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# Ohio Pathways Community HUBs: Understanding the Benefits for Patients with Diabetes


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## Individuals with diabetes often face challenges with food insecurity, transportation, housing instability, and employment that impact diabetes self-management.[1]

While clinical care and treatment account for 10% to 20% of the modifiable contributors to health outcomes, 80% to 90% of health outcomes are related to the social determinants of health and individual health-related social needs.[2] The co-occurrence of unmet social needs is a major barrier in diabetes management and control.[1]

The Pathways Community HUB model is a promising strategy to address these needs.[3] This comprehensive approach leverages the known impact of care coordination by Community Health Workers (CHWs) to address client-identified needs through centralized coordination of health and social services.[4-7] Data from a single HUB from March 2020 through July 2021 indicates that among 62 clients with type 2 diabetes, more than 50% reported food insecurity and experienced at least one additional social need.

## How it Works

In Ohio, 10 Pathways Community HUBs facilitate medical practice and community-based organization integration (Figure 1).[8,9] The HUBs are certified through the Pathways Community HUB Institute.[10]

Once a client is referred to the HUB, a comprehensive risk assessment is completed, guided by a checklist and expressed client needs. Based on the checklist, the CHW initiates core pathways (Table 1 and Figure 2), a defined action plan that describes how client needs will be addressed. CHWs become a single point of contact and meet face-to-face with each client monthly for up to 12 months

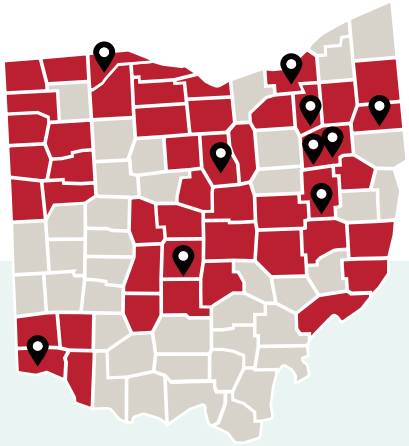

**Figure 1. Ohio Network of Certified Pathways Community HUBs**

**Better Health Pathways HUB: Cleveland**
jlever@metrohealth.org

**Bridges to Wellness HUB: Tuscarawas County**
sarah@accesstusc.org

**Central Ohio Pathways HUB: Columbus**
hcgc.org/hub-referrals.html

**Community Action Pathways HUB: Canton**
eform.pandadoc.com/?eform=c15f4cb9-4b93-4206-a635-4488c7c80195

**Community Health Access Project: Mansfield**
director@chaphub.org

**Health Care Access Now: Cincinnati**
surveymonkey.com/r/HCANReferral

**Mahoning Valley Pathways HUB: Youngstown**
medison@mahoninghealth.org

**Northwest Ohio Pathways HUB: Toledo**
csalamone@hcno.org

**Pathways HUB Community Action: Akron**
ca-akron.org/hub/contact

**Stark County THRIVE: Canton**
cantonhealth.org/thrive/?pg=548

Adapted from Healthcare Access Now and the Healthcare Collaborative of Greater Columbus

or until the individual's needs are addressed. Managed Care Plans and other community partners provide reimbursement for the HUB services. Individuals can be referred regardless of insurance status.

The Pathways HUB model uses a modified census-based deployment system whereby client data are visualized and mapped to the regional, nearby availability of CHWs. This feature enables the HUB to connect clients with a CHW who shares cultural and community knowledge with the client and enables greater efficiency in aligning comprehensive services to promote well-being and success.

### Figure 2. Flow Chart for Service Delivery in the Pathways Community HUB Model


| Enroll | Assess | Plan | Meet | Track | Train | Pay |
|---|---|---|---|---|---|---|
| CHWs enroll clients in the HUB. Healthcare providers and others also refer clients to the HUB. | Once enrolled, clients complete a comprehensive assessment to identify health and social service needs. | CHW works with supervisor to create a care plan based on the assessment using the HUB's online system that connects each need to a pathway. | CHWs regularly meet with their client to check in on the progress. | HUB staff review data and information to ensure clients receive a high quality experience and reduce any duplication of services. | CHWs receive training from HUB staff. | Managed Care Plans and other community partners provide reimbursement for the HUB services. |

