Connecting Those at Risk to Care

The Quick Start Guide to Developing Community Care Coordination Pathways

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Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Developed by:
Community Care Coordination Learning Network

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The information in the *Connecting Those at Risk to Care* quick start guide is intended to assist service providers and community organizations in creating care coordination pathways for the delivery of health care and social services. This guide is intended as a reference and not as a substitute for professional judgment. The findings and conclusions are those of the authors, who are responsible for its content, and do not necessarily represent the views of AHRQ. No statement in this guide should be construed as an official position of AHRQ or the U.S. Department of Health and Human Services. In addition, AHRQ or U.S. Department of Health and Human Services endorsement of any derivative products may not be stated or implied. None of the investigators has any affiliations or financial involvement that conflicts with the material presented in this guide.

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CCCLN Quick Start Guide Work Group

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Mark Redding
Dan Rubin

Members

Pat Kuratek
Mary Overall
Sarah Redding
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Overview

This *Quick Start* guide complements *Connecting Those at Risk to Care: A Guide to Building a Community "HUB" To Promote a System of Collaboration, Accountability, and Improved Outcomes*, published in 2010 by the Agency for Healthcare Research and Quality (AHRQ). That manual describes a "Pathways Community HUB," a new type of infrastructure that provides the beginning tools and strategies needed to ensure that at-risk individuals are served in a timely, coordinated manner. The HUB ensures that a person and populations are connected to meaningful health and social services that produce positive outcomes. HUBs help avoid duplication of effort and keep individuals from falling through the cracks.

This quick start guide is a reference and resource for public and private stakeholders engaged in improving the system for identifying and connecting at-risk individuals within a community to appropriate health and social services. The target audience includes all those involved in the design, implementation, and financing of care coordination services.

This guide gives an overview of the process for developing a community HUB and reviews the tools and resources needed to develop a HUB using pathways. Applicable to a wide array of biological, psychological, and social conditions, pathways are tools for coordinating health and social services provided to at-risk individuals by multiple providers in a community. Those using pathways get paid based on measurable value and outcomes (rather than the traditional approach of paying for inputs).

Additional information on the community HUB model and pathways is available in the full manual, available at www.innovations.ahrq.gov or from the AHRQ Clearinghouse at 800-358-9295 (Publication No. (09)10-0088).

Why Create a Community HUB and Pathways?

A community HUB and accompanying pathways represent effective vehicles for achieving the goals of recently enacted health care reform legislation, creating greater financial accountability for the delivery of high-value health and social services, and improving health outcomes.

Reason 1: To Promote the Goals of Health Care Reform

In addition to expanding coverage to 32 million previously uninsured Americans, the Patient Protection and Affordable Care Act aims to improve population health and quality of care while containing costs. The legislation includes incentives for the creation of accountable care organizations (ACOs), which will be paid based on their ability to improve overall population health, enhance the patient experience, and control per capita costs. To meet these goals, ACOs will have to provide the populations they serve (including at-risk individuals) with appropriate, timely access to high-quality, well-coordinated health and social services.

The community HUB serves as a framework that can help ACOs meet this challenge. The community HUB model was developed by the Community Health Access Project (CHAP) in Mansfield, Ohio, under the leadership of Drs. Sarah and Mark Redding. The model involves working across organizational silos within a community (CHAP worked with multiple stakeholders in three counties) to reach at-risk individuals and connect them to health and social services that yield positive health outcomes.

Through communication, collaboration, and built-in incentives, the HUB increases the efficiency and effectiveness of care coordination services. Rather than allow providers of health and social services to continue functioning in isolated silos, the community HUB requires them to work collaboratively, reaching out to those at greatest risk and connecting them to evidence-based interventions, with a focus on prevention and early treatment. (For more information about CHAP, the community HUB, pathways, and the 16-member national network, visit http://innovations.ahrq.gov/cccln.aspx.)

To ensure quality and accountability across all providers of care coordination services, the HUB acts as a central clearinghouse that "registers" and tracks at-risk individuals, making sure that their biological, psychological, and social needs are met. The HUB provides ongoing quality assurance that results in less waste and duplication, lower costs, improved health status, and fewer health disparities. In short, the HUB ensures a connection to community resources and holds providers, practitioners, employers, families, and individuals accountable for desired outcomes.

Reason 2: To Close the Nation's Cost and Quality Gap by Paying for Value, Not Volume

The United States spends significantly more money per capita on health care services than any other nation in the world. But we lag behind most other developed countries in terms of key outcome measures, including infant mortality, health equity, patient perceptions of safety, efficiency, and effectiveness. Much of the gap between spending and outcomes stems from the American health care system's difficulty identifying at-risk individuals and providing them with effective, coordinated medical and social services.

Connecting those at risk to timely, high-quality care requires expertise, accountability, and investment. Yet the current business model for the provision of care coordination services to at-risk populations

remains inadequate. Care coordination contracts typically purchase "work products" that have no meaning or clear positive impact on the clients being served.

Contracts typically do not require those who provide care coordination to ensure that individuals actually get connected to or benefit from needed services. Rather, payments are based on the volume of work products provided, such as the number of individuals added to a case list, visits or phone calls made, or notes charted. In addition, the current payment structure creates no incentive for the multiple organizations providing services to communicate or collaborate with each other, thus leading to duplication and other inefficiencies.

The Community HUB and its accompanying pathways can help improve the payment system by fundamentally changing the way care coordination contracts are written. Under the Pathways model, payments are revamped to recognize the time, resources, cultural competence, and skill required to achieve measurable and meaningful results. This type of system can help the United States close the health care cost and quality gap with other developed nations.

