Ji Im, MPH

system director II, community and population health, CommonSpirit Health

Background

Executive Summary

Innovation in health care does not always have to be radical for tremendous value to be created. Many times, the hard parts of improving the health care system are scaling evidence-based programs, creating community ownership and accountability, and meaningfully engaging diverse partners. This type of innovation can be challenging because it needs to work within the existing infrastructure and mindsets.

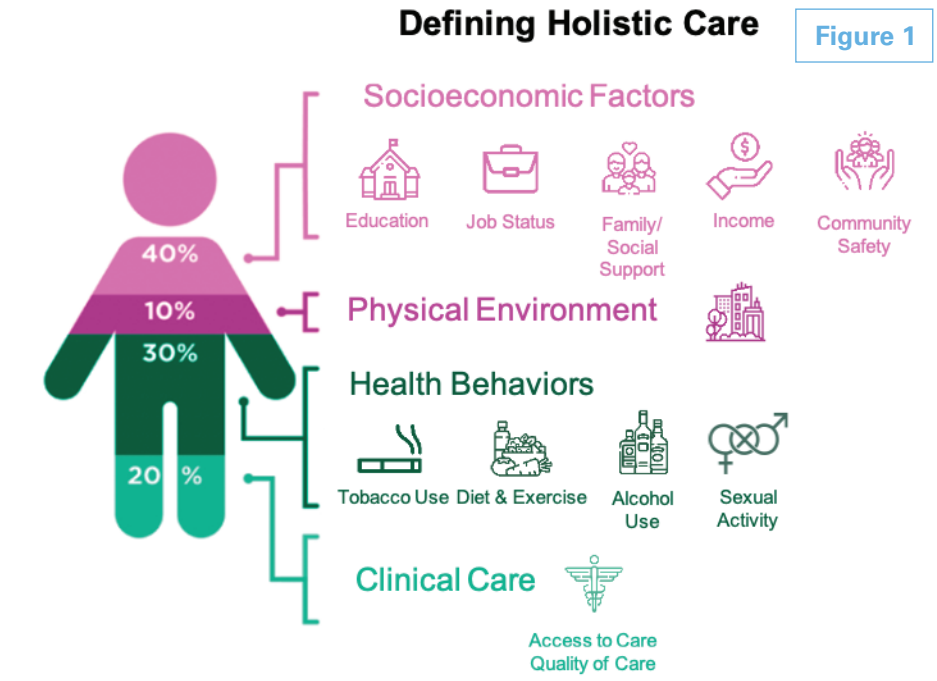
With more than 25 years of experience, the Pathways Community HUB model is a community care navigation model that has three key elements: outcome measures, financial sustainability and cultural diversity in its approach. This case study illustrates how CommonSpirit Health defined its role to catalyze the work across multiple states by convening national, state and internal stakeholders to collaborate and ensure alignment and integration to existing solutions in health care. The narrative and approach varies across communities, but the guiding principles of centering the needs of communities and addressing equity stand at the core of the work.

There is a commitment to build community-anchored initiatives that uplift the most challenged, most vulnerable phases of life for individuals. These phases can happen to anyone. As more PCHs are created, the hope is that individuals experiencing episodic or long-term struggles won't have to navigate so many systems alone. Having a trusted community health worker can make that journey more hopeful.

Catalyzing and Scaling an Evidence-based, Sustainable Community Care Navigation/Community Health Worker Model

Three major areas of research led to the decision to implement and scale the Pathways Community HUB (PCH). First, the U.S. spends nearly twice as much as the average Organization for Economic Co-operation and Development country on health care; however, it lags in key outcome measures, such as life expectancy and infant mortality.

