Provide care coordination services and are employed by care coordination agencies throughout the community
- Practice Whole Person, Whole Family Care
- Coordinates, partners, coaches and advocates
- Trained & supervised to deliver the PCH model to fidelity
- Represented on the Community Advisory Council

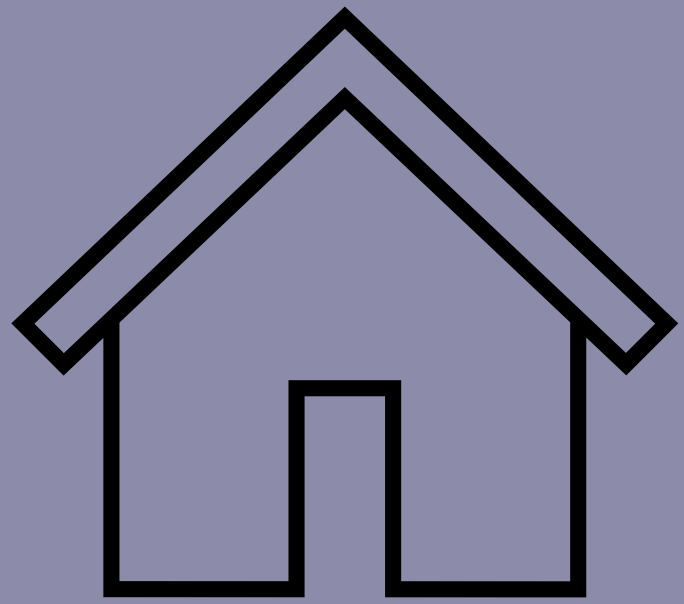


Inclusive Alliance

Care Coordination Agencies

Community-based organizations, clinics, & other entities

- Employs CHWs to:
  - Find community members at greatest risk
  - Visit enrolled participants in their homes
  - Identify individually modifiable risks
  - Use standardized Pathways to track risk mitigation
  - Provide “whole-person” care and “whole family” care
- Contracts with the HUB on an outcome-basis to be reimbursed for risks that were successfully mitigated (earned revenue – unrestricted)
- Represented on the Community Advisory Council



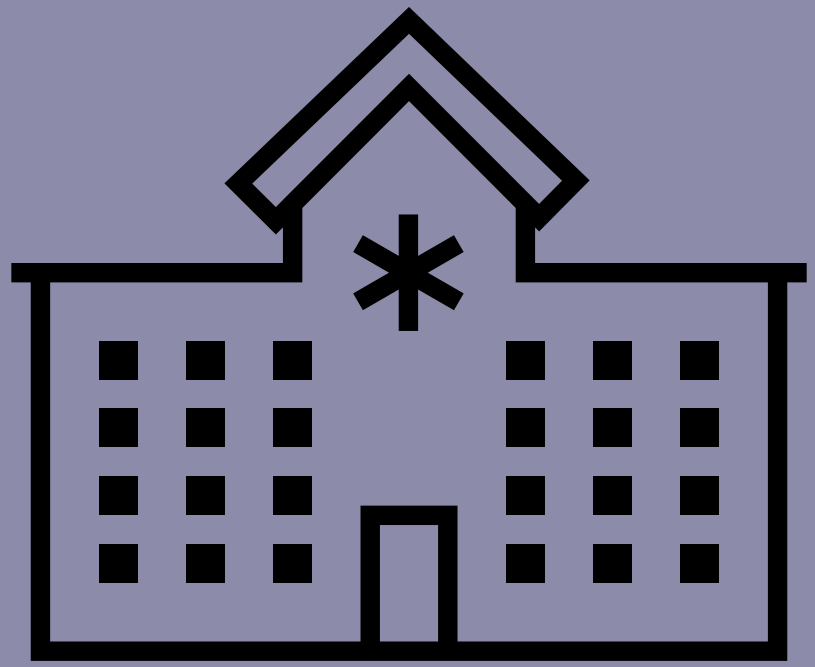
Attribution: Pathways Community HUB Institute®

Inclusive Alliance

Referral Partners

Other CBOs, Providers & Community Stakeholders

- Refer their patients/clients to the HUB for services
- Accept referrals from CHWs working to connect participants to services:
  - Medical Care
  - Mental Health
  - Substance use treatment
  - Housing
  - Food
  - Transportation
  - Etc.
- Benefit from HUB data about needs & improved social service safety net
- Represented on the Community Advisory Council



