PATHWAYS HEALTHCARE ALLIANCE

Innovative Approach to Care Coordination

For Supporting Individuals in their Communities

Presented by Pat Wilson

Agenda

- A Glance at Travis County
- Need for Program
- Obstacles/Barriers
- Pathways Program Approach
- Program Objectives
- Framework & Model
- Use Case

A Glance at Travis County

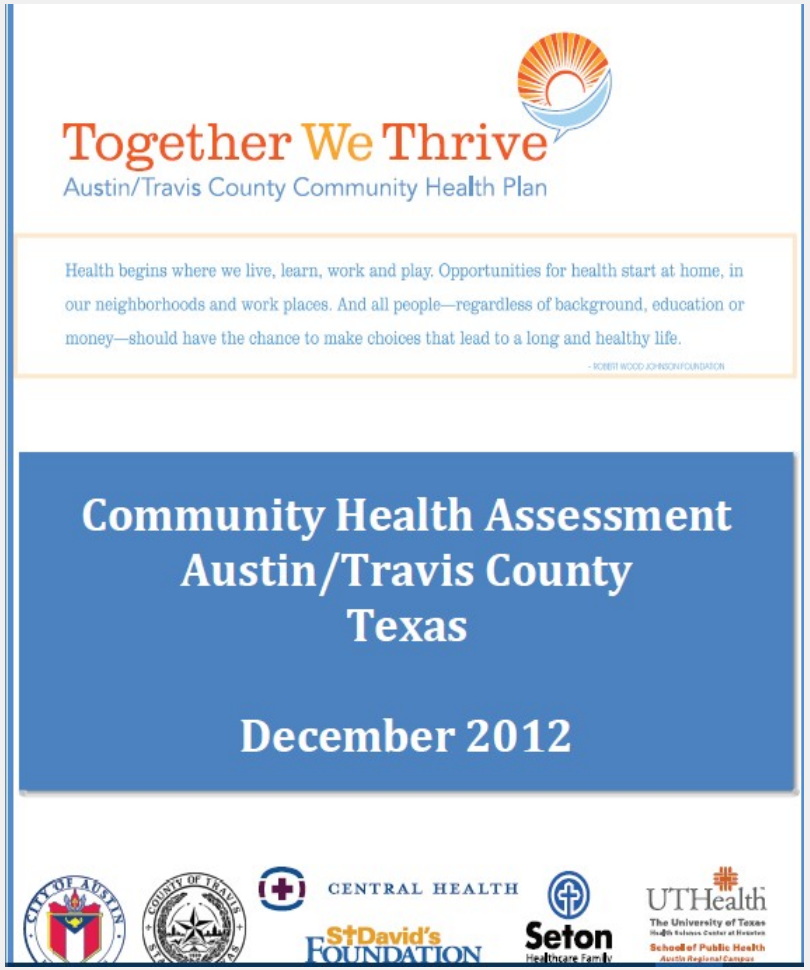
- Travis County has 1.1 million residents [1]:
  - 647,650 adults are overweight or obese
  - 200,000 or 18% are uninsured – of that 98,000 have incomes at or below 200% of the federal poverty limit
  - # of families in poverty is expected to increase by 12.8% by 2019
- 7.6% of adults in Travis County reported they have diabetes. That 7.6% corresponds to roughly 83,000 adults having diabetes. Disparities among diabetes predominantly exist by race and ethnicity in Travis County [2]:
  - 16.0% of Black adults have diabetes
  - 10.2% among Hispanics
  - 4.7% among Whites
- Hispanics and African-Americans have the highest poverty rates in Travis County. 27% of Hispanics and 22% of African-Americans had incomes below poverty levels in 2014.

(1) Central Health Travis County, 11/15.
(2) (2) 2015 Austin/Travis County Health and Human Services Critical Health Indicators Report.

Community Health Assessment

Health Care Access and Affordability

Focus group/interviews conducted for the *Community Health Improvement Plan* repeatedly cited the challenges of access to health care as a predominant theme among residents, such as transportation, language, and cost barriers…specifically the availability and accessibility of health care facilities and resources, emergency room overuse, challenges of navigating a complex health care system, and health insurance and cost related barriers.(1)



(1) Community Health Assessment Austin/Travis County Texas Report December 2012.