Adapted from http://www.hcgc.org/central-ohio-pathways-hub.html

### Table 1. Core Pathways/Social Service Referrals Available through Pathways Community HUBs

| **Core Pathways** | |
|---|---|
| Adult Education | Lead Screening |
| Behavioral Health Referral | Medical Home |
| Developmental Screening and Referral | Medication Assessment and Management |
| Education | Medical Referral |
| Employment | Pregnancy |
| Family Planning | Postpartum |
| Health Insurance | Smoking Cessation |
| Housing | Social Services (referral options outlined below) |
| Immunization Screening and Referral | |

| **Sample Referrals Under the Social Services Core Pathway** | |
|---|---|
| Childcare | Identification (e.g., birth certificate, driver license) |
| Child Development (e.g., Part C, Help Me Grow, Head Start) | Intimate Partner Violence Support |
| Child or Elder Abuse | Legal |
| Ongoing Resource for Clothing | Literacy Intervention and Educational Services |
| Resource to Obtain Citizenship | Medical Debt Support |
| Respite Care | Parenting Education Classes and Support |
| Family Crisis (e.g., emergency shelter, Red Cross ) | Phone Service Support |
| Fatherhood Program and Support | Safety Equipment (e.g., cribs, safety equipment for older adults, car seats, locked cabinets for guns) |
| Financial Support | Translation |
| Food Stability | Transportation |
| Household Items (e.g., furniture) | Utilities |

Adapted from Healthcare Access Now and the Healthcare Collaborative of Greater Columbus

## Addressing Social Needs with Patients

The Pathways Community HUB model provides comprehensive support to individuals with diabetes facing challenges managing their condition due to unaddressed social needs. Providers can develop protocols to address social needs so all individuals with diabetes have equitable opportunity for quality treatment and care. Consider utilizing screening tools and working with a HUB near you to develop a referral process (Figure 1).


A provider shares their experiences with the Pathways HUB model and the importance of addressing social needs.

**Continue to the video →**

## Connecting Diabetes Patients with COVID-19 Care and Resources

The CHWs in the Central Ohio Pathways HUB responded rapidly to the pandemic and provided more than 1,000 educational encounters regarding COVID-19 to clients. These meetings included providing information about the COVID-19 vaccine, support in finding a testing site, information on proper personal hygiene and social distancing, and updates on COVID-19 public health measures. These encounters were critical given the high morbidity and mortality of individuals with diabetes during the COVID-19 pandemic. Indeed, during the pandemic, CHWs in the Pathways HUB have connected more individuals than ever with access to care and services that have been in high demand due to pandemic-exacerbated health disparities experienced by marginalized populations.

*Vignette*

## Southwest Ohio Community HUB Supports Patient with Food Insecurity, Diabetes Management, and Behavioral Health


Melissa is a 45-year-old single mother with five children ranging from 11 to 25 years old. She was diagnosed with diabetes and hypertension at age 40 and has struggled to manage these conditions. After four visits to the emergency department in one year related to hyperglycemia, she went to her primary care provider. Her blood sugar was >250 mg/dL and systolic blood pressure was >180 mmHg. She had an elevated score on a depression screener and was prescribed an anti-depressant. During the visit, she was referred to Health Care Access Now (HCAN), the Southwest Ohio Pathways Community HUB.

At her home visit, the CHW found Melissa disheveled and the house disordered with the shades drawn and no food in the refrigerator. No grocery stores or other sources of healthy food were within a reasonable travel distance for Melissa. The HCAN HUB connected Melissa to food and utility assistance, a mental health counselor, medications, and medication management education. The CHW worked with Melissa diligently on taking her medications consistently and monitoring her blood sugar and blood pressure. She also connected Melissa with a mental health counselor, and they worked together on depression and diabetes distress.

After 18 months, Melissa was able to consistently obtain food. She participates in a community garden and joined a cooking class to learn how to prepare healthy foods. She learned how to use her blood pressure cuff and her glucose monitor, how to take her medications consistently, and how exercise impacts blood pressure and blood sugar. Her blood pressure and blood sugars normalized. She understood that both her medication and lifestyle behaviors were helping her feel well.

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