Inclusive Alliance

Payors & Funders

- Includes health insurance companies, philanthropy, and government
- May refer plan members to the HUB for services
- Have outcome-based contracts with the HUB for the delivery of services to populations that align with their priority populations
  - 50% of payment is tied to completion of Pathways
  - 50% of payment is tied to confirmed engagement with client
- Benefit from demonstrated return on investment (ROI):
  - Community Health Access Project ROI: $3.36 short term, $5.59 long term
  - Northwest Ohio Pathways Community HUB Project with Centene Ohio ROI: $2.36
- Represented on the Community Advisory Council

Attribution: Pathways Community HUB Institute®

Inclusive Alliance

Health Plans Contracting with PCHs in Other States

UnitedHealth Group

CareSource

BlueCross BlueShield

UnitedHealthcare

PARAMOUNT
Affiliate of ProMedica

Gateway Health

CENTENE® Corporation

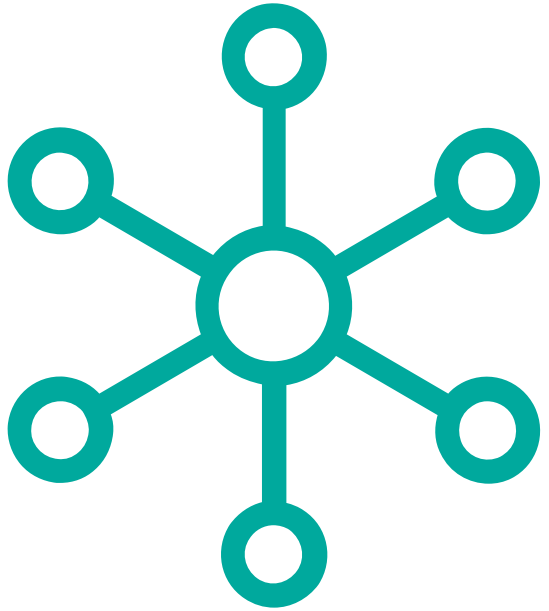
MOLINA® HEALTHCARE

Inclusive Alliance

The HUB Inclusive Alliance

Neutral, transparent, and accountable

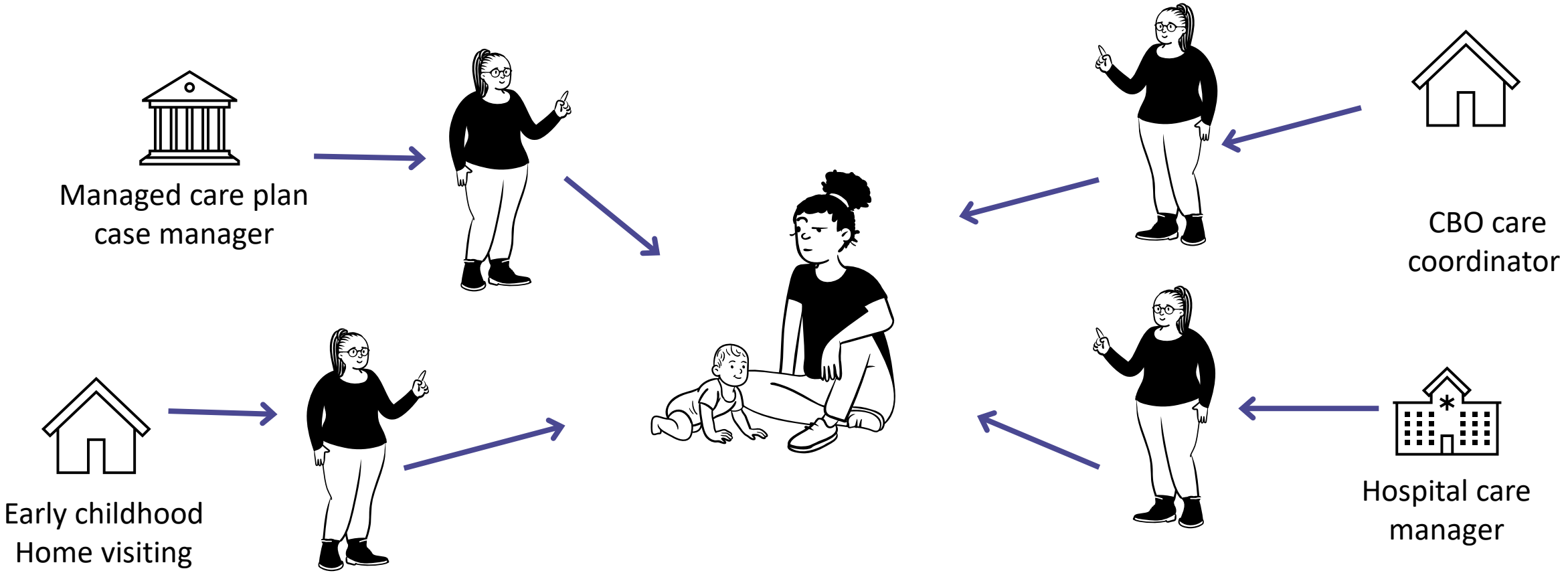
- Based in the community/region served (one per community/region)
- Develops a care coordination agency & referral partner network
- Works to complement, not disrupt or displace, work already underway in a community
- Does NOT employ community health workers
- Uses outcome-based contracting with funders and providers
- Facilitate the Community Advisory Council
- Uses PCHI® Model data collection tools, Pathways, data model
- Provides standard Quality Benchmark Reports to PCHI for aggregation
- Becomes PCHI Certified to ensure it follows PCHI Model to fidelity



