



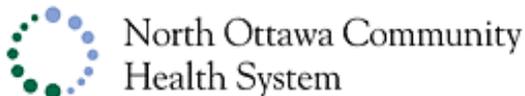
Ottawa  
**PATHWAYS**  
to better health

## Year 2 Progress Report

Released March 2019

# Thank you

Ottawa Pathways to Better Health  
program supporters:



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# Evidence of Need



Patrick Cisler  
Community SPOKE  
Executive Director

Community Health  
Improvement Plan  
Facilitator



[miOttawa.org/2015CHNA](http://miOttawa.org/2015CHNA)

[miOttawa.org/2015CHIP](http://miOttawa.org/2015CHIP)

[miOttawa.org/2017CHNA](http://miOttawa.org/2017CHNA)

[miOttawa.org/2018CHIP](http://miOttawa.org/2018CHIP)

In 2015, Ottawa County completed its first Community Health Improvement Plan (CHIP). The plan identified **access to care, mental health and healthy behaviors** as priority areas needing the most attention to improve the health and well-being of Ottawa County residents. As those involved in the planning process wrestled with what strategies could have an impact on these priority areas, we discovered an innovative model based on Community Health Workers (CHWs) called **Pathways to Better Health**. Thanks to the CHIP Steering Committee's dedication we secured funding to design Ottawa County's Pathways to Better Health (OPBH) model.

The value of a CHW model is two-fold. First, it helps connect health care and social service providers in a community. Health care providers treat a patient's medical issues but may not have a role in treating underlying root causes; often called social determinants of health. These can include food insecurity, lack of secure housing, transportation difficulties, unemployment, substance abuse and poor mental health. CHWs connect people with the appropriate, and much-needed, health and social service resources—taking a much more holistic approach to care. Second, the CHW model provides an advocate to the people with compounding health issues and helps them navigate the complicated health care system. For someone struggling, having a CHW by their side goes a long way to getting the help they need. CHWs serve as a trusted advocate; whether it's completing insurance applications, arranging transportation to an appointment, helping with language or cultural barriers, or encouraging them to follow a treatment plan.

In just the two years of the Pathways to Better Health program, it received more than **800 referrals**. You will find in this report, people's health is improving, they are finding it easier to navigate the health care system and they are getting connected to the appropriate care they need. Thank you to our incredibly talented CHWs, a strong Public Health Department to host the program and an amazing collaboration of organizations that have made this possible. This truly is one of the most collaborative funding projects I have seen with the three hospitals in Ottawa County (Holland Hospital, North Ottawa Community Health System and Spectrum Health Zeeland Community Hospital), Community Foundation of Holland/Zeeland Area, Grand Haven Area Community Foundation, Greater Ottawa County United Way, Community Mental Health of Ottawa County and the Ottawa County Department of Public Health; all providing funding to make this program possible. We celebrate the good work taking place and look forward to many more years of success!

# What is Pathways to Better Health ?



**The OPBH program** uses an evidence-based community health worker (CHW) model designed to identify and address individual risk factors. CHWs walk alongside clients to set goals and assist in achieving them. CHWs are trusted members of the communities they serve; sharing common ethnicity, language, culture and life experiences with their clients. With funding from multiple sources, the OPBH program was fully implemented in February 2017 as a 3-year pilot.

## Eligibility:

- 18 years of age (or older) or pregnant;
- Live in Ottawa County (including 49423 zip code);
- Enrolled in or eligible for Medicare and/or Medicaid;
- and have two or more chronic health conditions (such as diabetes, depression, anxiety, heart disease, arthritis, asthma, hypertension or long-term pain).



## OPBH has eight community health workers who:

- Meet clients at their convenience in their home or elsewhere.
- Help clients set goals.
- Guide clients through the health care system.
- Link clients to medical care based on their specific needs (primary, dental, specialty, mental health, substance abuse treatment or other).
- Help clients manage their health conditions and prescriptions.
- Help clients reduce hospital and emergency room visits.
- Link clients to community services and resources (food, clothing, housing, financial and utility assistance, transportation, education, employment and much more).

# Improving Health & Changing Lives



Shandra helps me not worry so much. She connects me with resources that are important.  
-Kimberly



Britney was so nice. She encouraged me to quit smoking and got me into LifeCircles. I haven't been in the hospital for almost a year.  
-Sara



This was the worst year of my life. I lost my job, my home and ended up in the hospital. I was referred to the program where I met Dan. He's been a lifesaver!  
-Lillian

# Improving Health & Changing Lives



**"As an evaluator of public health programs, the pathways model is the most beneficial I have seen in my 20-year career."**

**-Chris Wojcik, Michigan Public Health Institute**

**"The OPBH program and CHWs have been an important resource for care managers in linking patients to resources in the community. From finding alternative housing to linking people to community resources or assisting with navigating insurance, their ability to meet with people in their own surroundings has been invaluable. I appreciate they can be the 'eyes and ears' for our patients outside of the office and notify us when they have concerns that might require an in office assessment. Thereby, preventing a trip to the ER. The CHW has become a valuable member of the care management team and we value their work tremendously!"**

**-Susan McKinnon, RN Care Coordinator with Mercy Health  
North Ottawa Medical Group Internal Medicine**

**"In a very short time, the OPBH program has become an essential community resource. I have found that CHWs are quick to respond and have excellent follow-thru in terms of service delivery. My staff knows when we make a referral to the program, our clients will be receiving exceptional services.**

**-Laura Driscoll, Director of Housing Services with Good Samaritan Ministries**

**"Britney, a OPBH community health worker, and I have been working closely with a mutual client who has a difficult time communicating with his health care team because of a significant language barrier. Britney has been a great advocate for the client where she attends appointments and works to address his community needs; such as housing, food and clothing. I appreciate Britney's attention to details and giving regular updates on the client's progress. It is a pleasure to work with her!"**

