

MCHB/DHSPS August, 2010 Webcast

Exploring the Integration of the Healthy Start Model and the Pathways Delivery System

August 26, 2010

JOHANNIE ESCARNE: Good afternoon, my name is Johannie Escarne from HRSA's Division of Healthy Start and Perinatal Services in the Maternal and Child Health Bureau. On behalf of the division I would like to welcome you to this webcast entitled "Exploring the Integration of the Healthy Start Model and the Pathways Delivery System".

Before I introduce our presenters today, I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You don't need to do anything to advance the slides. You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. A 12 second delay typically provides optimum performance for the audience. We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from. On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loudspeaker

icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support.

We are very pleased today to have Ms. Josephine Ansah, Public Health Analyst with the Maternal and Child Health Bureau in Region V. Beverly Wright, who will be taking the place of Maribeth Badura; Ms. Wright is the Team Leader for Healthy Start in the Maternal and Child Health Bureau. We also have Ms. Maxine Reed Vance, who's the Chief Clinical Affairs and Quality Assurance Officer. Ms. -- Dr. Mark Redding, who's the Development Director of the Community Health Access Project, Ms. Sarah Redding -- Dr. Sarah Redding, who is the Executive Director of the Community Health Access Project. And Ms. Kim Phinnessee who is part of the Ohio Board of Nursing Certified Community Health Worker with the Community Health Access Project.

In order to allow ample time for the presentations, we will defer questions to the question/answer session following the presentation. However, we encourage you to submit commission via email at any time during the presentation. If we don't have the opportunity to respond to your question during the broadcast we will email you afterward. Without further delay we would like to again welcome our presenters and the audience and begin the presentations. Beverly?

BEVERLY WRIGHT: Good afternoon and welcome. In Healthy Start we view this as another pathway of coordination. We look for opportunities to improve services for the women and the families that we serve. We view this pathway program as another exciting opportunity for quality improvement. I will now turn this over to Josie so we can get started on this shared adventure. Josie?

JOSEPHINE ANSAH: Thanks so much, Beverly. Good afternoon, everyone. I also want to welcome you to today's webcast. I would like to begin my segment of the presentation by thanking Maribeth Badura for her support and the time she's taken to discuss this idea. I also want to thank Johannie Escarne for all the technical assistance that she provided in coordinating the webcast today. Dr. Mark Redding and Dr. Sarah Redding and Kim Phinnessee for all the time and energy that they dedicated in preparation for today, as well as the presenters that we have on the call today from the Baltimore Healthy Start program. I also want to thank my internal management team for their assistance and encouragement they provided, and lastly I want to thank all the Healthy Start programs that are viewing this for the great conversations and emails we've shared over the past few months, and just your willingness in general to hear about this. And the thoughts that you had that further inspired the reasons for why we're all here on this webcast.

So in terms of briefly setting the context I believe that most of you are aware that about ten some odd years ago I was a research assistant with the westside Healthy Start evaluation in Chicago. If I think about it, that was my first real exposure and introduction

to a comprehensive care coordination model for targeted populations. I was thrilled to work within the Healthy Start framework because it was so community based and employed people from the community, addressed perinatal disparities and led to significant outcomes. During that three-year period I was able to examine the model from a case management perspective. Research and evaluation as well as a participant level perspective.

You can imagine my excitement today as I sit with you realizing that I have the opportunity to work with Healthy Start programs across the country from this side of the spectrum. When I came to HRSA six years ago our regional administrator introduced me to Mark and Sarah Redding as well as Kim as a pathway service delivery system and I've seen it evolve in remarkable ways. Similar to my reaction to Healthy Start I was excited and intrigued by this system. Incentivizing community health workers and reducing service utilization. Come firming -- just its focus on accountability and outcomes and specifically tying dollars to outcomes.

So in terms of present day skipping ahead to present day when I attended the MCH state and Federal partnership meeting October 2009 I was really motivated by Dr. van Dyck's message about celebrating the successes and accomplishments of MCH and recognizing that there is still a long way to go related to perinatal disparities and that new and innovative strategies and ways of thinking needed to be employed by us to effectively address persistent challenges such as infant mortality and low birth weight and I think it really clicked for me then because of my experience with and appreciation

of Healthy Start and the Pathways model I thought it was interesting to see instead of implementing more structures that we could somehow leverage the existing assets of effective models such as Pathways and Healthy Start by integrating the two in some capacity.