A Quick Guide to Creating and Using a Community HUB and Pathways

As noted, the HUB infrastructure creates accountability among specific providers of care coordination services by tying payment to the achievement of patient-centered outcomes, including improved health status, fewer disparities, and lower costs. The aforementioned "pathways" serve as the primary mechanism for achieving this transition, as they promote and incentivize value rather than volume of services. A community HUB uses pathways to track, document, and report the provision of services to at-risk individuals and to hold providers of care coordination services accountable.

Rather than acting as a detailed procedural guide, pathways function as visual, logical work management tools that facilitate measurement of outcomes and payment based on those outcomes. Pathways can be used in three distinct ways: (1) within a single agency and its workforce; (2) across multiple agencies providing care coordination services to the same individuals within a community; and (3) across multiple communities that have their own unique approaches to connecting at-risk individuals to services.

Key Elements of an Effective Community HUB

Key elements of an effective community HUB include:

- **Governance documents:** These documents include a list of the providers and agencies involved, protocols for HUB governance, requirements for participating individuals and agencies, communication strategies, reporting and contracting requirements, privacy practices (as dictated by Health Insurance Portability and Accountability Act, or HIPAA, requirements), and any other legal documents required for clarification of the HUB.
- **Needs assessment:** This assessment identifies the health and social service needs, including baseline measurements for the at-risk population to be served. It can be refined and expanded on an iterative basis over time.
- **Care coordination program requirements:** These requirements specify appropriate practices for participating programs, agencies, and providers of care coordination services within the community. Examples include how to register new clients in the HUB (to avoid duplication), track required information (e.g., demographics, checklists, applicable pathways), and meet quality assurance protocols (e.g., training) and contract requirements.
- **Data system:** While a complex system is not required, the community HUB must create an accurate, efficient method for tracking demographics, checklists, and pathways. Most HUBs will rely on information technology to perform this task. Whatever approach is used, this system must ensure the protection of client information at all times.
- **Demographic and referral form:** This form serves as a mechanism for individuals, providers, and agencies to submit a new client referral to the community HUB. It should include a place to capture key demographic information about clients. (See sample forms in the appendix.)
- **Checklists:** Care planning checklists capture specific information on health and social issues at each face-to-face encounter. Health and social issues identified in completing the checklist support the care coordinator and supervisor in determining which specific pathways should be

assigned to address each issue. A more comprehensive checklist will be used at the initial encounter, ideally with different checklists available for specific populations (e.g., pediatric patients, pregnant women). Checklists are used on an ongoing basis to monitor changes in health or social status between visits. A sample checklist for adult clients is shown in the appendix (Exhibit A-2).

- **Tracking and payment system linked to outcomes:** Prior to the launch of HUB operations, a tracking and payment system must be developed that rewards participating organizations and individuals based on the completion of pathways—a step that indicates achievement of a positive, measurable outcome. Participating agencies within a HUB must be rewarded and incentivized to work in collaboration with other agencies to reach those at greatest risk and connect them to care. Those at greatest risk require the greatest time and expertise to serve. Payments scaled to risk and performance measures in completing pathways can strengthen and grow the initiatives with the greatest skills in community-based cultural connection, patient education, and effectiveness in achieving patient compliance with medical care.
- **Quality assurance:** Systems and reporting mechanisms need to be in place to monitor the quality of care provided to all clients. In addition, protocols must be developed that outline expectations for care coordinators with respect to the delivery and documentation of services.
- **Care coordinator requirements and training:** Many different types of professionals can serve as care coordinators, including social workers, community health workers, nurses, and others. These individuals meet face to face with clients in a community setting, including the home. To ensure the provision of high-quality services and effective collaboration across all providers, each community HUB should develop basic human resource requirements for care coordinators, along with a comprehensive initial training program. Participating agencies may expand on these efforts by developing their own additional requirements and training programs. At a minimum, care coordinators working with the HUB should complete training on the following: cultural competence, home visiting strategies (including safety), HIPAA and confidentiality of patient information, pathways used by the HUB, and requisite data systems and forms (or other methods for documentation).

A Step-by-Step Process for Using a Pathway

Pathways outline key stages required for the delivery of high-quality, efficient care coordination services. Each pathway focuses on one significant client need or problem and identifies and documents the key steps that lead to a desired, measurable outcome. To create incentives for positive outcomes, financial payments are tied to key stages of the pathway. What follows is a brief review of the key steps involved at the level of the client within a community HUB using pathways:

- **Engaging client:** Using his or her cultural competence and professional relationship skills, the care coordinator reaches out within the community to engage an at-risk individual in need of health and social services.
- **Enrolling client:** Once the client agrees to be connected to needed services, the care coordinator collects basic demographic information and registers the client in the community HUB to ensure that the client is not currently receiving services through another agency. Upon confirmation that there is no service duplication, the care coordinator becomes assigned to that

specific client, making him or her accountable for assisting the client in completing mutually agreed-on pathways.

