Improving Health Through the Central Ohio Pathways HUB

Healthcare Collaborative of Greater Columbus

STRATEGIC FOCUS AREAS

Value-based Primary Care

Quality Improvement

Care Coordination/ Population Health

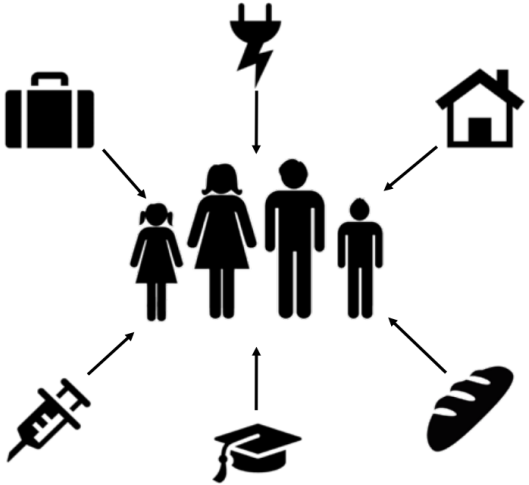
HCGC is also focused on work to improve health disparities and engage employers as key healthcare stakeholders.

Health Disparities: HCGC's mission is designed to serve "all people." However, we are acutely aware that total population measures can hide wide-ranging disparities among different portions of our community. HCGC is committed to seeking opportunities to close health disparity gaps.

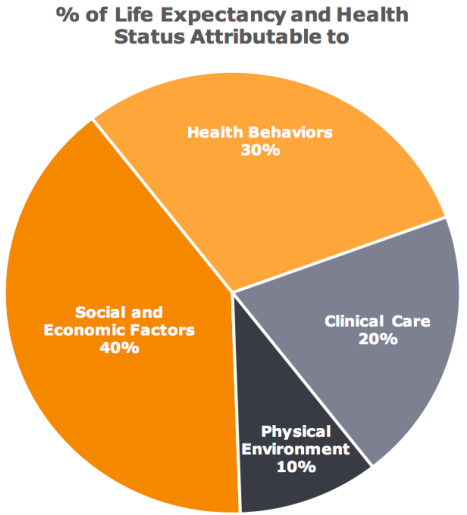
Employers as Key Healthcare Stakeholders: HCGC's focus on healthcare value requires consideration of the cost component of healthcare. Employers play a special role in funding our current healthcare system. HCGC has experienced that the wide variety in the Central Ohio's self-insured and fully-insured employer market makes singular employer strategies impractical. HCGC seeks opportunities to address cost issues whenever possible.

Healthcare Collaborative of Greater Columbus

Social Determinants



Social Determinants
(food, housing, transportation)



The Pathways Community HUB Model

creates an effective way for organizations to work toward common goals.

The Pathways Model utilizes a risk based **"pay for performance"** funding model--Care Coordination Agencies are paid based on positive outcomes achieved.

Medicaid Managed Care and other funders provide payments for outcomes achieved with high risk members.

Grant funding is sought to address social determinants, fund HUB operations, and provide payment outcomes to at-risk clients when no contract funds are available.

Community Health Workers

- Provide care coordination services and are employed by numerous medical clinics, social service agencies and other organizations throughout the community and the region
- Enrolled clients receive a comprehensive risk assessment, and work with their CHWs to prioritize all their health and social needs.
- CHWs develop a care plan using the Pathways HUB's online system by opening "pathways" for each unmet need, such as for health coverage, a medical home, food, housing and transportation.
- CHWs work closely with their supervisors to develop outcome-driven plans to address health, social and behavioral risk factors by opening and completing Pathways.
- Clients meet with their CHWs at least monthly to work as a team on care coordination plans, and they address each need one by one.
- Pathways HUB staff tracks data to reduce duplication of services and ensure clients receive the most appropriate high-quality, evidence-based services.

