What is a Pathways HUB?

Q: What is a Community Pathways HUB?

A: The Pathways HUB model is an evidence-based community care coordination approach that uses 20 standardized care plans (Pathways) as tools to address common areas of risk or barriers to health for individuals. North Sound ACH recognizes that achieving whole person health requires an approach that acknowledges and addresses the crucial impacts of social determinants of health. The Pathways Community HUB coordinates client services between both clinical and non-clinical providers.

Operationally, the HUB increases efficiency and effectiveness of the Care Coordination Agencies (CCAs) that are in its network. The HUB effectively centralizes the processes, systems, and resources to allow accountable tracking of individuals receiving care coordination among the CCAs, while the use of standardized Pathways allows a method to link payments to directly to outcomes. This centralized approach also reduces duplication through use of a singular technology system to track care coordinators and outcomes. The most important functions of the Pathways Community HUB are to:

- Centrally track the progress of individual clients (to avoid duplication of services and identify and address barriers and problems on a real-time basis);
- Monitor the performance of individual workers (to support appropriate incentive payments);
- Improve the health of underserved and vulnerable populations; and
- Evaluate overall organizational performance (to support appropriate payments, promote ongoing quality improvement, and help in securing additional funding).

Q: What are the benefits of a HUB to an agency currently offering care coordination services?

A: Agencies that join the HUB's regional network of Care Coordination Agencies (CCA's) benefit from the following:

- The HUB's centralized tracking of outcomes and program effectiveness allows CCAs to focus on care coordination while the HUB identifies and drives all quality improvement efforts.
- Cross sectoral analysis of care coordination efforts allows for building a business case and measuring cost savings to create leverage with payers.
- Participation in an outcome based model for reimbursement creates direct linkage between the work of the CCAs and the payers.
- One singular data repository and shared platform tracks care coordination work across payers, and organizational silos, allowing for easy identification and elimination of duplicative efforts.
- Tracking of barriers and closure rates of particular Pathways provides easy identification of regional need and resource gaps. The HUB can stand as an advocacy tool to highlight where unmet needs persist and need additional attention.

Q: How would this model be different from other care coordination efforts currently underway (i.e., Health Homes, or case management/care coordination services offered by providers and health plans)?

A: The model that is supported by the Medicaid Transformation Project is at two levels - coordination of the care coordinators, and explicit support for Community Health Workers as a component of workforce development.

The Hub is not aiming to replace or supplant other care coordination efforts that already exist. Instead, it is trying to improve communication among organizations that provide care coordination, by sharing assessment and coordination focuses, and to add support for place-based, community-based care coordinators who are trusted members of their community and are often seen as the "go-to' person when looking for resources or services.

The Hub would be partnering with, and coordinating with other care coordinators in the community who might be interacting with or providing services to a community member.

Q: Specifically, what happens in cases of Health Homes conflict?

A: North Sound ACH has worked extensively with the MCOs and Health Homes leads in our region to develop a bi-directional system of referrals between the Hub and Health Homes. Our goal is to avoid conflict by ensuring good communication and information sharing about who is eligible for Health Homes on a monthly basis and warm hand-offs between the Hub and Health Homes leads.

This has included discussion about what-if scenarios, such as:

- What happens if someone has opted out of Health Homes
- What happens if the Hub reaches someone that the is eligible for Health Homes who had not yet been reached by Health Homes
- What happens if the CCA makes a referral to Health Homes
- And many others.

It's important to remember that while some populations may look very similar to Health Homes clients, they might be more eligible for Pathways based on their PRISM score, whether or not the client engages with Health Homes, or whether or not they choose to opt out of Health Homes. We've developed a bi-directional referral process to insure that if/ when a client is deemed Health Homes eligible, that is the direction they will transition to. This begins the process of linking folks back into HH, (via a "social service referral" pathway).

Payment within the HUB model

Q: Is it possible for CCAs to be compensated prior to the completion of a specific Pathway? Is there something at the intermediate outcome? How do people get paid for time they might be spending to complete something that doesn't come together and end in an outcome?

There are interim points where payment is possible.