- **Identifying barriers and needed pathways on an ongoing basis:** Using a checklist (described earlier), the care coordinator collects basic information at each face-to-face visit with the client. The checklist identifies barriers[i] and necessary pathways to ensure connection to needed health and social services.
- **Tracking and documenting pathway steps on an ongoing basis:** The care coordinator tracks and documents the various steps included in the relevant pathways, beginning at initiation of each pathway and continuing until its completion.
- **Reporting to the HUB:** Individual care coordinators and agencies working within a community HUB provide ongoing reporting to the HUB, particularly focused on client progress in completing assigned pathways.
- **Evaluating HUB performance:** The community HUB collects and analyzes individual and population-based measures of performance, including those related to health outcomes and cost savings. The HUB reviews and aggregates data submitted by participating individuals and organizations and then reports on overall success in engaging at-risk clients and ensuring their connection to care. Data collection includes assessments and summaries of pathways in process and completed. To stimulate continuous improvement, the HUB evaluates the overall function of the network of agencies providing care coordination services.

The HUB generally monitors and tracks performance at three different levels:

- **Individual client:** Measurement at the individual client level occurs through use of the pathways.
- **Community:** Measurement of performance by the community delivery system includes evaluation of its ability to reach at-risk populations and connect them to needed services, reduce duplication, and increase efficiency.
- **Population:** Data (public health, HUB, plan) from the community delivery system can be combined with health system data to track improvements in population health and cost savings.

[i]Originally, the identification and resolution of barriers was considered a step in every pathway, but experience has shown that the same barriers tend to exist in connecting a patient to multiple services. Thus, the process of addressing barriers is now viewed as a fundamental work process that cuts across services and pathways.

Examples of Six Core Pathways

As noted, each community HUB uses pathways to ensure that individuals get connected to needed health and social services. This section of the guide provides a set of six core pathways that community HUBs can use to meet a wide range of care coordination service needs. These core pathways can be generalized—i.e., the same "architecture" and steps can be used with slight variations to address many other specific service needs within a community. If deemed necessary, new pathways can be created based on the definitions set forth in the CHAP Pathways Manual (available at: http://chap-ohio.net/press/wp-content/uploads/2010/09/PathwaysManual1.pdf), although communities should begin with the core pathways developed by CHAP before considering the creation of new ones.

A brief review of the six core pathways follows:

The first three core pathways—**Medical Home**, **Medical Referral**, and **Social Service Referral**—are used to track all recommended referrals through to completion.

The fourth core pathway, **Health Insurance**, addresses one of the most pervasive barriers to receiving needed medical services, which is the lack of insurance coverage or other means of paying for needed care, including primary care.

The fifth core pathway, **Medication Assessment**, can be used to make sure patients have the correct medications and use them as prescribed.

The sixth core pathway, **Pregnancy**, is among the most commonly used of all pathways. It addresses an important area with significant potential for improvements in birth outcomes and reductions in health disparities and costs.

Core Pathway 1: Medical Home

Ensuring access to patient-centered primary care homes is critical to creating a more effective, efficient, and sustainable health care system with few health disparities. The Medical Home Pathway model emphasizes the need for effective care coordination through a team-based, patient-centered approach.

The Medical Home Pathway uses a verified connection with an ongoing source of primary care as its primary outcome (end point). As the model is implemented in more settings, the pathway's completion step can be expanded from a confirmed initial primary care visit (used today) to evidence of true engagement[ii] with a provider at a clinic or practice that meets medical home standards.

Client Name_____

Date of Birth _____

Care Coordinator _____

Medical Home Pathway

INITIATION

Individual needs a medical home (ongoing source of primary medical care).

_____

Start Date

↓

Determine payment source for health care.

Payment Source:

___ Medicaid ___ Private Insurance

___ Medicare ___ Self-Pay

___ Other: _____

↓

Find appropriate primary medical provider who will accept payment source.

_____

Medical Provider

↓

1. Obtain release of information from client.
2. Assist family in scheduling appointment.
3. Provide education about the importance of keeping the appointment. Use education sheet.

_____

Date of Initial Appointment

Education provided: Yes_____ No_____

↓

COMPLETION

- Currently: Confirm appointment was kept.
- Future end point: Confirm patient engagement with medical home.

_____

Date of Kept Appointment

Standardized evidence of engagement (TBD)

Finished but incomplete (reason):

[ii]Measures of patient engagement, such as the Patient Activation Measure, are currently evolving.

Core Pathway 2: Medical Referral

The Medical Referral Pathway reflects the process for documenting a successful visit to a specialty provider, including mental health, or a return visit to the Medical Home provider. (The return visit is distinct from establishing the initial connection to ongoing medical care in the Medical Home Pathway). This pathway is used to track connections to a variety of specialty services (see coding below).

An individual client may have multiple Medical Referral Pathways to track his or her ongoing connection to primary care and confirmed connections to needed specialty services. To complete this pathway, clients must receive services along with specific education to support ongoing engagement and compliance.

Client Name_____

Date of Birth _____

Care Coordinator _____

Medical Referral Pathway

INITIATION

Client needs a **health care appointment.**

(Use codes to identify type of referral – see below.)

_____

Start Date

Type of Referral _____

↓

Educate client/family about the importance of regular medical visits and keeping appointments.

Education provided: Yes_____ No_____

↓

Appointment scheduled with provider/clinic.

_____

Appointment Date

↓

COMPLETION

Verify with medical home provider (or by another method) that **appointment was kept.**

_____

Date of Kept Appointment

_____

Document how appt. was verified

Finished but incomplete (reason):

Code Numbers for Medical Referral Pathway

1. Primary Care
2. Specialty Medical Care_____
3. Dental
4. Vision
5. Hearing
6. Family Planning
7. Mental Health
8. Substance Abuse
9. Speech and Language
10. Pharmacy
11. Other; please specify in chart:
    _____

Core Pathway 3: Social Service Referral

This pathway captures needs that fall outside the realm of health care as defined by the Social Determinants of Health model. This model emphasizes the importance of poverty, employment, social environment and support, and other factors in determining an individual's health status. (Visit www.healthypeople.gov/2020/topicsobjectives2020/ overview.aspx?topicid=39 for more details.)