Inclusive Alliance

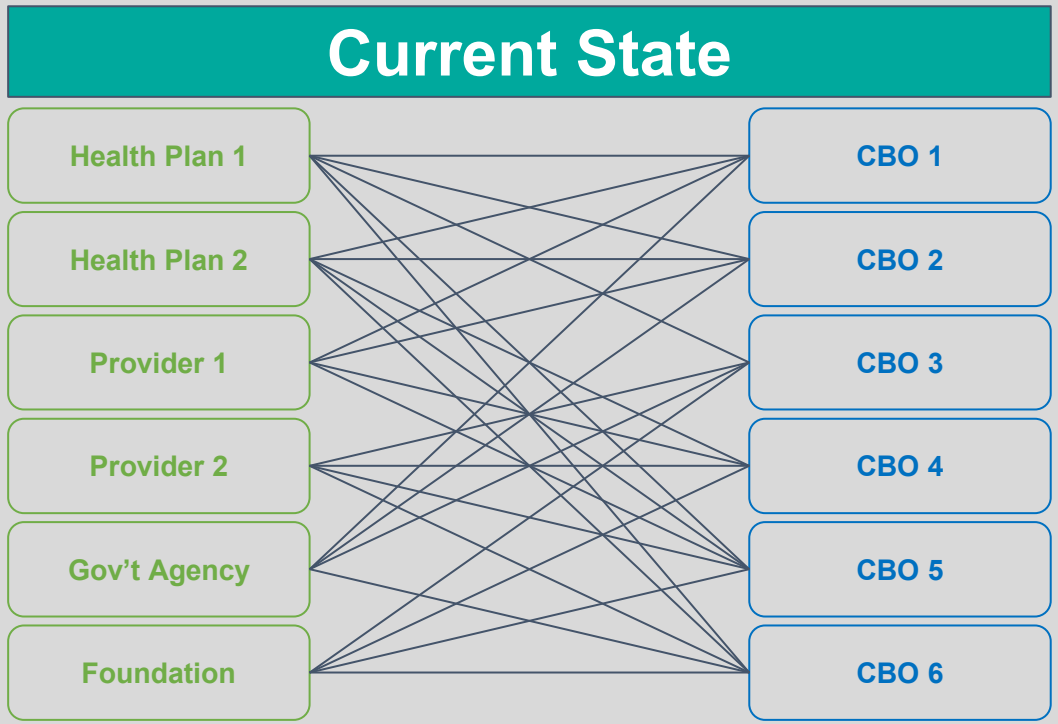
Why Do We Need a PCH in CNY?