1. Only a decade ago, another area of research showed that the U.S. actually ranks 13th among 30 industrialized countries when combining health and social service expenditures.
2. Of the total, the U.S. spends disproportionately more on health care than social services — very different from peers who spend more on social services and see better health outcomes. Finally, medical care only accounts for 10-20% of the modifiable contributors to healthy outcomes for a population.
3. The rest is attributed to health behaviors, social and economic factors, and physical environment — what has been defined as the social determinants of health (SDoH). This demonstrates that leaving out the economic and social determinants will only lead to more expensive health care. Additionally, achieving the triple aim of improving health



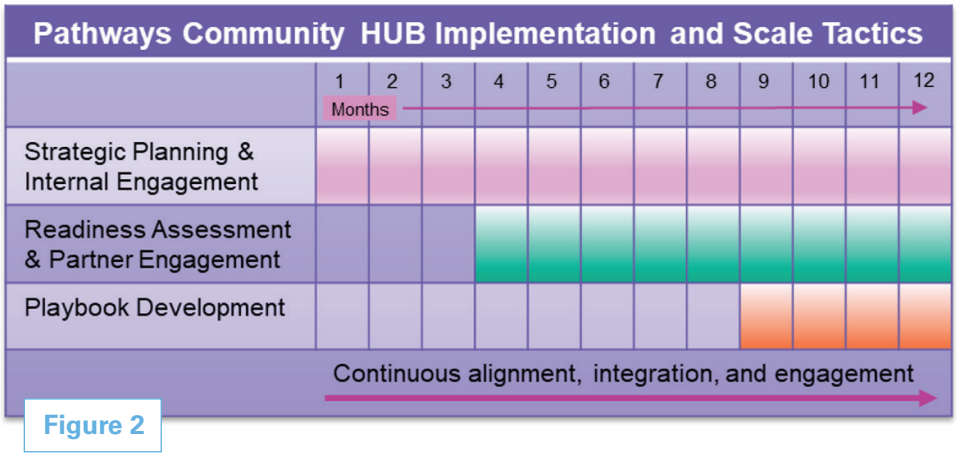


Figure 2

and experience of care and reducing costs cannot be done by health care systems alone.

The PCH model is based on the fact that the primary source of adverse health and social outcomes are risk factors (see Figure 1). The goal is to mitigate those health and social risk factors in a multicultural approach.

Approach

As an anchor institution, CommonSpirit played the role of a catalyst, convener and partner. As a system initiative, the following three workstreams were critical to initiating the work: **(1) Strategic planning and stakeholder engagement**, **(2) Readiness assessment and partner engagement**, **(3) Development of a playbook**.

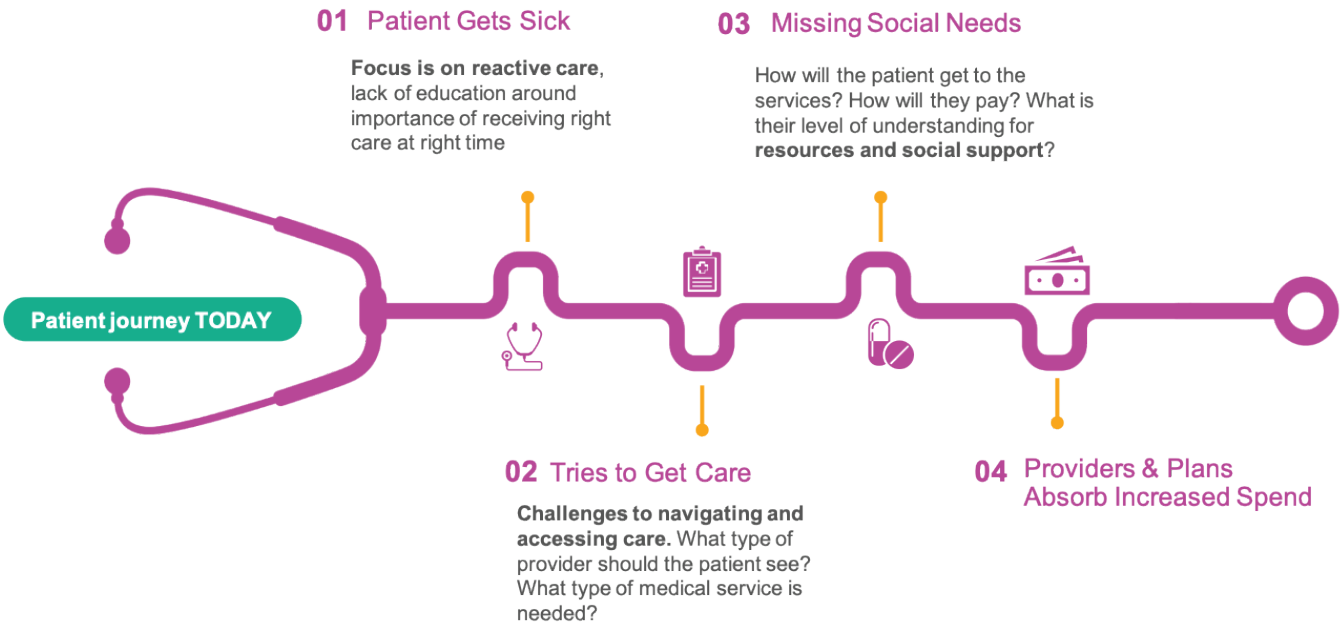
The first workstream meant assessing and socializing how PCH aligned with CommonSpirit's strategic focus areas. The second workstream went beyond the four walls of the organization to center the work in the community. This meant critically assessing the readiness of the communities and identifying critical partners to onboard the journey. Being inclusive of partners and funders from the beginning was key. The third workstream was to ensure quality across all the implementations and to ensure that the process of building equitable communities was as important as the outcomes.