The Social Service Referral Pathway covers priorities such as housing, food, and other basic survival needs. Understanding and addressing these needs becomes a prerequisite to improving overall health. In addition to the general Social Service Referral Pathway, a Housing Pathway illustrates a customized Social Service Referral Pathway that deals with a particular need.

Client Name_____
Date of Birth _____
Care Coordinator _____

Social Service Referral Pathway

INITIATION
Client needs a social service.

_____
Start Date
Code Number (below) _____

↓

Provide appropriate education and discuss the importance of keeping appointments or other areas of client participation.

Education provided: Yes_____ No_____

↓

Appointment scheduled and/or arrangements made with social service provider. (May include services provided by pathways agency.)

_____
Date of Appointment

↓

COMPLETION
Verify that services were provided to client; or for complex service, that an outcome for client occurred (see Housing Pathway below, for example).

_____
Date of Kept Appointment

_____
Document how appt. was verified

Finished but incomplete (reason):

Code Numbers for Social Service Pathway – Type of Service (Examples)

1. Child Assistance
2. Family Assistance
3. Food Assistance/WIC
4. Housing Assistance
5. Insurance Assistance
6. Financial Assistance
7. Medication Assistance
8. Transportation Assistance
9. Job/Employment Assistance
10. Education Assistance
11. Medical Debt Assistance
12. Legal Assistance
13. Parent Education Assistance
14. Domestic Violence Assistance
15. Clothing Assistance
16. Utilities Assistance
17. Translation Assistance
18. Other:_____

Client Name_____

Date of Birth _____

Care Coordinator _____

Housing Pathway

INITIATION

Individual is homeless, in imminent risk of losing current housing, or living in unsafe housing.

_____

Start Date

↓

Applications for appropriate housing program(s) completed and confirmed as received by housing program staff.

_____

Date of Completion

↓

Education provided, including the following:

1. How to check on status of housing applications
2. Tips for being a responsible renter
3. Rights related to discrimination, eviction, etc.

Education provided: Yes_____ No_____

↓

COMPLETION

Verify that the client has moved into HUD-defined "suitable housing."

_____

Date of Completion

Finished but incomplete (reason):

Core Pathway 4: Health Insurance

Lack of health insurance or other financial resources represents one of the most pervasive barriers to receiving needed medical services. The Health Insurance Pathway focuses on assisting clients in securing coverage, as evidenced by verification of enrollment.

Client Name_____
Date of Birth _____
Care Coordinator _____

Health Insurance Pathway

INITIATION
Client needs health insurance.

_____
Start Date

↓

Assist family in **completing forms** as directed and submit to appropriate agency.

_____
Date Application Sent

↓

Within 1-2 weeks, **confirm with agency** that all forms have been received and have been completed properly.

↓

COMPLETION

1. Arrange followup within 4-6 weeks of application submission **to confirm acceptance or denial** of insurance.
2. If **denied, record reasons** on client's chart and refer client to other community resources.
3. If **accepted, document status**—including insurance number—in client's chart.

_____
Date Approved

_____
Insurance

_____
Number

Finished but incomplete (reason):

Core Pathway 5: Medication Assessment

Making sure patients have access to, understand, and take prescribed medications appropriately and consistently is critical to achieving improved health outcomes. The Medication Assessment Pathway helps to determine what medications a patient has and how he or she takes them. This information can be entered into a Medication Assessment Chart (see pathway below) and sent to the patient's primary care provider for review. For those not taking their medications as prescribed, the primary care provider can use a Medication Management Pathway to resolve all outstanding medication-related issues.

Client Name_____

Date of Birth _____

Care Coordinator _____

Medication Assessment Pathway

INITIATION

Client needs assistance with medications. (Record referral source.)

Start Date

Referral Source

Complete the Medication Assessment Chart with your client and/or client's caregiver:

1. Include all medications your client says he/she is taking right now (prescription, over the counter, herbal, alternative, etc.).
2. Record what your client says about the medication in his/her own words, even if it is different from the label.

Send completed Medication Assessment Chart to client's primary care provider.

Date Chart Sent

___ FAX
___ HUB
___ Mail

COMPLETION

Verify with primary care provider that chart was received. If medication issues are identified, initiate Medication Compliance Pathway.

Verification Date

Medication Concerns:

___ **Yes**
___ **No**

Finished but incomplete (reason):

Core Pathway 6: Pregnancy

The Pregnancy Pathway tackles an area with tremendous potential for improvement in terms of better clinical outcomes, cost savings, and reductions in disparities. This commonly used pathway focuses on engaging at-risk clients in achieving a positive clinical outcome, with the completion step being the delivery of a normal-weight infant.

Client Name_____

Date of Birth _____

Care Coordinator _____

Pregnancy Pathway

INITIATION

Any woman confirmed to be pregnant through a pregnancy test.

_____

Start Date

↓

Provide pregnancy education.

_____

Date Education Completed

↓

Schedule appointment with prenatal care provider:

- Date of first prenatal appointment
- Date of next scheduled appointment
- Estimated Due Date
- Concerns identified

_____

Date of first PN appt. – set up by

___ Client

___ Care Manager

_____

Prenatal Care Provider

_____

Due Date

↓

Check on woman's prenatal appointments at least monthly.