20 Core Pathways – National Certification

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Health Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum

Certified Pathways Community HUB Model Endorsers

Ohio Commission On Minority Health

Ohio Department of Medicaid

Institute for Healthcare Improvement

The CMS Innovation Center

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

HRSA

Ohio Department of Health

National Science Foundation
WHERE DISCOVERIES BEGIN

NIH National Institutes of Health
Turning Discovery Into Health

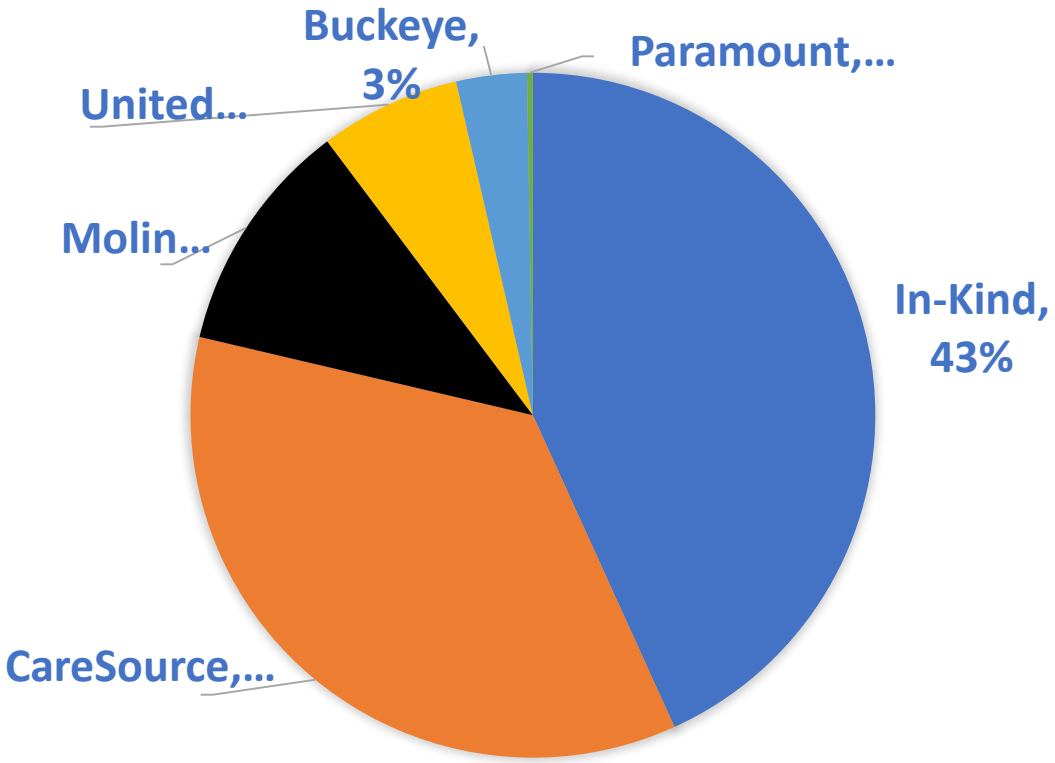
HUB Key Measures

- **401 clients-**”started to now”
- **Nearly 3000** pathways initiated
- **34** CHWs and **15** Supervisors
- **10** Care Coordination Agencies

OVERALL HUB DATA

Overall HUB Data	Reporting Period
	03/1/19-10/2/2019
Total Adult Clients	125
Total Maternal Clients	143
Total Pregnant Clients	133
Total Pathways Initiated	2908
Total Pathways Completed	1607

