

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

MCHB / DHSPS Webcast

August 26, 2010



Technical Overview

Moderator

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Opening Remarks

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Dept. of Health and Human Services (HHS)
Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau (MCHB)



Welcome

Josephine Ansah
Public Health Analyst, MCHB – Region V



Perinatal Monitoring Intervention

Overview and Impact

August 2010

Maxine Reed Vance, RN, MS

Chief Clinical Affairs/Quality Assurance Officer



Baltimore
Healthy Start, Inc.

Baltimore Project, Inc. 1990-1992

- 501 (c) (3) Infant Mortality Reduction Project
- Serving 200 Women in Sandtown/Winchester Community
- Funded locally
- Employed 20 Community Residents



Baltimore City Healthy Start, Inc.

Created in 1991



Baltimore
Healthy Start, Inc.

Case Management Model



Baltimore
Healthy Start, Inc.



Recruitment



In-Center



Interview



Clinic Services



In-Home

The Baltimore Project Team

Recruiter

Interviewer

Case Manager

Neighborhood Health Advocate

-
- a. Focused on the social determinants of health
 - b. CM services removed barriers to care and self-sufficiency
 - c. Supported by Rigorous Training and Comprehensive Data Collection



Baltimore
Healthy Start, Inc.

The Baltimore Healthy Start Team

Recruiter - conducts door-to-door recruitment

Interviewer - conducts comprehensive assessment

Case Manager - develops Care Plan and supervises NHAs

Neighborhood Health Advocate (NHA) — completes home-visiting checklists for early identification of signs and symptoms of pre-term labor

High Risk Nurse - reviews home-visiting checklists and coordinates urgent medical care as needed

Certified Registered Nurse Practitioner — individualized family planning counseling and contraceptive dispensing

LCSWC – on-site mental health counseling

Supported by Rigorous Training and Comprehensive Data Collection



Baltimore
Healthy Start, Inc.

The Addition of the Perinatal Monitoring Intervention

- Designed and implemented extensive medical training for all CM staff (based on the Redding's Alaska experience)
- Infused medical query on all existing prenatal and postpartum home visiting checklists
- Added in home family planning and STD testing
- Established extensive fetal/infant loss protocol



PMI Outcomes

Low Birth Weight

Very Low Birth Weight

Interconceptional Care

Obesity

STDs



Baltimore
Healthy Start, Inc.

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The Pathways Regional Delivery System

Sarah and Mark Redding

Community Health Access Project (CHAP)

Mansfield, Ohio





Baltimore City Healthy Start

2521 North Charles Street, Baltimore, MD 21218

(410) 396-7318

<http://www.baltimorehealthystart.org>

Ohio Funding Challenge



**Results and
Outcomes**

Richland County Community HUB

It's a systems issue. . . .

Do we serve the most at-risk? Why should we?

- 5% of population uses 50% of health care resources
- Most at-risk are often the hardest to serve → no incentive to serve them
- Access for all (insured and un-insured) has gotten worse over the past 10 years

Pregnant Client at-risk:

Her issues cross multiple agencies that function as silos:

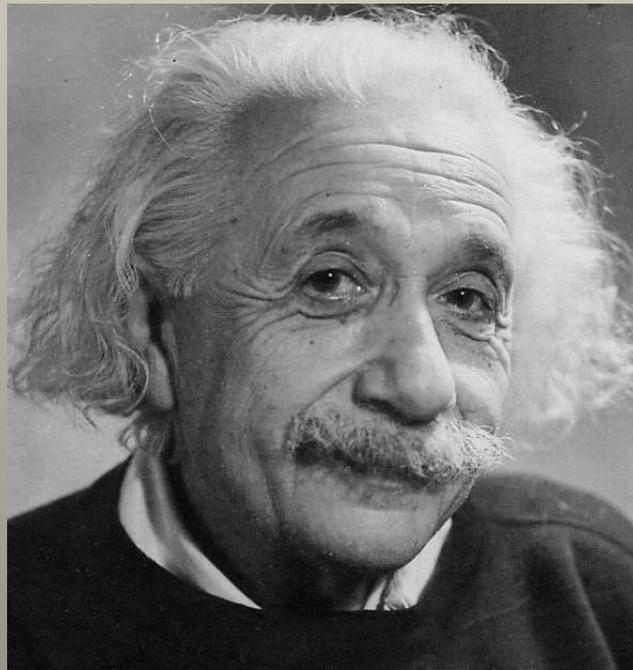
- Health care
- Insurance
- Housing
- Education / employment
- Mental health

Common to health and social services

Time = \$ At risk take more time, < \$

Albert Einstein

“We can't solve today's problems using the same kind of thinking we used when we created them”