_____

_____

_____

Concerns

COMPLETION

Healthy baby > 5 lb 8 ounces (2,500 grams)

Document baby's birth weight, estimated age in weeks, and any complications.

_____

_____

_____

_____

_____

Date of Birth

_____

Birth Weight

Finished but incomplete (reason):

Other Resources

Closing the quality gap: a critical analysis of quality improvement strategies: Volume 7—Care coordination. Available at: www.ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf.

Community Health Access Project. Focusing on outcomes: neighbors connecting neighbors. Available at: http://chap-ohio.net/.

Connecting those at risk to care: a guide to building a community "hub" to promote a system of collaboration, accountability, and improved outcomes. Available at: www.innovations.ahrq.gov/guide/HUBManual/CommunityHUBManual.pdf.

Cunningham PJ, Felland LE. Falling behind: Americans' access to medical care deteriorates, 2003-2007 results from the Community Tracking Study. Tracking Report No. 19. Washington, DC: Center for Studying Health System Change; June 2008.

Davis K, Schoen C, Schoenbaum SC, et al. Mirror, mirror on the wall: looking at the quality of American health care through the patient's lens. New York, NY: The Commonwealth Fund; January 2004.

Hispanics' hypertension better controlled with equal access to care. Science Daily 2007 Sep 14. Available at: www.sciencedaily.com/releases/2007/09/070913090355.htm.

Hoffman CB, Paradise J. Health insurance and access to health care in the United States. Ann NY Acad Sci 2008;1136:149-60. Epub 2007 Oct 22.

Institute of Medicine, Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press; 2001.

Klerman LV. Nonfinancial barriers to the receipt of medical care. U.S. Health Care for Children 1992; 2(2):171-85. Princeton/Brookings: The Future of Children. Available at: futureofchildren.org/futureofchildren/publications/journals/article/index.xml?journalid=67&articleid=477&sectionid=3266.

National Center for Health Statistics. Health, United States 2007: With chart book on trends in the health of Americans. DHHS Publication No. 2008-1232. Hyattsville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2007. Available at: www.cdc.gov/nchs/data/hus/hus07.pdf.

Appendix A: Pathways Compendium

Introduction: This document provides a quick reference on how to obtain information on the application of the Community Pathways Model to address key health concerns in communities across the country. It does not provide a comprehensive profile of all the programs. Contact information for each program is listed on pages 19-21.

	Health improvement focus area	Program name/geographic location of Pathway sites that address focus area	Special populations/ characteristics
1	Connection to a Medical Home	Pathways to a Healthy Bernalillo County/ Albuquerque, New Mexico	Urban setting
		Healthmatters of Central Oregon/Bend, Oregon	Children, chronically ill people,high emergency room (ER) users, indigent people, rural setting
		Health Care Access Now/Cincinnati, Ohio	Infants, urban setting
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Baylor Health Care System/Dallas, Texas	Urban setting
		ACCEL (Access El Dorado)/El Dorado, California	Children
		St. Vincent Health/Indianapolis, Indiana	Urban and rural settings
		Lincoln ED Connections/Lincoln, Nebraska	Urban setting
		Muskegon Community Health Project-MPRI & Muskegon Area Pregnancy Pathways Project/Muskegon, Michigan	Newly released from prison
		Central Oklahoma Project Access Program/ Oklahoma City, Oklahoma	Urban
		CHOICE Regional Health Network of Washington State/Olympia, Washington	Rural and small city
		Lucas County Initiative to Improve Birth Outcomes/Toledo, Ohio	Pregnant women
2	Medical Referrals	ACCEL (Access El Dorado)/El Dorado, California	Children
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Baylor Health Care System/Dallas, Texas	Urban setting
		Asthma Outcomes Pathway and Lincoln ED Connections, Lincoln, Nebraska	Urban setting
		Central Oklahoma Project Access Program/ Oklahoma City, Oklahoma	Urban setting
		Muskegon Community Health Project-MPRI & Muskegon Area Pregnancy Pathways Project /Muskegon, Michigan	Newly released from prison

	Health improvement focus area	Program name/geographic location of Pathway sites that address focus area	Special populations/ characteristics
2	Medical Referrals *(continued)*	CHOICE Regional Health Network of Washington State/Olympia, Washington	Rural and small city
		Lucas County Initiative to Improve Birth Outcomes/Toledo, Ohio	Pregnant women
3	Social Service Referrals	Healthmatters of Central Oregon/Bend, Oregon	Children, high ER users, indigent people, rural setting
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Rio Arriba Pathways Pilot Project/Espanola, New Mexico	Substance-using pregnant women, rural setting
		Muskegon Community Health Project-MPRI & Muskegon Area Pregnancy Pathways Project/Muskegon, Michigan	Newly released from prison
		Central Oklahoma Project Access Program/ Oklahoma City, Oklahoma	Urban setting
		Lincoln ED Connections/Lincoln, Nebraska	Urban setting
		Lucas County Initiative to Improve Birth Outcomes/Toledo, Ohio	Pregnant women
		St. Vincent Health/Indianapolis, Indiana	St. Vincent launching a Social Service Pathway targeted at rural and urban settings
4	Housing: A Detailed Social Service Pathway	Pathways to a Healthy Bernalillo County/ Albuquerque, New Mexico	Urban setting
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Muskegon Area Pregnancy Pathways Project, Muskegon Community Health Project/Muskegon, Michigan	Newly released from prison
		Lucas County Initiative to Improve Birth Outcomes/Toledo, Ohio	Pregnant women
5	Health Insurance	ACCEL (Access El Dorado)/El Dorado, California	Children
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Central Oklahoma Project Access Program/ Oklahoma City, Oklahoma	Urban setting
		St. Vincent Health/Indianapolis, Indiana	Urban and rural settings
		Muskegon Area Pregnancy Pathways Project, Muskegon Community Health Project/Muskegon, Michigan	Newly released from prison
		CHOICE Regional Health Network of Washington State/Olympia, Washington	Rural and small city