- **Only about 50% of the income is actually tied to the completion of Pathways themself.**
- There are some Pathways that consist of initial and ongoing assessments: Checklists, patient activation work, (For example, conducting a PHQ-9), education screenings, medication management, social service or medical referrals- work that the care coordinators will be doing continuously as a means of attaining a final outcome. For example, to attain an outcome on a Housing Pathway, a care coordinator might be working for months through Pathways dedicated to various social service referrals, or an employment Pathway.

- It's important to view **Pathways as comprehensive, not necessarily linear**. There are elements of care coordination that will be provided each visit, every few visits, or at different points in the ongoing care coordination process that will achieve an outcome and trigger payment. For example, to attain an outcome on a Housing Pathway, a care coordinator might be working for months through Pathways dedicated to various social service referrals, or an employment Pathway. **These are all payment points because they are Pathways in themselves. So effectively, the care coordinators are getting paid for their efforts and work being done in achievement of a final outcome.**
- The individual's needs may also change along the process. This may mean opening additional Pathways throughout their care episode, providing additional opportunities for reimbursements linked to education, assessments, referrals, etc.

Q: What are some of the reimbursement structures that this would entail? I'm concerned about the ROI for my agency and/ or staff to be involved.

A: Most organizations doing care coordination today are supporting this work through philanthropy or other grant support. There are few models where care coordination is paid for as a reimbursement for service. And we know that many agencies and their staff are already doing the work involved in Pathways, again without a strong reimbursement model.

As community based organizations tackle an increasing number of risk areas, the HUB, and completion of Pathways, provides an opportunity to link mitigation of those risks directly to compensation from Medicaid payers, other health plans, and other funders. The Pathways Community HUB model provides a lean overlay to current care coordination structures, and does not represent a large additional layer to the existing system. The Medicaid Transformation funding available through the North Sound ACH provides a funding bridge that will allow CCA's to evaluate the future ROI of Pathways-driven care coordination.

Q: I understand that cost of training will be covered, but will reimbursement for staff hours be reimbursed for time at training sessions?

A: Possibly, however we can't say for sure until the budget is approved end of June. Both the supervisor and the CHWs or care coordinator should be involved in the CCAs efforts on workflow adjustments and Pathways trainings. Therefore each will have their trainings paid for by North Sound ACH. Items that are still being determined in budgeting conversations include; How much FTE payment will be for Supervisors' time (considerations include the multitude of pay rates that this category might encompass.

Q: Is there any more information regarding payment rates?

A: Yes, there will be different payment rates for different Pathways. What is still being determined in budgeting, is how much the initial ACH funding will follow the outcome based reimbursement model of Pathways versus how much we might provide more cumulative lump sum payments while we transition our CCAs towards full outcome based payments. The initial pilot phase will likely see some sort of hybrid payment mechanism; a cross between lump sum payments to our CCAs to get started in the pilot phase, while we spend the pilot phase collaboratively developing a transition towards true outcome based funding.

Q: Can the CCA Supervisor also help with program start up and design, as well as provide some of the CHW work? A: Yes.

North Sound ACH Community Pathways HUB Frequently Asked Questions

Q: How is the funding of care coordination different within a Pathways HUB model?

"Three fundamental business model problems exist with the current approach to care coordination— lack of meaningful work products, duplication of effort, and failure to focus on those most at risk. The fragmentation and duplication of services and poor outcomes resulting from poor care coordination increase health care costs."

- ***Outcomes as Work Products:*** ***Whereas typical care coordination models center on*** *completion of actions or work products, Pathways is centered on completion of outcomes that will directly mitigate an individual's risks to health. The Pathways Community HUB model is also designed to create direct reimbursement channels between care coordinating agencies and the outcomes they produce with their clients.*
- *Reducing Duplication of Effort: Pathways empowers clients to identify the care coordinator with whom they have developed a trusted relationship, who is then authorized to work across service and funding silos to coordinate care in a comprehensive way. This direct link of payment to outcomes further incentivizes care coordination services to communicate or collaborate with each other, leading to less duplication and inefficiencies.*
- *Focus on Multiple Risks: When a client is referred to the HUB, an initial assessment of risk areas is done across the 20 Pathways, which encompass the many life domains that determine a person's health status.*
- *The centralized infrastructure of the HUB model also allows for identification of care breakdowns and resource gaps, and coordinated quality improvement or advocacy efforts to address such gaps.*
- *Regarding Health Homes, this care coordination model pays on a contacted per-member-per-month basis for clients contacted during the month, and the payment rate requires a caseload of 50-55 clients for providers to break even. The incentive is to limit contact for some clients in order to manage a higher intensity of service for other clients. Under Pathways, rates are negotiated with plans on the basis of cost to achieve outcomes, and can be stratified based on intensity of need.*

Q: Why would Medicaid payers be motivated to contract/ pay for this when they all have other care coordination efforts or programs underway?