I reach out to all of you, you caught onto the vision immediately and started generating your own ideas about integration such as using Pathways for a new prenatal teen populations and other things. Needless to say, talking to each and every one of you was very energizing. During our discussions you also raised very substantive questions and concerns regarding data system implementation and financing and put some real thought into the concept and I really appreciate that.

Mark Redding, Sarah Redding and Kim Phinnessee will present more detailed information about the Pathways service delivery system. As they present I encourage you to generate your questions even the ones that are sensitive. The purpose of this call is to determine the feasibility and potential benefits of integrating the two systems. It is merely a starting point to decide if and how we proceed. During the presentation, I also encourage you to consider the potential benefits of integrating the two systems. Pathways is currently being implemented in 18 communities across the country in the areas of perinatal health, access to care, medical home, case management, chronic disease management as well as medical debt management.

I think because of the model's flexibility based on some of our discussions Pathways can be used within the Healthy Start frameworks in various ways. Programmatically and interconceptional period from a systems approach by coordinating with other service providers to create a data hub to reduce service duplication and from a workforce level as it relates to -- I would like to conclude to present an offer that Dr. Redding has made and will repeat during his presentation. He's offered to speak to each one of you on an individual basis to discuss your particular program needs and how Pathways could potentially be integrated into your models. If you're interested in this offer or have additional questions moving forward I think everyone knows don't hesitate to contact me. And my email is also present on one of the slides. And I will forward those requests on to him and we'll coordinate the calls accordingly. So again I thank you for your -- I looked forward to our on going thoughts, relationships and questions and I'll turn it over to Maxine Reed Vance from the Baltimore Healthy Start program.

MAXINE REED VANCE: I'm going to discuss the perinatal monitoring intervention, Baltimore Healthy Start. In determining and I guess talking about how we came to implement our model here. We started -- this is slide number 7. I think I'm supposed to say that -- at the Baltimore project from 1990 to about 1992. And this particular project was locally funded and it actually used community health workers. They served about 200 women in Winchester and helped about 20 community residents.

The Baltimore project model used neighborhood health workers and we call them -- we called them the community health workers but we call them neighborhood health advocates here in Baltimore. And so the model included recruitment, the client was then recruited. We had a recruitment team that would knock on doors and recruit the pregnant women. The women would come into the center to be interviewed and a case care plan was devised and we would work basically from that care plan. Now, the Baltimore project team includes the recruiter, interviewer, case manager and neighborhood health advocate. The basic focus of this particular model had to do with the social determinants of health basically so the case managers were in place to remove barriers to care and self-sufficiency and they were supported by training and comprehensive data collection tools. We had checklists and master assessment needs and all kinds of ways to gather information about the participants, about our clients.

The Baltimore Healthy Start team, which came about in 1992 and early 1993, had a recruiter who conducted door-to-door recruitment the same as in the Baltimore project. The interviewer who did comprehensive assessments, a case manager who developed care plans and supervises the neighborhood health advocates. And the neighborhood health advocate's job was to complete home checklists for early identification of signs and symptoms of preterm labor and the high risk nurse manager reviews home visiting checklists and coordinates urgent medical care needed and we have on the team a certified registered nurse practitioner who does family counseling and contraceptive dispensing and a licensed clinical social worker who provides on-site mental health counseling and all of these parts work as a team in the care and coordination of

services to our clients. The addition of the perinatal monitoring intervention, this as I said before, the Baltimore project and the beginning of Healthy Start basically focus on the social determinants of health.

But I think it was in 1995 when doctor Mark and Sarah Redding came to Baltimore and offered us something that looked like a program in Alaska and I think you guys had been to Alaska before coming to Baltimore and so after a lot of discussion we infused a medical query on all existing prenatal and postpartum home visiting checklists and that included asking about contractions, asking about things that had to do with signs and symptoms of preterm labor.

In addition to that, along the way, we added in-home family planning and STI testing. In-home for chlamydia and gonorrhea and we had the CRMP to have all the clients enrolled in Healthy Start have -- come in to the center to be checked for bacteria vag -- we then established an extensive fetal and infant loss protocol. The perinatal monitoring intervention has been proven to be successful among our clients. The very low birth weight rate has been below the Surgeon General's goals of 2010 for the last three years. Now we're at about 1.3% of our clients who enroll pregnant throughout all of our sites had a baby that weighed less than 1500 grams. The interconceptional care, which includes our family planning nurse who goes in the home and offers education and administration has reduced the less month -- from 43% around 2003 to less than 10.5% at this time.