**-Lindsey, RN, Care Management with Priority Health Choice**

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# Client Demographics



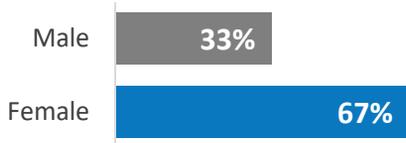
In the first two years, the 467 OPBH clients were **MORE** likely:

- Female
- Spoke English
- Earn less than \$10,000
- Live in the SW quadrant

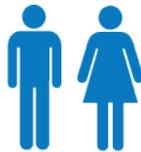
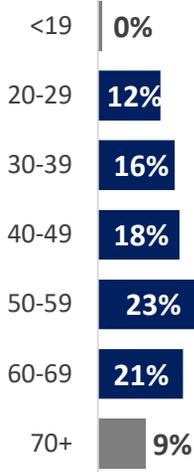
They were **LESS** likely:

- Younger than age 20
- Older than age 70
- A college graduate

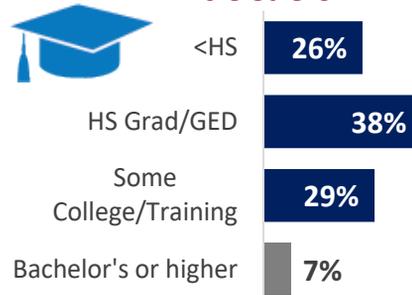
## Gender



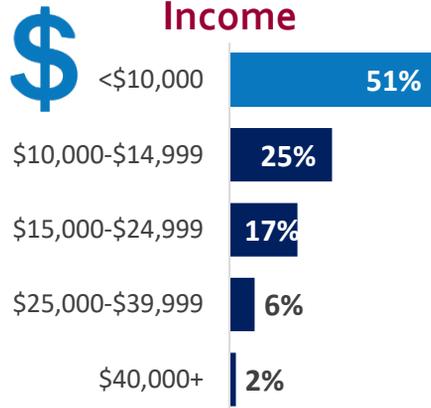
## Age



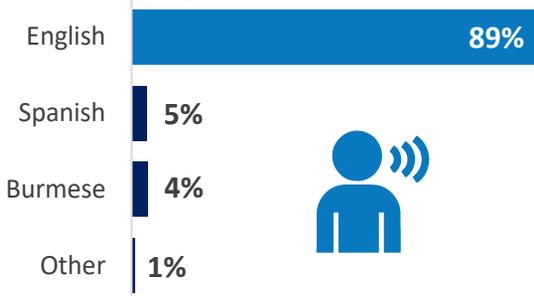
## Education



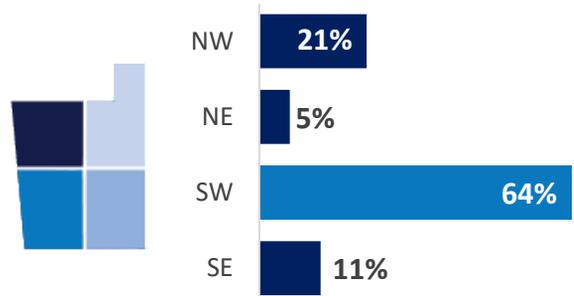
## Income



## Language



## Location

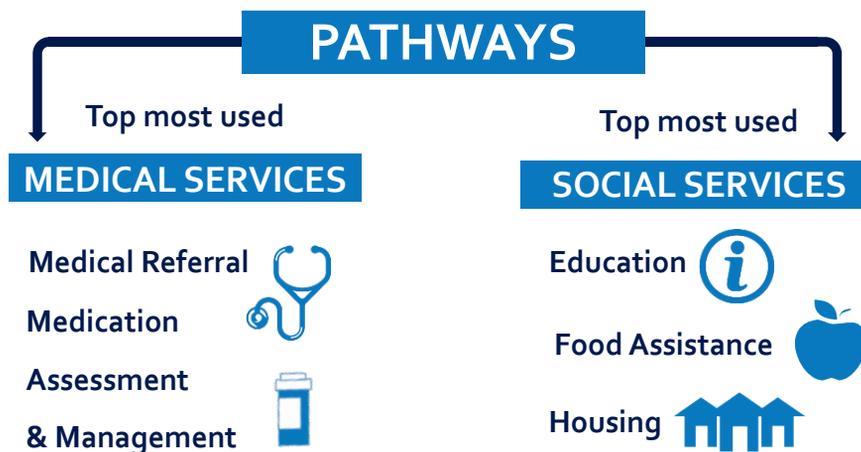


# Program Data Overview

## Top Referral Sources



## Top Chronic Conditions



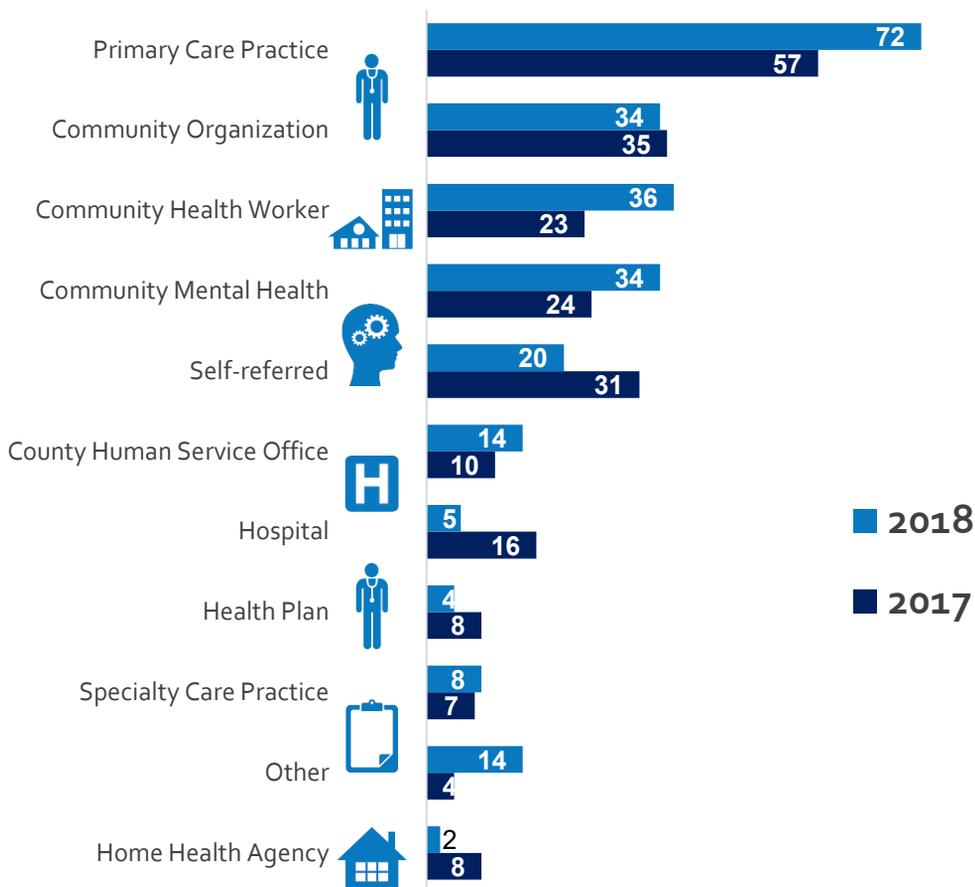
**459** **PATHWAYS COMPLETED** **642**

*This preliminary Year 2 report summarizes key measures from OPBH program data collected between February 2017 and December 2018. These data reflect clients who are in the referral process, are enrolled in active pathways, and who have completed pathways and are no longer active. As a result, the most recent data are subject to change.*

