Bridges to Health: A Pathways Program

Columbia Gorge Health Council first implementation in collaboration with Mid-Columbia Housing Authority

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Pathways is centralized system that coordinates, tracks and measures both the process and the resources that allow for Community Care Coordination of those served.
Pathways ties payments to milestones that improve clients health and well being.

Sarah Redding, MD, MPH, co-developed the Pathways Model with her husband, Mark Redding, MD, in 2001 and successive work led to the Pathways Community HUB Model

Target Population- Housing Challenged Criteria

- *Homeless or at risk of becoming homeless as defined by **one or more** of the following:
  - At risk of losing housing
  - In a "Double up" situation
  - Housing not meant for human habitation
  - Inadequate housing without usable utilities
  - In a shelter or transitional housing program
  - Fleeing or attempting to flee domestic violence
  - Homeless youth
  - Severely cost burdened (more than 50% of income on housing costs)
- Unable to acquire or maintain housing due to **one or more** of the following situations:
  - Severe medical concerns
  - Disability
  - Substance Abuse
  - Severe mental illness
  - Criminal record and/or justice involve
  - Lack of transportation
- Housing Choice Voucher holders seeking a place to utilize voucher

FIND: Care Coordinator working at Community Agency finds "housing challenged clients"

Sectors:
Housing
Early Learning
Primary Care
Health Departments
Justice
DHS

TREAT: Clients needs are assessed. Client & Care Coordinator prioritize needs to address

Education
Employment
Health Insurance
Housing
Social Service Referral
Behavioral Referral
Developmental Screening
Developmental Referral
Education
Family Planning
Immunization
Pregnancy
Postpartum
Medical Home
Medical Referral
Food
Smoking Cessation

TREAT: Care Coordinator:
-Connect clients to services
-Follow up to insure needs were met
-Collaborate with other Care Coordinators

MEASURE:
-document work
-evaluate benchmarks
-track outcomes & service gaps
-share data

The Pathways Model Overview:

- Community Care Coordination with clients that happens outside the office walls
- Uses a skeleton of steps (in a Pathway) to be completed to meet an outcome
- A closed loop system using shared measurements for accountability and quality work
- Recognizes the importance of social issues as well as traditional health issues
- Uses a "hub", a neutral clearinghouse that brings together the many agencies trying to reach those who are at greatest risk.

