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Financing Health System Social Impact Investments

Leveraging a Proven Community-based Model to Address Disparities and Drive Health Equity

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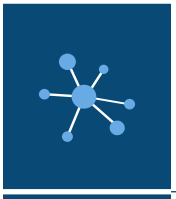
Introduction

Over the last three decades, the Pathways Community HUB Institute® (PCHI®) Model was developed to deploy Community Health Workers (CHW) to meaningfully connect patients to services and resources through an outcome focused community-based care coordination network. CHWs lead coordination and follow-up efforts as trusted individuals with a deep understanding of the community they serve.[1,2]

"Hospitals should act as anchor institutions and not take on the work of health equity alone. FQHCs have been doing this for years, and they can show ROI with their minimal resources. We need to get large health systems to that level, and it takes collaboration to get there. "

Nicci Bengtson, Managing Director,
Care Transformation Executive Lead,
Huron Consulting Group

The PCHI® Model requires six foundational players: [3]



A Pathways Community HUB (PCH)

An independent entity that facilitates a care-coordination network and is responsible for funding/contracting, training, quality improvement, compliance, and overall administration. The PCH must undergo national certification and adhere to the 18 standards to be a license to use the PCHI Model. A PCH is a neutral community-based backbone organization that is not a healthcare provider or care coordination agency.

Community Health Workers

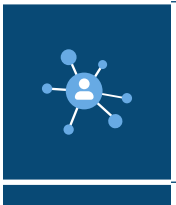
The workforce that drives PCH activity and hold several responsibilities, including 1) screen patients; 2) connect participants with resources; 3) engage participants to ensure needs are met; and 3) track outcomes over time.

Care Coordination Agencies (CCA)

Anchor institutions that employ and supervise CHWs that work through the PCH. Example organizations include community-based organization (CBOs), health systems, & federal qualified health centers (FQHCs).

Resource Partners

Provide services to support community health and social needs. Example organizations include food banks, transit/housing authorities, non-profits, and other healthcare providers.



Referral Partners

Organizations that refer people with complex health and social needs (e.g., patients, members, clients) to the PCH for a CHW to reach out and enroll them in the PCH to address their needs.

Funders

Support PCH and CHW workforce startup and operating costs. Contracts to pay for care coordination must be outcome based to ensure participants' risk factors are addressed. Example organizations include government agencies, foundations, health systems and health plans.

Through the PCHI® Model, CHWs use 21 Evidence-Based Pathways to identify and track participants' health and social risk factors until they are addressed. Reimbursement is divided into two parts—50% tied to completed Pathways (risks addressed) and the other half tied to confirmed Engagement (i.e., home visit) (see Figure 1). PCHI® has assigned each Pathway a standard number of outcome-based units (OBU), weighted based on the average time and complexity it takes to complete a Pathway. Reimbursement rates are determined by the dollar amount assigned to one OBU, that is negotiated between the payer (i.e., Medicaid Managed Care Plans) and the PCH. A dollar amount is also assigned to Engagement. Outcome and Engagement fees are collected by the PCH to support its operations and distributed to the contracted CCAs for the documented effort of their CHWs to address health and social risk factors.

A payment is only made when a Pathway is completed and documented. For example, if a CHW is tasked with supporting a participant to find employment, the "Employment" Pathway is completed once a participant remains employed 30 days from date of hire. The PCH completes a Quality Benchmark Report (QBR) that includes data on client demographics, risk reduction, pregnancy outcomes and other data points to demonstrate progress and performance to funders and other stakeholders.[4]

Figure 1. Payment Model Example

Pathway/ Engagement	Completion	Outcome Based Units	X OBU Value	= $
Housing	Maintained safe and stable housing for 30 days from move-in date	15	$50*	$750
Social Service Referral	Confirm item received or appointment kept	3	$50*	$75
Engagement	Monthly documented visit with client			$300*

**For illustration purposes only–Each PCH negotiates the Outcome Based Unit (OBU) rate and Engagement Fee*

Equity in Action

ProMedica Addresses Infant and Maternal Inequities using the PCHI Model

Ohio has one of the highest disproportionate infant and maternal health outcomes in the country, with an infant mortality rate of 14.3 deaths per 1,000 for Black, non-Hispanic infants compared to 6.9 deaths per 1,000 statewide.[5,6] Maternal mortality rates follow a similar trend, with Black, non-Hispanic, women experiencing a mortality rate of 29.8 per 100,000 live births compared to 13.7 per 100,000 live births for white, non-Hispanic, women.[7] With the documented successful use of the PCHI® Model in the Toledo region, ProMedica seized the opportunity to leverage this model to improve care coordination for infants and mothers to combat these disparities.

