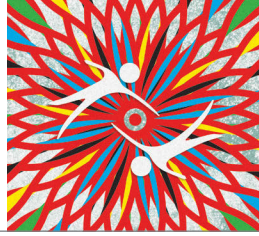

Pathways Model Aligns Care, Population Health

By PETER J. SARTORIUS, MA, MS

"Grace" had not been out of her home in seven years. She had been a client of the local community mental health program but was dropped as noncompliant after repeatedly missing appointments. In her late 20s, Grace also has uncontrolled diabetes. Her concerned grandmother contacted the local Michigan state representative, who referred her to the Health Project, the community benefit ministry of Mercy Health Muskegon, and its Pathways to Better Health Program of the Lakeshore.

Pathways assigned Grace a community health worker who for eight months visited her at home and brought her supplies before Grace had the courage to leave her house and re-enter the world. Grace resumed services from community mental health and began treatment for her diabetes. After 18 months of support from her community health worker and regular counseling, Grace's diabetes is now under control and she is ready to manage it on her own. Without Pathways, Grace likely would still be confined to her house with her health deteriorating.

This is just one of many stories about people who are chronically ill and who could be better served by their health systems. Most are low-income, uninsured or on some form of public assistance. Most experience several barriers to a healthy life; many have mental health issues and are socially and emotionally isolated.

Grace's story illustrates the street-level challenges of transforming health care from a volume-based to a value-based system that seeks to make people healthy and keep them out of emergency rooms and hospital beds. Mercy Health Muskegon uses the Pathways approach to align its community benefit ministry with the realities of health care transformation — particularly in terms of integrating clinical and community care and transitioning to population health management.

WHAT IS PATHWAYS?

In 2014, some counties in west Michigan ranked among the state's worst for health behaviors.[1] The Pathways to Better Health of the Lakeshore program targets residents in these communities who are hard to reach, vulnerable and who have poorly managed chronic diseases. The program's innovative approach, employing nonclinical community health workers who are familiar with the people, culture and resources of the local community, is making a positive difference.

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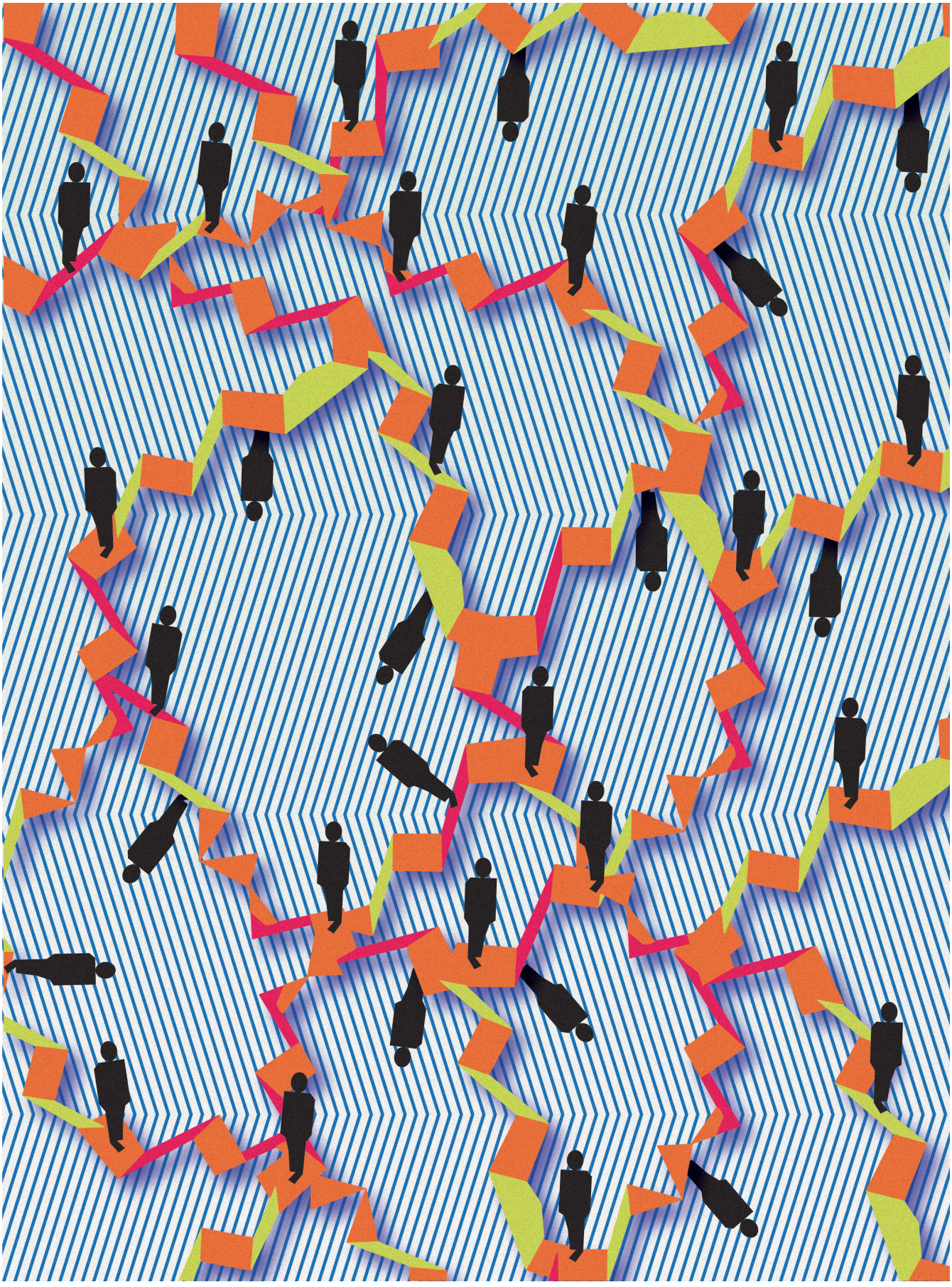