We have the evidence based interventions



Diabetes

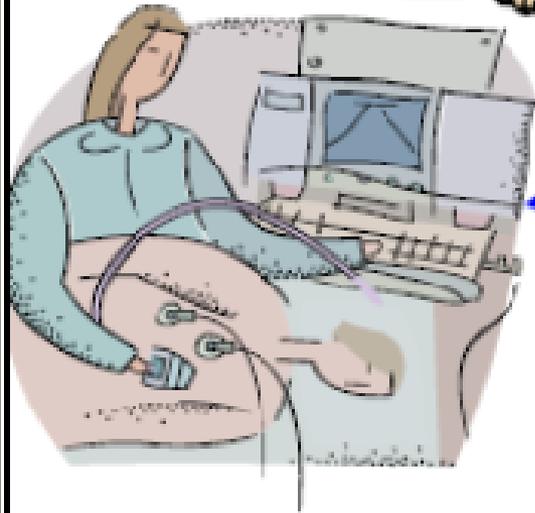
Asthma

Pregnancy

Homelessness

Adult Education

Unemployment



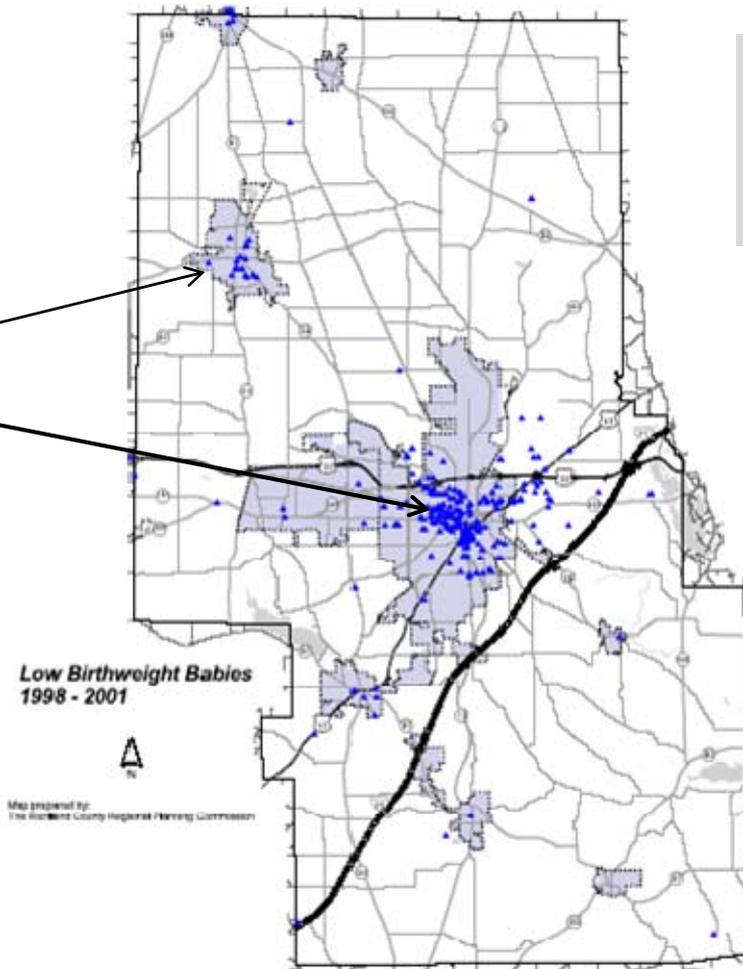
Care Coordination



Women at-risk of a poor birth outcome:

4 years of data from vital statistics – Low Birth Weight births

Areas of High Risk

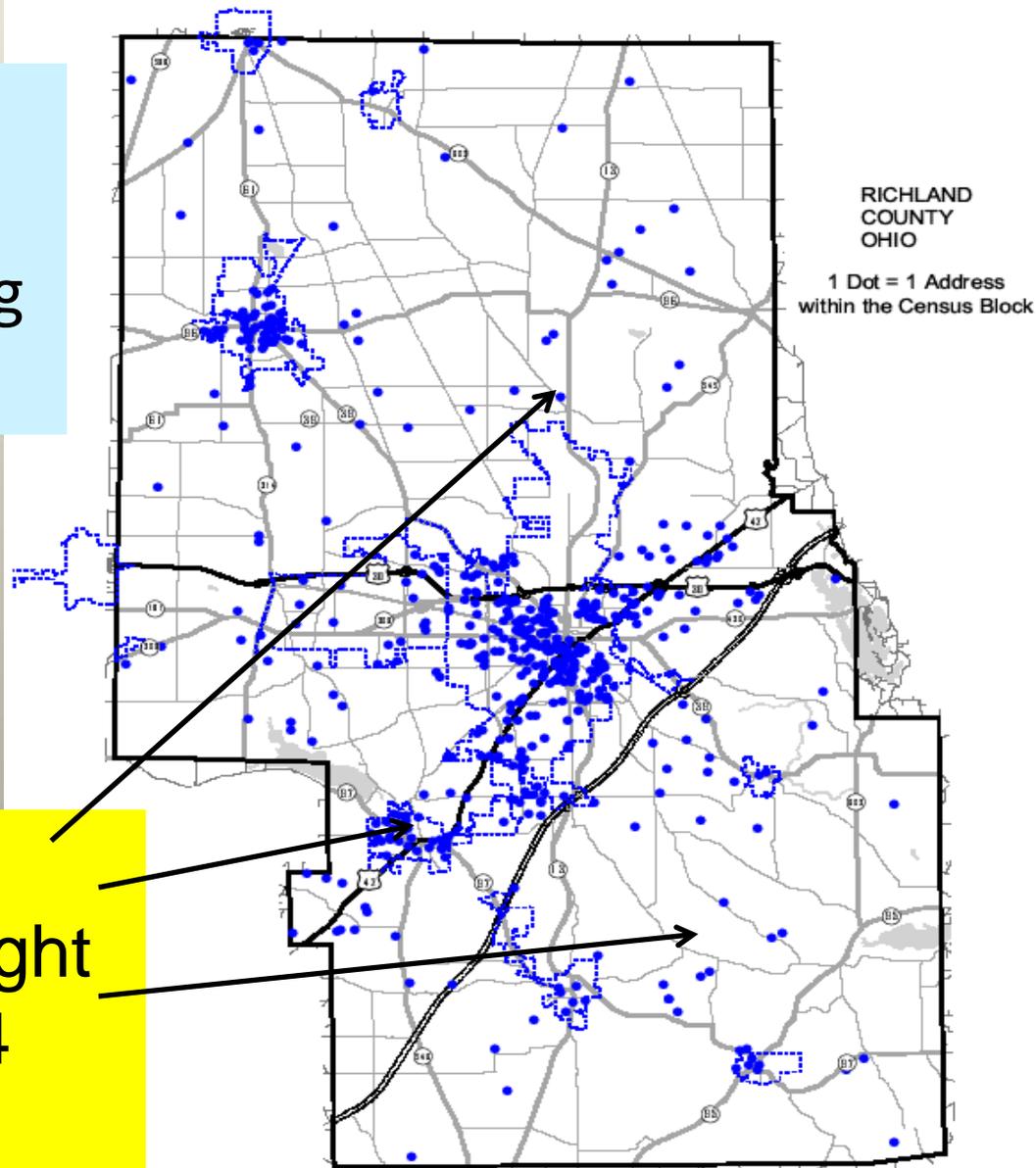


Richland County, OH

Where
services
were going

.....

NO Low
Birth Weight
births in 4
years!



Pathways Model

1

Find at Risk



2

Treat

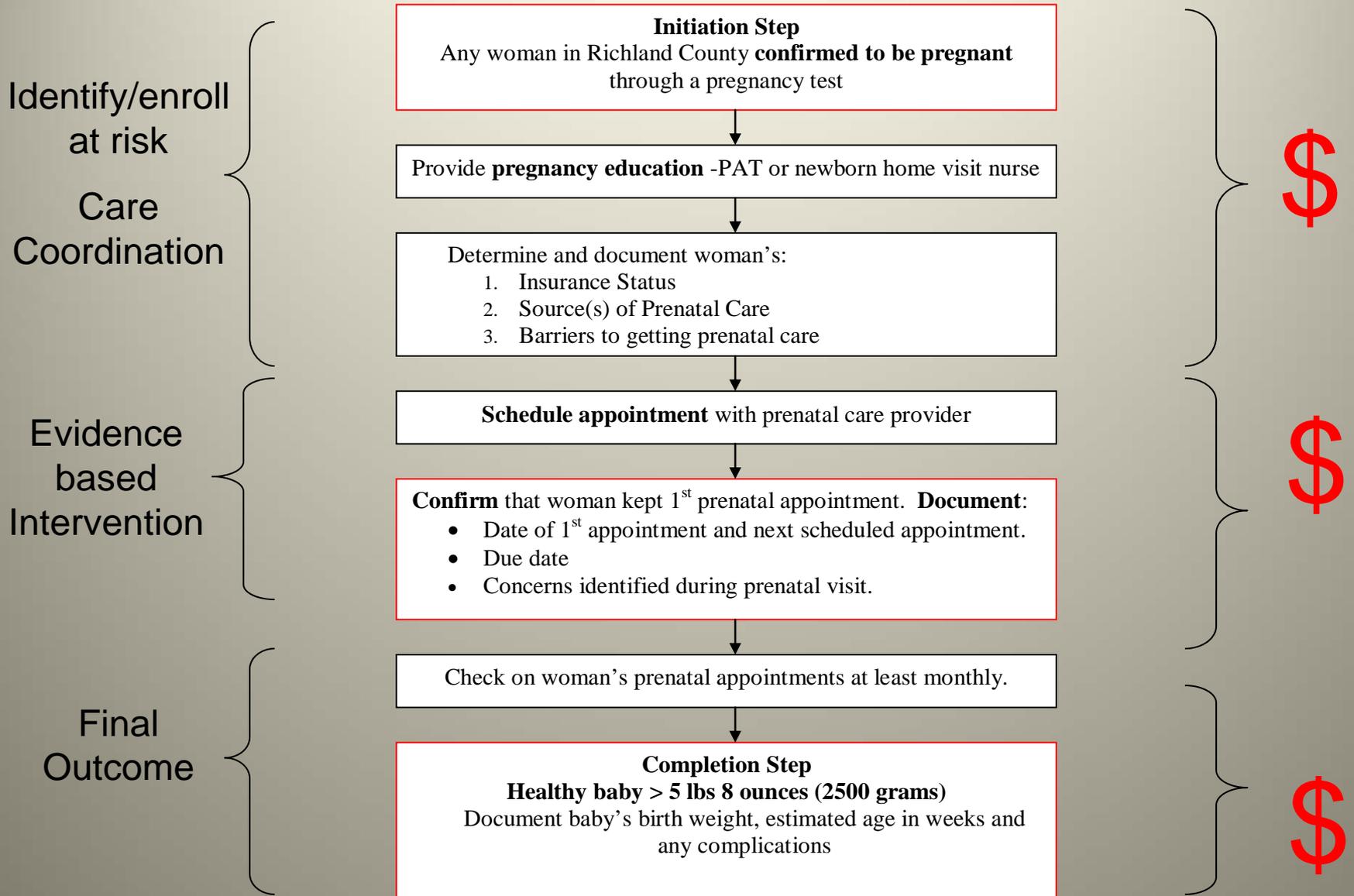


3

Measure



Pregnancy Pathway



The Pathways Case Management Process and Definitions

CHECKLIST

Yes	No	Question
	✓	Do you need a primary medical provider?
✓		Do you need health Insurance?
	✓	Do you smoke cigarettes
✓		Do you need food or clothing?