Need for Program – Patient Perspective

A Common Profile:

- Often difficult to connect with and start engaging
- Often have chronic conditions
- Unaddressed conditions that require assistance to access medical & social services
- Need support in complying with treatment plans
- Make disproportionate use of intensive inpatient services
- Most often poorly complies with outpatient follow-up care plan

Need for Program – Healthcare Perspective

A Common Manifestation:

- Contact via traditional telephone care management has limited effectiveness
- Preventable unplanned readmissions and a history of over-reliance on emergency health services and the most intensive levels of care
- Accounts for a substantially disproportionate share of total healthcare costs for payers
- Non-medical factors account for as much as 40% of health outcomes [1]
- Unmet social needs are associated with higher rates of emergency room use, hospital admissions and readmissions [2]

Sources: (1) AHRQ Statistical Brief #421 8/13 and Robert Wood Johnson Foundation Health Care's Blind Side Findings, 12/11. (2) Different Perspectives for Assigning Weights to Determinants of Health, 2/10

Unmet Non-Medical Factors

Obstacles/Barriers

- Lack of resources: e.g., food, suitable housing & transportation, child care, etc.
- Lack of knowledge of available resources and how to access them
- Lack of compliance with treatment plan and health literacy challenges
- Lack of personal relationship with their PCP and other care providers
- Need for reminders, advocacy, support system

Program Objectives – Patient Perspective

- Reduce and eliminate hurdles to better health
- Prevent and reduce readmissions by identifying root causes and eliminating barriers
- Improve their continuity of care through collaboration with healthcare providers
- Improve their compliance with medication and treatment plans
- Facilitating healthier lifestyle transformation

Program Model in Action

Deploying *in-the-field* Community Health Workers that fit seamlessly into **Total Population Management** and **Integrated Delivery System** initiatives.

Assess

- Engage members and family to assess needs
- Identify challenges that can drive avoidable ED/IP utilization
- Individualized pathways created to close multiple determinants of health needs

Connect

- Connections to community-based services and resources to address needs
- Connecting to Primary Care/PCMH if needed

