Acknowledgement

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Overview of MPBH

• MPHI, in partnership with MDHHS and multiple agencies and organizations in Saginaw, Muskegon, and Ingham Counties, received a CMS Health Care Innovations Award [~$14 million] to implement the Pathways Community HUB model in three Michigan counties

• Michigan Pathways to Better Health (MPBH) is a 4 year grant beginning July 1, 2012, extended through June 30, 2016
Project Goals & Target Population

• CMS Health Care Innovation Award:
  – Better care for patients
  – Better health for communities
  – Lower costs through health care system improvement

• MPBH focuses on
  – Social determinants of health
  – Integration of health care and social services

• Targets at-risk population
  – Adults with two or more chronic conditions
  – Enrolled in or eligible for Medicaid and/or Medicare
Pathways Community HUB Model

• The Pathways Community HUB Model
  – A centralized community resource that utilizes care coordinators (CHWs) to link individuals to health and social services

• Model based upon 3 principles:
  1) Find those at greatest risk
  2) Serve to ensure individuals receive evidence-based health and social services
  3) Measure and evaluate benchmarks and final outcomes
Pathways Community HUB Model

CCAs

CHWs

HUB

Health Care Services

Social Services
Roles within Pathways Model

• HUB
  – A central point of entry that links participants with needed community services
  – Evaluates the participant’s needs and assigns to the appropriate Care Coordination Agency (CCA)

• CCA
  – Accepts assignments from HUB
  – Recruits, hires, manages, and deploys CHWs

• CHW
  – Serves as “Care Manager Extender”
  – Meets with clients in their homes
  – Coordinates with case managers from other agencies (PCMHs, Medicaid Health Plans)
Clients Served Since Feb 2013:
Insurance Status

- Medicaid: 3,504
- Medicare: 1,448
- Dual Eligible: 1,474
- Pending/Other: 1,044

Total: 7,470 Clients

Results as of 9/5/15
Referral Sources

Results as of 9/5/15
Top 10 Chronic Conditions: Percent of Clients Reporting

Results as of 9/5/15
Top 10 Needs Identified: Percent of Clients Reporting Need

<table>
<thead>
<tr>
<th>Need</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing</td>
<td>39.6%</td>
</tr>
<tr>
<td>Dental Care</td>
<td>38.3%</td>
</tr>
<tr>
<td>Transportation</td>
<td>37.8%</td>
</tr>
<tr>
<td>Food</td>
<td>32.0%</td>
</tr>
<tr>
<td>Clothing</td>
<td>23.2%</td>
</tr>
<tr>
<td>Utilities</td>
<td>20.8%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>20.7%</td>
</tr>
<tr>
<td>Employment</td>
<td>17.7%</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>17.4%</td>
</tr>
<tr>
<td>Education</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

Results as of 9/5/15
Social Determinants: Number of Clients Linked to Social Services

Results as of 9/5/15

- Food/WIC: 1,784
- Transportation: 1,637
- Clothing: 920
- Housing: 911
- Utilities: 768
Connection to Care: Number of Clients Linked to Health Care

Results as of 9/5/15

Primary Care: 2,621
Specialty Care: 1,624
Dental Care: 836
Mental Health: 778
Vision: 496
Addressing Other Needs: Number of Clients Receiving Additional Services

Results as of 9/5/15

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>2,630</td>
</tr>
<tr>
<td>Chronic Disease Education</td>
<td>1,344</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>801</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>206</td>
</tr>
</tbody>
</table>
Interaction with Public Health

• MPBH partnership with MDHHS
  – Access to Medicaid data for cost analysis
  – Pathways related projects targeting chronic diseases

• MPBH partnerships include five county health departments and multiple health and human service agencies across the state

• MBPH participates in national collaboratives to support population health and CHWs
Ingham Partners*