Clients by Insurance Type

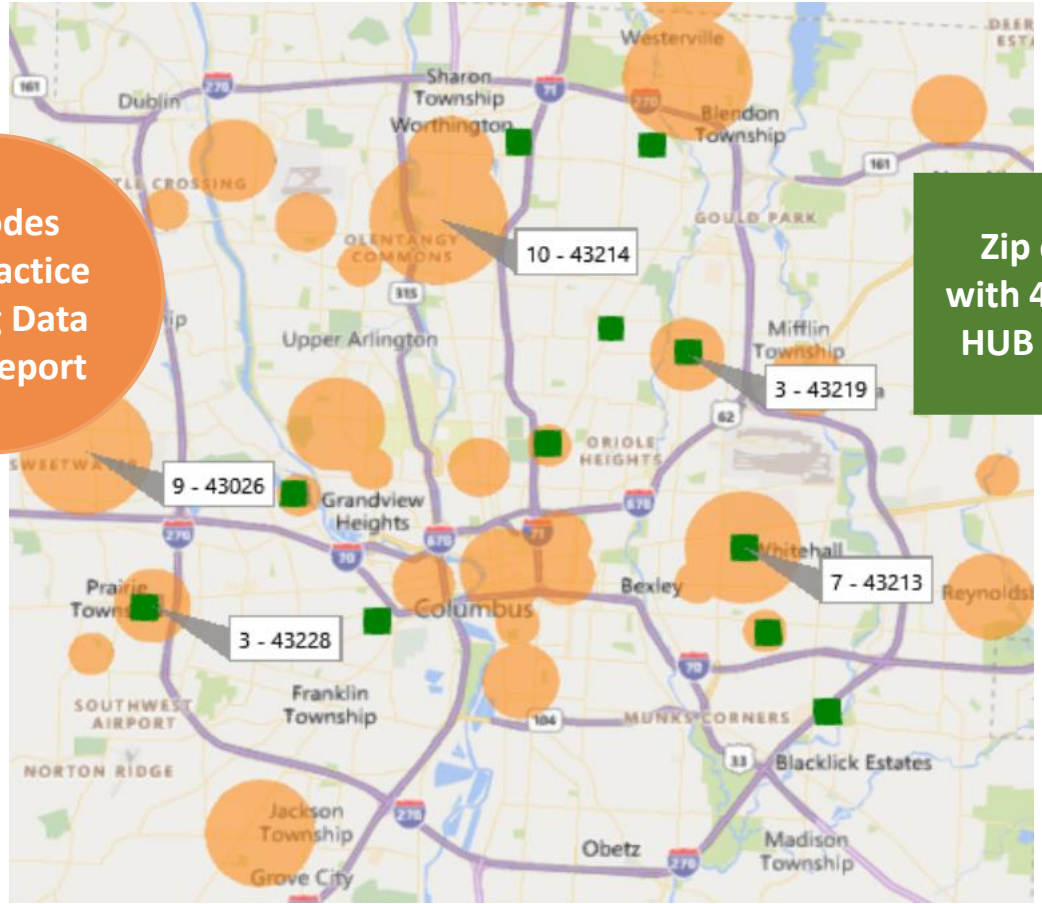


In-Kind Payer Sources

- Komen Foundation-Breast health pathways
- City Attorney's Office-Ending Recidivism
- CDC Grant-Preventing and treating Opioid Addiction
- Ohio Commission on Minority Health-Infant Mortality
- Engaging private payers, ACO's, Employers