A: This model provides an opportunity to bridge clinical and community (or social) factors that influence health. Yes, many health plans and health systems do provide care coordination services, and they are often directly connected to a medical condition, or the time period of treating a medical condition. It is also clear that payers are interested in preventing people from becoming more ill, with intervening earlier in their progression, and in addressing issues like housing, transportation and food/nutrition, that are serious factors in regaining or maintaining health.

Pathways populations of focus have been selected based on data that identifies populations experiencing poor health outcomes, as well as qualitative feedback from key informants, community based organizations, clinical providers, and payers serving the region.

The pilot population is one that MCOs have said they would support because they see the linkage between community and health services. Having MCO leaders at the table in our HUB startup conversations has provided insights into how we can contract and pay for services as we move forward, and how we can identify opportunities around overlapping care coordination efforts.

Q: How will CCA's be paid so that they are not at risk for negative cash flow and income, by having to wait until the completion of an outcome, or by working toward an outcome that cannot be completed for a client despite their best efforts?

A: Payment for Outcomes is conceptually a part of the State's move toward value-based payment in Medicaid. The payment methodology built into the Pathways HUB model is complex, and does provide for intermediate "outcome" steps toward global outcomes across multiple areas of risk. The details of the payment model will be reviewed with selected CCA's, who will participate with the HUB in developing a funding plan that recognizes start-up costs and a process and timeline for moving toward a full, sustainable "payment for outcomes" system.

We will be developing a payment mechanism that insures the ACH supports the cost for CCA startup and initial outcomes. But, we will also be developing (collaboratively, via the Executive SC of CCAs) the exact amounts and the timeline for phase out of ACH funding and transition to 100% outcome based reimbursement by funders.

Population Questions

Q: What is the distinction between the population of focus and what the care coordinator will be asked to work on? For example, if a risk area is homelessness, are care coordinators only working with clients to address homelessness?

A: For the Medicaid Transformation Project each ACH is required to define our initial population for the pilot. Once a client meets that general criteria, a care coordinator can and should work through any of the 20 Pathways that are creating barriers to health.

The better question could be "Does my agency see/serve people that fit this description of the initial population of focus?" Even if this is not your primary service population, it is possible that this population is presenting within your system and could therefore be brought into the HUB for a referral to a CCA, or that your organization could be the CCA asked to work on any of their risk areas.

Q: What do you do with clients who do not fit the eligibility criteria when they're referred in?

We would be doing a very specific announcement once the CCAs are in place and letting referral sources know what kinds of clients/patients would be appropriate referrals. This is very dependant on which organizations decide to become CCAs. The Hub takes responsibility for referring clients out, not the CCA, since referrals would come to the Hub.

Roles, Responsibilities and Characteristics of a CCA

Q: What is expected of the CCA?

A: The CCA will be expected to sign a partner agreement with the North Sound ACH that lays out specific expectations. Initially, the focus is on training. Each CCA will designate the staff persons to be participating in

Pathways and therefore trained in the Pathways Community HUB model and its electronic platform. This training will be provided at no cost to the CCA for the HUB pilot phase. Existing staff of CCAs are candidates to be designated and trained as care coordinators. The HUB model creates the potential for additional sources of reimbursement or funding for the work of existing care coordinators, as well as additional funds for adding care coordinator staff capacity as the HUB network of referrals is developed.

The CCA will also agree to work with North Sound ACH, the Hub and other partners as we work to improve health for community members across the region.

Q: What do we mean when we mention CCA organizational capacity?

