Improving Health Through the Central Ohio Pathways HUB
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.
Social Determinants

Social Determinants (food, housing, transportation)

% of Life Expectancy and Health Status Attributable to

- Health Behaviors 30%
- Social and Economic Factors 40%
- Clinical Care 20%
- Physical Environment 10%
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

The CMS Innovation Center

Ohio Commission On Minority Health

Ohio Department of Medicaid

Institute for Healthcare Improvement

CDC Centers for Disease Control and Prevention

Agency for Healthcare Research and Quality

HRSA

National Science Foundation

NIH National Institutes of 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

<table>
<thead>
<tr>
<th>Overall HUB Data</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>03/1/19-10/2/2019</td>
</tr>
<tr>
<td>Total Adult Clients</td>
<td>125</td>
</tr>
<tr>
<td>Total Maternal Clients</td>
<td>143</td>
</tr>
<tr>
<td>Total Pregnant Clients</td>
<td>133</td>
</tr>
<tr>
<td>Total Pathways Initiated</td>
<td>2908</td>
</tr>
<tr>
<td>Total Pathways Completed</td>
<td>1607</td>
</tr>
</tbody>
</table>
Clients by Insurance Type

- **In-Kind, 43%**
- **CareSource, **
- **Buckeye, 3%**
- **United...**
- **Molin...**
- **Paramount,...**
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**

- 9 - 43026
- 10 - 43214
- 3 - 43219
- 3 - 43228

**Zip codes with 4+ Adult HUB Clients**

- 7 - 43213
QT Reporting Practice & HUB Adult Clients w/ Medical Home Pathway Zip Code Comparison

Zip codes with Practice Sharing Data in QT Report

Zip codes with 4+ Adult HUB Clients w/ Med Home Pathway
Percent of patients with hypertension whose blood pressure is controlled

- Actual
- Original Target
- 2018 Target

68% 70% 69% 68% 71% 68% 69% 69% 73%

1/1/2014 - 12/31/2014 7/1/2014 - 6/30/2015 1/1/2015 - 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

Top Chronic Conditions Self-Reported by # of Adult Clients

- Hypertension (high blood pressure): 34
- Depression: 31
- Arthritis: 25
- Asthma: 22
- Diabetes Type II: 21
- Anxiety disorder: 20
- Obesity: 18
- Vision loss or impairment: 18
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
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