Once all the workstreams were in full gear, continuous alignment and integration to the organization's strategies and external initiatives became critical. Furthermore, engagement evolved from "getting to understand the model" to deeper and more intentional commitment.

Outcomes

Pathways Community HUB is an evidence-based model for mitigating risks and improving health outcomes (see Figure 2). PCH is extremely effective in identifying and outreaching to those greatest at risk and connecting them to social, medical and behavioral interventions. A total of 21 interventions, called "pathways," allow for community health workers (CHWs) to mitigate risks by addressing whole person care. Outcomes from various independent evaluations demonstrate that the return on investment are well worth it, with one citing $5.60 for every $1.00 invested.

In addition to the positive financial return on investment, the PCH model has far-reaching impacts on the individuals and communities served. The CHWs, who have lived experiences and shared



cultures, are the bedrock of the model. These CHWs, who work on behalf of community-based organizations, have built strong relationships and trust. Additionally, the PCH creates an equitable way for health providers, health plans and government agencies to work with community organizations by creating community governance and lessening administrative burden to contract, collect data, and perform quality and data analysis.

The PCH model allows a toe in for how health care systems can reduce the medical and social care navigation gap in this country, and a future payment mechanism to support a critical workforce.

Lessons Learned

Augustus, the founder of the Roman Empire, uses the phrase "make haste, slowly." This has served as a great reminder to ensure a balance of urgency and diligence throughout the process of launching and scaling the work.

Earlier on in the process, we created a comprehensive work plan to demonstrate the activities necessary to launch successful PCHs. Several communities were quickly identified to be potential sites for launching the PCHs. A readiness assessment was created and completed by individual communities, and based on those assessments, the PCH work started in six communities. With great enthusiasm, the work begun. However, two teams soon realized that the readiness assessments were conducted too hastily, leaving out critical factors that would ultimately hinder the advancement of the work. The teams needed to take a few steps back before moving forward.

As the work took off, more excitement for the work grew. Internal stakeholders and community partners expressed desires to move even faster. However, the teams have steadily moved forward with caution, ensuring that the process continues to remain inclusive and transparent, and most importantly, that the communities feel ownership and accountability for the work being created.

"Essentially, we needed to **go slow**, to **go fast**."

Next Steps

The PCH work is just beginning at CommonSpirit Health. Currently, five states have initiated the work and one state will pilot the work with an existing certified PCH.

The future goals are to:

- Establish at least two certified PCHs in the next two years,
- successfully pilot with a PCH,
- integrate CommonSpirit's community bank model to shift the power for communities to make decisions and create community-led solutions, and
- address the care gap many individuals experience between medical and social care while embracing multiculturalism.

The belief is that when community-anchored solutions are co-created with multiple partners including health systems, foundations, government agencies and community organizations, then the work can be more sustainable and equitable. Diverse voices and experiences will help build real solutions that address real problems. Continuous engagement and inclusion of the broader community will only make the work stronger and ultimately improve the population's health.

Resources:

1. https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019

2. The American Health Care Paradox: Why Spending More Is Getting Us Less. Elizabeth H. Bradley and Lauren A. Taylor. 272 pp. New York, NY, PublicAffairs, 2013. ISBN 978-61309-209-9 (hbk.: alk. paper); 978-1-61309-210-5 (e-book).

3. Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024
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Enabling Outcome Based Results