A: There are notable time, resource, and staffing needs for agencies coming into the HUB network as a CCA. During the pilot phase of the HUB, North Sound will financially support Care Coordination Agencies with these startup funds for training, staffing, and development of new HUB related workflows. Though it is important that a CCA has other funding and/or funding strategies available or in mind for sustaining their involvement in the HUB network. We are developing a timeline for phasing from North Sound as the primary funder, to funding based solely on Pathways outcome as funded by health plans and other payers.

The Hub model provides a tool for outcome based payment directly to a CCA, and the HUB will lead all network sustainability work from the point of contracts with various payer sources for the creation of a robust braided funding model for the HUB. But it is **important that the HUB is not viewed as the sole long term financial sustainability plan for any individual Care Coordination Agency**.

Q: How much care coordination does my organization need to be providing in order to be eligible to be a CCA?

A: Organizations eligible to become a Care Coordination Agency are providing some form of care coordination services for Medicaid beneficiaries within the North Sound region.

Q: What if the initial pilot population is not one my organization currently works with or provides services for?

A: The current best practice in HUB startup requires starting with a small focused population both demographically and geographically, then expanding out and scaling up once the HUB is operational and has worked out any initial issues. If you don't serve the pilot population we still very much need you as a partner to remain engaged and provide us important insight into continued areas of need. Recognizing that there are many different populations in the North Sound ACH region that could benefit from a Pathways Community HUB, we want to scope the startup in a way that is manageable to insure we're learning crucial lessons early on and optimizing HUB operations prior to bringing in additional populations.

We will need the following:

- **Referral Partners:** The HUB network will rely on a group of agencies that serve as primary referral sources. Referral partners are agencies that interact with the HUB's population of focus, and are seeking appropriate resources to help these individuals remove social barriers that may be keeping them from optimal health.
- **Direct Service Providers:** CCA's producing successful coordination outcomes depends on the availability of services and resources to address the health risks of CCA clients, for example medical services, medication management, transportation, housing, educational opportunities and employment. The HUB will need partners who provide these services so that the care coordinator has services to link clients to.
- **HUB Advisory Council:** The HUB will form an Advisory Council made up of members who reflect the community and the North Sound region. This group will inform the direction of the HUB through data analysis, policy development and strategic guidance. Contracted CCA partners, additional community partners and referral sources will be invited to participate on the HUB Advisory Council.
- **Core team partners:** Initial PW Champions identified across the region. The folks who will be involved in the conversation and continue to usher the work forward. NOT necessarily all CCAs or representatives of CCAS, just key partners in the conversation at a regional level.
- **CCA Executive Subcommittee:** High level direction setting, development of referral network and process/ criteria, discussion of budgetary considerations around startup funding from ACH -> transition process and timeline towards full
- **Ad hoc learning sessions:** front line CCA staff, supervisors, care coordinators. Issues of granular workflow and operations nature. (beginning to come together closer to launch, once initial CCAs have been selected, and staff have been trained, and initial workflows have been developed.

HUB Operational Questions

Q: What MTP measurements will you be looking at?

The metrics that will show the most improvement will depend on the selected pilot target population and overlap with other project areas. For the Medicaid Transformation Project we are tracking the following:

- Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence;
- Follow-up After Hospitalization for Mental Illness;
- Inpatient Hospital Utilization;
- Mental Health Treatment Penetration (Broad Version);
- Outpatient Emergency Department Visits per 1000 member months;
- Percent Homeless (Narrow definition);
- Plan All-Cause Readmission Rate (30 Days); and
- Substance Use Disorder Treatment Penetration.

Additionally, the strategy for our high risk pregnancy population will focus on integrating pregnancy intention and family planning services, as well as considering the needs of pregnant women and children into the project areas of Bi-Directional Integration of Primary Care and Behavioral Health, Care Coordination (utilizing the Pathways Community Hub model), Care Transitions, Diversion, Addressing the Opioid Crisis, Oral Health, and Chronic Disease. In addition to the Education, Housing, Employment and various Developmental Pathways most (if not all) individuals will be utilizing, High risk pregnancy areas addressed specifically through Pathways such

as the Pregnancy, Family Planning, and Postpartum Pathways. The outcomes of these Pathways that we'll be looking at include:

- Normal infant birth weight;
- Suitable housing; and
- Linkage to appropriate social services for establishment of child care and ongoing family planning.