Lead Agency/Fiduciary: Ingham County Health Department

Community HUB: Ingham Health Plan Corp, CareHub

Convener: Power of We

Care Coordination Agencies – 10

- Allen Neighborhood Center
- Barry-Eaton District Health Dept.
- Capital Area Community Services
- Ingham County Health Dept.
- Mid-Michigan District Health Dept.
- National Council on Alcoholism
- NorthWest Initiative
- Southside Community Coalition
- Tri County Office on Aging
- Volunteers of America

Additional Referral Partners – Lansing Fire Department, Ingham MiPCT, PHP Medicaid, McLaren Greater Lansing ED

*Year 3 Partners
Muskegon Partners*

Lead Agency/Fiduciary: Muskegon Community Health Project
Community HUB: Muskegon Community Health Project
Community Convener: Muskegon Community Health Project

Care Coordination Agencies—13

- Call 211
- Access Health
- Community enCompass
- Disability Connections of West Michigan
- District 10 Health Department
- Every Woman’s Place
- Hackley Community Care
- Mercy Health Partners
- Lakeshore Health Network
- Mission for Area People
- Muskegon Community Health Project
- Pro-Med
- Senior Resources of West Michigan

Additional Outreach Partners: Muskegon County Homeless Continuum of Care Network, Muskegon County Cooperating Churches, MiPCT, 1 in 21, Wellville Initiative, United Way of the Lakeshore, Community Coordinating Council, Great Start Collaborative, Family Resource Centers

*Year 3 Partners
Saginaw Partners*

Lead Agency/Certified HUB:
• Saginaw County Community Mental Health Authority

Co-conveners:
• Alignment Saginaw
• MiHIA

Care Coordination Agencies:
• Covenant HealthCare/Visiting Nurse Special Services
• Health Delivery, Inc. (FQHC)
• Saginaw County Department of Public Health
• St. Mary’s of Michigan/Center of HOPE

Outreach Agency Partners:
• Mobile Medical Response (ambulance)
• 2-1-1 NE

*Year 3 Partners
Benefits – Ingham

• Coordinated Partnerships

• Improved Coordination of Care

• Enhanced Continuum of Care for Clients

*Benefits observed by the awardee
Benefits – Ingham

- McLaren Hospital Emergency Department
- Lansing Fire and Emergency Services (EMS)
- Bridge to Care for FQHC’s

*Benefits observed by the awardee*
Benefits – Ingham

• Physicians Health Plan (PHP)

• Michigan Primary Care Transformation (MiPCT)

*Benefits observed by the awardee
Benefits – Muskegon

- Wellville Community Plan
- Hospital ED/EMS/Provider Offices
- Million Hearts - improving community linkages
- District 10 Health Department

*Benefits observed by the awardee*
Benefits – Saginaw

• SPBH supports public health goals for improving the well-being of the community, particularly with respect to achieving health equity and improving health outcomes
• SPBH has created a new workforce – CHWs – who are able to engage hard-to-reach populations
• SPBH has helped to strengthen community partnerships focused on health improvement

*Benefits observed by the awardee
Saginaw Community Care HUB

• Vehicle for community collaboration for health improvement projects
  – SPBH (Saginaw Pathways to Better Health)
  – CAHV (Central Access to Home Visiting)
  – BCCCP/WW (Breast & Cervical Cancer Control/WISEWOMAN) outreach contract with Huron County Health Dept.
  – CHAP (Children’s Health Access Program)
  – PATH (Personal Action Toward Health) classes for CMH consumers
Challenges

• Ingham
  – Sustainability
  – CHW Boundaries
  – Appropriate Clinical Supervision
  – Placement of CHWs in community organizations

• Muskegon
  – PHMC structure

• Saginaw
  – Biggest challenge/barrier = ongoing funding to support CHWs
  – CHW work = full time work
Summary

• The Michigan Pathways to Better Health model is a partnership of multiple health, public health, and social service agencies working to create a culture of health, improve population health, and lower health care costs

• MPBH trains and supports CHWs to:
  – Link high-utilizer clients to health and human services that improve health
  – Educate clients about their health and support them in making healthy changes
Presenters

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