# Program Data: Referral Sources

**Primary care practices referred the most clients who were eligible** and willing to enroll in OPBH. Various community organizations, the OPBH community health workers and Community Mental Health are other top referrers of enrolled clients. Many referral sources to OPBH remained stable, but others saw changes between the first and second years.

## Referral Source for Enrolled Clients



### Referrals Increased

- ✓ CHWs
- ✓ Health Plans
- ✓ PBH website

### Referrals Decreased

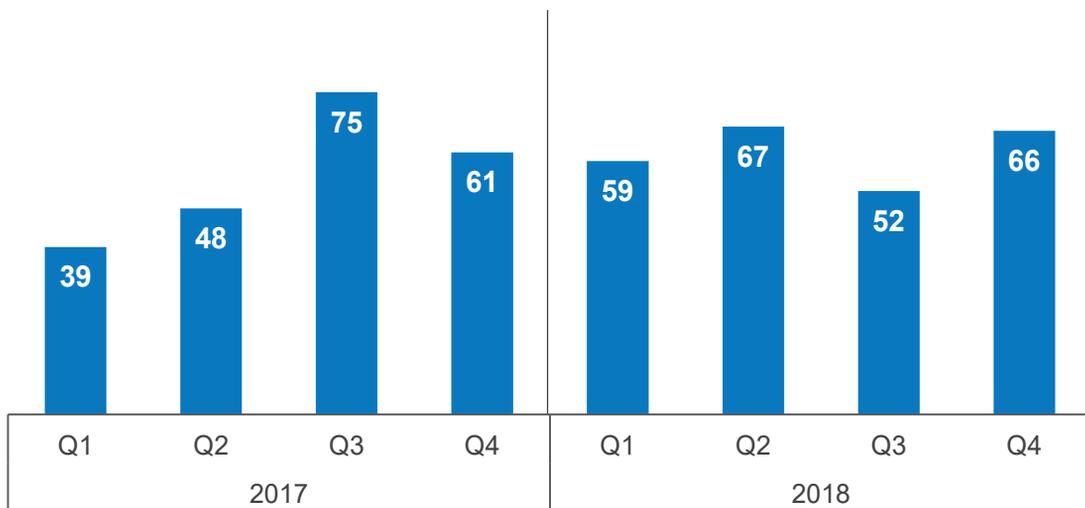
- ✓ Hospitals
- ✓ Self-Referral
- ✓ Home Health Agencies

# Program Data: Enrollment

## Enrollment in OPBH grew steadily each quarter of the first year.

Growth brought several challenges to year two. Increasing the number of CHWs in 2018 included hiring and training four new staff members; one to replace a CHW and three to expand general capacity and to better serve chronic mental health needs. Also, the closure of Ingham CareHub (agency that managed referrals and client records) prompted the OPBH Advisory Committee to recommend local management of referrals and the purchase of a proprietary software designed specifically for the Pathways model of care and risk factor reduction.