Health System Snapshot

PROMEDICA

- 50,000+ employees
- ~2,900 physicians
- 12 hospitals
- 23 counties across 2 states

Financing

ProMedica joined as a care coordination agency alongside other prominent organizations to launch a PCH in Northwest Ohio to improve maternal and infant health. A PCH is launched using a braided funding approach, incorporating a mix of federal, state, local and philanthropic dollars among agencies and funders to pay for startup and sustainability costs (e.g., CHW trainings and certifications, technology, materials). ProMedica incurred minimal costs to support the launch of the PCH and worked closely with their Foundation to obtain financial collateral to fund initial staffing and technology (e.g., tablets, PCHI®'s data platform to obtain data collected by CHWs at the PCH).

Evaluation & Impact

According to a 2020 assessment by the Toledo-Lucas County Department of Health, African American babies whose families engaged in a PCH for 120+ days experienced:[8]

11% Low birth weight rate compared to a rate of 14% among those who did not engage over a 4-year period.

10% Preterm rate compared to a rate of 15% among those who did not engage over a 4-year period.

11 Deaths per 1,000 live births compared to a rate of 15 deaths per 1,000 live births among those not engaged over a 3-year period.

Additionally, a retrospective study conducted by Buckeye Health Plan found that high-risk pregnancies with no care coordination provided by the Northwest Ohio PCH were 1.55 times more likely to deliver a baby with complications requiring NICU services equating to a cost saving of $2.36 for every additional dollar spent in baby's first year.[9]

Next Steps

Revamping Their CHW Workforce

ProMedica continues to expand their CHW workforce. Current priorities include reaching 150 patients through the PCH and creating cohesion among CHWs. They are also investing significant time and resources to adopt common practices, education, and training to better equip their CHW workforce. ProMedica aims to create a strong peer supported CHW workforce through formalized reporting structures.

Internal Assessment

To support financial sustainability, ProMedica is conducting an analysis to assess the PCH's impact on their infant and maternal mortality rates and associated cost savings compared to their patients who do not receive coordinated care through the PCH. As ProMedica expands the use of the PCH, they are monitoring data to understand which additional subpopulations would most benefit from care coordination services and support health system cost savings.

"The Pathways model enables us to provide high-quality support for at-risk patients while being reimbursed for CHW staff time by health plans. There are few other models in the social determinants of health space for reliable outcomes-based payment."

VP, ProMedica Social Determinants of Health Institute

Resource Guide

Integrating a Hub-Based Approach to Community Care

The PCHI Model is a proven community-based framework for organizations equipped with the resources and organizational commitment to advance community health. The following guide outlines action steps and relevant resources for health systems and community partners striving to address one or more of the following care coordination challenges:

- Inconsistent tracking and / or reporting of community referrals, collaboration activities, or home visits
- Incentivizing and equipping providers to screen and address patient social risks
- Quantifying the direct health outcomes and value from collaboration efforts between the health system and local / regional communities

Stage of Change[10]	Recommended Action Steps	Relevant Resources
Preparation My organization is planning for a significant change in our approach to community engagement, including one or more of the following organizational investments of time and resources: ■ Active evaluation of CHW engagement in one or more future programs ■ Analysis of previous care coordination efforts among a range of internal and external stakeholders ■ Prioritization of multi-stakeholder engagement in updated organizational strategic plans	Identify funding opportunities (e.g., grant funding) to begin to integrate a CHW workforce in your community.	**The Brookings Institution:** Budgeting to Promote Social Objectives – A Primer on Braiding and Blending (April 2020)
	Craft messaging with supporting evidence to request funding from your organization's Foundation to employ 3-5 CHWs.	**FrameWorks:** Framing the Foundation of Community Health: Communications Toolkit (August 2019)
	Identify community partners who currently utilize CHWs to find overlapping opportunities to target high-risk communities and/or subpopulations that are affected by your organization's health priorities.	**The National Association of Community Health Workers:** CHW Networks and Associations by State (regularly updated)
Planning My organization is actively designing for change, including building a clear vision to garner buy-in among key organizational and community stakeholders and outlining plans for an initial pilot program.	Rally support from service line leaders, frontline staff, and Foundation leaders to help build your case for the model.	**Health Equity Alliance:** Rightsizing Relationships Blueprint (April 2022)
	Connect with leaders from the closest PCH in your service region to learn about their organizational process in adopting a hub-based model, including the building of leadership buy-in and additional learnings.	**Pathways Community Hub Institute:** Certified Pathways Community HUBs and Pathways Agencies (regularly updated)
Implementing My organization is actively pursuing change in our approach to community engagement, including resources that have been secured to support our work long-term (3+ years).	Review established approaches from mature community-based hub programs, including relevant outcomes and programmatic adaptations.	**Health Affairs:** Improving Health and Well-Being Through Community Care Hubs (November 2022) **Agency for Healthcare Research and Quality:** Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes (January 2016)

Interested in learning more about the PCHI Model?

For additional information, please reach out to equity@hmacademy.com to schedule a 1:1 with the PCHI team.

Sources

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