Working Together to Improve Population Health

Meeting of the Care Culture and Decision-Making Innovation Collaborative
National Academy of Medicine

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Vice President, Hospital Council of Northwest Ohio
May 17, 2018
In 10 (billion) easy steps . . .
The Hospital Council of Northwest Ohio (HCNO) is a member-driven regional hospital association that represents and advocates on behalf of its 24 member hospitals. **HCNO also provides collaborative opportunities for its members and community partners to improve the health and well-being of Northwest Ohio’s residents.**

Additionally, HCNO has an affiliated group purchasing organization, Northwest Ohio Shared Services (NOSS).
“Lucas County Hospitals are to be commended for uniting under the banner of the Hospital Council of Northwest Ohio to create a new collaborative foundation to fund innovative health care programs here.” *The Blade* Editorial, 1/29/1999

- Lucas County Community Health Assessment 1999-
- Released RFPs to fund programs to improve health
- Toledo/Lucas County CareNet 2002-
- WellBiz Workplace Wellness 2007-2010
- Lucas County Initiative to Improve Birth Outcomes 2005-
- Bullying Prevention Campaign 2013-14

- Community Health Assessment (Regional) 2000-
- Northwest Ohio Regional Trauma Registry 2000-
- Disaster Preparedness 2002-
- Tobacco Control 2001-2009
- Tobacco Free Hospital Campus Campaign “HEALTHY H” 2006-
- NW Ohio REC for EHR 2009-14
- Komen Regional Access Project—Yes Mamm!
- Northwest Ohio Pathways HUB 2007-
IRS CHNA Regulation started in the first tax year on or after March 23, 2012.
Community Health Assessment & Heath Improvement Plan Footprint

Red=CHA/CHIP at least once
Aqua=CHA/CHIP planned

HCNO was a contracted partner to help conduct Ohio’s SHA & SHIP
Community Health Improvement Plans

- Aligned with the State of Ohio Health Improvement Plan
- Aligned with Hospital and Public Health Mandates
- Based on The National Association of County and City Health Official’s (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP)
Mission

• To improve the health of the community.

Purpose

• Provides a forum for ProMedica, Mercy Health and the University of Toledo Medical Center to leverage resources to improve the health of the community.
• Provides a foundation for Lucas County hospitals to comply with state/federal community health improvement requirements.
• To foster innovation and collaboration.
• To create one voice to partner with other sectors to improve health.

Strategies

• Provide leadership and resources to Healthy Lucas County to conduct community health assessment and health improvement plan every three years.
• Provide annual funding to strategically further the health improvement plan.
• Seek external funds to further the assessment & health improvement plan.
• Discuss and address community issues impacting the health of the community.
• Coordinate Fostering members’ involvement in the community, e.g., grant applications, project support.
**2018-2021**

Aligning collective and organizational investments to serve as catalysts for the four Healthy Lucas County Health priorities.

### Ohio Health Outcomes

<table>
<thead>
<tr>
<th>↑ Health Status</th>
<th>↓ Premature Death</th>
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### Ohio Priority Topics

<table>
<thead>
<tr>
<th>Mental Health and Addiction</th>
<th>Chronic Disease</th>
<th>Maternal and Infant Health</th>
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</table>

### Lucas County Priority Topics

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Addiction/ Drug and Opiate Use</th>
<th>Chronic Disease/Obesity</th>
<th>Maternal and Infant Health/ Infant Mortality</th>
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### Lucas County Priority Outcomes

<table>
<thead>
<tr>
<th>↓ Decrease adult and youth drug use</th>
<th>↓ Decrease adult and youth alcohol use</th>
<th>↓ Decrease adult and youth depression</th>
<th>↓ Decrease adult and youth suicide</th>
<th>↓ Decrease adult, youth and child obesity</th>
<th>↓ Decrease adult diabetes</th>
<th>↓ Decrease adult heart disease</th>
<th>↓ Decrease infant mortality</th>
<th>↓ Decrease preterm births</th>
<th>↓ Decrease low birth weight</th>
</tr>
</thead>
</table>

**Equity:** Priority population for each outcome above
Healthy Lucas County Cross-Cutting Strategies

- Expand school-based health centers
- Expand complete streets
- Implement smoke-free policies
- Increase health insurance enrollment and outreach efforts
- Improve access to comprehensive primary care
- Expand the use of community health workers (CHWs)
- Increase care coordination using the Pathways Community HUB model
- Implement cultural competency training for healthcare professionals
- Implement policies to decrease availability of tobacco products (Tobacco 21)
- Increase links to tobacco cessation support
- Implement a universal screening and referral process
Evidence of population health improvement through partnership