In terms of obesity. Now that there is a lot of literature that suggests that obese pregnant women have a chance of having a poor pregnancy outcome based on their obesity and we noticed that in Baltimore city there were trends along that line. However, clients who were enrolled in Healthy Start, even though we have the same percentage of obesity among our clients as we have in the city, our clients fare much better having babies who are healthy and at healthy birth weights. And with the STI testing throughout our community in the areas where we serve our chlamydia rate in 1999 was something like 18.2%, the prevalence. Our gonorrhea rate was something like 9.1. It has decreased to 6.8 and 1.0 respectively.

So we have integrated the social determinants of health with the medical piece and it has proven to be very effective in reducing infant mortality and in this year we had no infant deaths among our targeted population. Those two -- that combination has actually worked very well for us and I'm leaving I guess a few minutes because I have colleagues, Julia Hamilton and Peter Schaefer who are listening who may want to add something that I have forgotten. I'm sure I've forgotten something. And so I just want to give them this opportunity to do that. And if they don't have anything to add, then Dr. s mark and Sarah Redding and Kim Phinnessee will be your next presenters. Hold on. Hold on, they are here and do you guys have anything? Peter looks like he wants to say something.

PETER SCHAEFER: I just wanted to add to what Maxine presented again Healthy Start was really I think in a lot of communities as in Baltimore, it was the needs

assessment indicated that we had sufficient healthcare resources available. Baltimore, like many large cities, is in the project area for Healthy Start like in many large cities is adjacent to Medical Centers and numerous hospitals, prenatal care providers. But that - - so the premise was originally that what was needed was really social support. But what we found out, and this is sort of practice with experience, that our clients, despite the fact that these prenatal care providers were very much available to them in a physical sense, their utilization of the healthcare resources in a timely fashion was not adequate in that the Healthy Start program, through its very regular home visiting and more regular contact with clients than a prenatal care provider had an opportunity to identify early on signs and symptoms of preterm labor and as that has evolved, early identification of perinatal infection. We were the liaison between the community and formal systems of healthcare that wasn't originally envisioned. Our experience brought to our attention that the Reddings approached us. So through that collaboration of our experience and our practice and the Redding's experience and the design of integrating medical care, monitoring with a community-based home visiting program, that's how our program developed. I'm out of breath because I ran down the hall, thank you.

JULIA HAMILTON: This is Julia I wanted to add in addition to our working with partners, we also work with the community college so that the staff that participated in the training actually could receive three hours of credit for the training that was developed by the Reddings and the Healthy Start start. I think that was a benefit as people began to explore this opportunity to look how the training is extensive and look how it can benefit staff in their educational pursuits.

MAXINE REED VANCE: Okay. My colleagues have spoken. And so I am going to turn this over to the Reddings and to Kim. Go ahead.

MARK REDDING: We appreciate very much getting to be part of this and if you can see us on the screen, my name is Mark Redding and to my right is Kim and to my left is my wife, Sarah Redding. We'll make some comments and hopefully have time for your questions and just like Josie said, we want to also be available after this event for other questions that you might have. It was -- we haven't had a chance to catch up with Baltimore city Healthy Start for a while so it was really great to hear Maxine and Peter and the presentation from there. That was a very important part of our development in this work.

To jump right to kind of the last slide of our presentation here just in case you would happen to nod off or anything during this next few minutes, all we really want to accomplish is that people who are at risk connect to both the health and the social service interventions that they need. Research tells us clearly that they are not. And so Pathways and the tools and strategies that have been developed so far should point to that.

There are three principles of this work that I think you'll see tied together. One is that we identify and figure out who is most at risk. Number two, that we assure that they connect to intervention, be it both health and social service and number three, that we

measure some form of an outcomes from that so that we can learn how to do it better, faster and smarter.

I am now on slide 15 from the master set. It should show an airplane view of Alaska.

