



Community Care Coordination Systems:
Connecting Patients to Community Services



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INTRODUCTION

As states, communities, health systems and providers begin to address the social determinants of health, an essential element is a comprehensive system that connects patients with both the health and social service sectors so all needs are addressed. We refer to these as community care coordination systems. Patients with multiple health and social needs tend to be high users of health care services and incur high health care costs.¹ These patients with multiple needs are often left on their own to navigate our fragmented systems.² When medical and social service providers have a care coordination system to which they can refer patients for needed services, it offers an opportunity for communities to address social determinants of health needs more effectively and efficiently.

We have found through our work with Oregon on this project, as well as our work with other states, that this type of community care coordination system is critical for connecting the clinical system with social support systems and is an essential part of moving health care upstream. Another brief developed as part of this project is based on our work in Oregon with the PacificSource Columbia Gorge Coordinated Care Organization (CCO) and their efforts to identify sustainable financing mechanisms for the Bridges to Health Pathways Hub, a community care coordination system. That brief, *“Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value-Based Purchasing,”* provides critical information on how to finance community care coordination systems under Medicaid.

Community care coordination systems that connect patients to community services are organized at the community level. These systems often are developed by a small group of individuals within the community; many systems are initially designed to address one segment of the at-risk population.³ An organizing entity or “community hub” on the ground serves to: form partnerships with organizations in the community; set policy (e.g., payment, training

Nemours Children’s Health System was awarded a one-year grant to help three state Medicaid programs test approaches to financing upstream prevention and population health through AcademyHealth’s Payment Reform for Population Health initiative, with funding from the Robert Wood Johnson Foundation. While almost all states have begun Medicaid delivery system reform, initiatives and programs geared toward upstream prevention and population health are in varying stages of development. Nemours provided technical assistance to three states – Maryland, Oregon and Washington – as they developed or implemented upstream prevention strategies using Medicaid funds. This brief is one in a series of six “how to” briefs illustrating how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives. The entire series of briefs can be found at <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention>. To learn more about AcademyHealth’s Payment Reform for Population Health initiative, visit www.academyhealth.org/p4ph.

requirements); collect data; and track outcomes. We became familiar with the Pathways Community HUB model (see spotlight below for more detail) through our work in Oregon with the Bridges to Health Pathways Hub.

Recognizing the importance of community care coordination systems in helping clinical systems go upstream to address the social determinants of health, our goal was to develop a checklist of the functions and features of a successful comprehensive system. We found, however, that some systems are focused on only a few functions; other systems may lack a core feature necessary for success. For example, a variety of electronic platforms have emerged that connect patients to community services through cloud-based technology. While these platforms enable health systems to manage care and share data across providers and settings, they may not include personal follow-up and may lack important functions and features such as a closed loop referral mechanism.



CHECKLIST OF COMMUNITY CARE COORDINATION SYSTEM FUNCTIONS AND FEATURES

This section presents our view of the key functions (see sidebar) and key features (see box on page 4) that should be in place for communities wanting to design a community care coordination system that connects patients to community services. These findings are based on Nemours' experience and work in a number of states. In the next section, we spotlight the Pathways Community HUB model (although many other models/variations exist) and illustrate how each of these functions is operationalized on the ground.

Checklist of Key Functions

- **Identify** and engage patients who are likely to have multiple health and social needs.
- **Screen** patients for social determinants of health (SDOH) needs and determine the appropriate organizations with the resources and knowledge to address their specific needs.
- **Connect** patients with these community organizations that can help address their social needs within the community care coordination system.
- **Follow up** to ensure patients are connected and facilitate completion of the SDOH intervention or activity. This includes providing support to patients who receive services outside the medical system and communicating that information back to the patients' medical provider.
- **Track outcomes** of patients receiving community-based services.

Checklist of Key Features

The following are factors, conditions of success and strategies that we believe should be in place to facilitate the development of a comprehensive community care coordination system.