**Despite challenges, the 2<sup>nd</sup> year served more clients.**

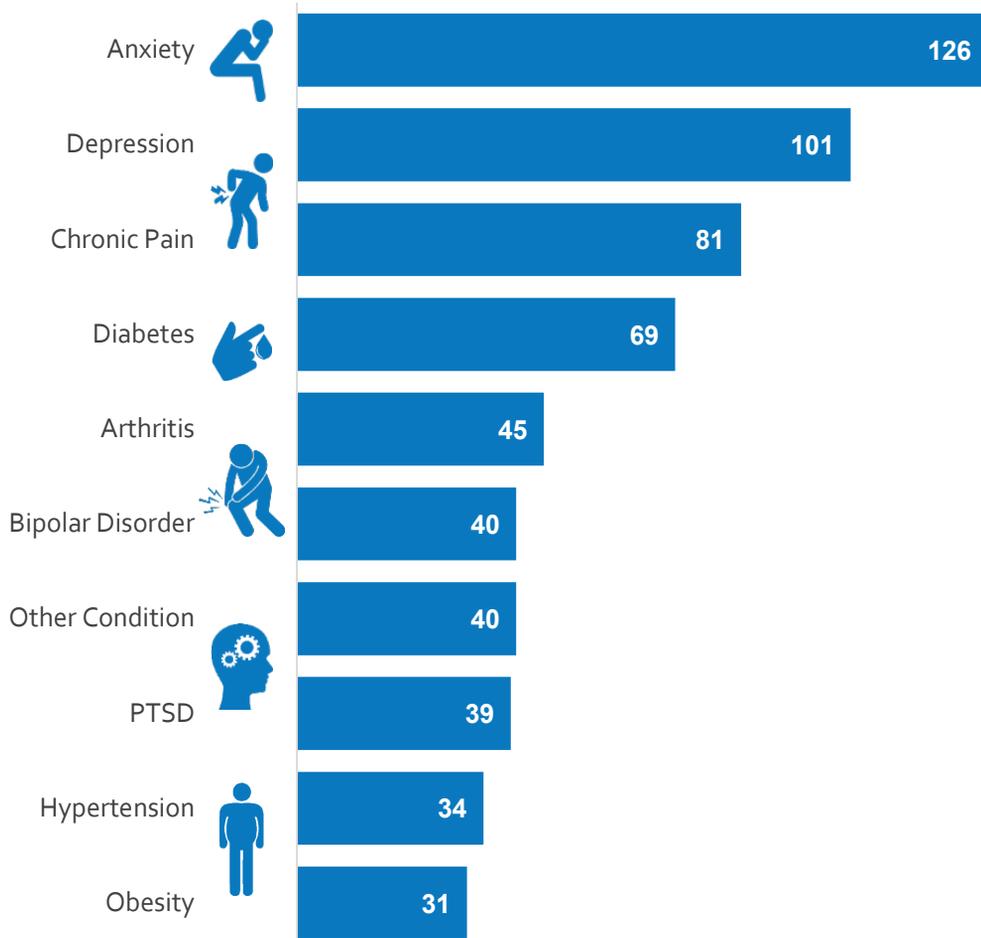


# Client Chronic Conditions

## The top reported conditions are related to mental health.

OPBH serves clients with many needs, including chronic mental and physical conditions. Mental health conditions, such as anxiety and depression, are reported the most by clients followed by physical conditions like chronic pain, diabetes, and arthritis. One of the primary features of the OPBH program is that it addresses mental health in the community – a priority area identified in the 2018 CHIP.

## Top 10 most reported chronic conditions

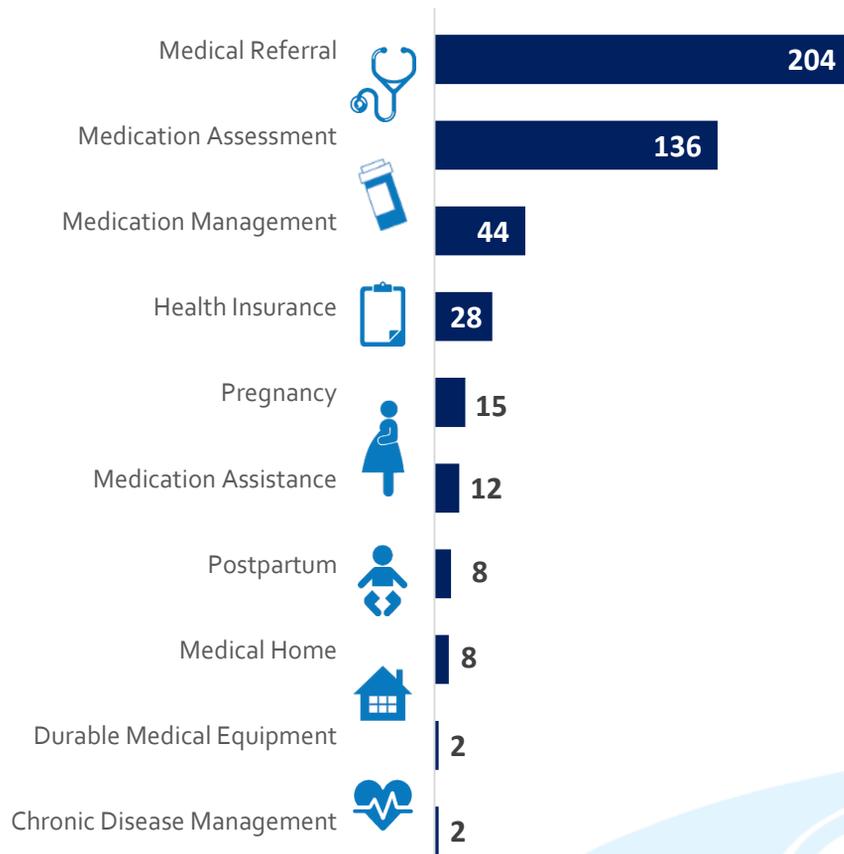


# Program Data: Completed Medical Pathways

## The road to improved health takes many paths.

Of all the **38 pathways** used by OPBH clients in the first two years, getting in to see a **specialist and help with prescriptions** are the two most common needs. Not included in the top ten highlighted below, but still important for stabilizing health, clients also needed assistance with obtaining family planning services and getting a solid start with tobacco cessation.