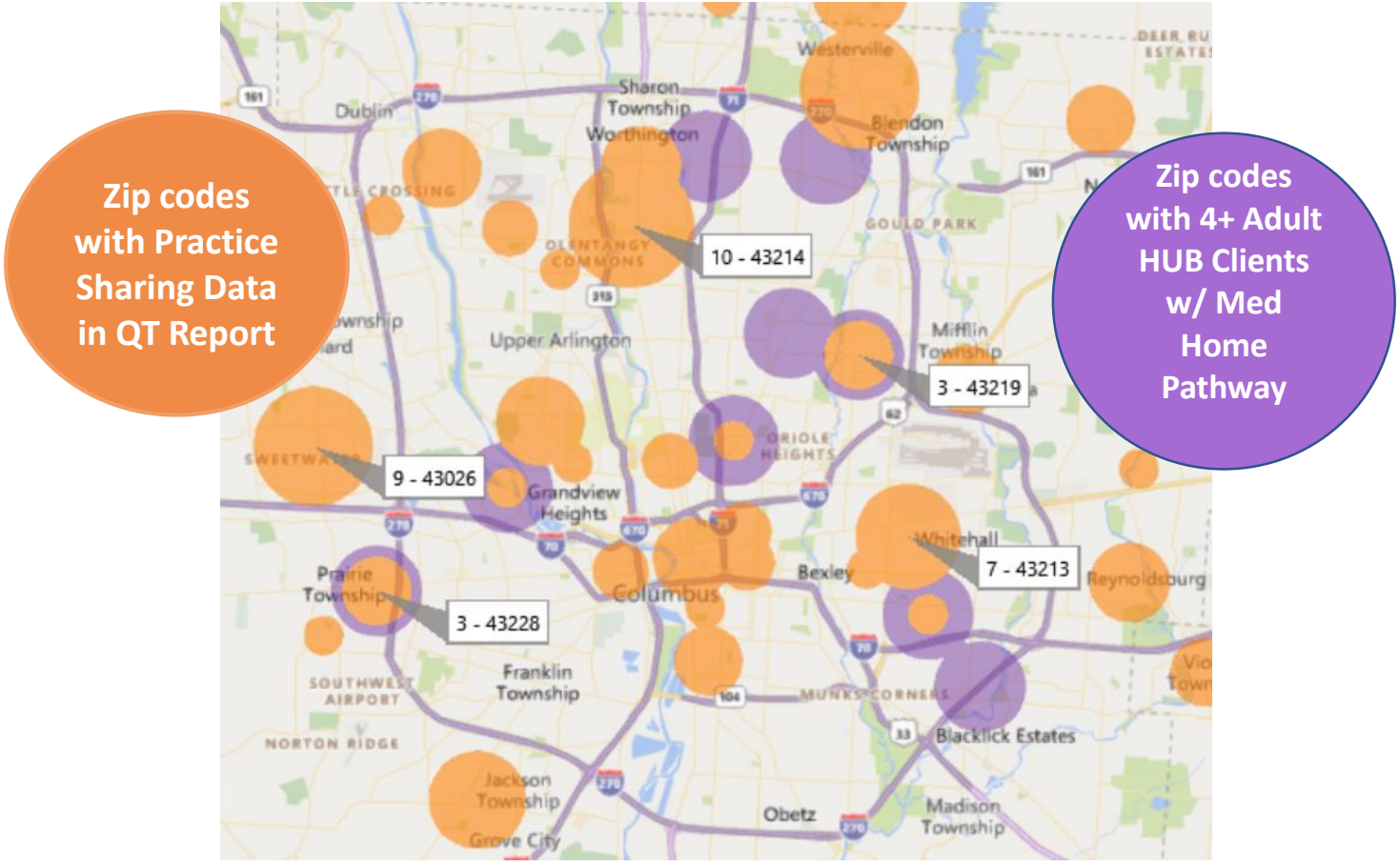
QT Reporting Practice & HUB Adult Client Zip Code Comparison

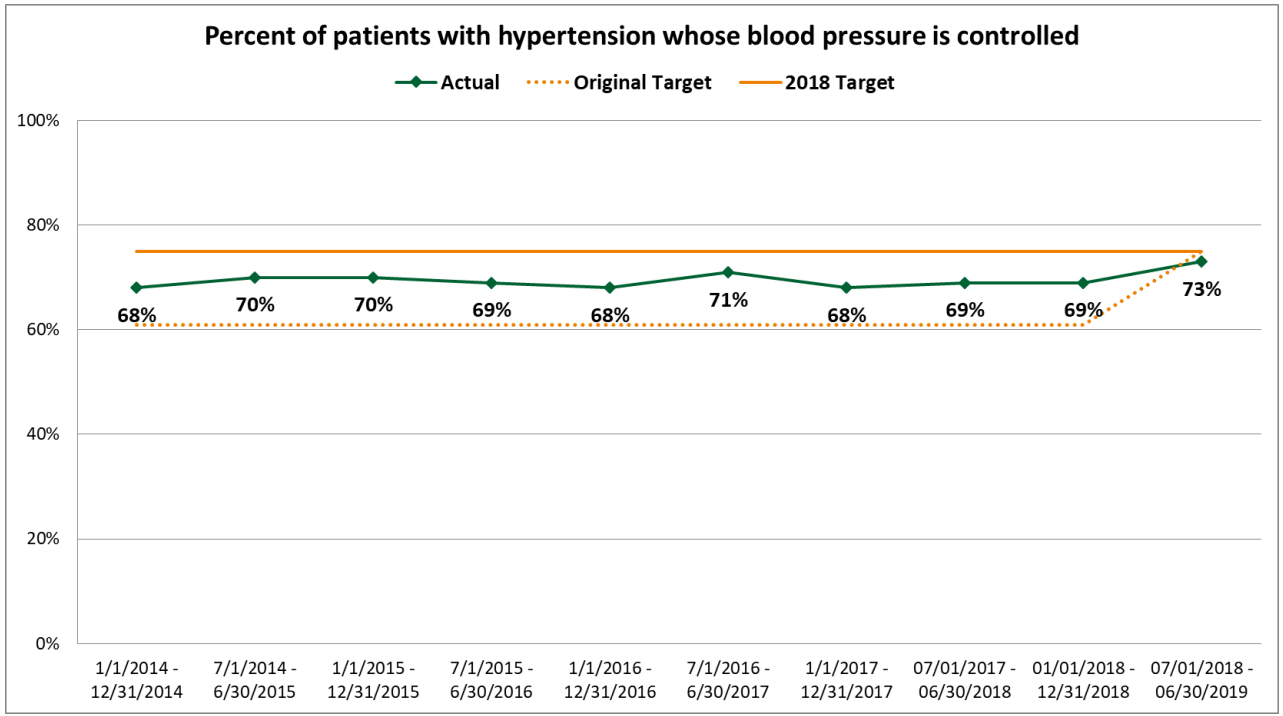
Zip codes with Practice Sharing Data in QT Report