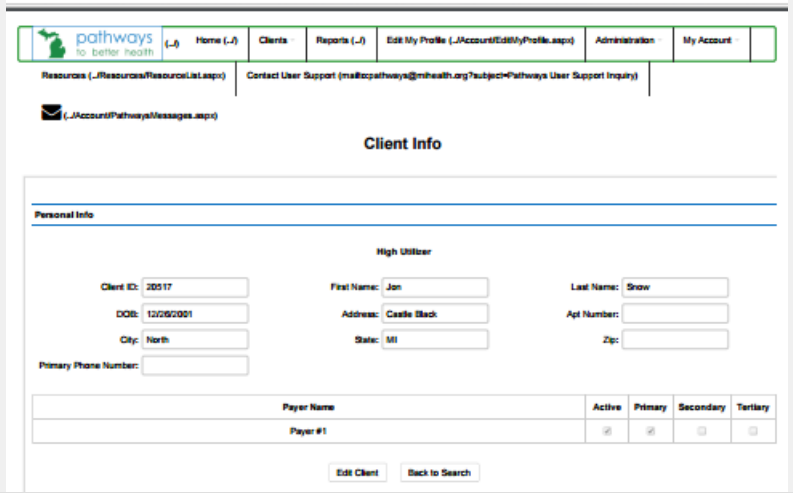
Engage

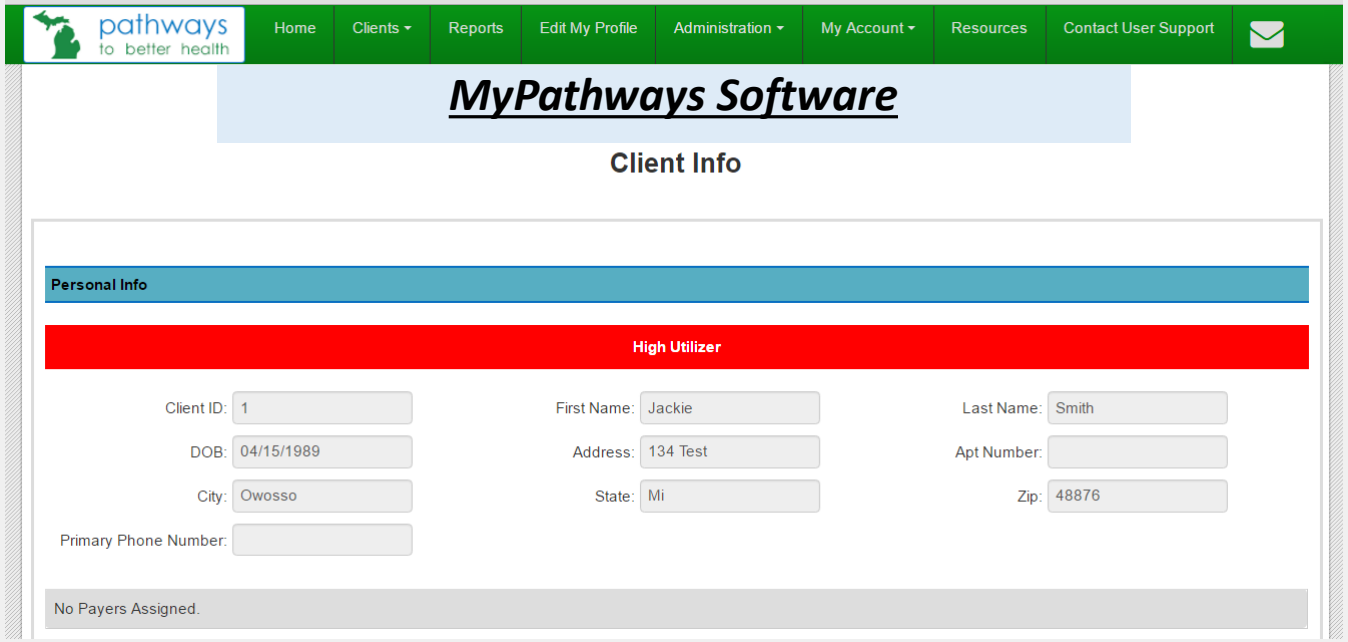
- Advocacy and accompany patients if needed
- Education to improve knowledge of medical condition
- Improve compliance with mental and medical treatment plans and medication adherence
- Goal setting, coaching and motivating

Technology to Track/Report Program Results

Technology Platform from Intake to Outcomes

- Customized referral Intake Form for Clinic
- Customized Pathways to close care gaps
- Comprehensive client record
- Pathways tracking elements
- Secured internal messaging
- Outcome reporting





Complex Use Case: Joy's Story

A Care Case to Think About…

- 50 years old, married, with a teenage daughter.
- Recently received a heart valve replacement. A clerical error caused the family's benefits to be suspended, and a month later, Joy landed back in the hospital with a staph infection.
- In addition to staph infection she suffers from Type 2 diabetes, high blood pressure and obesity.
- Had filed for disability under Social Security, but case was unresolved.
- Family was overwhelmed. Medical bills were going unpaid, little money for medications, lacked adequate food and their home was in foreclosure.

Complex Use Case: Joy's Success Story

With the help of the Pathways program, Medicaid benefits were restored, Social Security disability was approved and the family was able to avoid foreclosure.

Using a CHW care coordination approach developed a personal relationship with the patient to identify and remove all barriers:

- Coordinated transportation / child care
- Coordinated Pharmacy prescriptions
- Scheduled appointments and follow-up reminder calls
- Enrolled in Medicaid / Other insurance
- Worked with physicians to ensure adherence to care plan(s)

Question to Consider

Would Joy have been able to recover from her medical and social circumstances without the support of the Pathways program care coordination?

Complex Use Case: Joy's Success Story

Pathways HCA Model at Work:

- An innovative approach accountable for health improvement and better outcomes.
- CHWs that build personal connection between patients and the patient's medical and social support providers.
- A CHW that helps patients address a wide range of challenges and behavioral issues and the timely and efficient delivery of social services and education needed to support clinical care plan.

Summary: Innovative Approach to Success

Compassionate Patient-Centered CHWs

- Comfortable working with complex, challenging populations
- Infrastructure for training, certification and continuing education
- Integrate technology and data to collect, connect and share

In-the-field Presence

- Find, assess, connect and engage
- Collaboration with to change lives
- Better connections to health & community resources

Designed for Specific and Measurable Outcomes

- Reduction in admissions/readmissions
- Saving unnecessary care costs in the system
- Reduction in health disparities
- Support to avoid unnecessary ED visits

Questions

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