Mark Pernice

Pathways is a model that connects at-risk clients to community services that support care plans and produce positive health outcomes. The model focuses on prevention and early treatment. It uses a "hub," a neutral clearinghouse that brings together the many agencies trying to reach those who are at greatest risk. The hub receives referrals, determines eligibility, enrolls clients, conducts training for community health workers and monitors their performance along with provider performance.

Pathways also uses community health workers, clinical care managers and innovative technologies to deliver coordinated community care from multiple service providers. Through its hub clearinghouse and monitoring functions, it provides ongoing quality assurance that helps reduce duplication, lower costs, improve health status and reduce health disparities by recording and reporting client service utilization and health outcome data.

Mercy Health Muskegon, part of Trinity Health, acquired the Health Project in 2010 as its community benefit ministry with a mission to focus on community benefit investments that could improve overall health in its service area. Since then, the Health Project has applied the nationally recognized Pathways model, which along with the Pathways community hub were developed by Sarah Redding, MD, and Mark Redding, MD. Their goal was to improve access to care, delivery and quality of care and individual health behaviors among vulnerable populations that include low-adhering diabetic African Americans, parolees with chronic diseases re-entering the community and women with high-risk pregnancies.[2]

Health Project Executive Director Stevi Riel said, "The hub model helps us take great care of our patients, but it also makes sense as a model for community benefit. It satisfies our reporting requirements and serves our patients and ultimately improves the health of the broader community."

The Mercy Health Muskegon service area includes the urban and rural areas of three West Michigan counties currently ranked 56, 66 and 67 of the 82 counties ranked in overall health status by the University of Wisconsin's *2014 County Health Rankings*.[3] Interestingly, Muskegon County is the lowest ranked in health behaviors, but it ranked 5th best in clinical care. The conundrum represents an intriguing challenge to Mercy Health, which is the primary health system in the three counties it serves.

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"The hub model helps us take great care of our patients, but it also makes sense as a model for community benefit."

— Stevi Riel

Most recently, the Health Project is one of three Michigan sites involved in the Michigan Pathways to Better Health program intended to demonstrate the effectiveness of the Pathways model. The Health Project's participation is funded by the Health Care Innovation Award program and the Centers for Medicare and Medicaid Studies (CMS). It is co-directed by the Michigan Public Health Institute's Elaine Beane, PhD, and the Michigan Department of Community Health's Carol Callaghan, MPH (ret.).