- **leadership** to galvanize key community members around the need to create a community care coordination system that connects patients to community services
- **governance structure** to set the system-wide policies and procedures (e.g., define population segment served, set staff training requirements, determine payment level for achieving outcomes, obtain legal capacity to enter into contracts and agreements)
- **adequate staffing** (e.g., community health workers) to perform critical functions such as identifying and engaging at-risk patients, conducting a comprehensive assessment of health, social and behavioral risk factors, developing a care coordination plan and following up with individual patients
- **screening tool** to assess the needs/risk factors of patients engaged in the system
- **care plan** that is customized for each patient's unique set of health-related and social needs
- **network of community resources/partners** that can address a variety of social determinants of health needs to serve clients. The capacity of social service providers to provide needed services should be monitored. If gaps in social services are identified, there should be a mechanism to inform policy
- **patient communication** so the care coordinator can keep in touch with patient (e.g., text messaging, e-mail, patient portal)
- **closed loop referral mechanism** to facilitate a patient's referral to and receipt of a community service or upstream intervention and ensure that the information is communicated back to the patient's provider
- **interoperability** of the system so an individual patient's information (e.g., demographics, social needs, care plan, referrals and outcomes) can be shared between health and community service organizations
- **quality improvement** to monitor and improve the quality of care coordination services and social services provided to individuals engaging with the system. There should be a system in place to evaluate the care coordinators, referral process, payment methodology, duplication of services, etc
- **funding** to support both start-up costs and ongoing maintenance. Strategies are needed to manage/braid funding from multiple sources (e.g., Medicaid, MCO, grants)
- **data collection mechanism** that allows information from patients to be collected,

SPOTLIGHT: PATHWAYS COMMUNITY HUB

In this section, we use information from the Pathways Community HUB Manual⁴ to illustrate how a community care coordination system is intended to work on the ground. Care coordination, a term often associated with the health care system, is the process of identifying at-risk individuals and connecting them with health and social services.⁵ While local, state and federal health and social service funding streams often cover care coordination services, the care coordination is frequently siloed across different organizations serving the same individual.⁶ Thus, one individual may have multiple care coordinators addressing his or her risk factors. This fragmented approach to care coordination results in duplication and inefficiency.⁷

The Pathways Community HUB model (i.e., the HUB model) addresses “community care coordination,” which is defined in the HUB manual as the coordination of services provided outside the health care system.⁸ The HUB model relies on community care coordinators – community health workers, nurses, social workers and others – to meet individuals in their homes or community settings and to address a variety of needs such as housing, transportation, employment, education and access to health care services.⁹ The HUB model works across sectors within a community to reach at-risk individuals and connect them to the evidence-based interventions and services that they need to have positive outcomes.¹⁰

The HUB model was first developed by Drs. Sarah and Mark Redding as part of the Community Health Access Project in Mansfield, Ohio.¹¹ Community-based models like the HUB model often start with the concerted efforts of a small group of people who are determined to make a difference for the highest-risk members of their community.¹² They may begin by addressing the needs of one subsection of the population such as adults with multiple chronic conditions. Once the infrastructure is in place, they often expand to include other high-risk groups.

In the HUB model, the HUB serves as an organizing entity that “supports, coordinates and tracks outcomes for all the agencies that provide the direct on-the-ground community-based care coordination.”¹³ The HUB does not directly provide care coordination services; rather, it addresses duplication by bringing all the care coordination agencies into one network. There can only be one HUB in a geographic area.¹⁴ The HUB provides a centralized set of processes, systems and resources that enable communities to track individuals being served and provides a way to align payments and outcomes.¹⁵

Once a person is identified and an assessment of risk factors is completed, a specific standardized “Pathway” is assigned for each of the individual’s risk factors. An individual may have multiple Pathways assigned simultaneously. Completion of the Pathway indicates that the person has obtained an evidence-based intervention to address the risk factor.¹⁶ The Pathways are the specific tools the HUB model uses to track an individual’s outcomes.¹⁷ A complete list of the Pathways Community HUB model’s approved Pathways can be found in the box.

The HUBs engage with care coordination agencies (e.g., local health departments, Head Start, housing authority and medical clinics) that employ community care coordinators to find and connect at-risk individuals to needed services. In an individual community, the HUB and its partners, including care coordination agencies, perform a number of key functions. We illustrate these key functions (as described in the HUB manual) using our checklist of functions as a framework.

Community HUB Pathways⁸

- Adult Education Pathway
- Behavioral Health Pathway
- Developmental Referral Pathway
- Developmental Screening Pathway
- Education Pathway
- Employment Pathway
- Family Planning Pathway
- Health Insurance Pathway
- Housing Pathway
- Immunization Referral Pathway
- Immunization Screening Pathway
- Lead Pathway
- Medical Home Pathway
- Medical Referral Pathway
- Medication Assessment Chart
- Medication Assessment Pathway
- Medication Management Pathway
- Postpartum Pathway
- Pregnancy Pathway
- Smoking Cessation Pathway
- Social Service Referral Pathway

Identify and engage patients who are likely to have multiple health and social needs.

In the HUB model, the community care coordinators (CCCs) spend most of their time working in the community and, through this work, identify at-risk individuals in need of services. CCCs employ strategies to not only find at-risk individuals but to engage them in care coordination services. If the individual agrees to participate, he or she signs a release of information form. The CCC checks with the HUB to make sure that the individual is not working with another CCC within the HUB network. Once a determination is made that the individual is not yet enrolled, the CCC registers the individual as a new client with the HUB. Data collection begins at this point through a standard demographic intake form.

