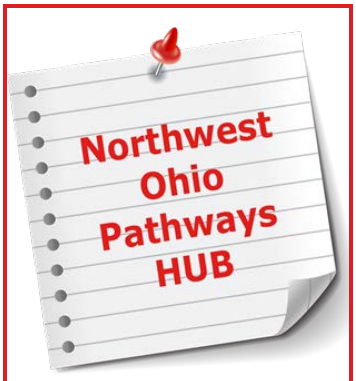
FIELD NOTES



Problem

A 2013–2014 community health assessment of Lucas County, Ohio, showed that more than 37% of residents had high blood pressure, heart disease, or other cardiovascular disease conditions. Rates were higher among African Americans and Hispanics, who also had more hospital readmissions and barriers to care.[1]

Program

The Northwest Ohio Pathways HUB at the Hospital Council of Northwest Ohio runs the Adult Pathways program, which addresses chronic disease risk factors among low-income residents of Lucas County. The Adult Pathways program contracts with agencies employing community health workers to connect people with or at risk of chronic disease to appropriate medical care and social services in the community.

For more information:

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Overview

The Pathways Community HUB model is nationally recognized by the Agency for Healthcare Research and Quality for creating an infrastructure that connects health care organizations and trained community health workers (CHWs) with clients that have unmet health and social needs.[2] The HUB model employs culturally competent community health workers (CHWs) to identify people with health and social risk factors, connect them with community resources, and track progress toward addressing those risk factors. The HUB is the organizational infrastructure that supports CHW-led care coordination, and each pathway represents a risk factor.

The Hospital Council of Northwest Ohio (HCNO) houses the Northwest Ohio Pathways HUB, which works to address the health and social needs of residents in Lucas County, Ohio. The HCNO launched the Pathways Community HUB model in 2007 to address high rates of infant deaths. In 2015, it added the Adult Pathways program to address CVD and other chronic conditions for low-income and underserved adults in Lucas County, Ohio.

The Adult Pathways program partners with health care agencies across Lucas County to provide health and social services to low-income residents across 20 standardized pathways.[2] Pathways are specifically designed to address barriers to care, such as medication management and housing, that represent distinct health and social risk factors. The program contracts with Medicaid Managed Care plans to tie reimbursement to CHW care coordination and completion of a pathway, meaning their immediate health or social risk factor was addressed. CHWs are included in clinical care teams to help coordinate and reinforce a comprehensive care plan for their clients. Through the Adult Pathways program, CHWs identify clients with health risk factors (like lack of health insurance or a chronic disease diagnosis) or social risk factors (like housing instability or lack of reliable transportation). They connect clients to medical and social services to address these needs and monitor and track client progress and health outcomes.

Core Component	Program Description
Find Those at Greatest Risk	In collaboration with partner agencies and CHWs, Adult Pathways staff receive referrals from health care providers or work directly in the community to identify people with or at risk of chronic disease, including CVD, who are medically and socially underserved. CHWs develop a relationship with clients and conduct a comprehensive risk assessment—in the form of a standardized checklist— to identify unmet health and social needs and address risk factors that could lead to adverse health outcomes. Clients must have an identified need in at least two pathways to be eligible for the program. They cannot be currently receiving treatment or services to meet these needs from other sources.
Treat Each Risk Factor	Once the comprehensive risk assessment is complete, each chronic disease risk factor and unmet need is translated into one of 20 nationally standardized pathways that are part of the Pathways Community Hub model.[2] Once the appropriate Pathways are assigned, CHWs develop care plans and connect clients to health and social programs and services and other local resources. They also educate clients about chronic disease and CVD prevention, treatment, and management and help them find resources that support healthy behavior changes. CHWs meet with clients in person or over the phone.
Measure Progress	A client's progress in the program is primarily tracked by the completion of the assigned pathways. Pathways represent health and social risk factors, and completion of a pathway indicates that the client and CHW addressed the immediate health or social need. CHWs use an online database hosted by the Adult Pathways program to record client contacts and progress toward pathway completion. CHWs also measure clients' blood pressure and record self-reported height and weight every 3 months while the client is actively enrolled in the program. CHWs that are employed by a clinic may access a client's electronic health records to document clinical data, including blood pressure, body mass index, and cholesterol levels. Clients may continue working with a CHW until they complete all of their pathways.