The NW Ohio Strategic Alliance for Tobacco Control (2001-2010) will significantly reduce tobacco use through community-based partnership of more than 70 organizations in 16 counties, and the implementation of a comprehensive research-based tobacco control plan.
Focus on Social Determinants

**Infra-structure/Awareness**
- Healthy Lucas County CHA/CHIP and Operations
- Fostering Staffing & Operations

**Chronic Disease**
- Care coordination for low-income adults with chronic disease through NW Ohio Pathways HUB to reduce readmission and improve health
- Toledo/Lucas County CareNet to support connection to coverage, uninsured & care coordination (outside of Fostering budget)

**Reducing Infant Mortality**
- Infant Mortality “Getting to One Assessment & Referral” to the Northwest Ohio Pathways HUB for community based care coordination
- Matching funds for housing for pregnant women and families with children <1

**Mental Health & Addiction Services**
- Select Opioid Task Force recommendations or emerging strategy to coordinate through Fostering
- CHW motivational interviewing and referral to treatment
- Training on MAT for primary care
- Strategic Alliance for regional coordination
- Awareness Campaign/Training on prescription guidelines, reporting
- TBD
Mission: To increase access to coordinated healthcare services for low-income residents of Lucas County.

Founded 2002 and enrolled its first member in 2003

- Organized Charity Care Network
- Licensed Navigators Certified Application Specialists for Medicaid and Marketplace Coverage
- Addressing Social Determinants of Health through Community Health Worker Community Based Care Coordination
- Local, State & Federal Advocacy for Low Income
Toledo/Lucas County
CareNet’s Partners

MERCY HEALTH

SEAL OF THE CITY OF TOLEDO
JANUARY 7, 1837

PROMEDICA

dental center
of northwest ohio

TOLEDO-LUCAS COUNTY
HEALTH DEPARTMENT
Stay informed. Stay healthy.

United Way of Greater Toledo

The University of Toledo
MEDICAL CENTER

St. Luke’s Hospital
Health, plus care.
Charity Care Network

Eligibility

- Resident of Lucas County for at least 6 months
- Up to 200% of the federal poverty level
- Not eligible for public or private healthcare coverage
- Cooperate with the application process to determine eligibility

Benefits

Access to free or reduced cost healthcare services

- Primary Care – 15 medical homes
- Hospital Inpatient and Outpatient Services
- Limited Specialty Care
- Pharmaceuticals
- TARTA Transportation
Outstanding Health Outcomes

• 25% decrease in CareNet member emergency department visits and 22% decrease in inpatient days from 2007 to 2011

• Study conducted by the University of Toledo Pharmaceutical Care and Outcomes Research Lab (PCOR)
  • 60% of CareNet members with high blood pressure and 62% with high blood sugar moved to the normal range for these conditions while being enrolled in CareNet.
  • 78% of women age 40+ enrolled in CareNet had a mammogram in the last year.
The Northwest Ohio Pathways HUB is a data-driven, community-wide system that connects low-income residents to needed medical care and social services to improve health outcomes.

Nationally Certified Pathways Community HUB
HOW IT WORKS

NORTHWEST OHIO PATHWAYS HUB
The Northwest Ohio Pathways HUB is a data-driven, community-wide system that connects low-income residents to needed medical care and social services to improve health outcomes. Key to the system are community health workers (CHWs), who provide care coordination services and are employed by numerous medical clinics, social service agencies and other organizations throughout the community and the region.

CHWs Serve as Partners, Coaches & Advocates for Their Clients

Enroll
CHWs canvass the community for at-risk residents and enroll them in care coordination. Healthcare providers and others also refer patients to the Pathways HUB.

Assess
Enrolled clients receive a comprehensive risk assessment, and they work with their CHWs to prioritize all their health and social needs.

Plan
CHWs develop a care plan using the Pathways HUB’s online system by opening “pathways” for each unmet need, such as for health coverage, a medical home, food, housing and transportation.

CHWs work closely with their supervisors to develop these outcome-driven plans to address health, social and behavioral risk factors.
Meet
Clients meet with their CHWs at least monthly to work as a team on care coordination plans, and they address each need one by one.

Track
Pathways HUB staff tracks data to reduce duplication of services and ensure clients receive the most appropriate high-quality, evidence-based services.

Train
Staff at the Pathways HUB provide training and education for both CHWs and their supervisors.

Pay
Organizations employing CHWs receive payments from Medicaid managed care plans and other funding partners when clients are successfully connected to needed medical and social services and achieve important health outcomes.