Community health workers are at the heart of Pathways. Recruited from the same high-risk communities where their vulnerable clients live, community health workers are not clinicians. Instead, they have extensive familiarity with the people, cultures and resources in their communities. They also possess the personal attributes needed to establish trusted relationships with clients.

Clients receive individual care plans, and clinical care managers track their progress and direct the community health workers, who are the link back to the clients' medical home. Community health workers go through a training curriculum and receive ongoing supplemental training in HIPAA compliance, motivational interviewing,

mental health, first aid, chronic disease management, tenants' rights and so on. Typically, they can manage a caseload of 25 to 30 clients within a balanced range of complexity. They use mobile tablets equipped with wireless capability and customized software for recording and reporting Pathways' data, as well as documenting social determinant information that is made available for the client's care team. Their tablets also contain specially developed, literacy appropriate, educational videos for use with clients.

COMPLEX CARE AND OTHER SUPPORT: JOY'S STORY

"Joy" is 57 years old, married, and has a teenage daughter. Joy recently received a heart valve replacement. A clerical error caused the family's Medicaid benefits to be suspended, and a month later, Joy landed in the hospital with a staph infection.

In addition to her infection and heart condition, Joy suffers from Type 2 diabetes, arthritis, high blood pressure, degenerative disk disease and obesity. She had filed for disability under Social Security, but her case was unresolved. Meanwhile, her family was overwhelmed. Medical bills were going unpaid, there was no money for medications, they lacked adequate food and their home was in foreclosure.

A hospital social worker referred Joy to the Pathways program, where she was assigned a community health worker who stepped in to assist. After five months, Joy was free of the staph infection. She lost a significant amount of weight, increased her physical activity and improved her eating habits. As a result, her diabetes and her overall health status came under control. Additionally, with the help of the Pathways program, Medicaid benefits were restored, Joy's Social Security disability was approved and the family was able to avoid foreclosure.

Would Joy have been able to recover from her medical and social circumstances without the support of her community health worker? Not likely. The Pathways approach holds both client and service provider accountable for health improvement. Community health workers are the connection between the client and the client's medical and social support providers, which ensures that the connections are made and recorded.

A community health worker can help clients address a wide range of medical problems and behavioral issues and help see to the timely and efficient delivery of social services needed to support clinical plans of care. The Mercy Health Muskegon program has community health workers embedded in primary care practices, emergency rooms, various hospital departments, clinical settings and community agencies that routinely work with such vulnerable patients as low-income minorities, women and youth.

The Pathways hub tracks, records and reports all client connections and outcomes, ensuring that care coordination and follow-through among all service providers produce effective outcomes for the clients and cost efficiencies for providers.

"The Pathways to Better Health program is a great example of how addressing the social determinants of health makes it possible to improve wellness, increase the quality of care we deliver and reduce costs, while changing peoples' lives in significant ways," said Richard J. Gilfillan, MD, president and CEO of Trinity Health. "When our ministries work with other community partners in programs like this, they are helping achieve lasting change of individuals and communities. It's a great demonstration of what it means to be a people-centered health system."

"When our ministries work with other community partners in programs like this, they are helping achieve lasting change of individuals and communities. "

— Richard J. Gilfillan, MD

HIGH-RISK PREGNANCY SUPPORT: HOPE'S STORY

"Hope" was pregnant and recently homeless, couch-surfing with friends and relatives while trying to attend classes at the community college. She had no transportation from her rural home to her medical appointments and classes, so she hitched rides wherever she could.

The high-risk care manager in her obste-

"The Pathways program brings to light the challenges our patients face in trying to manage their own health outcomes and, in turn, we are creating partnerships that can help them address those challenges."

— F. Remington Sprague, MD

trician's office referred Hope to the Pathways Healthy Pregnancy program, where Hope got her own Pathways community health worker. Soon Hope found herself enrolled in Medicaid and connected with a local housing program to arrange for a place to live within walking distance to the obstetrician's office and the hospital. The community health worker helped Hope through her pregnancy, preparing her for motherhood.

At 30 weeks, Hope began having contractions and was prescribed bed rest for the duration of her pregnancy. Technology played an important part in communication between Hope and her community health worker, who were able to be in regular contact, even after hours.

Hope delivered a healthy 6-pound baby girl. Six months after her daughter's birth, Hope is continuing her education at the community college, works at a part-time job and has a stable support system in place.

