

WHAT IS THE CENTRAL OHIO PATHWAYS HUB?

The Healthcare Collaborative of Greater Columbus (HCGC) is proud to manage the Central Ohio Pathways HUB, a neutral, central convener that assesses medical, behavioral and social risks for our most vulnerable neighbors and connects them with community resources to mitigate those risks. Different from other referral networks or programs, the HUB tracks risks, connections and outcomes via “pathways” and a specialized technology system. Community Health Workers (CHWs) working at Care Coordination Agencies (CCAs) work hand-in-hand with clients enrolled in the HUB to attain success in completing pathways; successful outcomes (“completed pathways”) have payments associated. By providing this innovative model to Franklin and contiguous counties, HCGC continues its mission to increase optimal health for all in our region; reduce duplication and variation of services; increase health and healthcare value by proactively addressing social determinants of health and connections to care; and increase health equity in Central Ohio.

CARE COORDINATION IN CENTRAL OHIO

Community Health Workers (CHWs) serve as partners, advocates, and coaches for their clients and work to identify health needs and risks. Each risk is then translated into a pathway—including unmet needs for transportation, housing, and more—and tracked through completion in an electronic database. CHWs are employed by medical clinics, social service agencies, and other organizations throughout the region. There are currently 12 Care Coordination Agencies (CCA's) employing over 30 CHWs participating the HUB:

- CelebrateOne
- Columbus Urban League
- Franklin County Public Health
- Heart of Ohio Family Health Centers
- PrimaryOne Health
- Physicians CareConnection
- The Breathing Association
- Ethiopian Tewahedo Social Services
- Urban Strategies
- Wellness First
- Union County Public Health
- Grace Haven

HOW IT WORKS



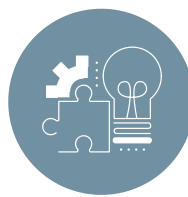
1. Find: CHWs enroll clients in the HUB. Healthcare providers and others refer clients to the HUB.



2. Engage: Once enrolled, clients complete a comprehensive assessment to identify health and social service needs (risks).



3. Plan: CHW works with their supervisor to develop a plan of care based on the identified risks. Each risk translates into a standardized Pathway.



4. Problem Solve: CHWs meet regularly with clients in their homes to build trusting relationships and offer support. Behavioral change is supported through the use of Learning Modules.



5. Track: HUB staff reviews data on a regular basis to ensure that clients receive a high quality and meaningful experience. The HUB works to reduce duplication of services and identify community gaps in resources.



6. Pay: HUBs bill Medicaid managed care plans and other funding partners for successfully completing Pathways. HUBs distribute payments to the organizations that employ CHWs. HUBs keep a small administrative fee.

PATHWAY INFORMATION

20 Available Pathways

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

CURRENT HUB DATA
UPDATED 11/5/2020



1,932 Total Clients Since March 2019



587 Clients Currently Receiving Care Coordination



11,708 Total Pathways/Connections to Care Initiated

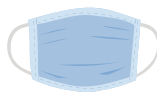


8,087 Total Pathways/Connections to Care Completed and Reimbursed



Most Frequently Opened Pathways:

- Social Service Referral
- Education
- Medical Referral
- Pregnancy
- Medical Home



Over 500 Educations Related to COVID-19 including health, personal hygiene, assistance finding a testing site.



Over \$107,000 Reimbursed to HUB Care Coordination Agencies (From January 2020-August 2020)

A CERTIFIED NATIONAL MODEL

The Pathways HUB Model encompasses community network development guidance, incentives for community-based organization collaboration, client and family risk assessments, CHW training, Pathways risk-mitigation workflows to confirm that of outcomes are achieved, as well as billing and common reporting and benchmarks. When combined, these tools help communities in their initiatives to improve health equity and measure success of those initiatives. With published evidence of both outcome improvement and cost savings, this approach and its national Certification is officially recognized by both payers and policy makers focused on pay for outcomes.