Sarah and I went to medical school together and went from there to Alaska trying to be missionaries and the only problem we ran into is that -- I remember it pretty well during a medical staff meeting there that Sarah came down the hall from the Maternal and Child Health department there and said she had data to show that Alaska had better birth outcomes than just about anywhere reported in the continental U.S. It was hard for the people in the room to take her seriously on this but she worked with others and Alaska has had and continues to have extremely good birth outcomes up in the top two or three states in the United States having started with an infant mortality rate of over 60 back in the 1940s.

What Alaska has that we don't have down here is they have a network that extends into local communities so that if you're an at-risk individual in COVAK, Alaska, you have somebody within that community who has some basic training and is going to assure that you connect with care. We brought with us today one of our local community health workers who fits that role very well here in our community, has been on the job for more than ten years. Alaska has more than 500 community health workers across the state and they work also with nurses and social workers and others to make sure that those at risk connect to care.

Next slide. 16. We moved from Alaska to Baltimore and an interesting thing here was our initial contact there was Dr. George Comstock who had helped set up the Alaska program back in the 1940s. He was in his 80s when Sarah met him at Johns Hopkins and he is the one who connected us to Maxine and Peter and others at the Baltimore city Healthy Start program where we went to work trying to extend and add on to their great programs some of the ideas from Alaska. Sarah and I moved back where our original homes are in Ohio and I'm on slide 17 now. And began this work and began writing grants and making some progress. But in one of our most significant funders, the question was, how do you take this kind of intangible community-based cultural connected work and show specific impact measures and outcomes? And how can those be tied to dollars? And that kind of turned us on our head for a while trying to rethink our whole approach to this issue of connecting those at risk to care.

SARAH REDDING: This is Sarah Redding. I'm flipping onto the next slide, slide 18. And what I want to present to you is that this is a systems issue we're talking about and our whole talk will end up convincing you of that. But when we really look at the big question is, are we serving the most at risk in our communities now? The second question is, if we're not, should we be? And clearly, if you look at the literature, well, the most at risk in our communities are driving the healthcare costs. It's been estimated that 5% of the population uses half of our healthcare resources. So for that reason alone it makes sense. But then when you look a little deeper, if we're really serious about serving the most at risk, then why aren't we paying people to do that? If we look at all the programs at least in our community right now, there is no incentive to go find

those most at risk in the community? You're paid the same whether you're serving somebody who is basically compliant with care or if they're absolutely non-compliant with care. And we know that access for everybody is getting worse.

Now, there is hope with healthcare reform but in our current situation whether you have private or public insurance or no insurance your access to care has gotten worse over this past decade. When we look at the pregnant client in the community, and we think about all the issues that she may have and all the agencies she must interact with, not just with getting prenatal care. She may have a mental health issue. She may need a job. She may be dealing with children's receives. She's dealing with multiple agencies who oftentimes have multiple care coordinators telling her very different pieces of information. And unfortunately, unless your community is really different than ours, those agencies don't communicate very well. There are often big black holes that we don't communicate at all. So what we really need is somebody measuring the whole system. Not just an agency or provider or hospital, but a way to measure what is happening to that person within the entire community?

MARK REDDING: We found a good quote, I believe. Einstein said, we can't solve today's problems using the same methods we did when we created them. So what is it that we -- what is it that we have? And I'm now on slide 20.

Interestingly, as a nation and as a healthcare system, what we have are fantastic evidence-based interventions from immunizations prenatal care, primary care. There

are now specific evidence-based education packages that have been proven to prevent obesity, that have been proven to prevent behavior problems, ADHD just as one example. There is a parenting package out of Australia called PPP that we use in our pediatric practice. It has been proven to reduce ADHD by almost 40% and improve school performance by almost 50%. Then going on to reduce juvenile -- if you're a wealthy person in this nation in general you're benefiting from them. But if you're poor, you're not getting them and your chances of actually receiving them, like Sarah said, have gone down.

Go to slide 21. Using this real simple view and again we know that it's complex but we hope that there can be progress with simplicity, we need a system that makes sure that the people most at risk actually receive the packages. So in a sense, if you'll look at this like UPS, just for simplicity purposes, we've got the packages, we need a both programmatic and overall regional system of delivery to make sure we're specifically getting the people who need the services the most the packages and not as the data would appear right now avoiding them.

