Central Ohio Pathways HUB
Equity. Access. Quality.

HEALTH IMPACT OHIO

Equity-Driven Care Coordination

August 2022

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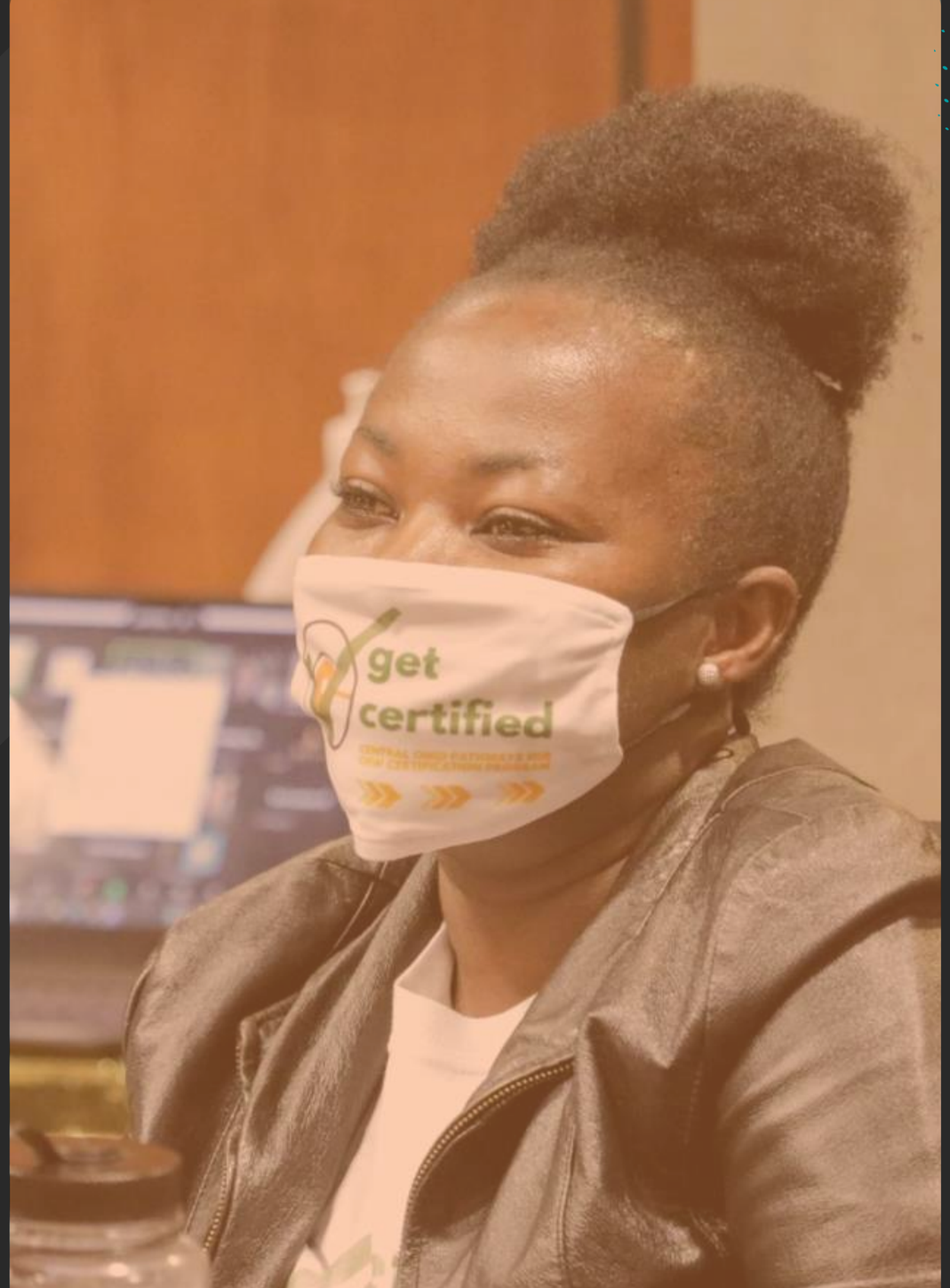
HEALTH IMPACT OHIO'S MISSION

We improve social drivers of health, health equity, access and quality in all communities, through community engagement and partnership; multi-stakeholder training and coaching; data collection and integration; and strategy development and deployment.