Intended Participants

The Adult Pathways program primarily serves adults at high risk of chronic disease, including CVD, who live within six zip codes in the Lucas County area. A 2013–2014 community health assessment found a high proportion of low-income residents with unmet health and social needs in these zip codes. Of the approximately 337,000 adults in Lucas County, 23% live below the federal poverty level.[1]

Goals and Expected Outcomes

The Adult Pathways program works to improve chronic disease and CVD outcomes for Lucas County residents by helping them overcome barriers to accessing and receiving health care or adopting healthy lifestyles. The program's short-term goals include reaching more residents, increasing program participation, increasing client knowledge and awareness of how to manage chronic conditions, and meeting the health and social needs of more clients.

Long-term program goals include:

- Increasing the number of clients who are managing and controlling their high blood pressure and other CVD conditions.
- Reducing emergency room visits, avoidable hospital admissions, and out-of-pocket health care costs.
- Improving health outcomes among low-income residents of Lucas County.

> ***"We let people know what is available to them. We educate them about the right resources to get them stable so they aren't worrying about other issues associated with their health. You have to treat the whole person in order to improve health outcomes."***
>
> —Adult Pathways Program Staff

Progress Toward Implementation

The Adult Pathways program started in July 2015. The most frequently identified risk factors and completed pathways include social service-related activities like assistance with food, clothing, transportation, and utilities. The program also makes medical referrals and provides health education to help clients better manage their health, including chronic conditions like CVD. From July 2015 to May 2017, the number of partner agencies using CHWs to help low-income, high-risk adults in Lucas County rose from four to eight. As of May 2017, the program has served more than 400 clients and achieved the following milestones:

- Four out of the six health systems in Lucas County are now participating in the program and are using CHWs to identify unmet health and social needs and coordinate care for their clients.
- The Northwest Ohio Pathways Hub contracted with three Medicaid Managed Care organizations, which allows the Adult Pathways program to receive reimbursement for chronic disease care coordination and pathway completion.

Addressing Health Disparities

The Adult Pathways program has worked to improve chronic disease outcomes and reduce health disparities among low-income residents in Lucas County, Ohio. A 2013–2014 community health assessment of Lucas County residents found that low-income, African American, and Hispanic residents had higher rates of diagnosed high blood pressure and that factors like health care costs and lack of access to reliable transportation were barriers to accessing care.[1] The Northwest Ohio Pathways Hub conducts the following activities to address health disparities in Lucas County:

- **Community Health Workers Provide Culturally Competent Care Coordination:** The use of CHWs is an evidence-based strategy for improving health outcomes among patients with chronic diseases, including CVD, and CHWs can be an important part of a culturally competent health care team.[3] The program uses CHWs who are familiar with or live in the local community to support and help clients meet their health and social needs. CHWs also help clients overcome barriers to care through education and connection with community resources.

- **Care Coordination Addresses Unmet Health and Social Needs:** Addressing health and social risk factors like lack of access to affordable medication[4] and transportation[5] may improve chronic disease outcomes. The program uses CHWs to match clients with resources that address their unmet needs. For example, they may enroll clients in health insurance plans or connect them with local transportation resources. The nationally recognized Pathways Community HUB model[2] can be used to identify people at the highest risk of adverse chronic disease and CVD outcomes and connect them with community resources and support. It can also be used to centrally track the progress made toward addressing their unmet health and social needs and reducing barriers to care on a real-time basis.

1. Healthy Lucas County. *Lucas County Health Assessment 2013/2014: Examining the Health of Lucas County*. Toledo, OH: Hospital Council of Northwest Ohio.
2. Agency for Healthcare Research and Quality. *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*. Rockville, MD: Agency for Healthcare Research and Quality; 2016.
3. Brownstein JN, Bone LR, Dennison CR, Hill MN, Kim MT, Levine DM. Community health workers as interventionists in the prevention and control of heart disease and stroke. *Am J Prev Med*. 2005;29(5):128–133.
4. Ferdinand K, Senatore FF, Clayton-Jeter H, et al. Improving medication adherence in cardiometabolic disease: practical and regulatory implications. *J Am Coll Cardiol*. 2017;69(4):437–451.
5. Syed ST, Gerber BS, Sharp Lk. Traveling towards disease: transportation barriers to Health care access. *J Community Health*. 2013;38(5):976–993.