We looked at this issue a little bit more specifically and I believe I'm on 22 in our own community. It's very easy. We all know where those most at risk are. And I would say eligible for Medicaid or under 200% of poverty isn't enough. There is -- if we look for those at risk we can find huge concentrations. As you can see from this map, this was looking at low birth weights. The community where we live, the low birth weight rate is about 3% or 4% in this concentrated area of the dot map low birth rate weight is over

20% and that is just not right. Next slide, please. Then we looked at where the perinatal care coordination and outreach services were going. As you can imagine, since a lot of the people providing those services were not comfortable with that community and could much more easily get into the homes in other parts of the community, the large majority of the services were going to more wealthy and less at risk populations.

So working with HRSA, working with other partners across the country, really as Josie said and Rick Wilk, who is next to her who have had a lot to do with this, there has been an evolution over time and we've come up with these three principles that we need to find the people who are most at risk whether they're urban or rural and we're on slide number 24 now, sorry. We need to make sure that they are engaged and connected to care, overcoming their barriers. Then we need to measure some form of an outcome. Kim is going to give us a little bit more information about those barriers.

KIM PHINNESSEE: As Dr. Redding was just saying. We know that the clients are out there. We know that the system is set up for them to get there but as he said, there are so many barriers that these clients are facing, multiple caseworkers in their home. Just different things and as community health worker, our main goal is to help eliminate some of those barriers and a lot of things that we found out was the transportation in our city was getting them to an appointment. We have it available but it took a couple of our community health workers and an office manager did a bus trip. It took almost four hours round-trip to get to the prenatal appointment with two other children in tow and

just getting there. Once they got there they were lot and they were turned away because of missing the appointment and that's a barrier that these young women are facing trying to get transportation to the appointment when they have so many other problems in their lives socially, economically, just different problems occurring in their lives and if we could just find a way to eliminate some of those problems I think it will help us out.

SARAH REDDING: If you flip to slide 25 I'll give you some of the meat of the talk now on what we were talking about these Pathways. This is what one of our Pathways looks like. Again, like Mark said earlier, it was in response to a funder's challenge to us. They basically said you know, we don't care how many home visits you do. We don't care how many phone calls you make we want to know what your measurable outcomes are. That's hard in a program like ours where we're dealing with all kinds of issues and tracking them through our charts and progress notes. We needed a more simple way to really be able to respond to that. So Pathways are just a tool.

When we developed Pathways it wasn't to change what we were doing it was to measure what we were doing. So it's just a measurement tool. For example, with our pregnancy pathway you'll find in the basic skeleton of a pathway has the three things Mark mentioned. Find those at risk, the target population. Connect them to an evidence-based service. In this case it's prenatal care because it's pregnancy and measure the results. In this pathway the end stop or the completion step is a normal birth weight infant. So you kind of see that identified to the left of the pathway but then

you'll see dollar signs to the right. We'll get into that a little farther down the road as this story develops.

Move to the next slide. This is a schematic showing how the pathways fit into our process. We use, and our community uses home visiting checklists. The checklists are designed so that a Yes question will trigger a pathway. For example, do you need health insurance? If the answer is yes, it starts the health insurance pathway. Do you need a job? Yes, starts the employment pathway. We can track that. We can look in on the individual care coordinators. We can see how many clients and who's on which pathway at any given time. Or we can track that across an agency or across a community. Now a key thing with the pathway model is that one person can have multiple pathways. It's not unusual for client to have ten different pathways. She may have ten different issues that need to be resolved. Some of those are health, some of those are social issues.

Next slide please. As we begin to see some results within our own program, we realized we were making an impact. I'll show you that data in just a little bit. But there was also the realization that if we're truly going to impact outcomes on a bigger scale, one agency, no matter how big you became wasn't going to be able to do that. If we're really talking about impacting health disparities and having more quality of care, we weren't going to do this as a silo agency, like everything else has been done before. We approached our community and we asked, this model is working for us, what if we

try to take it to the community level. And we did. We got a grant. We developed what we called community wide pathways and we started out focusing on pregnancy.

Once you develop pathways on a community level, you have to have a way to track what your doing. So that's how the whole community hub model developed, that we'll talk about in more detail. A community hub is really a central point of registry. It's a point when somebody is identified, they're registered in the hub, they're assigned to a care coordinator, and that care coordinator belongs to an agency. That means that if somebody else finds that client next week and they go in and try to put them in, they are already tracked as belonging to somebody. So it immediately cuts the duplication right at the get go. This also allows the community to use its resources more efficiently and effectively. You don't need three people working on the same issue. There are plenty of people to go around to help.