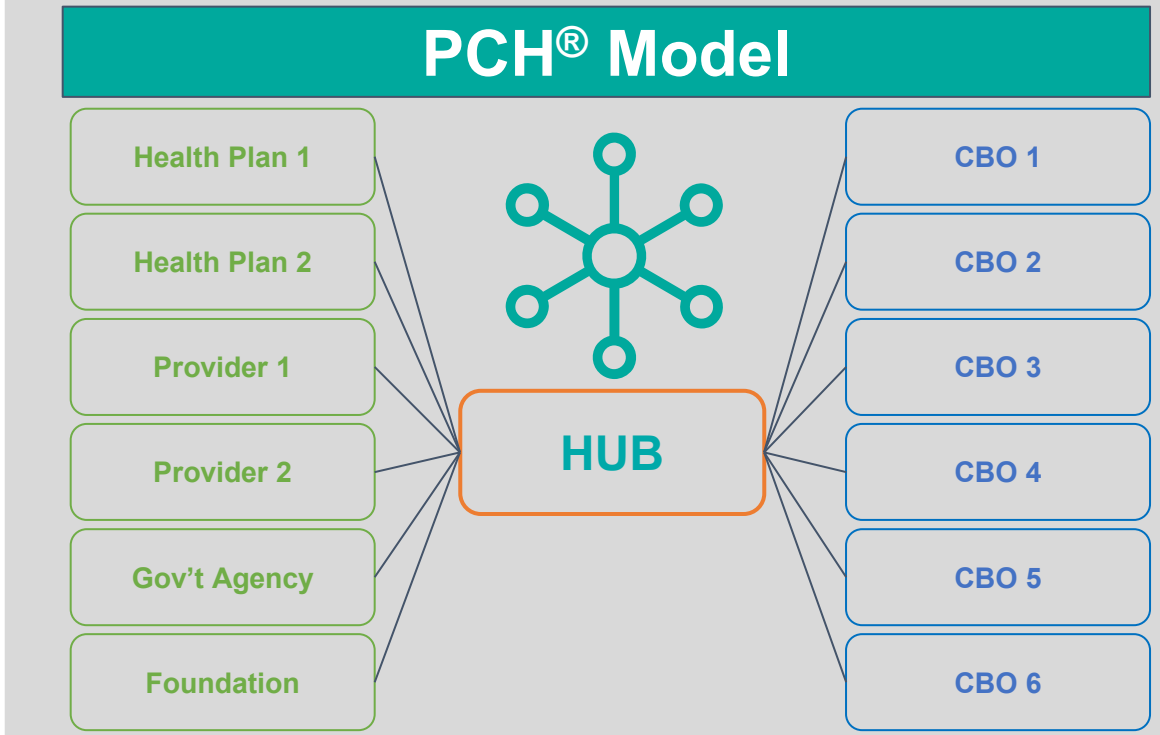
Inclusive Alliance



Multiple agencies involved – limited communication –
No effective tracking of identified and addressed risk factors
- Inefficient use of limited staff –
- Duplication of services -

Why Do We Need a PCH in CNY?