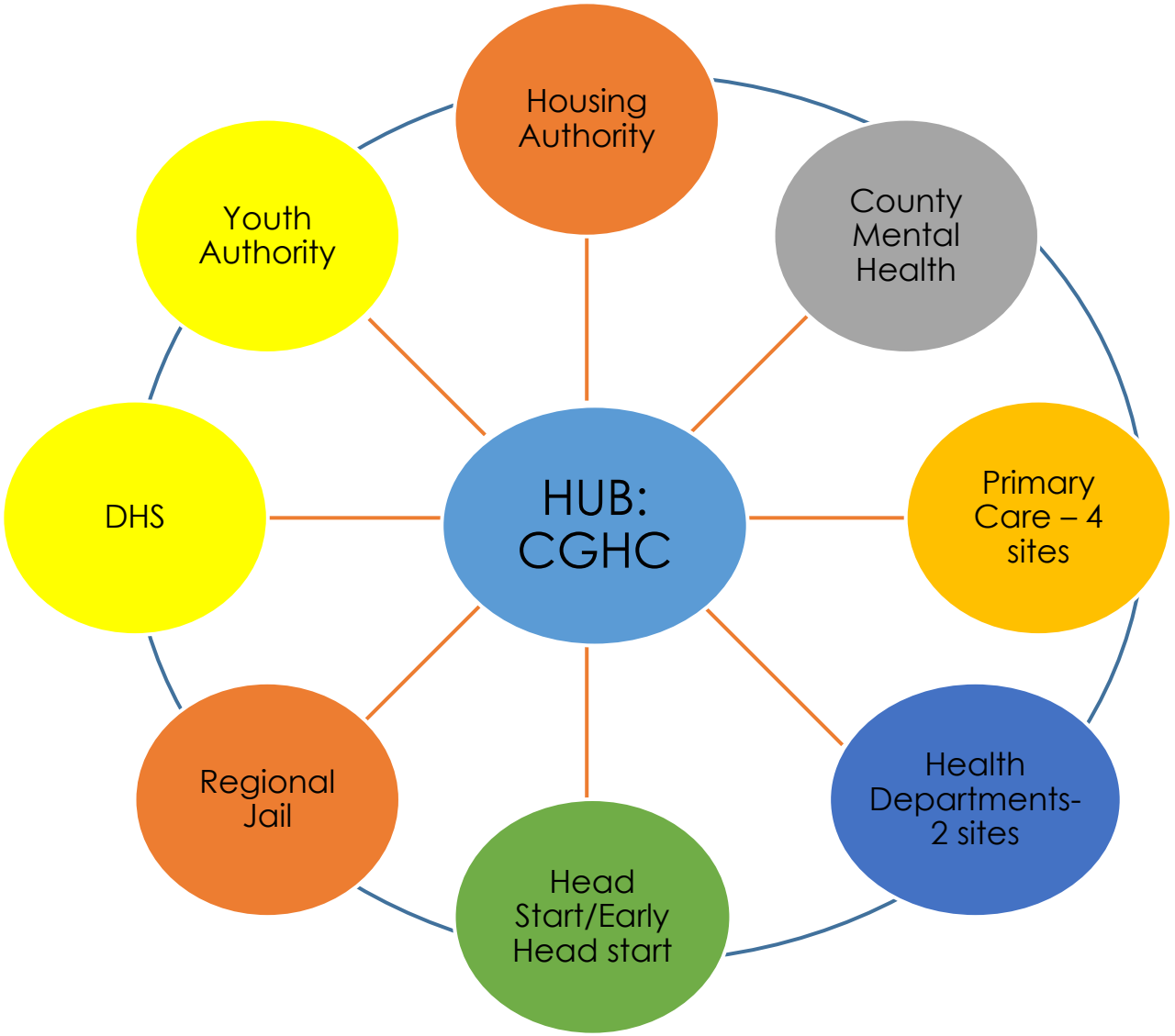
Core Pathways

- Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral (medical appointments and screenings)
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Food
- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization
- Pregnancy
- Postpartum

Social Services Pathways (examples)

- Food
- Housing Emergency Assistance
- Utilities
- Insurance (other than medical)
- Finances
- Medical debt
- Medication assistance ($)
- Transportation
- Services for seniors and/ or caregivers
- Child care
- Legal issues
- Parenting
- Domestic violence
- Clothing
- Spiritual/ Faith Assistance
- Assistance for people with disabilities
- Interpretation services
- Documentation assistance

Initial Care Coordination Agencies



Bridges to Health key points

- Funding pays for outcomes met
  - Both healthcare and social services
- Client needs / choice directs where the funding ultimately ends up
- Resulting data will highlight where largest service gaps exist
  - Helps housing and other agencies for future investments
- GORGE Pathway design= community standards of care
  - meet metrics across sectors (housing, healthcare, early learning, justice)
  - sets high standards of care for clients based on need

Learnings thus far

Challenges

- Shared release of information is challenging
- More community participation means increased clients= more costs
- CCO's are limited to what they can pay for
- Care Coordination looks different at different agencies
- Agencies may have limited home visiting experience
- Lack of resources (i.e. housing) can lead to frustrating work

Successes

- Strong cross-sector collaboration
- PSCS Health Plan involved in design, Providence Health Plan in pilot
- Subject expert sub-groups designed Pathways to meet metrics
- Sets high standard of care
- Software allows for:
  - standard processes
  - standard tracking
  - limits duplication of services & of surveying of the population
- Collective impact model used in the Gorge supports cooperation
- Funding allows for agencies to get paid for work they are doing

Thank you for your time

Comments?

Questions?