What we didn't realize, though, once we developed this, is how attractive this model was to funders because it now provided a mechanism for a funder to come into a community and do one contract that could serve a whole bunch of people instead of making multiple contracts are individual agencies. And what we now have in our community in Richland County is that every Medicaid managed care provider in this county is contracting with our community hub to provide services to their pregnant members because it is very easy for them. They come in, do the contract and we take care of the rest. We're also at a point now where we have managed care providers outside of our county asking for services so it's not a hard sell for the folks that are paying for care.

Next slide, please. This graphic shows you kind of when we very first started this hub model we had seven agencies in our county providing prenatal services to at-risk women. We put our pregnancy pathway in place during this 2004-2005 contract year and we already knew from looking at the maps that Mark showed you earlier where the bad outcomes were. But the reality hit us at the end of the year when we looked at our data and realized those seven agencies with \$1 million in funding served only 19 at-risk women. It's not that we're bad agencies. We were doing what everybody does. Finding the easier to serve folks and meeting our requirements and getting paid. Well, we convinced the funders to change the next contract year and we actually encouraged them to add incentives to get agencies to go find the women that were living in the high-risk areas. The contracts were changed and the incentives were added and that very next year we found and served 146 women with no increase in dollars. We had the same amount of funding. But what we did is we targeted our resources on really going after those women that were most in need.

Next slide, please. There are two graphs on this slide. The top graph is showing what happened within CHAP, within our own agencies and community health workers when we first put the Pathways model into play. And we've -- we really started that around 2000, 2001 and since really 2003, 2004 we've hovered around the Healthy People 2010 low birth weight. The more striking graphic is on the bottom showing our entire county. 2005 is the year we really put our hub model into play and you'll see the blue line represents low birth weights county wide. The red line being Ohio's low birth weight

which has been pretty stagnant over time. We actually just got data back on the 2008 vital statistic and dropped below the Ohio rate, down to 8% for our county. In the span of four years we've seen a 2% point drop county wide in our low birth weight and it fits the hypothesis we started with. If we could really target the people that needed the services the most and make sure they were actually connecting and measuring they were connecting we would start to see the population health improve.

MARK REDDING: Next slide, please. I believe we should be on slide 30 now. So part of our dilemma with this, and I think I'm sure with many of the Healthy Start programs out there, is we have employees like Kim, for example and her colleagues that know the community, that are respected in the community. If you're pregnant, they're there and if you don't think you're going to connect to pre-natal care if you're Kim's client you need to do a home visit with her here in Mansfield because you're going to connect.

The problem is, as critical as we know -- we all know that is, it's irrelevant to our current health and social service system. Our current health and social service system does not have a delivery system of care. We have programs and we have more funding than anybody in the developed world, but if you are poor and you are expecting to connect to prevention or early treatment, you would be as well off in the Czech republic or some other near Third World country. And so what we've -- what the community hub and what this systems-based model does, hopefully, and it's a work in progress, is begin to make the work that Kim and her colleagues and the public health nurses and folks like Kim do extremely relevant. It builds the care.

This graphic needs your help for improvement but what it's trying to show is that we have direct services and we have these care coordinators that can work with direct services that can specifically target extremely at risk urban and rural areas, reach out, engage those clients, make sure they connect to care. And that information and those benchmarks of impact measure and outcome can be tracked with something as simple as Pathways. I would like to think that it was us doctors and that wisdom that developed this, but I think Sarah and I would have to both admit that 80 or 90% of it came from individuals like Kim and her colleagues who taught us that if the young mother with a 15-month-old baby who is pregnant is going to connect to care, we also need to make sure that she has safe housing that night and something to feed her other child. And so in this delivery system, we are not just tracking connection to medical care, but also the critical and critically interlinking social determinants of health.

In implementing a Pathways model and now I'm on 31. It's not easy. And it's more accountable but what is so exciting about Healthy Start is on going over this with Maribeth many of the measures in Pathways you guys are already tracking because you're already an accountable approach. It's designed in such a way to not have somebody come to your program and tell you how you need to do your work, it is designed in such a way like Legos that you put it together in a way that fits for you and then hopefully it begins to track the meaningful impact measures and outcomes for your at-risk population.