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HEALTH IMPACT OHIO'S VISION

We believe in optimal health outcomes for all individuals in every community.

PRESENTERS

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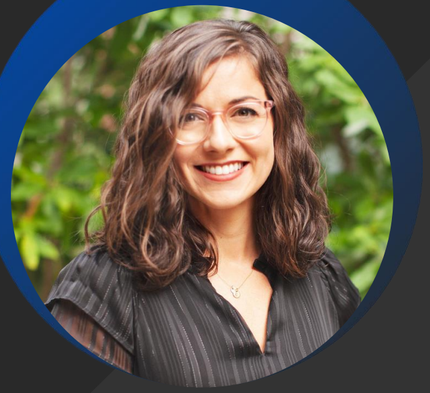

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NETWORK DEVELOPMENT DIRECTOR,
UNITE US

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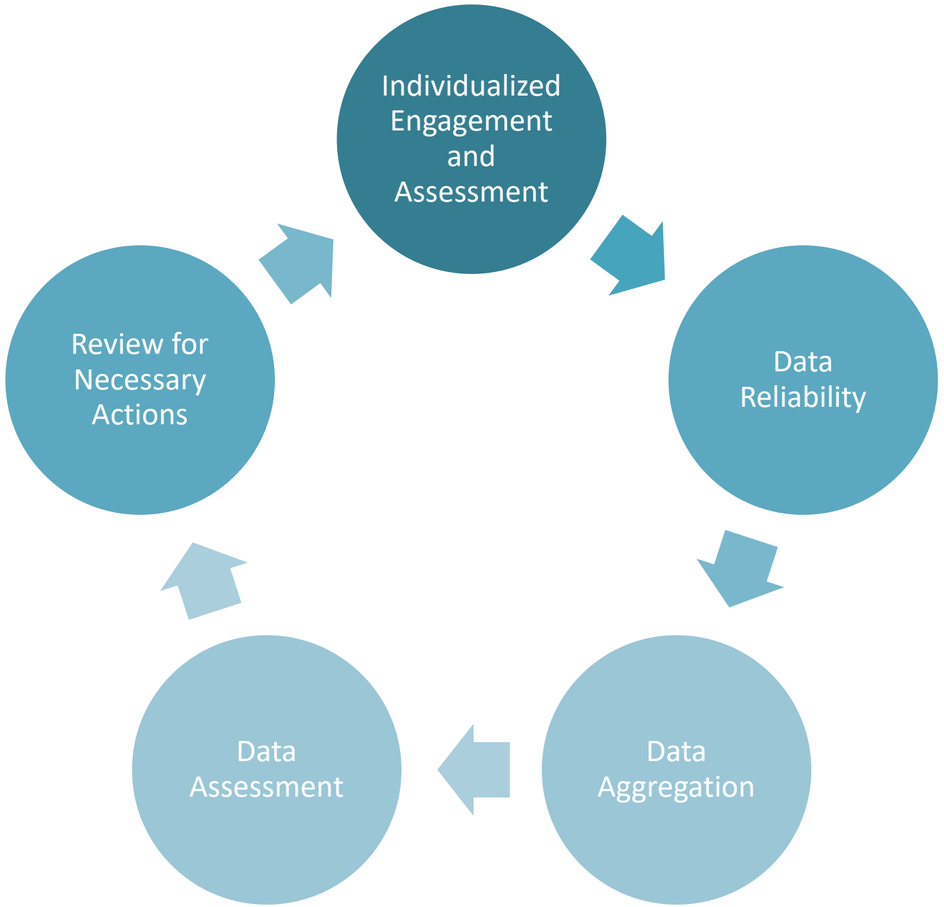
RECIPE FOR NEEDED CHANGE



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PATHWAYS HUB BACKGROUND

OHIO SENATE BILL 332

Largely focused on infant mortality crisis

- **Support for CHW Certification**
- **Definition of "Certified HUB" in Ohio Revised Code**
- **Requirement that Medicaid Managed Care Organizations contract with HUBs**