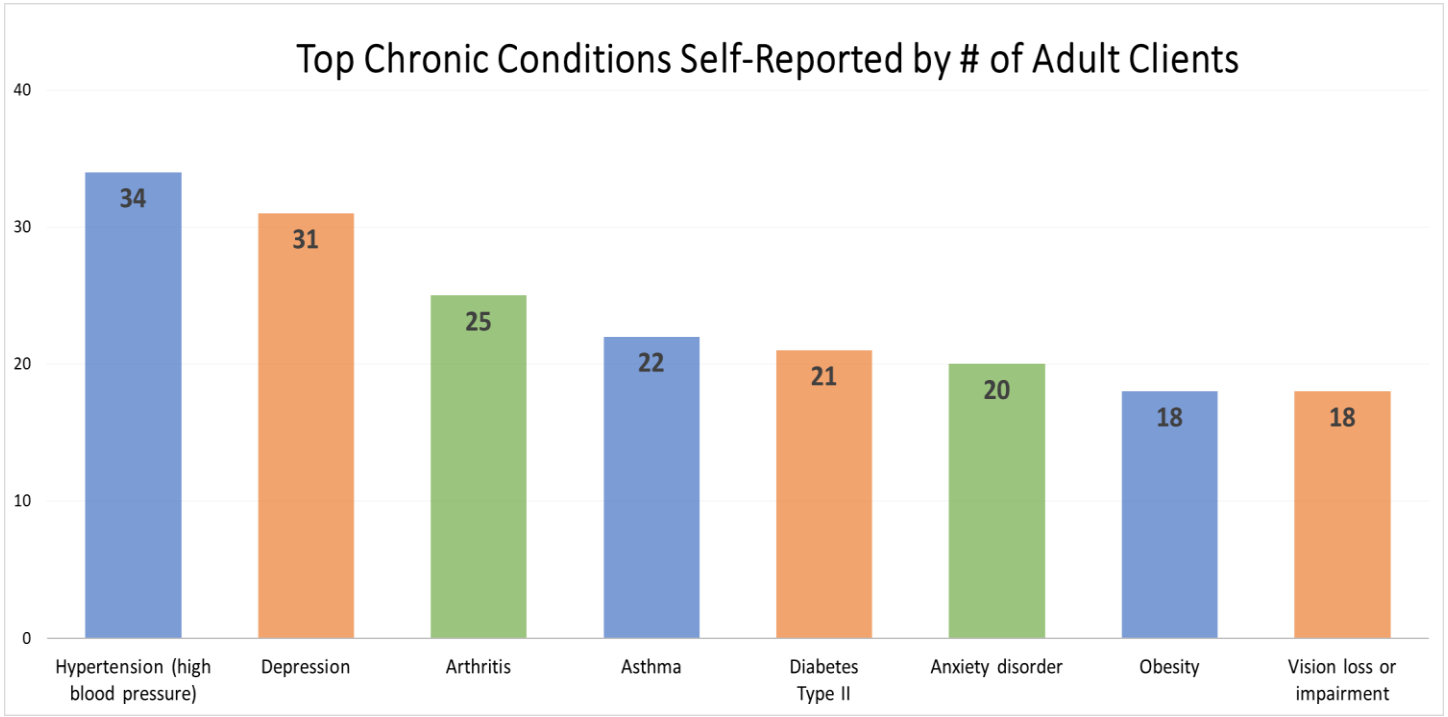
Zip codes with 4+ Adult HUB Clients

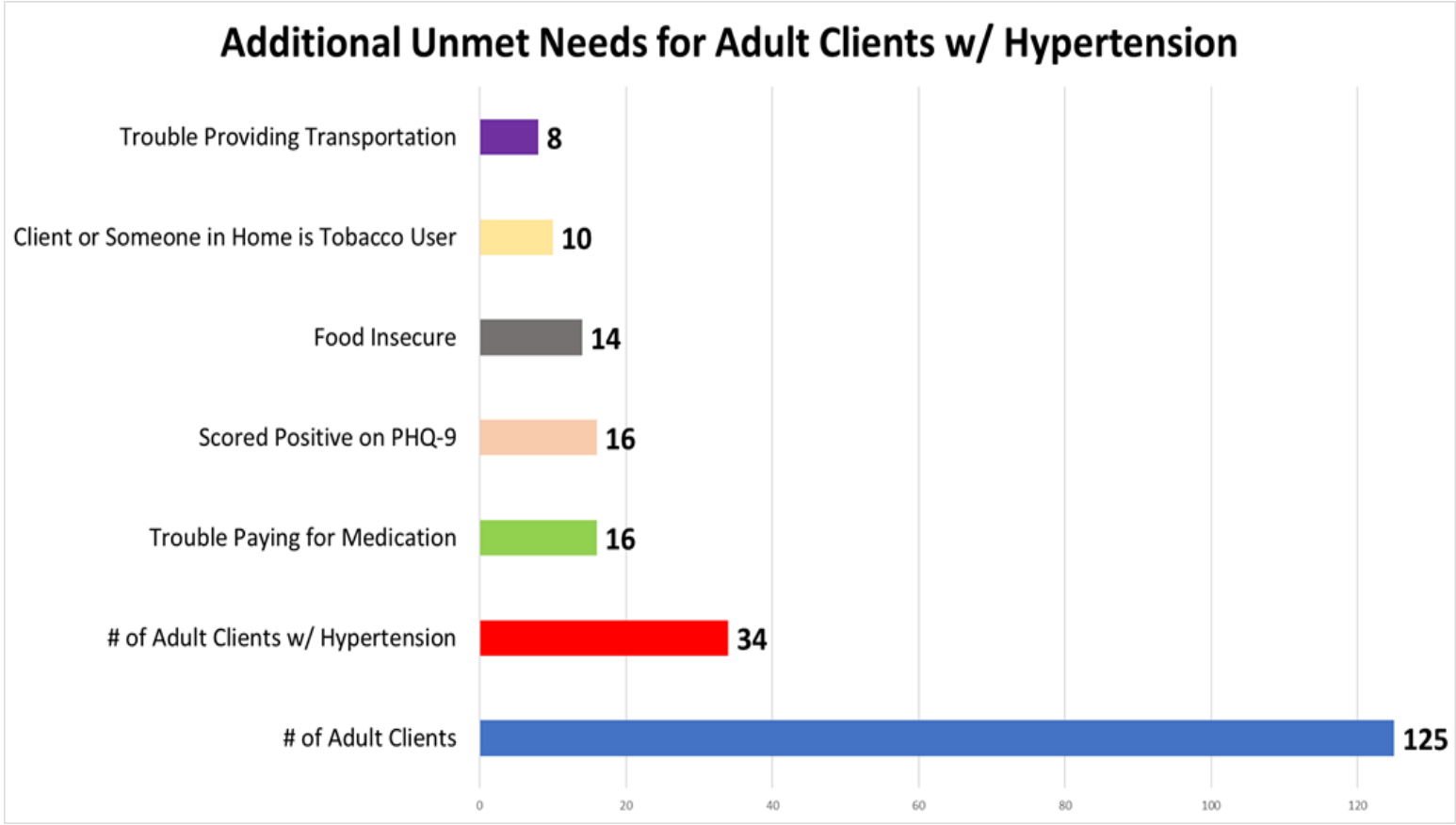
QT Reporting Practice & HUB Adult Clients w/ Medical Home Pathway Zip Code Comparison