ADDRESSING RISK FACTORS

Clients in the Health Project's Pathways to Healthy Pregnancy program have twice the risk factors of other Medicaid recipients. Over 70 percent are low-income; over two-thirds of the pregnancies are unplanned; nearly all the women are single; and about 20 percent are teenagers, homeless, have mental health issues or have previously had poor pregnancy outcomes.

Four years into Pathways to Healthy Pregnancy and two and a half years into Pathways to Better Health of the Lakeshore, the preliminary findings for both programs are very promising. Together, they have been responsible for a significant reduction in low birth weight babies, an increase in healthy birth weights, reduced costs of care for newborns and happier, more capable moms.[4]

The Pathways to Better Health program has reduced costs to the health system and improved the health status of Medicaid and Medicare patients with multiple chronic diseases. Since implementation, emergency department visits and hospitalizations have decreased by half, primary care office visits doubled and patients' conditions generally stabilized within 10 months.[5]

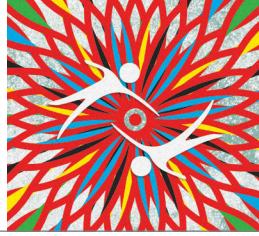
Additionally, community health workers were able to help people who were previously uninsured and unable to pay to obtain the coverage needed to ensure they could access care and that providers could be reimbursed for that care. What the clinicians themselves experienced, though, has been the greatest achievement.

"Pathways and its community health workers help our physicians reach patients in a unique way," said F. Remington Sprague, MD, vice president and chief medical officer, Mercy Health Muskegon. "By reinforcing physician recommendations in terms patients can better understand, and helping patients overcome barriers our physicians are often not aware of, the [community health workers] and case managers promote greater adherence to patient plans of care. The Pathways program brings to light the challenges our patients face in trying to manage their own health outcomes and, in turn, we are creating partnerships that can help them address those challenges."

COMMUNITY AND HEALTH SYSTEM INTEGRATION

Today, Mercy Health Muskegon continues to work toward integrating community care coordination, health system care coordination and the regional accountable care organization. The Michigan Primary Care Transformation project is collaborating with the Pathways model on best practices for facilitating referrals and communication between primary care medical home practices and the Pathways community hub. MiPCT is a CMS-initiated, statewide demonstration project aimed at expanding the care management and coordination capacity of patient-centered medical homes, as well as reforming primary care payment models.

At Mercy Health Muskegon, technology



enhancements soon will connect hub operations and community health workers directly with the hospital's health information exchange and add real-time communication capability for client status information, risk assessment notifications and other messaging with clinical care managers in primary care offices and hospital or clinic settings.

LOOKING TO THE FUTURE

Looking to the future, Mercy Health supports efforts to pursue national certification of hub operations, formal certification for community health workers and changes that would open a path for third-party payment of community health workers' services.

These steps would provide entry-level access to a career ladder for community health workers and, in doing so, help address the growing shortage of these front-line health workers who help minimize clinician time on nonclinical patient issues and, most importantly, have a deep understanding of the communities they serve. Community health workers are an important resource for keeping communities healthy, one person at a time.

PETER J. SARTORIUS is the grants and planning manager for the Health Project, a community benefit ministry of Mercy Health Muskegon, a member of the Trinity Health system.

KRISTINA BAAS, the community benefit program coordinator at the Health Project, assisted in writing this article.

NOTES

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1. University of Wisconsin Population Health Institute, *2014 County Health Rankings,* www.countyhealthrankings.org/app/michigan/2014/overview.
2. Community Care Coordination Learning Network, *Connecting Those at Risk to Care: A Guide to Building a Community "HUB" to Promote a System of Collaboration, Accountability and Improved Outcomes* (Rockville, Md.: Agency for Healthcare Research and Quality, 2010) http://chap-ohio.net/press/wp-content/uploads/2010/09/CommunityHUBManual3.pdf.
3. *2014 County Health Rankings*.
4. Sarah Redding et al., "Pathways Community Care Coordination in Low Birth Weight Prevention," *Maternal and Child Health Journal* 19, no. 3 (2014): 643-50.
5. The claims savings have not been independently verified by the CMS evaluation contractor. Statements are supported by unpublished internal data analysis.

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