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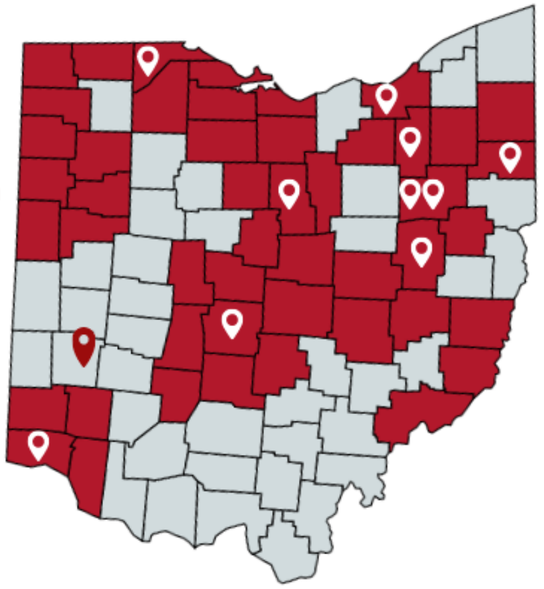
PATHWAYS HUB BACKGROUND

Ohio Network of Certified Pathways Community HUBs

Member HUBs

- Better Health Pathways HUB: Cleveland
- Bridges to Wellness HUB: Tuscarawas County
- Central Ohio Pathways HUB: Columbus
- Community Action Pathways HUB: Canton
- Community Health Access Project: Mansfield
- Health Care Access Now: Cincinnati
- Mahoning Valley Pathways HUB: Youngstown
- Northwest Ohio Pathways HUB: Toledo
- Pathways HUB Community Action: Akron
- Stark County THRIVE: Canton
- Dayton Regional HUB: Dayton



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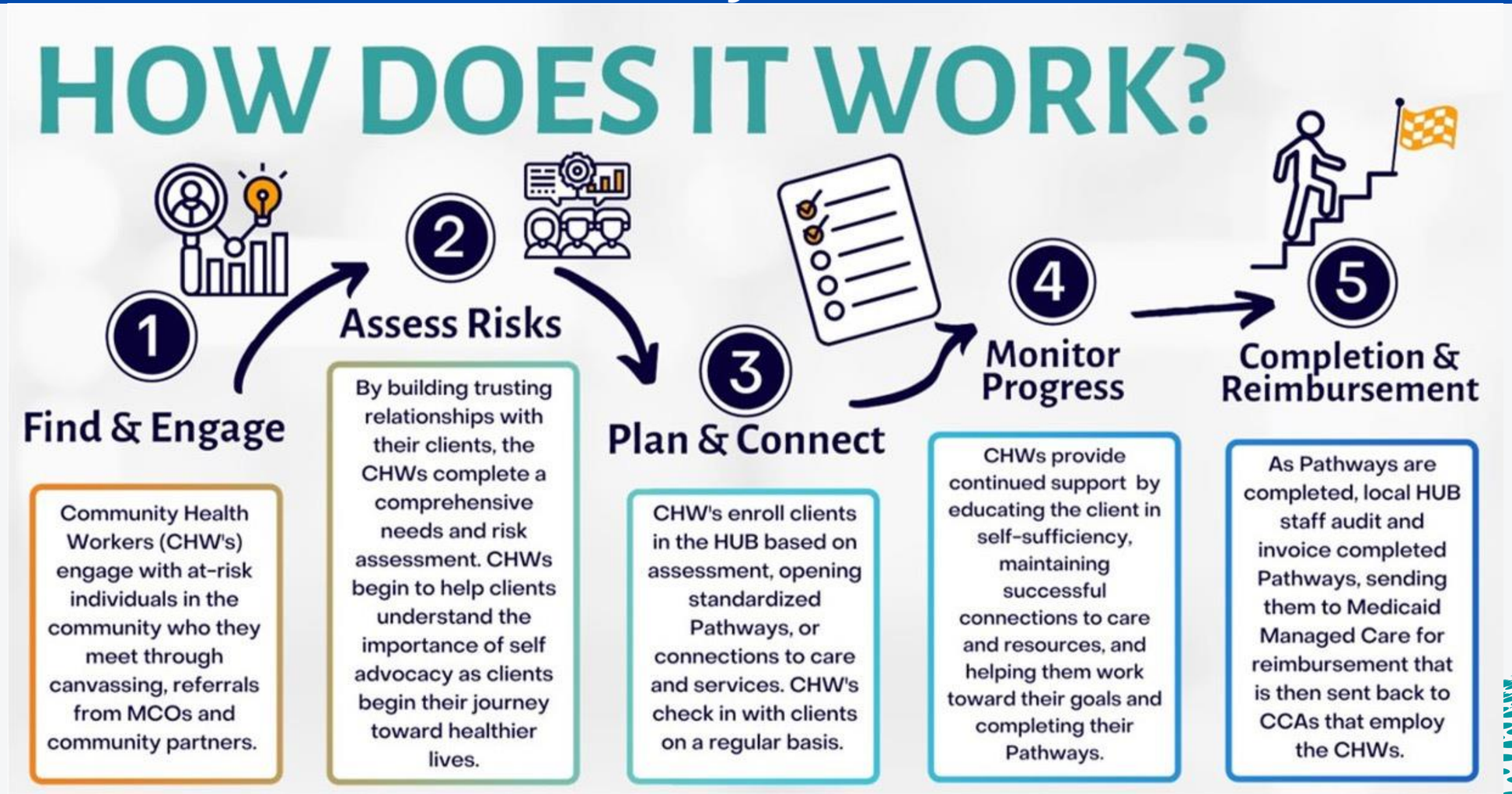
PATHWAYS HUB BACKGROUND