Percent of patients with hypertension whose blood pressure is controlled
Actual
Original Target
2018 Target
100%
80%
60%
40%
20%
0%
68%
70%
70%
69%
68%
71%
68%
69%
69%
73%
1/1/2014 - 12/31/2014
7/1/2014 - 6/30/2015
1/1/2015 - 12/31/2015
7/1/2015 - 6/30/2016
1/1/2016 - 12/31/2016
7/1/2016 - 6/30/2017
1/1/2017 - 12/31/2017
07/01/2017 - 06/30/2018
01/01/2018 - 12/31/2018
07/01/2018 - 06/30/2019

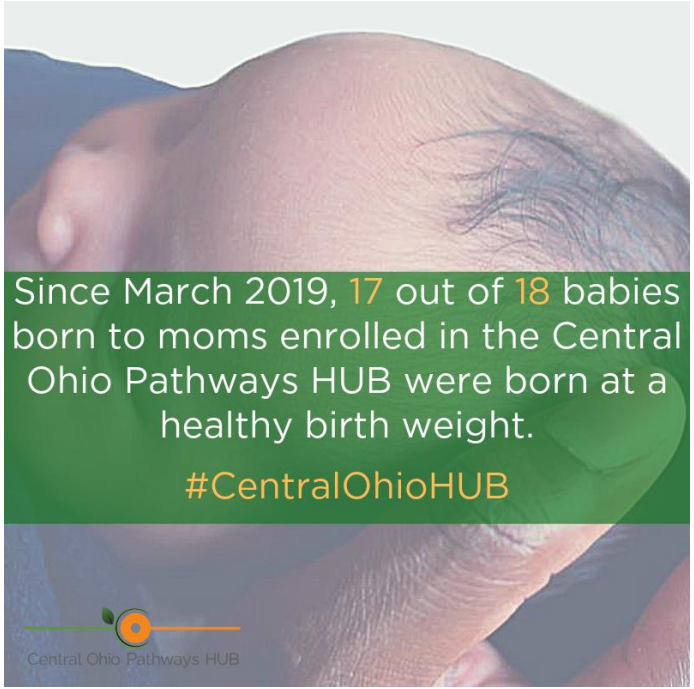
HUB Adults with Chronic Conditions




Additional Unmet Needs for Adult Clients w/ Hypertension
Trouble Providing Transportation
8
Client or Someone in Home is Tobacco User
10
Food Insecure
14
Scored Positive on PHQ-9
16
Trouble Paying for Medication
16
# of Adult Clients w/ Hypertension
34
# of Adult Clients
125
0
20
40
60
80
100
120

Successful Birth Data Points

- 31 Closed Pregnancy Pathways since March
  - 84.35% HBW babies, including a set of twins
  - LBW babies came to the HUB 1 month or less before delivering
  - Completing baby basics, housing and parenting education social service pathways



Opportunity for RHICs

- Works best with a neutral convener
- Non-profit in healthcare but not a provider, funder or public health agency
- Infrastructure we have in place:
  - Experienced staff, high value reputation in the community, Board of Directors; clean, successful audits, accounting/fiscal sponsorship services/experience
  - Experience in technical assistance, data/HIE/NQIIC/QE and coaching for quality/process improvement, contracting
- Community/partner trust

Major Takeaways

- Strategically: If 80% of a person's health status is determined by non-clinical factors, how can we as a RHIC only look at the 20% and expect to meet mission?
- The opportunity to treat SDOH as a "provider type/service" and be compensated should be a part of every value conversation, and not just mandated on clinicians and/or insurance
- We have become one of the largest in the country
- As a % of HCGC Total Revenues, HUB has grown to be 1/3rd with more anticipated in 2020 for meeting MISSION

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