PATHWAYS HUB COMMUNITY ACTION

by Community Action Akron Summit

Region 5 • Akron, Ohio
ca-akron.org

Infant Mortality • Maternal Health • Child Health

INITIATIVE OVERVIEW

Pathways Community HUB is an evidenced-based, care coordination model that Community Action Akron Summit has been replicating since 2016 (pchi-hub.com/resources/peer-reviewed-evidence-of-pathways-value). Community Action was the first Community Action Agency in the country and in Ohio to be certified nationally as a Pathways Community HUB (pchi-hub.com/hubs). The HUB serves as the fiscal and administrative agent that provides training for Community Health Workers (CHWs), data management, grant writing and Medicaid billing and compliance.

The HUB creates a network of agencies, hospital systems, Federal Qualified Health Centerss (FQHCs), non-profit and government organizations to address the complex, multi-system needs of individuals a community. CA contracts with community partners that employ community health works to provide services. CHWs work directly with families to address and mitigate risk. The HUB is built on the three principles of find, treat, and measure. Find is the concept that the HUB identifies the most at-risk individuals in a community that can be connected to a sub-contractor in the network. The CHWs "treat" the families by assessing their risks and needs, and then connecting them to evidenced intervention and resources in the community. The outcomes are measured and compensated through a pay for performance model.

The subcontractors input data into a shared software system (managed by CA) that processes referrals through a centralized point of intake, tracks, and

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reports outcomes and monitors progress. The outcomes or twenty pathways are opened based on the families' needs, social determinants of health and health conditions. The tracking of risk factors and management of performance metrics allows communities to improve health and social outcomes while collecting information about system barriers in a community.

In Summit County, Pathways HUB Community Action initiated its work with a focus on eliminating black infant mortality and improving the disparities that exist between black and white infant birth outcomes. More recently, the Hub has expanded to improve health outcomes among adults and children with chronic

diseases. The Hub also serves as the referral and intake center for the county's Addiction Help line and sober housing referrals.

LOCAL NEED ADDRESSED BY INITIATIVE

The local need that the HUB addresses is infant mortality. In 2015, Ohio was 48th in the country for Black infant mortality (ranking as the near worst state in the United States). In Summit County, Black infants are two to three times more likely to die than white, non- Hispanic infants. In 2015, Black infant mortality rate in Summit County was 15 per 1,000 exceeding that of the county's and state's overall infant mortality rate. In Summit County, clusters of neighbors represented not only the highest rates for infant mortality, but also the highest proportion of persons living below 100% of the federal poverty line. From 2007-2011 in Summit County, 77,375 individuals, or 14.49% of the population, lived below 100% of the federal poverty level (FPL). The Summit County clusters with the highest percent of persons living below 100% of the FPL were Central Akron (51.79%), Southwest Akron (33.68%), South Akron (29.69%) and West Akron (26.17%).

The costs of preterm and low birth weight infants to a community is extraordinary. March of Dimes estimates that the cost of prematurity is $41,116 per infant with a lifetime cost of over $300,000 per infant based on gestational age of delivery (Waitzman and Jalali, 2019). Between 2006 and 2015, 192 or 42.9% of the infant deaths were attributed to prematurity. The rise in premature births, especially among African American mothers, has contributed to the high numbers of infant mortality in Black families.

ROLE OF CSBG FUNDS

CSBG has provided dollars to support the HUB's infrastructure and staff when other funds did not cover these cost centers. CSBG has been the flexible funding to fill in the gaps when other funds had shortfalls. CSBG standards were also an important consideration for the planning and implementation of the HUB.

TRANSFORMATIVE IMPACT

The transformative impact of the model is in the delivery and management of services specifically the outcome-based approach connected to the model's pay for performance. The model not only collects data and information and successful completion of pathways, but also collects information about incomplete or unsuccessfully closed pathways.

The power of the model to systematically track and collect information about community needs, barriers and challenges provides the data for community transformation. The focus of the model is to eliminate health disparities and identify systemic challenges that impact the most at-risk families.

The transformative impact of the model includes the use of an evidenced based model demonstrating effectiveness to reduce health disparities and the shared approach to community care coordination through a centralized data system. **The model empowers families to be in the center of their care while partnership with a Community Health Worker and aligns the systems and services to support that family under the umbrella of the HUB network.** It constructs a central point of intake and data collection improving efficiency.

EVIDENCE-BASED OUTCOMES

The Hub model has demonstrated evidence in reducing Black infant mortality and improving health outcomes in the community (Alley et al, 2016). There has been research published about the model's return on investment (Buckeye Health Plan, 2018; Redding et al, 2015; Ziegler et al, 2015) when the model is implemented to fidelity. The model has been endorsed by Agency on Healthcare Research and Quality (www.innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf.).

EQUITY LENS

The goal of the Pathways HUB is to identify and provide services to those individuals with the

greatest needs and health disparities. The model systematically addresses individuals' needs and risks while identifying barriers to care and resources in communities. All of this information is tracked on one of 20 pathways providing community level data about gaps in resources and services. Additionally, there has been published research demonstrating the model's effectiveness in reducing health disparities and advancing equity. One area where this has been documented is in black infant mortality, one of the focused of the Hub in Summit County. The community health worker workforce is another component of the advancement of equity. Many of the community health workers have become employed in this field bringing their knowledge and lived experience into their work. This model serves as a means for economic development in communities and advancing equities in neighborhoods of opportunity. In the Summit County HUB, 95% of the CHWs live in the neighborhoods in which they work (a legacy of community action).

CUSTOMER VOICE

The implementation of the Hub has been co-designed by CHWs, community partners, and customers of the services. The Hub receives regular input about processes and services from monthly CHW meetings. Hub staff collect feedback from customers formally on a quarterly basis through customer service surveys. The customer rates their interactions with the CHW and other service information. The data and feedback are reviewed frequently by Hub staff and shared with CA Board on a monthly basis.

PARTNERSHIPS

There are several rings of Hub partnerships. The first layer are the contracted partners called care coordination agencies. The 7 partners are sub-contractors with CA and provide direct services to clients via Community Health Workers. These partners are a key component to the strength of the Hub network. The partners represent health care systems, nonprofits and mental health providers.
The second ring of partnerships are the community agencies that refer clients to the Hub for services. These partnerships serve as the community connectors for the families and provide outreach and education about the Hub. The third ring of partners include the agencies that provide services and resources that CHWs connect families to, and these include community food pantries, clinics, rental assistance programs and housing services. Lastly, there are partners that have invested in the Hub through financial, planning and/or implementation supports. These partners include Commission on Minority Health, Huntington Foundation, local health department, Medicaid MCOs and Summit County Jobs and Family Services. All of these partnerships support different aspects of the project and assist in producing system efficiencies within communities.

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