Next slide, please. So a couple of resources that are developing out there for anyone who would like to consider or look into this further, there is this American -- agency for health quality and research has put together a network of communities across the country doing this. And they have recently completed a guide or a manual that's an official AHRQ manual available free online or in text on September 14th. There is a webinar on the AHRQ innovations exchange website that will discuss this and some other AHRQ-related issues. And—

SARAH REDDING: The other exciting thing that's going on now that developed out of this network of communities is that one of the realizations was there is no measurement tool right now to measure care coordination across the community so we have funding from the national institutes of health to create those. And it's probably going to land on Pathways because we haven't found anything else at this point that works any better. So kind of the exciting thing with this is that we're going to be using Pathways in a variety of communities measuring all kinds of things beyond pregnancy. We'll be looking at chronic disease, hospital readmission, just a variety of things. So that is actually actively happening right now. That's another exciting development.

MARK REDDING: So we look to you in Healthy Start as a substantial potential partner and also a group that has played a huge role in our development, especially in Baltimore, and then even Alaska's program started at HRSA. So this is a neat collaboration. Josephine Ansah has put it together and knitted things together in a

wonderful way I know with great support from Rick Wilk and Maribeth Badura and the team at Healthy Start and we want to say thank you.

JOHANNIE ESCARNE: Thank you, everyone, for such great presentations. We have now entered our question and answer session but we have yet to get any questions. I guess your presentations were so comprehensive that we have not had any questions yet. If anyone else has any comments to make, I will give the audience a couple of minutes here to get their questions in via email.

MARK REDDING: I was going to say we do have our contact information listed within the Power Point for Josephine Ansah and for Sarah and myself and that can allow any kind of direct questions for comments and -- and specifically any ideas that might be out there to help us improve and work together to do a better job with this.

JOHANNIE ESCARNE: Thank you, Dr. Redding. We still haven't gotten any questions yet. Josie or Baltimore Healthy Start, do you have anything else to add while we give the audience a couple minutes here?

MAXINE REED VANCE: I just wanted to add that I was listening to Dr. Redding's presentation and talking about Pathways and what happens when you find a barrier. Systems change has been very difficult here in Baltimore and we're in the process now of working with the city-wide initiative that we hope will change some of the problems inherent in systems. What we have chosen to do in the meantime I guess is similar to

what Kim talked about, is that if a client comes and she is not in prenatal care, then we have applications for medical assistance and we also have connections with certain providers and we have an OB/GYN on site here at Healthy Start so we can fill the gap until her healthcare insurance comes through or we can actually send her to another clinic.

For example, where she can receive care until she gets her medical assistance. And part of that system issue has to do with the Department of Social Services and the fact that most of our Medicaid-eligible clients also have a case or an associated case with DSS. For example, they receive food stamps or some other type of services from DSS, which causes a slowdown in their medical assistance and that is an issue we have been trying to work through. The big system issue for us in Baltimore has to do with housing. About 65% of our clients live with relatives or friends. And so it's really difficult sometimes to know where they are because when a relative or a friend says that you spent enough time with me, you need to move on, then we lose contact. So we are looking at some way to coordinate with

[MISSING TRANSCRIPT, 2 MINS]

>> I'm going to ask a second question.

JOHANNIE ESCARNE: We have no takers on the first question.

>> OK, then the second question may not be helpful. And I guess answers to both of these questions. I thought the participants would be interested in hearing your questions even if you don't have time now to share. You have everybody's email at the end of the presentation I think they'd be very interested from hearing from you on the first question, you know, what is the most exciting thing you heard today. Then the second is what might you consider doing differently as a result of what you heard from the folks in Baltimore or the folks in Richland County in the Pathways approach. So I'm curious to know what you might consider doing differently as a result of what you heard. Thank you.

JOHANNIE ESCARNE: Okay, well, if we don't get responses to those questions in the next few minutes, I'll make sure you get an e-mail with those responses.

JOSEPHINE ANSAH: Johannie, this is Josie. I just wanted to encourage the participants that are viewing the webcast, as they process and digest this information just to contact me at any point if they have any additional questions, comments, or concerns. I believe everyone has my contact information. My e-mail is also listed on slide 33, and that's jansah@hrsa.gov. I want to encourage everyone to reach out to me. Hopefully, this will be a benefit to all involved.