Definition:

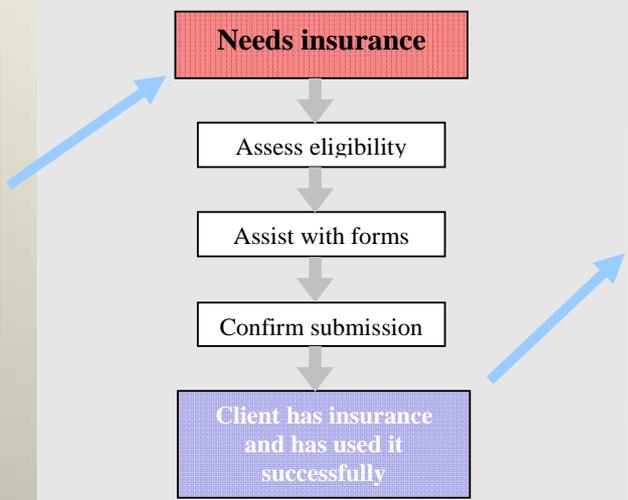
Checklists are groups of questions designed to evaluate the client's:

- ❖ Home stability
- ❖ Mental health
- ❖ Substance abuse
- ❖ Medical home
- ❖ Insurance
- ❖ Domestic violence

A "yes" answer would indicate that there is a problem. Another way to think of this is that a "yes" answer usually triggers a Pathway (outcome production process).

Client specific checklists (pregnant client, newborn, etc.) are developed to be used at home visits.

Pathways



Definition:

Each Pathway defines the problem to be addressed (Initiation Step), the evidence-based steps to address the problem, and the positive, measurable outcome (Completion Step). Pathways are not credited as complete unless the final outcome is achieved.

Pathways differ from standard protocols in being an outcome production model of accountability. If you follow a protocol and the client is 'lost to follow-up', then there are no consequences. A Pathway is only complete if the desired outcome is achieved.

Each client may have multiple Pathways - which are focused on, prioritized, and completed - one at a time.

Evaluation and Quality Assurance

Pathways/Month by Outreach Worker

Name	Immz.	Insurance	Preg.
Johnson	5	2	10
Reed	1	3	4
Pickens	9	15	18

Pathways/Month by Site

Site	Immz.	Insurance	Preg.
Johnsville	50	25	22
Elkins	64	17	35
Danville	40	32	19

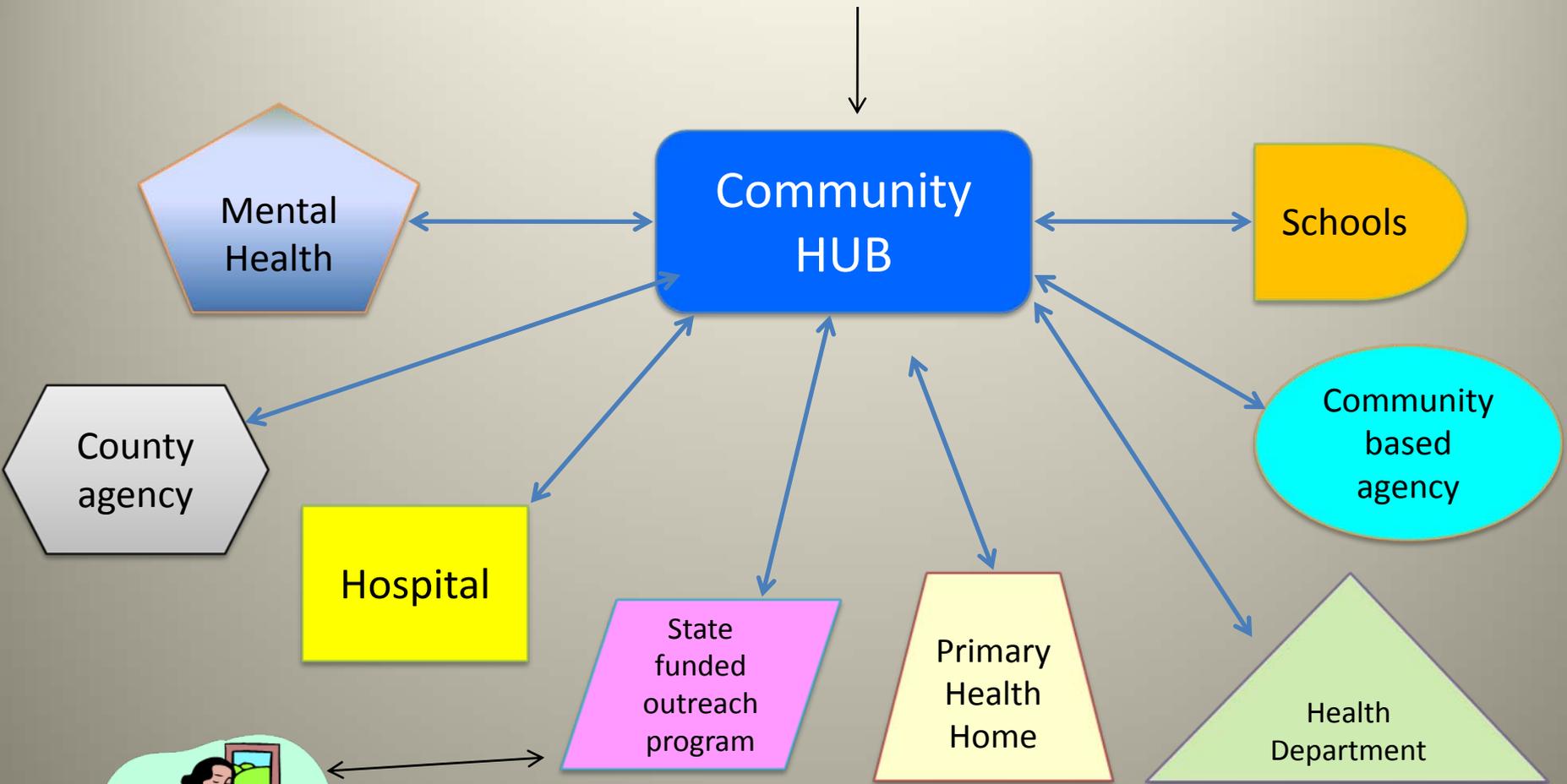
Evaluation – Remove Disparities:

Pathway production can be evaluated from many perspectives. Focus on specific outcome production can be brought to the level of each case worker. Their results can be compared to others in similar settings. This allows strengths and weaknesses to be identified.

The focus is not to be punitive, but to try to help increase the production of positive outcomes. Barrier steps can be identified and focused on to increase production. Education and specific interventions can be deployed, and then outcome production can be reevaluated to assess the impact.

Positive outcomes are not always brought about by global changes. Placing the accountability and focus on one individual, one outcome at a time, may actually have a greater impact on health disparities.

Multiple Funders – Payments for Outcomes



One Care Coordinator → One Outcome (Pathway)

- NO DUPLICATION
- MEASUREABLE RESULTS

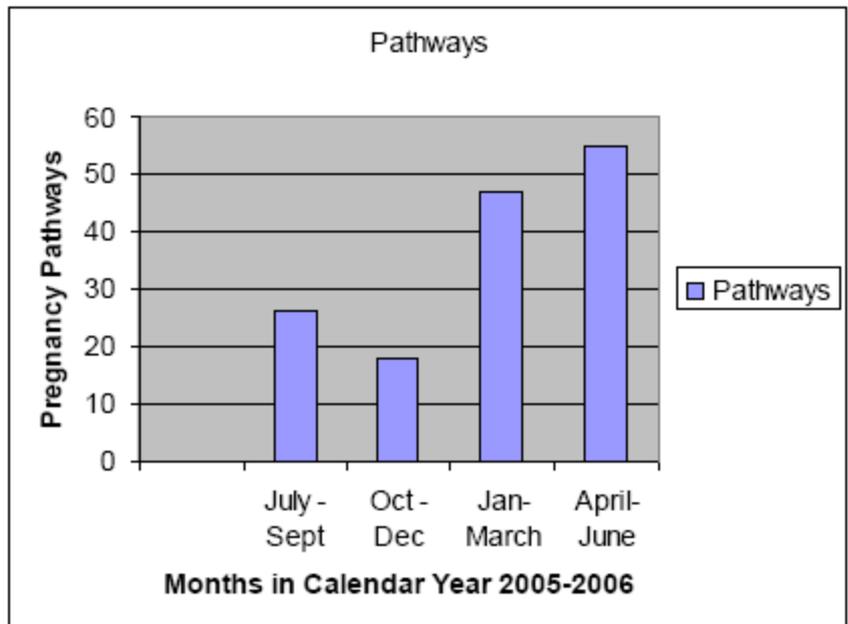
Richland Help Me Grow – Pregnancy Pathways Contracting Seven Care Coordination Agencies Serving Richland County