	Health improvement focus area	Program name/geographic location of Pathway sites that address focus area	Special populations/ characteristics
5	Health Insurance *(continued)*	Healthmatters of Central Oregon/Bend, Oregon	Children, low-wage uninsured health benefit plan
		Lucas County Initiative to Improve Birth Outcomes/Toledo, Ohio	Pregnant women
6	Medication Assessment and Management	Baylor Health Care System/Dallas, Texas	Urban setting
		St. Vincent Health/Indianapolis, Indiana	Urban and rural settings
		Asthma Outcomes Pathway and Lincoln ED Connections/Lincoln, Nebraska	Urban setting
		Muskegon Area Pregnancy Pathways Project, Muskegon Community Health Project/Muskegon, Michigan	Newly released from prison
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Muskegon Community Health Project/ Muskegon, Michigan	Newly released from prison
7	Pregnancy	Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
		Lucas County Initiative to Improve Birth Outcomes/Toledo, Ohio	Pregnant women
		Health Care Access Now/Cincinnati, Ohio	Pregnant women, urban setting
		Muskegon Area Pregnancy Pathways Project, Health Project/Muskegon, Michigan	Muskegon community Newly released from prison
		Rio Arriba Pathways Pilot Project/Espanola, New Mexico	Substance-using pregnant women, rural setting
		Muskegon Area Pregnancy Pathways Project/Muskegon, Michigan	Pregnant women
		Community Health Access Project (CHAP)/ Mansfield, Ohio	Pregnant women
8	Emergency Department Diversion	Healthmatters of Central Oregon/Bend, Oregon	Rural setting
		Baylor Health Care System/Dallas, Texas	Urban setting
		ACCEL (Access El Dorado)/El Dorado, California	Children
		Lincoln ED Connections/Lincoln, Nebraska	Urban setting
		Central Oklahoma Project Access Program/ Oklahoma City, Oklahoma	Urban setting
		CHOICE Regional Health Network of Washington State/Olympia, Washington (ED Consistent Care Program)	Rural and small city; high ED users referred by hospitals, health plans, and primary care
		Health Care Access Now/Cincinnati, Ohio	Urban, uninsured, and Medicaid-eligible adults

Program Name and Contact Information

Program name	Geographic location	Primary point of contact	Data management technology
Community Health Access Project (CHAP) AHRQ Innovations Exchange Link: www.innovations.ahrq.gov/content.aspx?id=2040	Mansfield, Ohio	Sarah Redding, M.D., M.P.H. Executive Director Community Health Access Project 35 North Park Street, Suite 132 Mansfield, OH 44902 Phone: (419) 525-2555 sredding@att.net	Web-based, custom-designed technology.
Lucas County Initiative to Improve Birth Outcomes	Toledo, Ohio	Jan L. Ruma, B.A., M.Ed. Vice President, Hospital Council of Northwest Ohio Executive Director, Toledo-Lucas County CareNet 3231 Central Park West Drive Suite 200 Toledo, OH 43617 Phone: (419) 842-0800 Fax: (419) 843-8889 jruma@hcno.org	A specialist who receives data from the care coordinators enters it into a spreadsheet, forwards the resulting information to be analyzed by the evaluator, and creates invoices for payment.
Health Care Access Now	Cincinnati, Ohio	Judith Warren, M.P.H. Executive Director Health Care Access Now 8790 Governor's Hill Drive Suite 202 Cincinnati, OH 45249 Phone: (513) 707-5696 Fax: (513) 677-1647 jwarren@healthfoundation.org	CareScope care coordination software that captures client assessments and summary data for routine reporting and appointment scheduling, with interface capability with electronic medical record products and a community resource module for tracking resources and referrals.
Rio Arriba Pathways Pilot Project AHRQ Innovations Exchange Link: www.innovations.ahrq.gov/content.aspx?id=2916	Espanola, New Mexico	Lauren Reichelt, M.A. Executive Director Health and Human Services 1122 Industrial Park Road Espanola, NM 87532 Phone: (505)753-3143 Mobile: (505) 929-2589 LMReichelt@rio-arriba.org	Paper records; electronic case management record currently under development.
Asthma Outcomes Pathway and Lincoln ED Connections AHRQ Innovations Exchange Link: www.innovations.ahrq.gov/content.aspx?id=3003	Lincoln, Nebraska	Jean Stilwell, M.A. Resource Development Coordinator Saint Elizabeth Foundation 6900 L St., Suite 100 Lincoln, NE 68510 Phone: (402) 219-7051 JStilwell@stez.org	