Creation of the Central Ohio Pathways HUB



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DATA AND IMPACT

Current HUB Data
Updated 7/19/2022

4,253 Total Clients Since March 2019

An average of **600** clients receive HUB services per month

Most Frequently Opened Pathways:

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

Over 1,800 Educations Related to COVID-19 including information on vaccines, variants, health orders, personal safety, etc.

30,500 Total Pathways/Connections to Care Initiated

22,658 Total Pathways/Connections to Care Completed and Reimbursed

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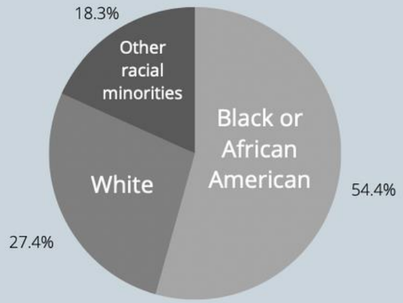
DATA AND IMPACT

The HUB reaches unique, at-risk populations

92%

of babies born to Black and African American mothers who were a part of funding from the Ohio Commission on Minority Health in the HUB were born at a **healthy birth weight.**



54.4%

of participants receiving services in the HUB are Black or African American. This data shows us that HUB services are essential to **addressing health disparities** amidst the COVID-19 crisis.

95%

of participants in the **theft diversion** program with Columbus City Attorney Zach Klein have successfully completed the program, receiving connections to care and services rather than jail time.

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DATA AND IMPACT

92%

of babies born to Black and African American mothers who were a part of funding from the Ohio Commission on Minority Health in the HUB were born at a **healthy birth weight.**

Quarter 2 of 2022: 100%

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PARTNERSHIPS

Care Coordination Agencies (CCAs) in the community employ the CHWs that provide care coordination for HUB clients

Central Ohio Pathways HUB CCAs

Physicians CareConnection
An affiliate of the Columbus Medical Association

Columbus Urban League

The Breathing Association
Better Breathing for Better Lives.