2004-2005

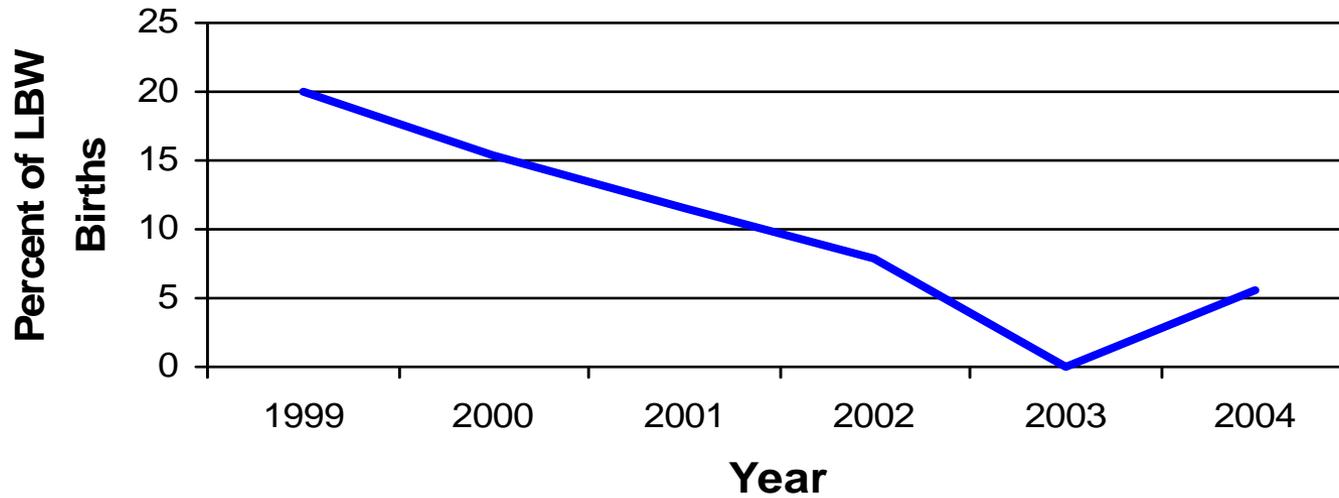
Contracting for Process

19 At Risk Served

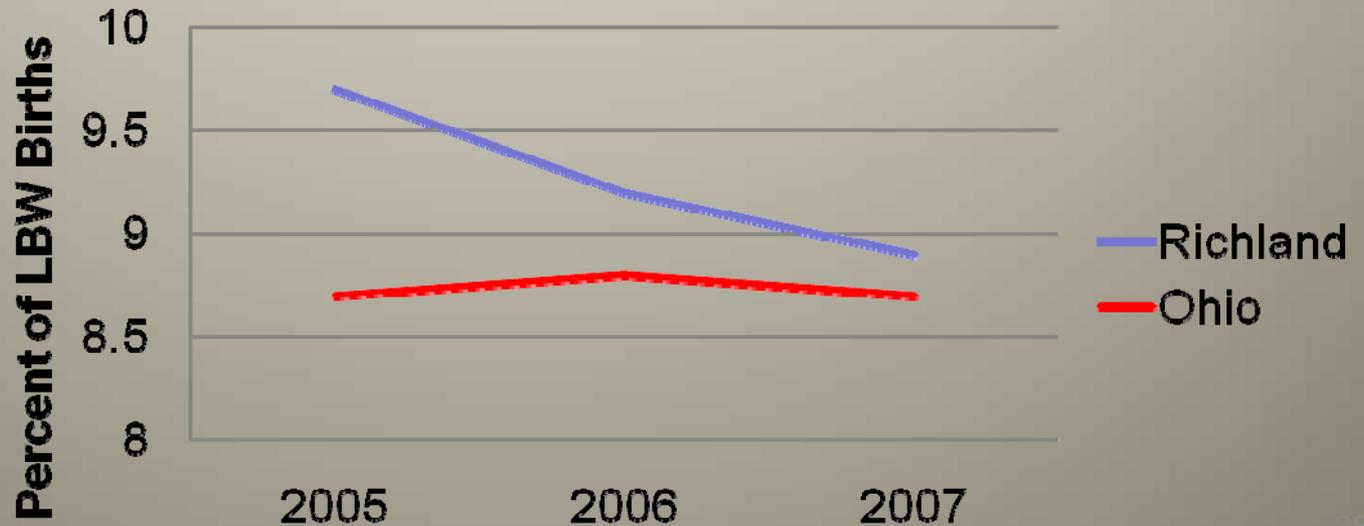
**2005-2006 –
Dollars tied to Performance
Duplication Removed
146 At Risk Served**