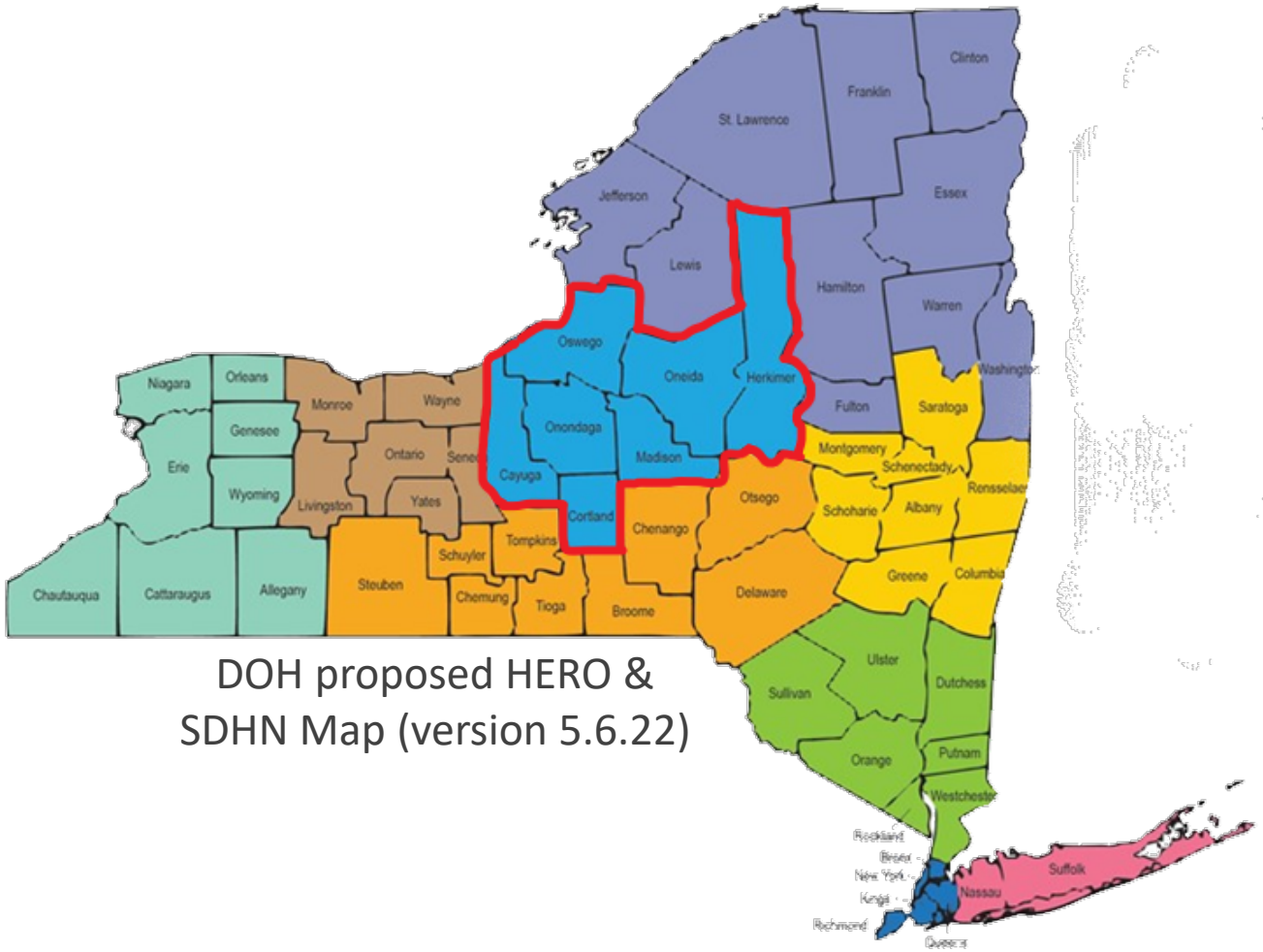




Attribution: Pathways Community HUB Institute®

Inclusive Alliance

Why Do We Need a PCH in CNY?



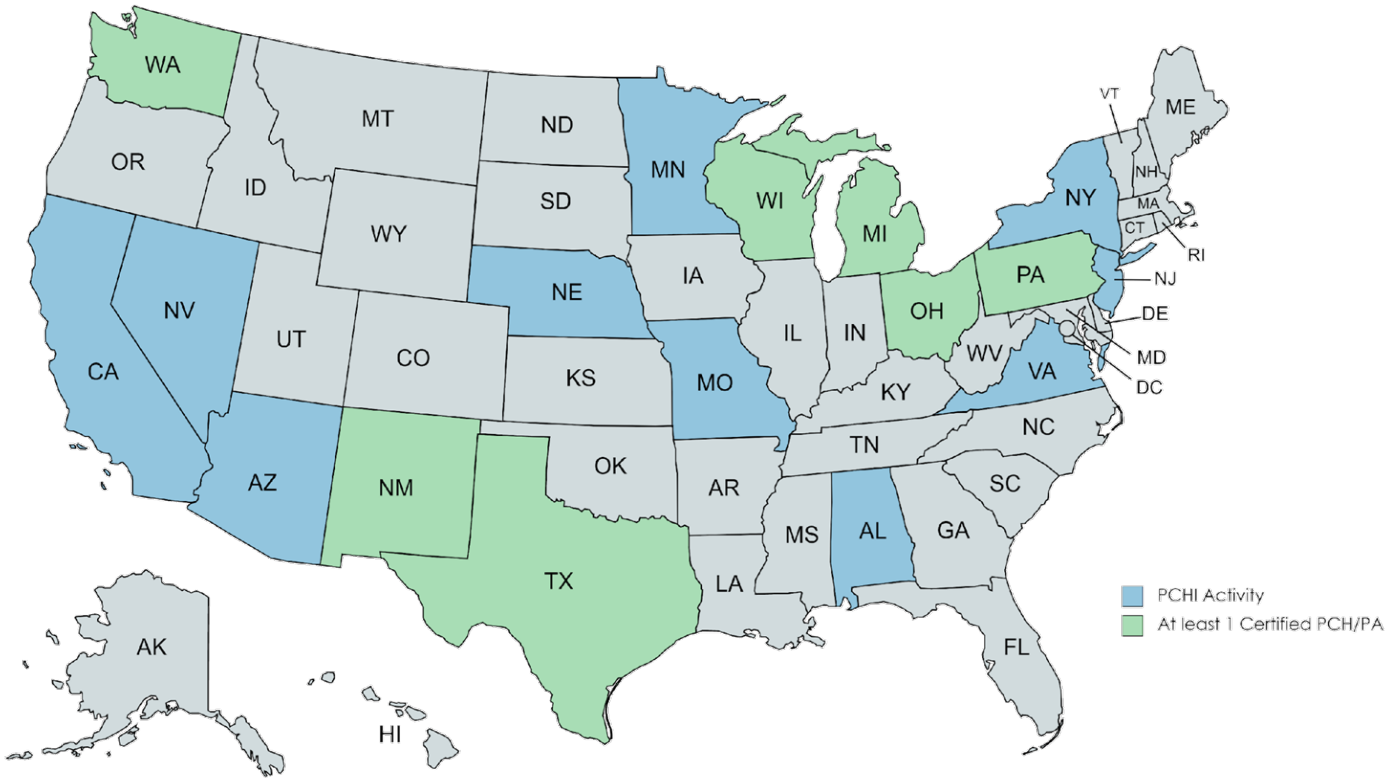
DOH proposed HERO & SDHN Map (version 5.6.22)