Ross County Health District

UNITED CHURCH HOMES®
Celebrating the Spirit®

Franklin County Public Health

UNION COUNTY OHIO
Public Health

AFRICAN AMERICAN ALZHEIMER'S & WELLNESS ASSOCIATION

etss
ETHIOPIAN TEWAHEDO SOCIAL SERVICES

PrimaryOne Health
Your first choice for quality care

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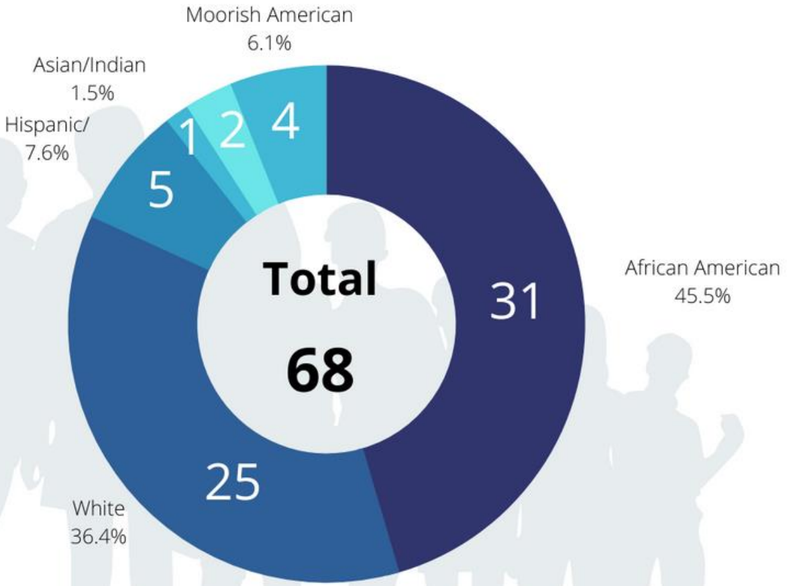
CHW CERTIFICATION PROGRAM

Central Ohio Pathways HUB CHW Certification Program Graduates

Gender:
54 Females
13 Males
1 Nonbinary

Citizenship:
60 US Citizenship
8 Permanent Legal Immigrant

Ages:
23-64



Employment Backgrounds of Participants:
Farhat Advance Medical Interpreting, Heart of Ohio Family Health Center, Kroger, PrimaryOne Health Centers, The Breathing Association, Urban Strategies Inc., Wellness First, Womenkind OB/GYN, Physicians CareConnection, Columbus Urban League, Anthem, Carmella Rose Health Foundation, Bridges to Wellness Tuscarawrus County HUB, Columbus Developmental Center, Insurance Navigator,MetroHealth Medical Center, Neidig Health Care, Physicians CareConnection, Pregnant with Possibilities Resource Center, PrimaryOne Health, Ross County Health District , Senior Resource Connection ,St. Mary's Develpoment, United Church Homes, United Way of Greater Cleveland, Unemployed, Self-Employed

Calvin Klein

get certified

CENTRAL OHIO PATHWAYS HUB
CHW CERTIFICATION PROGRAM
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CDC FUNDED WORK:
CCR COMPONENT B-TRAINING CHWS FOR COVID RESPONSE