## Top 10 most used medical service pathways

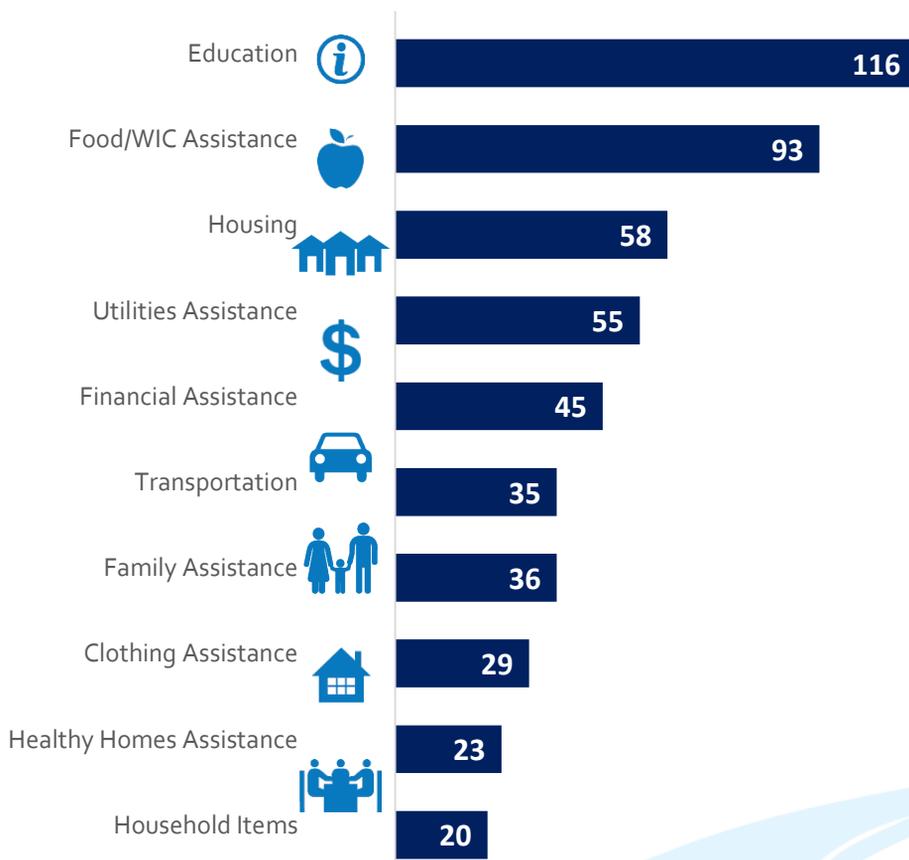


of **459**  
Completed Pathways

# Program Data: Completed Social Services Pathways

**Medical pathways addressed many health needs in the first two years** of the program. However, OPBH clients **needed even more assistance with social issues** that prevented them from improving their health. Not included in the top ten, but still important for stabilizing health, clients also needed assistance with employment, non-health insurance, medical debt, legal circumstances, obtaining identification, support groups, exercise, domestic violence, furniture, among others.

## Top 10 most used social service pathways



of **642**  
Completed Pathways



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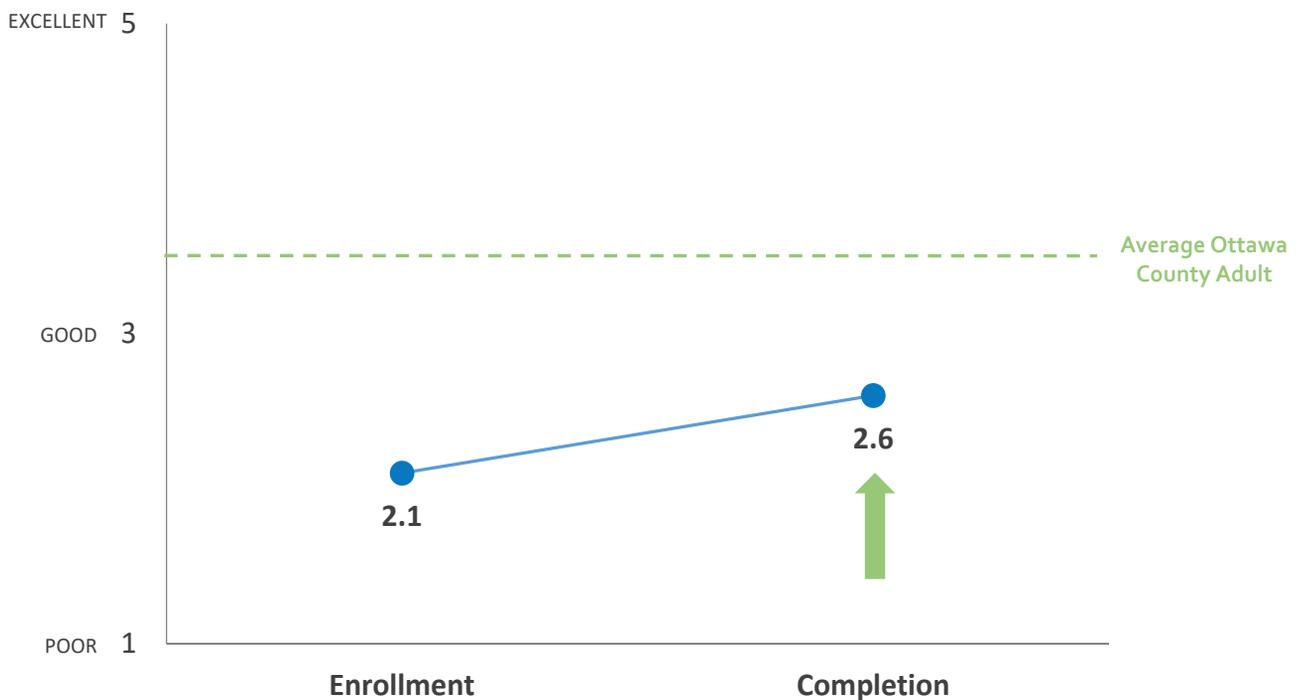
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## Overall Health Status

**Clients report a statistically significant increase in their overall health.**

On average, clients report a small but significant **improvement** in their perceived overall health. It is important to note that at enrollment, the average OPBH client rates their health as only “fair” – much lower than the average Ottawa County adult’s rating of between “good” and “very good”. This is indicative of the challenges faced by incoming OPBH clients and the importance of communication in the referral network.