- Onondaga & Oneida counties are service-rich and can benefit from <u>improved coordination</u>, with both urban and rural health disparities
- Cayuga, Cortland, Herkimer, Madison, & Oswego counties experience rural health disparities and can benefit from <u>maximizing existing resources</u> to help keep care local

Inclusive Alliance

Where Are There Other PCHs?

- The COVID-19 Pandemic has highlighted national issues of health equity
- This has increased interest and use of the Pathways Community HUB Institute Model Nationally



Attribution: Pathways Community HUB Institute®

Inclusive Alliance

Where Are There Other PCHs? (Ohio Example)

- Ohio House Bill 166 codified use of Pathways Community HUB Institute Model
- Result: 10 Pathways Community HUBs, 3 emerging, covering nearly 90% of state
- All Medicaid plans reimburse PCHs for their work
- PCHs throughout the state started with a focus on health equity regarding pregnant women of color and have expanded to support:
  - Adults with chronic conditions
  - Criminal justice – Jail diversion and reentry programs
  - Housing insecure individuals
  - Many more

Attribution: Pathways Community HUB Institute®

Inclusive Alliance

Where Are There Other PCHs? (Growth in NY)

- Proposed Chisolm Chance Act would create administrative hubs in Kings and Bronx counties to coordinate community-based organizations and community health workers to combat the maternal health crisis.
- Health-equity focused legislation: NY is among the bottom third for # of women dying from poor maternal health care, with women of color dying at a rate of 3 ½ times more than other women
- Will require use of certified Pathways Community HUB in named counties
- Bill is currently in committee

Attribution: Pathways Community HUB Institute®

Inclusive Alliance

How Does The PCH Fit Into The 1115 Waiver

Inclusive Alliance

Overview of New York's 1115 Waiver Amendment

New York is requesting $13.52 billion over five years to fund an 1115 Waiver Amendment.

The Amendment includes one goal and four main strategies:

Goal: Reduce health disparities, advance health equity, and support the delivery of social care

Strategy #1	Strategy #2	Strategy #3	Strategy #4
Building a More Resilient, Flexible and Integrated Delivery System that Reduces Health Disparities, Promotes Health Equity, and Supports the Delivery of Social Care	Developing and Strengthening Transitional Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations	Redesign and Strengthen System Capabilities to Improve Quality, Advance Health Equity, and Address Workforce Shortages	Creating Statewide Digital Health and Telehealth Infrastructure

INITIATIVES IN THE WAIVER AMENDMENT

Goal #1: Building a more resilient, flexible and integrated delivery system that reduces health disparities, promotes health equity, and supports the delivery of social care
Health Equity Regional Organizations (HEROs)
Social Determinant of Health Networks (SDHNs) Development and Performance 
Advanced Value Based Payment (VBP) Models that Fund the Coordination and Delivery of Social Care via an Equitable, Integrated Health and Social Care Delivery System 
Ensuring Access for Criminal Justice-Involved Populations
Goal #2: Developing and strengthening supportive housing services and alternatives for the homeless and long-term institutional populations
Investing in Supportive Housing Services and Alternatives for the Homeless and Long-Term Institutional Populations
Goal #3: Redesign and strengthen system capabilities to improve quality, advance health equity, and address workforce shortages
COVID-19 Unwind Quality Restoration Pool for Financially Distressed Hospitals and Nursing Homes
Developing a Strong, Representative, and Well-Trained Workforce 
Goal #4: Creating statewide digital health and telehealth infrastructure