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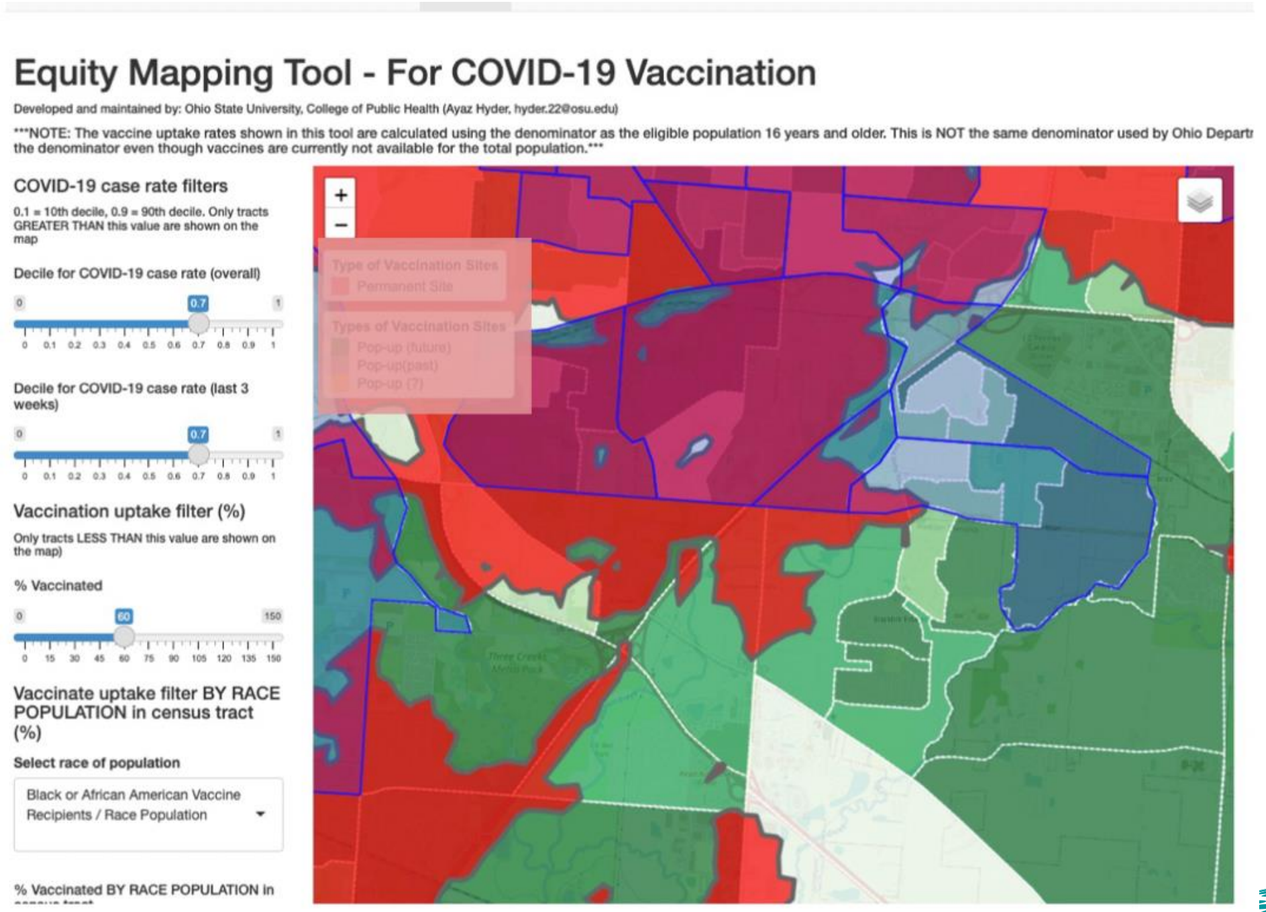
CDC FUNDED WORK:
CCR COMPONENT C-DEPLOYING CHWS USING PUBLIC HEALTH DATA

Use Case #1: Franklin County Public Health/Columbus Public Health use the Equity Mapping Tool (EMT) and weekly reports on the gap in uptake rate between more and less vulnerable populations to identify where to target vaccine education and outreach efforts.

Use Case #2: Healthcare systems (e.g., OhioHealth) is using the EMT to guide its mobile vaccination strategy.



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CDC FUNDED WORK:
CCR COMPONENT C-DEPLOYING CHWS USING PUBLIC HEALTH DATA

Component C Year 1 Goals:

1. A co-created plan for data sharing based on shared values and goals between CHWs/HUBs and LHDs for enhancing community resilience and supporting COVID-19 public health response.

2. A working version of the EMT that is securely accessible to participating CHWs/HUBs and LHDs.

3. Access for CHWs and LHDs to a version of the EMT based on their catchment area and ability to use the mapping tool for co-planning of COVID-19 public health response activities (e.g., targeted education and outreach in hard-to-reach communities around booster vaccine shots in late 2021).

Component C Year 2 Goals:

1. Accessible, dynamic and engaging training materials that will support the practical use of the EMT by CHWs in their day-to-day interactions with clients and other community members in support of the COVID-19 public health response.

2. A series of case studies on new uses of the mapping tool from CHWs/HUBs and a feedback loop between real-world use of the mapping tool based on input from CHWs and the developers of the mapping tool.

3. Workflows that are personalized to each participating HUB showing how to integrate the EMT within day-to-day activities of CHWs and CHW supervisors and case studies for CHW supervisors and HUB leaders on the topic of how to sustainably share data, integrate data across sectors and use data in support of the varied roles and activities that CHWs undertake during stressor events, such as pandemics.