The approach helps residents become self-sufficient while also addressing the social determinants of health, reducing disparities and improving population health.
20 Core Pathways – National Certification

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum
Pathways Community Care Coordination in Low Birth Weight Prevention

Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

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Abstract The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social services, and intervene to improve their birth outcomes. The study population included 1,220 women participating in CHAP and having a live birth in 2001 through 2004. Logistic regression was used to examine the association of CHAP participation with LBW.
Certified Pathways Community HUB Model Supporters

Ohio Commission On Minority Health

Ohio Department of Medicaid

Institute for Healthcare Improvement

Centers for Disease Control and Prevention
CDC 24/7. Saving Lives. Protecting People™

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

HRSA

Ohio Department of Health

National Science Foundation
WHERE DISCOVERIES BEGIN

National Institutes of Health
Turning Discovery Into Health

The CMS Innovation Center
### Milestones to Reduce Health Disparities

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2005</td>
<td>Lucas County Initiative to Improve Birth Outcomes adopted HUB Model with local funding</td>
</tr>
<tr>
<td>2010</td>
<td>NW Ohio Pathways HUB began contracting with Medicaid Managed Care Plans for community based pregnancy care coordination</td>
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<tr>
<td>2013</td>
<td>Lucas County Equity Institute &quot;Getting to 1&quot; formed with Toledo-Lucas County Health Department and Hospital Council of Northwest Ohio as co-leads - Pilot HMG HUB</td>
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<tr>
<td>2014</td>
<td>Healthy Start Grant Awarded to TLCHD for reproductive life planning to serve pre/conception and expand Pathways HUB</td>
</tr>
<tr>
<td>2014</td>
<td>HUB Certified - GRC funded UT AHEC Partnership for CHWs to train and hire CHWs to work through HUB/Medicaid settings - Awarded CDC grant to build adult Pathways</td>
</tr>
<tr>
<td>2015</td>
<td>IM and Chronic Diseases are priorities in Healthy Lucas County Plan - Assisted OCMH to secure funding to enhance/replicate HUB Model - Implemented Getting to 1 -Assess/Refer - Breast Health through Komen</td>
</tr>
<tr>
<td>2016-18</td>
<td>Funded by OCMH to expand HUB and mentor new HUBs - Becoming regional - Received funds to bring to scale IM reduction efforts in hotspot zip codes - Awarded federal transportation grant - Healthier Buckeye Expansion - Housing pilot - Contracted with 5 Medicaid Manage Care Plans for pregnancy and 3 for chronic disease care coordination and interconception</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>FTE CHWs</th>
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<tbody>
<tr>
<td>2005</td>
<td>.25 FTE 3 CHWs</td>
</tr>
<tr>
<td>2010</td>
<td>.75 FTE 5 CHWs</td>
</tr>
<tr>
<td>2013</td>
<td>1.25FTE 10 CHWs</td>
</tr>
<tr>
<td>2014</td>
<td>2.25 FTE 20 CHWs</td>
</tr>
<tr>
<td>2015</td>
<td>6.5 FTE 35 CHWs</td>
</tr>
<tr>
<td>2016-18</td>
<td>13 FTE 48 CHWs</td>
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[23]
Client Enrollment Through the Years
2007-2017
Northwest Ohio Pathways HUB
Care Coordination Agencies
HUB System Efforts to Improve Pathways Completion

- Mommy & Me Ride Free
- Getting to 1 Housing Pilot
- Getting to 1 Diaper Bank
2017 BIRTH OUTCOMES

<table>
<thead>
<tr>
<th></th>
<th>Low Birth Weight</th>
<th>Preterm</th>
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</thead>
<tbody>
<tr>
<td>African American</td>
<td>8.4%</td>
<td>11.8%</td>
</tr>
<tr>
<td>White</td>
<td>10.9%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Total</td>
<td>9.8%</td>
<td>13.4%</td>
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2016 ODH:
Lucas AA – 14.3%
Lucas Overall – 9.7%
Northwest Ohio Pathways HUB
Funding Partners
Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change.

www.collaborationforimpact.com/collective-impact/

Source: Santa Fe Community Foundation
Health Assessment is the Foundation.
The power is in the COMMUNITY Health Improvement Plan . . .

THIS IS AN OPPORTUNITY TO ALIGN THE HOSPITAL WITH THE COMMUNITY AND ITS RESOURCES TO BEGIN TO ADDRESS THE ROOT CAUSES OF HEALTH DISPARITIES WHICH HAVE PERSISTED FOR DECADES.