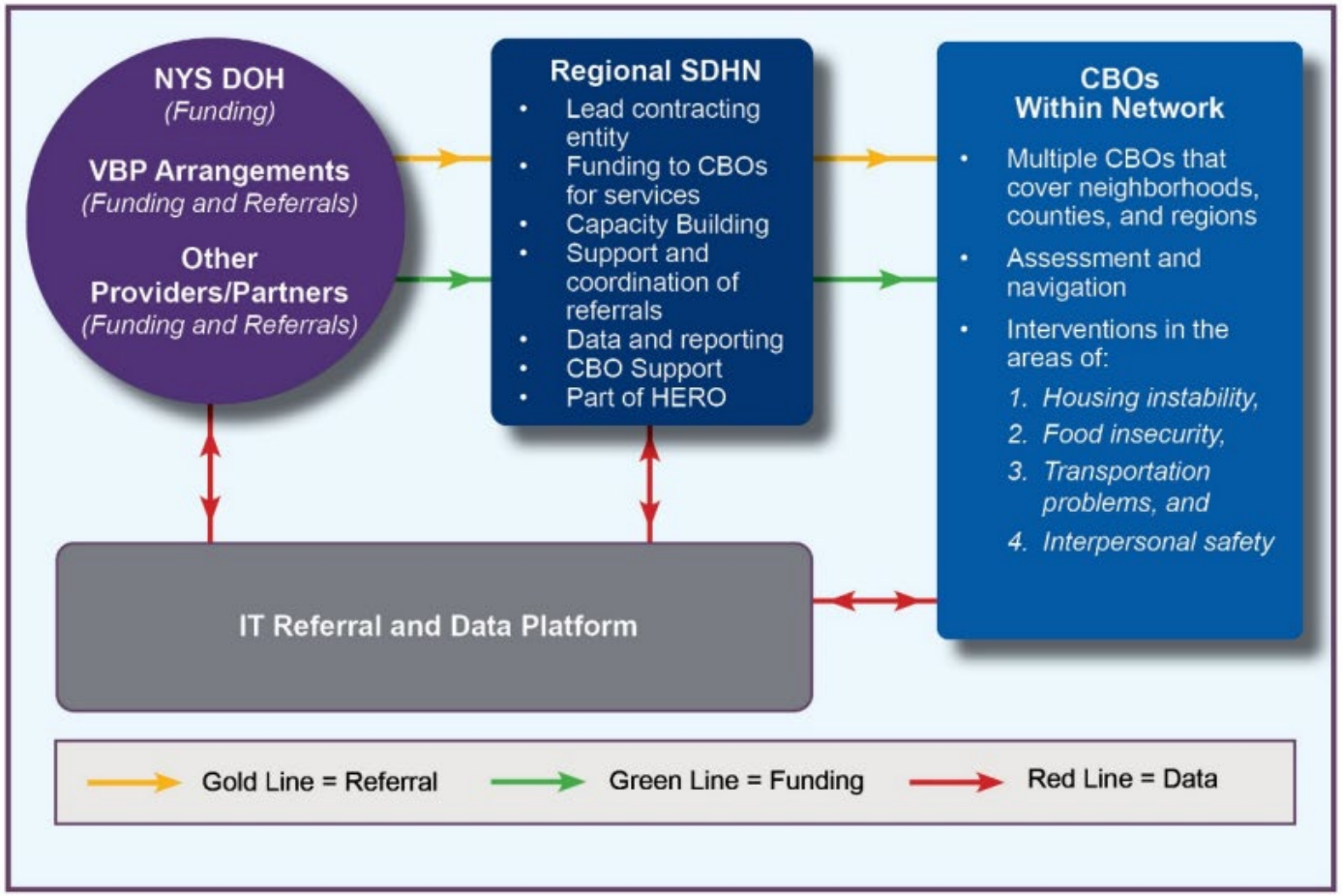
Strategy #1: Health Equity-Focused System Redesign

Social Determinants of Health Networks (SDHNs) – *$860 million*

- SDHNs will be **coordinated referral networks of CBOs that provide HRSNs**.
- DOH will contract with **one SDHN per region**, and the regions will **mirror the HERO regions.**
- Each SDHN will be managed by a Lead Entity that will act as a central vehicle for referral management, fiscal administration, VBP contracting, and reporting.
- The Lead Entity will also **support the CBOs in developing efficient business and operational practices and technological infrastructure**; and SDHN funding includes specific **dollars for CBO capacity building**.
- ***NYS will leverage existing IT systems for HRSN data collection and referral. SDHNs will be the primary vehicle for screening Medicaid members for HRSNs and collecting HRSN data and referral information, which will be integrated with clinical data through the Statewide Health Information Network for New York (SHIN-NY) to provide more holistic view of a member's needs and care.***

Social Determinant of Health Network (SDHN)

Exhibit 2: SDHN Structural and Funding Diagrams



Strategy #1: Health Equity-Focused System Redesign

Targeted VBP Arrangements – *$6.8 billion*

- VBP is an effective vehicle for advancing health equity and HRSN services and incentivizing improvements in the quality of care.
- ***VBP will fund –***
  - HRSN screening and services provided through SDHNs with services reimbursed via fee schedule;
  - Referral management and fiscal administration support for CBOs performed by the SDHN lead entity; and
  - Targeted, health equity-focused VBP arrangements (e.g., global budget, bundled, episodic, and other advanced arrangements).
- The **VBP Roadmap will be updated** to address health equity and regional social care needs.