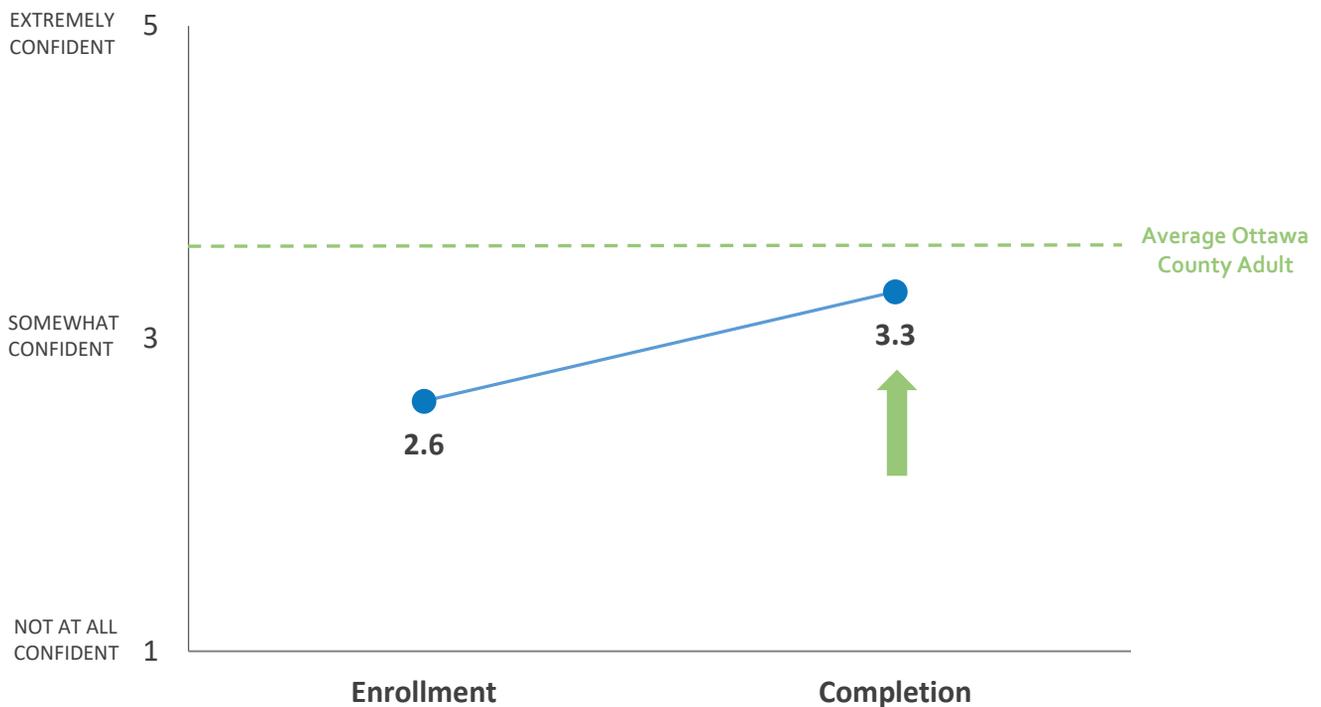


Question: Would you say in general that your health is.... Excellent (5), Very good (4), Good (3), Fair (2), Poor (1)

Sources: Results from 118 OPBH clients who completed both the enrollment and completion questionnaires between February 2017 and December 2018. The Ottawa County adult average (3.5) is from the same question asked of 1,318 adults in the 2017 Ottawa County Community Health Needs Assessment’s Behavioral Risk Factor Survey.

## Navigating the Health Care System

Clients report a statistically significant increase in their confidence navigating health care system. Clients **gained confidence** in their ability to successfully navigate the often complex health care system. In fact, after program completion the average OPBH client reports nearly as much confidence as the average Ottawa County adult – between “somewhat” and “very” confident.

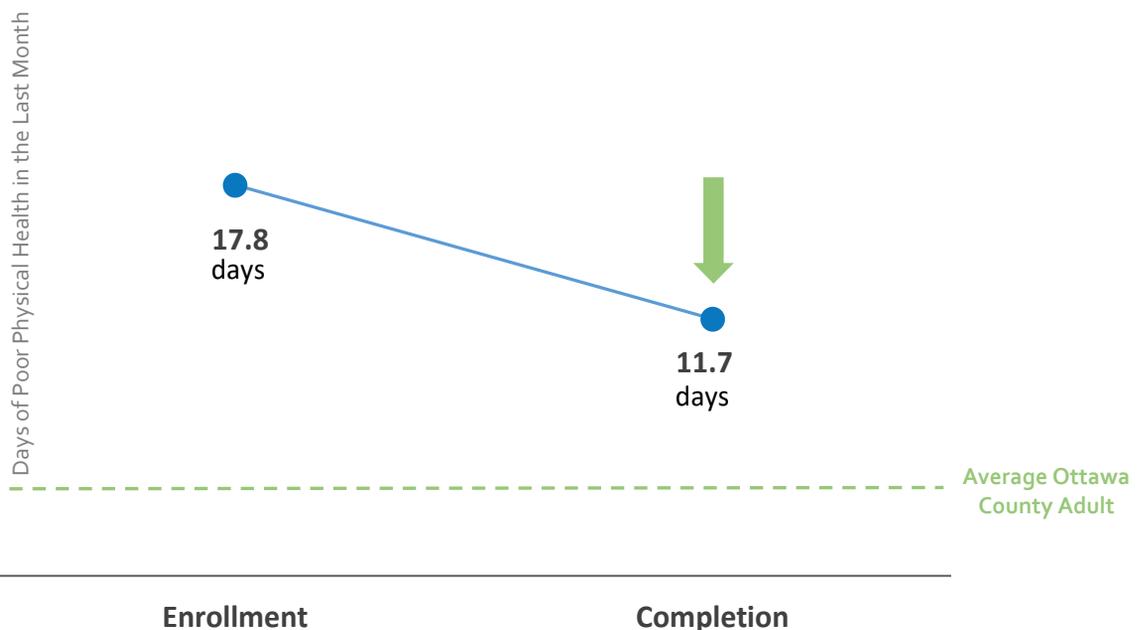


Question: How confident are you that you can successfully navigate the health care system? Not at all confident (1), Not very confident (2), Somewhat confident (3), Very confident (4), Extremely confident (5)

Sources: Results from 118 OPBH clients who completed both the enrollment and completion questionnaires between February 2017 and December 2018. The Ottawa County adult average (3.6) is from the same question asked of 1,318 adults in the 2017 Ottawa County Community Health Needs Assessment's Behavioral Risk Factor Survey.