Screen patients for social determinants of health (SDOH) needs and determine the appropriate organizations with the resources and knowledge to address their specific needs.

Once an individual is identified and agrees to participate in a HUB, the CCC completes an assessment of the individual's health, behavioral health and social risk factors that may lead to poor health outcomes. As part of coordinating care, the HUB must build and maintain a network of community care agencies (i.e., partners) that provide health (physical, behavioral and prevention) and social services. These community partners have the resources and knowledge to address social determinants of health.

Connect patients with these community organizations that can help address their social needs within the community care coordination system.

Each at-risk individual referred to a HUB develops a relationship with a CCC. A CCC develops a supportive relationship with the individual by understanding: the needs of the individual; past treatment experiences and preferences; strengths and resources of the individual; and the barriers that the individual faces.¹⁹ The CCC and the individual together develop a care plan that addresses all identified risk factors with a basic approach of addressing survival-based priorities first (e.g., housing, food).²⁰ An individual is assigned a specific Pathway to address each of his or her identified risk factors. Assigning a specific Pathway ensures that an individual who is assessed with health or social needs is connected to the appropriate community care agency and that the risk factor is addressed with an evidence-based or best practice intervention.

Follow up to ensure patients are connected and facilitate completion of the SDOH intervention or activity. This includes providing support to patients who receive services outside the medical system and communicating that information back to the patient's medical provider.

After an individual is assigned one or more Pathways, the CCC continues to work with the individual until the Pathways are completed and outcomes achieved. The CCC provides follow up with the individual to facilitate and ensure completion of each of the required steps in the Pathway. For example, the CCC might confirm weekly that the individual has attended the class for which she or he has registered and document progress. During home visits, the CCC will continue to evaluate the individual's medical, behavioral health and social risk factors.

Track outcomes of patients receiving community-based services.

In the HUB model, the "Pathways" are the standardized outcome measurement tools that the HUB uses to track progress.²¹ As an individual completes a Pathway, the risk factor is eliminated or reduced. HUBs have the capacity to track and measure an individual's risk status over time.²² The HUB runs reports that evaluate the speed and effectiveness of addressing each risk factor. Barriers are identified in the community service structure both at the individual and population level.²³ Pathways not completed are also documented. The community can use this

information to assess gaps in services and address these issues on a policy level.²⁴ In addition to tracking outcomes, the completed Pathways are tied to the billing report.

In addition to the key functions outlined above, a community care coordination system needs to ensure its financial sustainability. The following examples show how Pathways Community HUBs can finance both start up and ongoing costs.

Finance start-up costs. Pathways Community HUBs need funding to set up an infrastructure and establish partnerships with community-based organizations. Some HUBs receive grant funding to help with start-up costs. For example:

- The Ohio Commission on Minority Health has funded the replication and expansion of Pathways Community HUBs in Ohio.²⁵
- The Meyer Memorial Trust provided a two-year grant to the Columbia Gorge Health Council with the goal of linking housing and health using the Pathways Community HUB model through their Affordable Housing Initiative grant. This two-year grant was geared toward launching the Bridges to Health Pathways Hub by providing funding for program development, training and then support for the initial housing pathway payments.²⁶

Finance ongoing maintenance costs. In addition, there are ongoing HUB maintenance costs such as staffing, building partnerships with community organizations, and soliciting and managing funds. HUBs can contract with health plans, such as Medicaid managed care organizations, to pay for certain ongoing costs such as care coordination and medical services. For example:

- The HUBs in Ohio contract with four out of the five Medicaid managed care organizations in the state to pay for completion of a Pathway.²⁷
- The Bridges to Health Pathways Hub (with technical assistance supported by Nemours and AcademyHealth) is seeking to contract with PacificSource (Managed Care Organization) to begin billing in 2018 for many of the services provided to Medicaid beneficiaries through its Pathways. Most of the Pathways established in the Bridges to Health Pathways Hub include services that can be reimbursed by Medicaid through several different federal and state regulatory provisions such as those for care coordination and “value added services.” Most of the services in the Pathways may be considered in the numerator of the CCO’s medical loss ratio and certain services may be considered for rate setting. More detail can be found in the brief referenced on Page 1, “*Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value-Based Purchasing*,” that draws lessons from the work with the PacificSource Columbia Gorge CCO.

CONCLUSION

We believe community care coordination systems offer an opportunity to address social determinants of health needs more effectively, improve outcomes, reduce duplication and, thereby, lower costs. The core functions of these systems are presented as well as a checklist of the critical success features that should be in place in communities that want to move forward. In addition, we highlight a specific model, the Pathways Community HUB, to provide more detail about how a community care coordination system operates on the ground.

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