Pathways Community HUB Model

Central Health Collaborative

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Goals/Objectives

- Together we will:
  - Develop a shared understanding of the Pathways Community HUB Model
  - Review examples of Pathways programs across the nation
  - Identify/brainstorm recommendations for priority populations that may benefit from the model

What is the Pathways Community HUB Model?

- Evidence-based community care coordination approach to connect at-risk individuals to care and services
- Risk factors are addressed through ‘Pathways’
- Risk factors may include:
  - Diagnosis → mental health, chronic conditions
  - Pregnancy status → normal risk, high risk
  - Health behaviors → tobacco, alcohol use
  - Utilization patterns → ED or 911 use
  - Social needs → food insecurity, housing instability

What is a HUB?

- Centralized access point that guarantees efficient and effective service delivery
- The HUB contracts with Care Coordination Agencies (CCAs) to hire, manage and deploy care coordinators (CHWs, Nurses, LCSWs)
- The HUB assigns referrals to care coordinators to connect individuals to needed care and social services

Key Functions of the HUB

- The HUB serves as a neutral clearinghouse that:
  - 1. Registers at-risk individuals
  - 2. Connects an at-risk individual to a care coordinator
  - 3. Monitors the quality, effectiveness and efficiency of community care coordination services
  - 4. Ties payments to health improvements and outcomes

HUB Process

Find

- Identify individuals at greatest risk and provide comprehensive assessment of health, social and behavioral health risk factors

Track

- Ensure that each identified risk factor is assigned to a specific Pathway that will ensure the risk factor is addressed with an evidence-based intervention

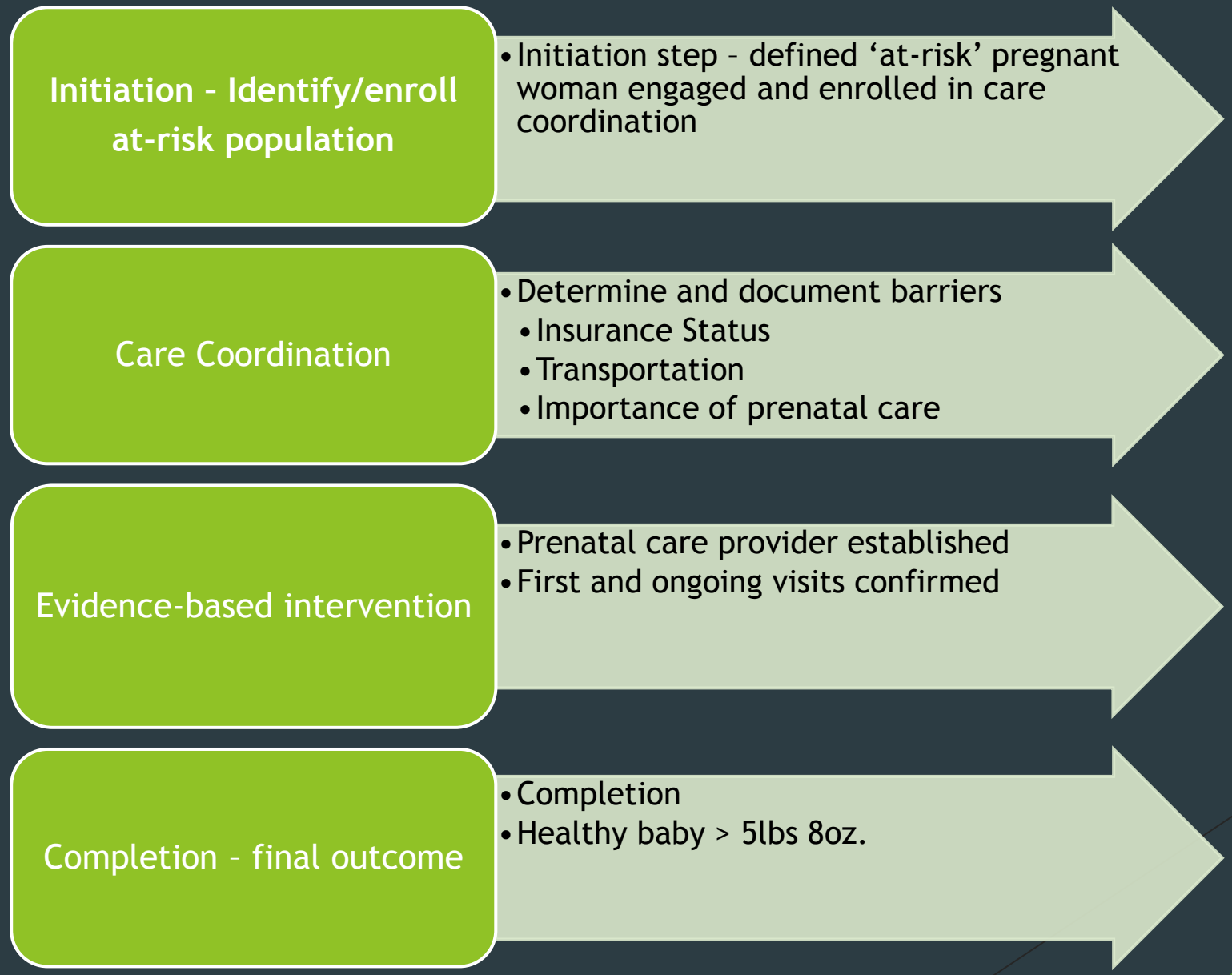
Measure

- Completion of each Pathway confirms that the risk factor has been successfully addressed. Measurement may include improvement in chronic disease, reduction in ED visits, adult education, or a healthy birth weight baby

Core Pathways - Required for National Certification

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

Example: Pregnancy Pathway



Pathways Community HUB - Video

THE PATHFINDER HUB - LEARN HOW THE HUB GETS COMMUNITY ORGANIZATIONS WORKING TOGETHER FOR BETTER HEALTH.

MEET JOE - LEARN HOW THE PATHFINDER HUB WILL HELP HIM TRANSITION OUT OF JAIL TO STABILITY.

MEET KATHY - LEARN HOW COMMUNITY CARE COORDINATORS WITH THE PATHFINDER HUB HELP THEIR CLIENTS OVERCOME RISKS.

National Examples

- Community Health Access Project (CHAP) – Mansfield, OH
  - Low birth weight babies
  - Number of at-risk pregnant women served increased from 19 to 146 in 1 year
  - Low birth weight rate went from 23% to less than 5%
- Michigan Pathways to Better Health – Ingham, Muskegon, Saginaw
  - Two or more chronic conditions, high social service needs
  - 2,500 linked to a primary care provider
  - Reduction of 153 transports to ED among 70-80 frequent users
  - 1,700 linked to food services/1,600 linked to transportation

National Examples Continued

- Northeast Oregon Network – Union, Wallowa, Baker
  - Adults with chronic disease – heart disease and diabetes
  - Trained 80 community health workers
  - Reached 200 individuals with Living Well classes
  - Served over 400 individuals with prevention and self-management education
- Buffalo County Community Partners – Kearney, NE
  - Uninsured community members with diabetes
  - 59% of clients have not returned to the ED for medical care, resulting in $3.5 million in cost savings
  - 73 clients have been able to obtain 633 prescriptions
  - 52% of clients were connected to social needs

Activity – Identify a Priority Population

- Based on your knowledge of the community, what populations should be brought forward for consideration?

- What data should be considered to inform priority populations for this project?