Program name	Geographic location	Primary point of contact	Data management technology
Pathways to a Healthy Bernalillo County AHRQ Innovations Exchange Link: www.innovations.ahrq.gov/content.aspx?id=2933	Albuquerque, New Mexico	Daryl Smith, M.P.H. Office of Community Affairs University of New Mexico Health Sciences Center Albuquerque, NM 87131 Phone: (505) 272-0823 dtsmith@salud.unm.edu	Web-based, custom-designed data system.
Healthmatters of Central Oregon	Bend, Oregon	Pat Kuratek, RN Nurse Director Healthmatters of Central Oregon 2525 NE Twin Knolls Drive, Suite 7 Bend, OR 97701 Phone: (541) 647-1765 ext. 306 Fax: (541) 647-2646 pat@healthmattersco.org	Primarily paper records with some electronic components in place; a more robust electronic case management record currently under development.
Baylor Health Care System	Dallas, Texas	Adam Chabira, M.H.A. Director, Baylor Community Care Baylor Health Care System 8080 N. Central Expressway Suite 1700, LB83 Dallas, TX 75206 Phone: (972) 860-8681 Fax: (972) 860-8601 adamch@baylorhealth.edu	
ACCEL (Access El Dorado)	El Dorado, California	Christine Sison, M.S. ACCEL Program Manager ACCEL (El Dorado) 929 Spring Street Placerville, CA 95667 Phone: (530)621-6216 accelqa@gmail.com	
St. Vincent Health	Indianapolis, Indiana	Susie Dittman, M.H.A. Internal Operations Data Analysis Reports on Project Outcomes St. Vincent Health North Office Building 10330 North Meridian Street, Suite 415 Indianapolis, IN 46290 Phone: (317) 583-3213 SBDittma@stvincent.org	
Muskegon Community Health Project AHRQ Innovations Exchange Link: www.innovations.ahrq.gov/content.aspx?id=2134	Muskegon, Michigan	Peter J. Sartorius, M.A., M.S. Development and Planning Manager Muskegon Community Health Project/Mercy Health Partners 565 W. Western Avenue Muskegon, MI 49440 Phone: (231) 672-3201 (Office) (231) 672-3204 (Direct) Fax (231) 672-8404 sartorip@mchp.org	

Program name	Geographic location	Primary point of contact	Data management technology
Central Oklahoma Project Access Program	Oklahoma City, Oklahoma	Mary Overall, B.S., M.S.N. Director Health Care Systems, Compliance and Outreach; Coordinator, Central Oklahoma Project Access Program Central Oklahoma Integrated Network System 3815 North Santa Fe, Suite 122 Oklahoma City, OK 73118 Phone: (405) 524-8100 ext 111 maryo@coinsaccess.org	
CHOICE Regional Health Network of Washington State	Olympia, Washington	Ann Edington Assistant Director, Client Services CHOICE Regional Health Network of Washington State 2409 Pacific Ave SE Olympia, WA 98501 Phone: (360) 493-493-5760 edingtona@crhn.org	Multiple systems, including a new module for Pathways Compass software (from Pathways Community Health Network in Atlanta, Georgia).

Exhibit A-1: Sample Demographic and Referral Form

Richland Community HUB
Sample Demographic Form
Pregnant Client

Date: _____ Referred by:_____

Client's Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

Client's Date of Birth: _____ Gender: M F

Insurance Provider/Number: _____

Reason for Referral: _____

_____

_____

_____

_____

Is Client Pregnant? Y N Estimated Due Date: _____

Estimated Weeks: _____

Date of 1st Prenatal Visit: _____

Referral Received by: _____

Referral Assigned to: _____ on _____

Referral Outcome: _____

_____

_____

_____

Exhibit A-2: Sample Care Planning Checklists

Initial Adult Checklist

Visit Date: _____ Start: ___ End: ___ Visit Type: _____

Care Manager: _____

Name: _____ DOB: _____

Address: _____ Phone: _____

SSN: _____ Race: _____ Ethnicity: _____ M / F

Insurance _____ Medicaid Number: _____

Referral Date: _____ Emergency Contact Number: _____

YES	NO	Client Information
___	___	**Are you single?** If no: 1-significant other, 2-married, 3-separated, 4-divorced, 5-widowed, 6-other _____
___	___	**Do you rent your home or apartment?** If no: 1-own home, 2-live with relatives, 3-live with friends, 4-not from this area, 5-homeless, 6 other _____
___	___	**Do you speak another language besides English at home?** **If yes**, do you need a translator for appointments? _____
___	___	**Are you in school now?** If no: 1-college graduate, 2-high school diploma, 3-GED, 4-dropped out of high school, 5-other _____
___	___	**Are you interested in finding a job?** If no: 1-employed, 2-on disability, 3-enrolled in a training program, 4-other _____ If disabled, what is the reason? _____
___	___	**Do you need help with transportation to appointments?** What are you using now for transportation? _____
___	___	**Do you have children?** If yes: How many? _____ How many children live with you? _____ Do any of your children have special needs? _____
___	___	**Do you need help with child care?**
___	___	**Do you have any problems providing:** 1-housing, 2-food, 3-clothing, 4-utilities, 5-other: _____
___	___	**Do you have any legal issues?** _____

YES	NO	General Health
___	___	**Do you need health insurance for yourself?** If no: Health insurance: _____
___	___	**Do you need a family doctor?** If no: Family doctor's name _____
___	___	**Do you need a dentist?** If no: Dentist's name _____

If you don't have a family doctor, where do you get your care?
1-ER, 2-Urgent Care, 3-Walk-in Clinic, 4-Other _____

Previous illnesses:_____

_____

Previous surgeries and hospitalizations: _____

_____

Allergies: _____

_____

YES	NO	Current Medical Issues
___	___	**Are you currently being treated for any of the following conditions?** 1-infections, 2-asthma, 3-chronic medical conditions, 4-mental health conditions, 5-mental retardation, 6-developmental disabilities or delays, 7-other: _____ _____
___	___	**Are you taking any medicines?** 1-prescribed by your doctor, 2-over the counter, 3-herbal or alternatives, 4-other_____ List all medications: _____ _____