JOHANNIE ESCARNE: Thank you Josie. I think we have a pretty quiet group because I haven't received any questions. Are there any last minute comments from either Baltimore or our friends in Ohio?

MARK REDDING: We just want to say thank you for this opportunity and that it's wonderful to begin this discussion of partnering and teaming up with Health Start Programs in potentially a more formal way. As has been said, Kim, Sara, and I are available for any questions that you might have.

JOHANNIE ESCARNE: Thank you Dr. Redding. Since we have received any questions, the presentations are just that great. Oh, actually, OK. We have one question. The question is: Please discuss contracting and payment structures. For example we a singular Healthy Start project here with no sub-contractors. We do not pay for other services directly. How might our pathways project look?

SARAH REDDING: This is Sara. The way our contracts are set up right now, are basically payment for outcomes. As we contract with the medicaid managed care provider, they'll usually pay for the initial in-home, one you make contact in-home with the client, they'll pay for that assessment. Some providers will pay for each and every prenatal visit. Some managed care providers won't. They're different in how they approach things, but they will all pay once the outcome is achieved of a normal birth weight infant. We've kept to model of payment for outcomes. If you would build a pathway around pregnancy, you could design it -- really there is a lot of variations. We've worked with some other communities on developing those contracts.

MARK REDDING: One thing that may not be well known is, if as a care coordinator program, going back to that UPS model, if you confirm Kim finds a homeless, extremely at risk teenage patient, and she confirms that they've gotten their first prenatal care and all it's related screening, that connection to care has an evidence basis behind it for improving that individuals health. Even though Kim is not doing the prenatal care herself, she's the one who got them transportation, their medicaid card, overcame their fear of the doctor's office, and a whole bunch of other things. That confirmed connection can rank, not as a process measure, but as measure of impact, because there is an evidence basis that it has an impact. If we go on to measure the birth weight of the baby, we've got a real outcome to measure. Medicaid managed care and others are definitely willing to tie dollars in contracts to measure of impact for care coordination programs. I know Healthy Start measures that too.

SARAH REDDING: One thing to add. I've been working with a lot of the Medicaid managed care providers, and they live and breathe the HEATUS measures. So a lot of things we do around care coordination match up around their HEATUS measures. Making sure they have a post-partem visit. Making sure that there are well child visits. Making sure that there is prenatal care. If you are trying to contract with Medicaid managed care, make sure you are well aware of those measures before you start.

MARK REDDING: There is an expanding fund of knowledge in this contracting and we would recommend not re-learning what a lot of other people are out there bruised up from learning once already. It's still a steep learning curve, but there's many

communities and close to a thousand agencies out there that are doing this kind of contracting and work, that you could potentially learn from. Josie knows how to connect those dots. Contact her if you have any specific resources that are needed.

>> Mark, I have a follow-up question. When you say, agencies that are contracting, my question is how many health plans do you contract with in Richland County, and are you aware of other communities that contract with health plans, and if so how many? And the same questions for the folks in Baltimore.

SARAH REDDING: Right now, we have three active contracts with Medicaid managed care in Richland County. There can only be three in each county in Ohio, but we're actually entering into a fourth one with an agency that wants us to serve surrounding counties, that border our county. I've been working with one of the sites. Toledo, Ohio actually has a hub and they just signed their first managed care contract this week. I'm going up there Monday to see them. Cincinnati too. Our other hub in Ohio has contracted with Medicaid managed care.

>> That's very exciting. Thank you.

MAXINE REED VANCE: From Baltimore, we are presently contracting with six Medicare organizations at the present time. We also started a little more than a year ago to build Medicaid services that we provide here are Healthy Start. Especially our OBGYN clinic.

>> Thank you.

JOHANNIE ESCARNE: Thank you for your responses. I believe that is the final question, for right now. If anyone else has any questions, you can e-mail them and we'll make sure that they get to the presenters of this webcast. On behalf of the Division of Health Start and Parinatal Services I would like thank all of our presenters and the audience for participating in this webcast. I would also like to thank our contractor the Center for the Advancement of Distance Education at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website MCHcom.com. We encourage you to let your colleagues know about his webcast. Thank you, and we look forward to your participation in future webcasts.