Goal #3: System Redesign and Workforce Capacity

COVID-19 Unwind Quality Restoration Pool – $1.5 billion

- A VBP Quality Incentive pool available to financially distressed safety net hospitals and nursing homes to engage in VBP arrangements, with a focus on ***quality improvement, advancing health equity, and expanding workforce capacity***.

Develop a Strong and Well-Trained Workforce – $1.5 billion

- Funding to address long-standing workforce shortages that were exacerbated by the COVID-19 pandemic to make the field more attractive to workers and provide opportunities for advancement.
- *Funds will be used to support the following activities –*
  - Recruitment and retention activities,
  - Development and strengthening of career pathways,
  - Workforce training initiatives,
  - Expansion of the community health workforce, and
  - Standardization of occupations and job training.

THE PATHWAYS COMMUNITY HUB VALUE PROPOSITION FOR SDHN

The Pathways Community HUB Alignment with the SDHN & VBP Incentive Pool

Collective CBO Contracting	Coordinated CHW Support and Referrals	Standardized QI framework for SDOH integration and population health planning

• Standardized approach for a SDHN's partners to collectively engage in value-based healthcare contracting to address social health needs for a shared target population
• Streamlined participation from CBOs of all sizes
	• CHW outreach to engage high need target population
	• CHW assignment for "whole family" support
	• Coordination within the region to maximize CHW capacity and facilitate access to available home visiting programs
	• Comprehensive risk assessment
	• Streamlined access to needed services, which would include but not be limited to social care funded by the Waiver
		• PCH model facilitates accurate and meaningful data collection:
		  • Population reached
		  • Risks identified
		  • Impact on outcomes
		  • Gaps in the service system
		  • Impact of gaps in the service system
		• Brings a recognized model to SDHN; proven to improve outcomes and reduce costs

When is the PCH Going to Launch?

- Target Launch Date: Later in 2023 (date TBD)
- The CNY PCH core planning team have a lot of work to do first!
  - Engaging stakeholders (you!)
  - Identifying population(s) to focus on for the initial launch of the hub (then expand)
  - Identifying start-up funding
  - RFP process to identify interested care coordination agencies & technology platform
  - Much, much more

Core Team Members		
Marnie Annese, HFWCNY	Scott Ebner, Circare	Beth Spier, Cathy Berry & Assoc.
Liz Crockett, REACH CNY	Patty McMahon, FLIPA	Kara Traverse, Excellus BCBS

Staff & Consultants		
Heidi Arthur, HMA	Nicole Hall, Inclusive Alliance	Michelle Edison, PCHI
Annalisa Baker, HMA	Michael Rock, Inclusive Alliance	Dr. Sarah Redding, PCHI
	Lauren Wetterhahn, Inclusive Alliance	Amy Vreeland, PCHI

Inclusive Alliance

How Can My Agency Get Involved?

- Sign up for our Network Scoop newsletter
  - In-Person Public Kick-Off: Spring 2023 (date TBD)
- Resources:
  - Pathways Community HUB Institute®
  - Association of Maternal & Child Health Programs Best Practice: Pathways Community HUB
  - Agency for Healthcare Research and Quality (AHRQ): Pathways Community HUB Manual
  - Rural Health Information Hub: Rural Services Integration Toolkit – Community HUB Model
  - RWJF Leveraging Federal Funds to Improve Health & Equity: Pathways Community HUB Model
  - Ohio Cardiovascular & Diabetes Health Collaborative: Best Practices – Pathways Community HUB
- Contact us to get added to our stakeholder engagement schedule for a meeting

Inclusive Alliance

Contact US

Lauren Wetterhahn, Executive Director
- Lauren.Wetterhahn@inclusivealliance.org
- 315-899-1043

Nicole Hall, Network Development Manager
- Nicole.Hall@inclusivealliance.org
- 315-971-0398

Michael Rock, Network Development Manager
- Michael.Rock@inclusivealliance.org
- 315-887-8233

inclusivealliance.org

Inclusive Alliance