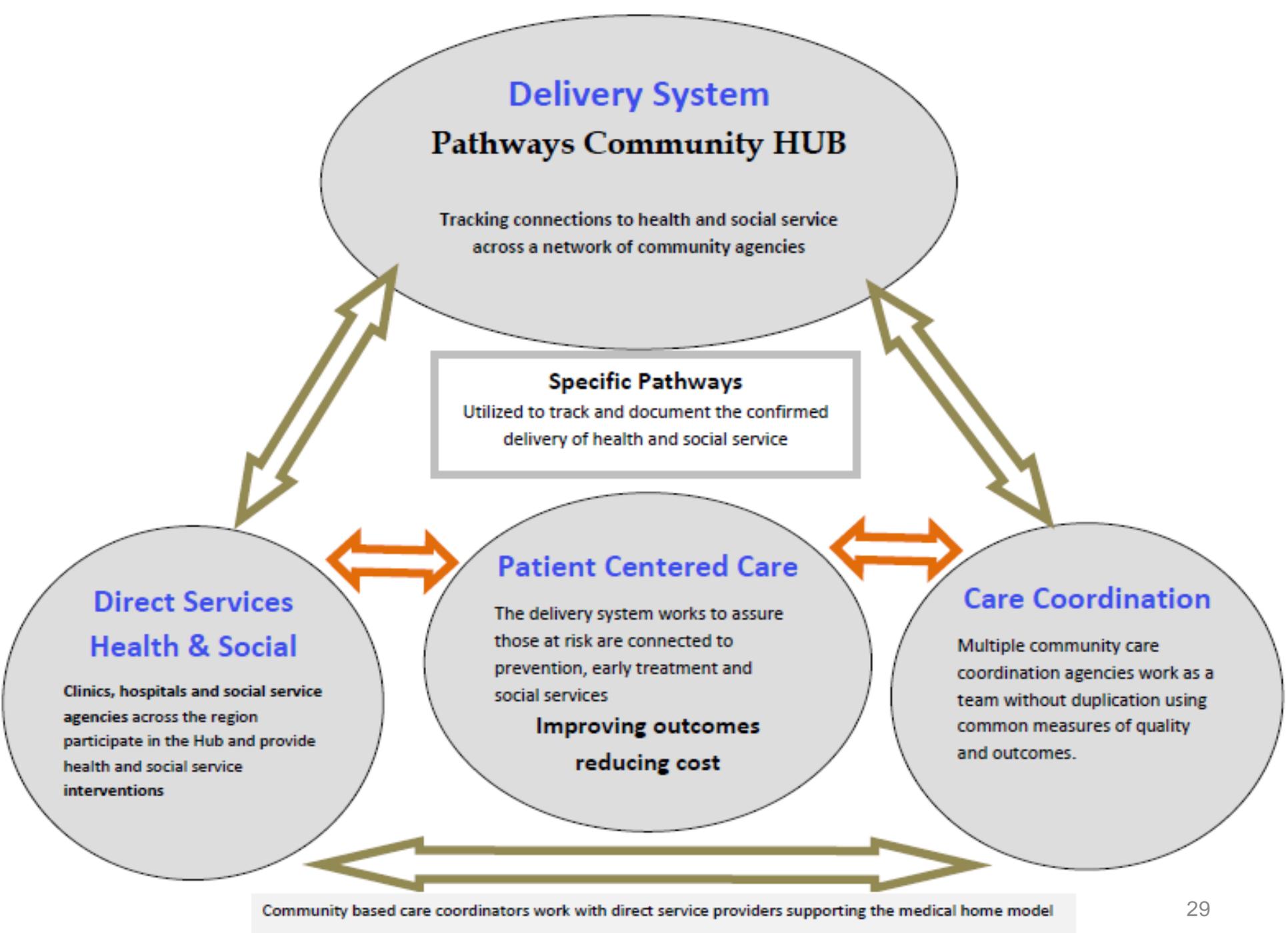


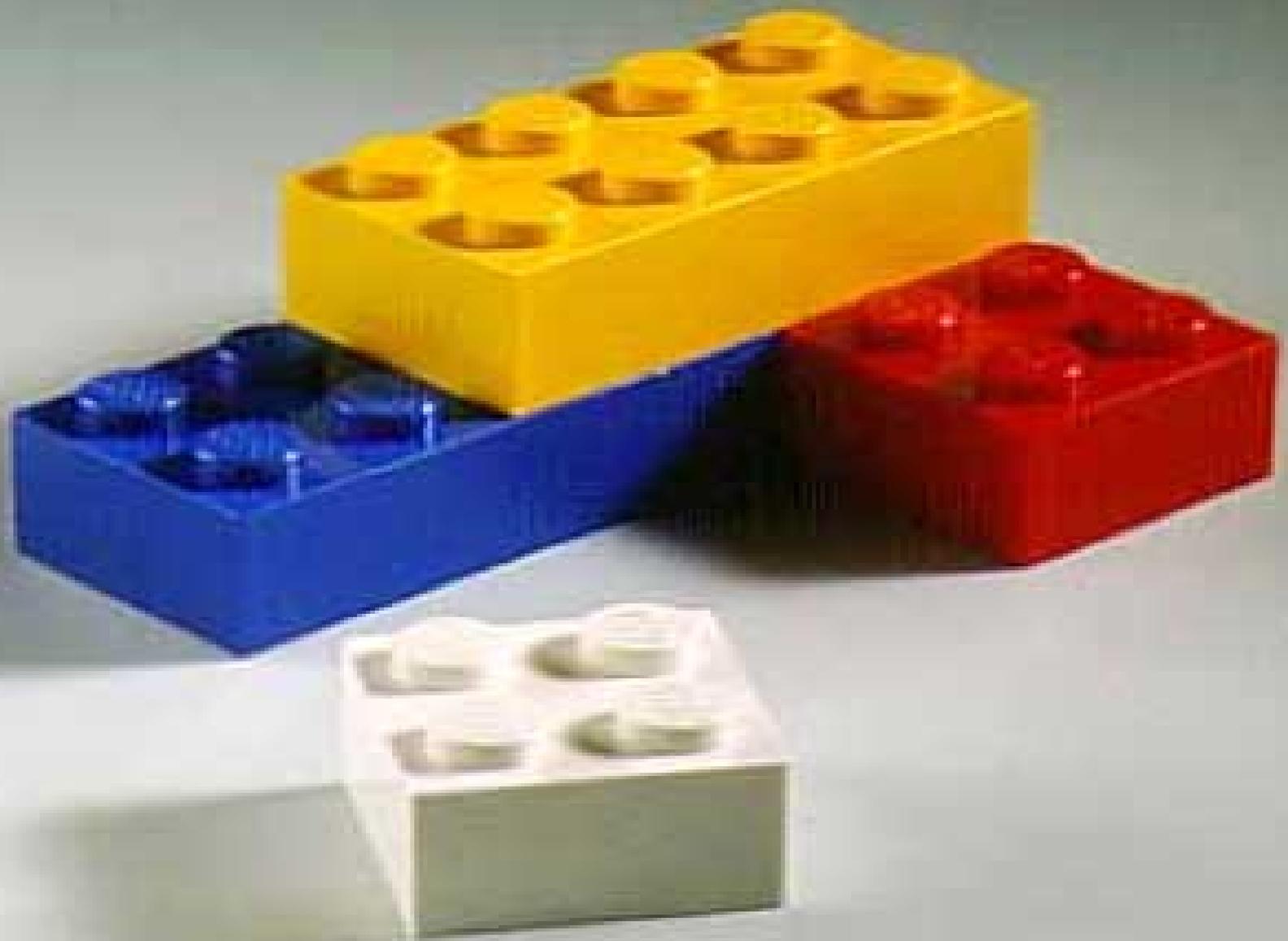
Low Birth Weight - CHAP: 1999 - 2004



Low Birth Weight - Richland County: 2005 - 2007







AHRQ Health Care Innovations Exchange

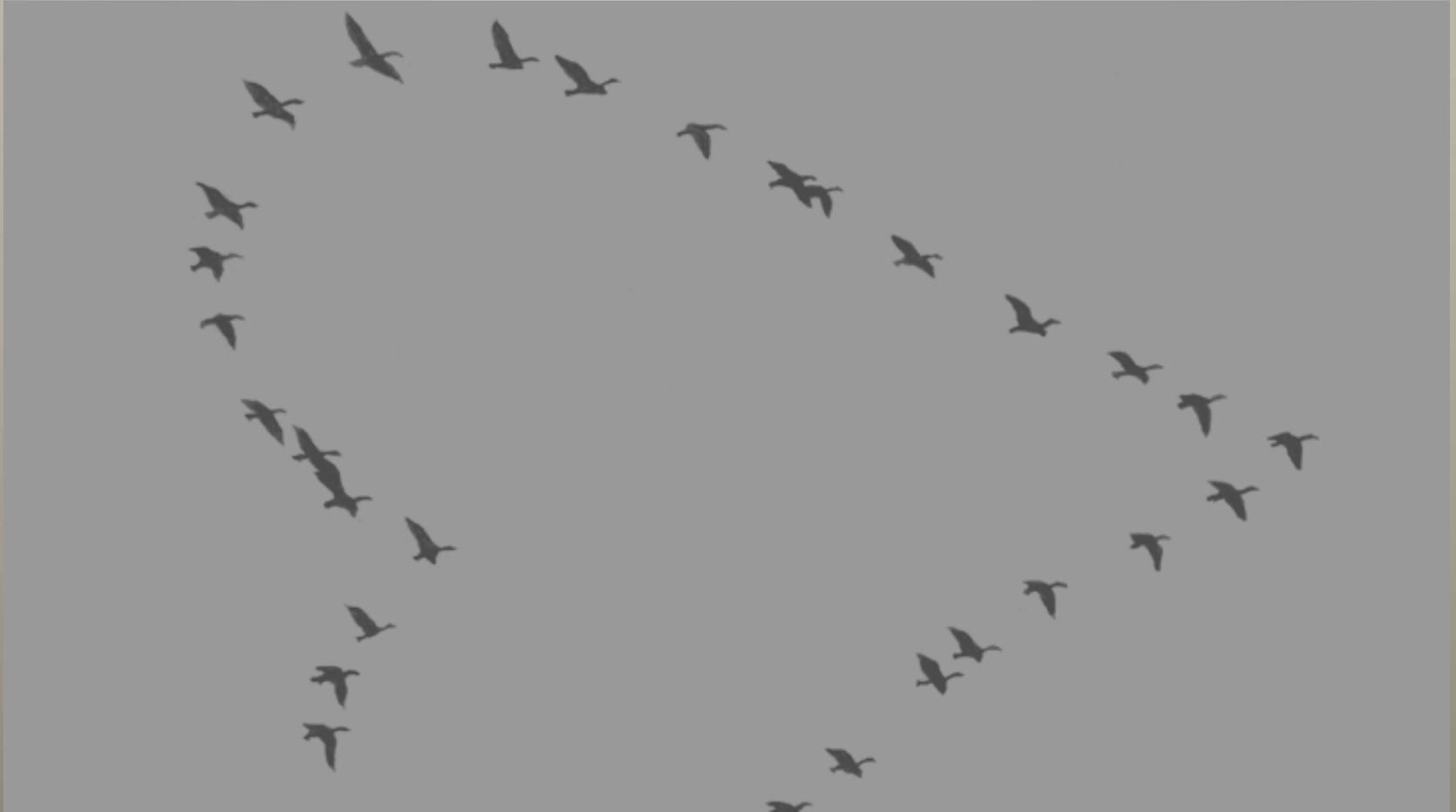
- Community Care Coordination Learning Network (CCCLN)
- Connecting Those at Risk to Care: A Guide to Building a Community “HUB”
- Measurement development in process

Resources

Contact us – Pioneering Pilots Needed!

- AHRQ - <http://www.innovations.ahrq.gov>
“Connecting Those at Risk to Care”
- CHAP - <http://www.chap-ohio.net>
- Josephine Ansah - jansah@hrsa.gov
- Mark or Sarah Redding - reddingmark@att.net

The Premise of Collaboration



Q&A Session

Moderator

Johannie Escarne, MPH
Senior Public Health Analyst, MCHB