YES	NO	Safety and Emotional Health
___	___	**Are you using tobacco products?**
___	___	**Does anyone smoke in your home?**
___	___	**Are you drinking alcohol?**
___	___	**Are you using other substances?**
___	___	**Are you stressed?**
___	___	**Are you feeling depressed?**
___	___	**Have you experienced emotional, verbal, or physical abuse?**
___	___	**Do you have a working smoke detector?**
___	___	**Are there any safety concerns in the home?** Describe: _____ _____

___ ___ **Is there a gun in the home?** If yes, is the gun locked? Yes___ No___

___ ___ **Are there any pets in the home?**

___ ___ *If children at home, ask:* **Do you read to your child(ren)?**
If yes, how often? _____

List all other agencies that you are working with now: _____

_____

_____

_____

NOTES _____

_____

_____

_____

_____

Please add the following Pathway(s): (Represents the request from the care coordination agency to the HUB to add pathways to the Care Coordination Plan and tracking. List of Pathways here represents local set.

___ Adult Education
___ Chemical Dependency
___ Depression
___ Employment
___ Family Planning
___ Family Violence
___ Health Insurance
___ Immunization Screening
___ Immunization Referral
___ Lead
___ Medical Referral _____
___ Medication Assessment
___ Medication Management
___ Pregnancy
___ Postpartum
___ Smoking Cessation
___ Social Service Referral _____
___ Suitable Housing
___ Other: _____

_____

Next home visit date: _____

Exhibit A-3: Followup Adult Checklist

Visit Date: _____ Start: ____ End: ____ Visit Type: _____

Care Manager: _____

Name: _____ DOB: _____ Age: _____

Address: _____ Phone: _____

Insurance _____ Medicaid Number: _____

Referral Date: _____ Emergency Contact Number: _____

Last Home Visit: _____ Last Health Care Visit: _____

YES	NO	General Health
___	___	**Have you had any changes in:** Health insurance?_____ Family doctor? _____ Dentist? _____
___	___	**Have you been to the emergency room since I've seen you last?** If yes: Why? _____ _____ _____
___	___	Have you been to the doctor for any reason besides a regular checkup? If yes: Why? _____ _____ _____
___	___	**Do you need help with transportation to appointments?** What are you using now for transportation? _____ _____
___	___	**Do you need help with child care?**
___	___	**Are you having any problems providing:** 1-housing, 2-food, 3-clothing, 4-utilities, 5-other: _____?
___	___	**Are you employed?** If yes: Where/hours: _____ _____
___	___	**Are you interested in finding a job?**
___	___	**Are you in school?** If yes, describe:_____

YES	NO	Current Medical Issues
___	___	**Are you currently being treated for any of the following conditions?** 1-infections, 2-asthma, 3-chronic medical conditions, 4-mental health conditions, 5-mental retardation, 6-developmental disabilities or delays, 7-other: _____
___	___	**Are you taking any medicines?** If yes: 1-prescribed by your doctor, 2-over the counter, 3-herbal or alternatives, 4-other List all medications: _____ _____

YES	NO	Safety and Emotional Health
___	___	**Are you using tobacco products?**
___	___	**Does anyone smoke in your home?**
___	___	**Are you drinking alcohol?**
___	___	**Are you using other substances?**
___	___	**Are you stressed?**
___	___	**Are you feeling depressed?**
___	___	**Has there been any violence in the home?**
___	___	**Do you have a working smoke detector?**
___	___	**Are there any safety concerns in the home?** Describe: _____ _____
___	___	**Is there a gun in the home?** If yes, is the gun locked? Yes___ No___
___	___	**Are there any pets in the home?**
___	___	*If children at home, ask:* **Do you read to your child(ren)?** If yes, how often? _____

Are any new agencies working with you? _____

_____

_____

Have any agencies stopped working with you?_____

_____

_____

NOTES: _____

_____

_____

Please add the following Pathway(s): (Represents the request from the care coordination agency to the HUB to add pathways to the Care Coordination Plan and tracking. List of Pathways here represents local set.

___ Adult Education
___ Chemical Dependency
___ Depression
___ Employment
___ Family Planning
___ Family Violence
___ Health Insurance
___ Immunization Screening
___ Immunization Referral
___ Lead
___ Medical Referral _____
___ Medication Assessment
___ Medication Management
___ Pregnancy
___ Postpartum
___ Smoking Cessation
___ Social Service Referral _____
___ Suitable Housing
___ Other: _____

_____

Exhibit A-4: Examples of Reports for the Community HUB and Participating Agencies

Participating agencies and Community HUBs can produce a variety of reports, as outlined below:

Agency Level:

- Number of pending and completed pathways per client
- Number of pending and completed pathways per care coordinator
- Number of pending and completed pathways per agency
- Increase in pathway production over time (care coordinator and agency)

Community HUB Level:

- HUB enrollment and duplication reports
- Total number of pending and completed pathways across the community
- Invoices (payments based on pathway completion) for funders
- Demographic reports focusing on those in the community most at risk for poor outcomes
- Number of "finished but incomplete" pathways and barriers to completion ("Finished but incomplete" represent situations where a pathway is no longer being used, but the desired outcome has not been obtained)

Population Level:

- Cost per pathway
- Cost per person served
- Effectiveness in connecting those at risk to care
- Cost savings
- Changes in health status

Notes

Notes

Notes

U.S. Department of Health and Human Services

Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

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