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EVOLUTION AT PATHWAYS COMMUNITY HUB INSTITUTE (PCHI)

PCHI | Pathways | COMMUNITY HUB INSTITUTE MODEL CERTIFICATION

THE PCHI® MODEL IMPACT

"Pathways Community HUB InstituteR is here because we've seen first-hand the impact that a community-designed care coordination network has on individuals and their families. It means these individuals - once connected to routine health, wellness and social services - can lead healthier, more fulfilling lives. What started out in Mansfield, Ohio is now, nationally in 35 communities and counting. We invite you to check out the transformational work happening in communities implementing the PCHI Model."-pchi-hub.org

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EVOLUTION AT PATHWAYS COMMUNITY HUB INSTITUTE (PCHI)

Pathways 2.0

IT Vendor Accreditation

- Care Coordination Systems (CCS)
- Innovacer
- Unite Us

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THE TECH SOLUTION FOR OUR HUB

UNITE US

- Social Service Driven, CHW Friendly
- Building a system FOR us, WITH us
- Interoperability
- Confidence in Data, Data Dashboards
- Community Engagement & Data Input

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THE TECH SOLUTION FOR OUR HUB

Envisioning a future with Unite Us:

- See clients in totality
- Interoperability to HIE and EHRs
- Find gaps in community need vs resources
- Generational and Community Impact
- Trust Equation

Our vision is to build connected communities.

Together, we can improve health.

- **Increase capacity** for CBOs
- **Breakdown data silos** across sectors
- **Expand access** for individuals seeking services

UNITE US

Our Approach: Leveraging Existing Strengths

Our Human Centric, Community Focused, Tech Enabled, Data Driven. Approach

Health Impact Ohio
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Community Focused

UNITE US

Tech Enabled

CliniSync

Data Driven

Multi-Stakeholder Workgroup

2021 Mission: *"…improve care, health disparities and equity for all Ohioans, regardless of demographic or socioeconomic status…."*

Social Service Organizations

Catholic Social Services
Columbus Partnership
Dayton Area Food Resource
Direction Home
Feeding America
Health Impact Ohio
Help Network of Northeast Ohio
Human Service Chamber
Lifeline
MidOhio Foodbank
Pathways of Central Ohio
Summit County ADM Board
United Way Summit and Medina

Health Plans

Anthem
CareSource
Humana
Molina
Molina HealthCare
United Healthcare

Association

Ohio Association Community Health Centers
Ohio Hospital Association
Ohio Osteopathic Association
Ohio State Medical Association

Diversity Consulting

More Inclusive Healthcare

Health Systems

Akron Children's
Bon Secours Mercy Health
Cleveland Clinic
Dayton Children's Hospital
Firelands Regional Medical Center
Fisher Titus
Genesis HealthCare System
Lake Health
Nationwide Children's Hospital
OhioHealth Corporation
OSUWMC
Premier Health Partners
Sisters of Charity Health System
SOMC
Southwest General
Summa Health System
The Metro Health System
University Hospitals
Wooster Community Hospital

Behavioral Health

Netcare

FQHC/Provider

COPC
Madison Pediatrics
Orthopedic One
Logan Elm Health Care

An aligned approach in managing SDoH referrals

Creating an efficient process to coordinate with community resources, boots on the ground Navigators, Community Service Organizations and closing the loop within the workflow.

- More accessible local services that can be connected.
- A community collaborative approach: Moving this needle is difficult; providers, managed care plans nor agencies can solve this on their own.
- A statewide approach that would solve for technologies and data.
- A sustainability plan that provides resources back into the community.
- *"Measurable" s*uccess through Key performance indicators (KPIs) measurement

A person-centered design that is a win/win for all those involved.

Critical Success Criteria

"…Creating Key Performance Indicators (KPIs) will help identify and build upon sustainable, effective models of care that address health disparities and equity. Through the use and analysis of real-time, reliable data from across all areas of the Public – Private efforts, we can dramatically strengthen outcomes and target sustainability models for the community support structures showing success."

A Statewide "Interoperable Technology Stack"

- **A social needs closed-loop referral platform**
- **A Resource Library that is an Ohio asset**
- **An enhanced identity management solution that can be leveraged by Stakeholders across Ohio**
- **A certified data quality system**
- **Pathways Hub software**
- An expanded clinical interoperability suite
- Extending interoperability to the *“last mile”*
- An enterprise analytics suite focusing SDoH
- CFR 42 Part 2 compliant Patient consent process
- **An interoperable solution for school-based caregivers the ability to coordinate with community providers**

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SEARCH "HEALTH IMPACT OHIO"