## Poor Physical Health

**Clients report a statistically significant decrease in days impacted** by poor physical health. At program completion, the average client experienced five fewer days of poor physical health each month than before the program—a **34% improvement**. Though this is a significant gain, OPBH clients report many more days a month of poor physical health than the 3.6 days reported by the average adult in Ottawa County, indicating that referrals are reaching the desired population for this program.

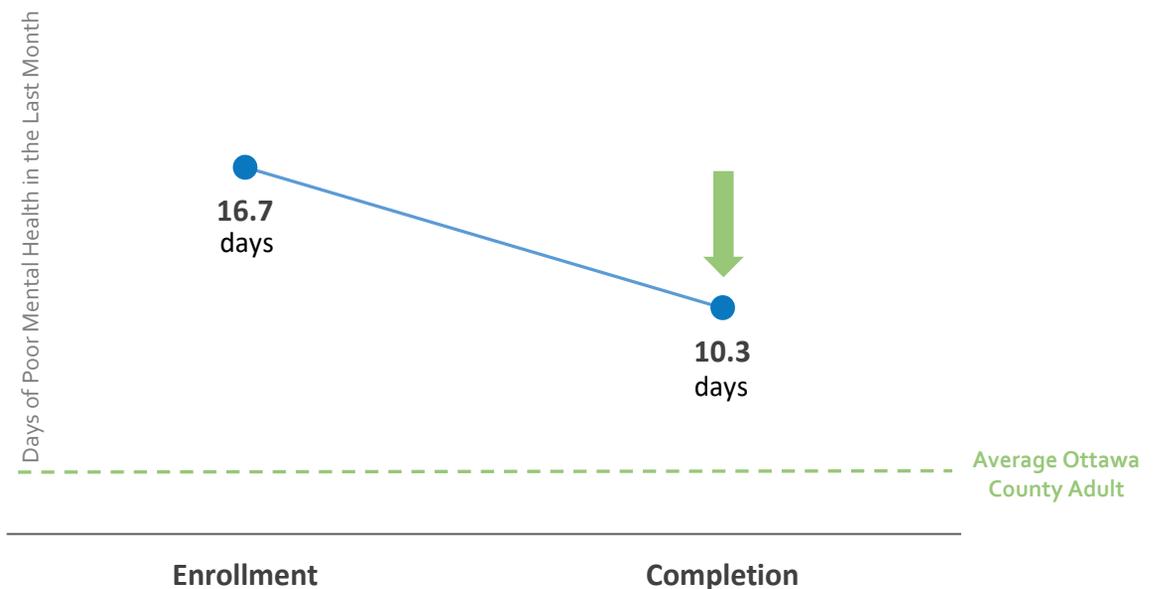


Question: Now thinking about your physical health, which includes physical illness or injury, for how many days during the past 30 days was your physical health not good? (0 – 30 days)

Sources: Results from 114 OPBH clients who completed both the enrollment and completion questionnaires between February 2017 and December 2018. The Ottawa County adult average (3.6) is from the same question asked of 1,318 adults in the 2017 Ottawa County Community Health Needs Assessment's Behavioral Risk Factor Survey.

## Poor Mental Health

**Clients report a statistically significant decrease in days impacted** by poor mental health. After OPBH, the average client experienced six fewer days of poor mental health per month than they reported before the program—a **38% improvement**. Gaining nearly a week of improved mental health each month is a significant outcome for a population with many more poor mental health days than the 2.5 days/month of the average Ottawa County adult.

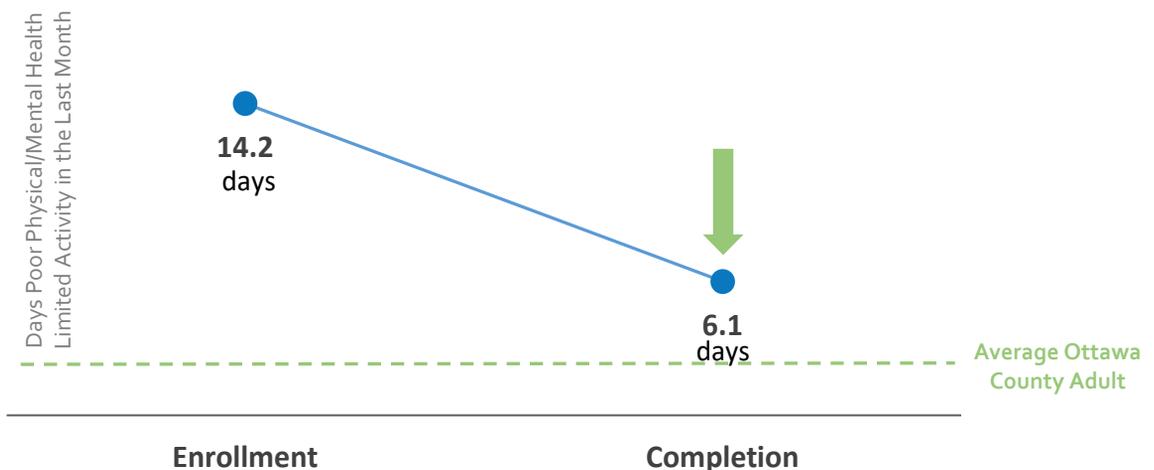


Question: Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good? (0 – 30 days)

Sources: Results from 116 OPBH clients who completed both the enrollment and completion questionnaires between February 2017 and December 2018. The Ottawa County adult average (2.5) is from the same question asked of 1,318 adults in the 2017 Ottawa County Community Health Needs Assessment's Behavioral Risk Factor Survey.

## Activity Limitations

**Clients report a statistically significant decrease in days** when poor physical/mental health limited their activities. The number of days per month when daily activities were limited due to physical or mental health declined 8 days—almost **57% improvement** for the average OPBH client. At enrollment, clients experienced activity limitations on seven times more days than the 2.2 days/month the average Ottawa County adult reports. The progress reflected by these results suggests that CHWs are effective and trusted partners in their communities as one by one they work with clients to improve their health and their lives.



Question: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation? (0 – 30 days)

Sources: Results from 113 OPBH clients who completed both the enrollment and completion questionnaires between February 2017 and December 2018. The Ottawa County adult average (2.2) is from the same question asked of 1,318 adults in the 2017 Ottawa County Community Health Needs Assessment's Behavioral Risk Factor Survey.



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# Challenges & Accomplishments



## CHALLENGES

- Ranking as the [healthiest county](#) in Michigan makes it harder to compete for outside funding of innovative solutions for local health challenges.
- [No reimbursements](#) from Medicare/ Medicaid limits services.
- Health plans not recognizing the need to stabilize, and reimburse for, [social determinants of health](#) to improve health outcomes.
- Funding [sustainability](#).



## ACCOMPLISHMENTS

- [Local partners](#) identified community needs to discuss in further detail.
- One of the 2018 CHIP Access to Care recommended strategies was to [expand the OPBH program](#) to enable more CHWs to serve a greater number of people.
- [Greater impact](#) made through leveraged financial and organizational resources than one organization doing alone.
- A focus on health outcomes using a [whole person approach](#).
- [Creates a link](#) between the health care system and the community care system.
- Clients report [improved health](#), navigating the health care system with more ease and getting connected to the care they need.

## Spectrum Health's Mosley Team Award for Extraordinary Community Health Worker Service



### OPBH's Community Health Worker Team

This award recognizes and acknowledges outstanding service, dedication and excellence within the profession. The OPBH team members received the award because they exemplify excellence, accountability, compassion, integrity, respect, teamwork and collaboration to achieve significant and impactful accomplishments.

## Ottawa County Outstanding Customer Service Award



### Britney Brown, Community Health Worker

In his nomination Britney's client wrote: "I was in a bad place...and got nowhere for years. When Britney came into the picture, she was able to move things forward in just a few months, saved my life!"



### Judy Ketting, Community Health Worker

In her nomination Judy's client wrote: "She's supported us and helped with a lot of needs. She even delivered diapers and wipes to my baby when I had no transportation. Judy has helped us get our utilities and lot rent paid. I am very grateful that she is working with me. !"

- On October 1, 2018, OPBH transitioned from an administrative relationship with Ingham CareHub and brought all administration in-house. Services formerly provided by CareHub, such as intake and assignment of referrals; software management; reporting of client data; billing to Medicaid health plans; and various administrative and quality assurance functions, came under OPBH management. With the administrative transition, OPBH also moved from Essette software to Care Coordination Solutions (CCS) software to document, monitor and assess the progress of clients and CHWs. While most data were migrated without issue, one challenge identified was that all Essette clients, including referred but unenrolled clients, were considered “Enrolled” in CCS. This issue resulted in an artificially inflated number of enrolled clients in the Preliminary Year 2 Program Data Report. This issue has been addressed and the OPBH program will continue to refine data collection and management processes to ensure future reports are accurate and useful. Because data collection, management, and analysis methods may be updated in the future, expect minor differences in future reports.
- Data from this report were sourced from CCS, Essette, and internal data collection systems.
- The 467 clients included in this report have a status of “Enrolled” as of March 15, 2019. Enrolled is defined as follows:
  - Client new to CCS: Enrollment Status=“Enrolled”
  - Client originally in Essette: Release of Information Signed=“Yes”
- Most indicators featured in this report are described for all 467 enrolled clients of OPBH referred from February 1, 2017 through December 31, 2018. *If there are descriptive differences between 2017 and 2018 not already noted for a given indicator, they will be noted below according to their page in this report.*
- Program data were analyzed using SAS 9.4 (Cary, NC). All statistical tests utilized a 95% confidence level and a significance cutoff of 0.05.
- Page 9. The number of clients with missing data for each demographic indicator varies: Language – 8 missing; Education – 52 missing; Income – 80 missing; Quadrant – 3 missing.
- Page 11. Figure for top referral sources enrollment displays enrolled clients referred 2017-2018.
- Page 12. Figure for enrollment displays enrolled clients referred 2017-2018.
- Page 13. Top ten most common self-reported chronic conditions reported by enrolled clients who were referred 2017-2018. Due to data collection challenges, the number of chronic conditions reported in 2017 was substantially lower than 2018.
- Page 14-15. Figures include clients referred 2017-2018 who completed pathways. Completed medical pathways: 286 in 2017, 173 in 2018, 2 missing. Completed social service pathways: 375 in 2017, 267 in 2018, 4 missing.
- Page 17. Analysis of overall health using a paired sign test; significance at  $p < 0.001$ . One of five questions developed for OPBH to compare to those asked in the Ottawa County Community Health Needs Assessment (CHNA) and identified by the 2015 CHIP as community indicators to track going forward. Results include only those who completed the question on both the enrollment and completion surveys ( $n=118$ ).
- Page 18. Analysis of ability to navigate health system using a paired sign test; significance at  $p < 0.001$ . One of five questions developed for OPBH to compare to those asked in the Ottawa County CHNA and identified by the 2015 CHIP as community indicators to track going forward. Results include only those who completed the question on both the enrollment and completion surveys ( $n=118$ ).
- Page 19. Analysis of poor physical health days using a paired t-test; significance at  $p < 0.001$ . One of five questions developed for OPBH to compare to those asked in the Ottawa County CHNA and identified by the 2015 CHIP as community indicators to track going forward. Results include only those who completed at least one question on both the enrollment and completion surveys ( $n=114$ ).
- Page 20. Analysis of poor mental health days using a paired t-test; significance at  $p < 0.001$ . One of five questions developed for OPBH to compare to those asked in the Ottawa County CHNA and identified by the 2015 CHIP as community indicators to track going forward. Results include only those who completed the question on both the enrollment and completion surveys ( $n=116$ ).
- Page 21. Analysis of activity limitations using a paired t-test; significance at  $p < 0.001$ . One of five questions developed for OPBH to compare to those asked in the Ottawa County CHNA and identified by the 2015 CHIP as community indicators to track going forward. Results include only those who completed the question on both the enrollment and completion surveys ( $n=113$ ).

