Testimony in support of Ohio Commission on Minority Health Efforts to Scale the Community Pathways HUB Model

Mark. Redding, MD, FAAP, Co-Developer of the Pathways Community HUB Model, Akron Children's Hospital Considine Research Center and the CHAP HUB

Chairman Romanchuk, Ranking Minority Member Representative Sykes and Members of the Committee, thank you for this opportunity to support Director Dawson and the Ohio Commission on Minority Health in their work to expand the health impact and cost savings of the Pathways community HUB model. This work approaching 20 years in Ohio has involved The Legislature, The Commission on Minority Health, Medicaid Managed Care and the Ohio Department of Health. 11 other states are now following Ohio's leadership. In an effort to address infant mortality I work with the Pathways Community HUB Institute, Akron Children's Hospital Research Center and Primary Pediatrics in Richland Co.

Like every other initiative across health and social services the basic premise of the HUB model is to identify and reduce risk factors. There are two basic categories of addressing risk one is to help the patient overcome barriers care coordinating them to assure they connect to the services that will address the risk factors. The other category are the direct services themselves. These include medical visits, physical therapy, housing, adult education all with an evidence basis to address the identified risk factor. The HUB model serves in the finding and connection to intervention services role.

What sets the HUB model apart and provides the evidence for impact on improving health and reducing cost is how we identify those at greatest risk, comprehensively assess and accountably address their risk factors. The latest data regarding improving health and wellbeing demonstrates that it is not just about finding someone at risk and helping them with one or two risk factors. To substantially improve outcomes and reduce cost it requires a comprehensive approach. Risk factors spanning connecting to a medical home, behavioral health, housing food, adult education and employment must all be identified and addressed. For example if a care coordinator finds a 22 year old expectant mother and assures she has prenatal care that may help. The research shows that unless the care coordinator also addresses her housing issues, depression, connection education resources and preparation for employment the prenatal care alone may not change the outcome for her and her infant.

The care coordination extends to her other children to ensure assistance for the provision of evidence based parenting, nutrition education and many other factors that result in stabilization for the family and improving future childhood outcomes of better school performance and job readiness all based on a holistic and accountable approach to reducing risk.

The HUB model stands upon national evidence based standards that have been proven to deliver to you improved outcomes and reduced cost. This evidence not only comes from Ohio publications. Michigan just recently in collaboration with the Center for Medicaid Services has also demonstrated significant savings and better results for adults with chronic diseased served within their three HUBs. The only HUBs to demonstrate health and cost impact are those working within the National Certification set of HUB Standards required by the Ohio Commission on Minority Health grant funding.

HUB Components Connected to Outcomes

1. HUBs work as a network across the community reducing service duplication and establishing common standards of quality for care coordination across a team of agencies that deploy CHWs. CHWs are most often from and part of the community served. Their supportive, knowledgeable and trusted relationship with struggling and highly at risk community members can have an amazing impact on helping expectant mothers stop smoking, reenroll with adult and secondary education, attend medical visits and reach wellbeing in physical, behavioral and economic health.
2. The HUB model requires a comprehensive approach. The expectant mother, child or adult with chronic disease receives a comprehensive assessment of their health, social and behavioral health risk factors. The CHW, their supervisor and others work through the accountable Pathways tied to each risk factor to assure each one of their identified risk factors is addressed. Billing and payment are tied to confirmed risk reduction in a pay for performance approach. The results of these completed Pathways are tabulated. As you have seen from the initial scaling of the HUBs supported by Ohio Commission on Minority Health funding, we report the risk factors that are identified and exactly how many we address, including the median time that it takes to address them. We can also present the average cost per risk factor addressed. If improved wellbeing and health are directly tied to the identification and reduction of risk we are handing you and other policy makers the completed work products and cost, that accountably define our impact. Pay for performance

work products that tell the story of hundreds of expectant mothers connected to housing, medical care, adult education and many other interrelated and interdependent factors all combining and interrelated in their impact on larger measures such as infant mortality, low birth weight, school success, employment and economic health.

3. Evidence based model –The use of nationally standardized and certified care coordination will provide opportunities to demonstrate proven impact. As care coordination is part of every health and social service funding stream and the large majority of it is not evidence based, why would we pay for services that have not been proven to work. Care coordination looks simple – just find at risk people and connect them to what they need. Going out on home visits with a HUB CHW takes you to the urban housing complexes and rural house trailers where you will find the most at risk, highest morbidity and mortality individuals and families in Ohio. These individuals can be on multiple medications, have legal, behavioral health, educational and many other issues. Evidence based care coordination has built within it the training, supervision and team management structure to assure all of those risk factors are assessed, addressed and reported, involving multiple agencies and related professional services of care.

Juanita one of our CHAP CHWs found just such a client a few years ago pregnant, 17 and at the homeless shelter. Juanita in addition to helping her with housing, food clothing, prenatal care and so many risk factors got her client a baby outfit for pictures, went to her high school and community college graduations. Then after a couple years of caring for her the last visit in the chart reads that Juanita was stopping in to congratulate her, her client was starting as assistant manager at Target. Juanita, Kim, Shanay and their team in Richland Co. have demonstrated a scientifically published reduction in low birth weight and a county wide reduction in infant mortality reported by our Health Commissioner a couple weeks ago. There is hope for each one of those at risk. There are effective community members and evidence based models you can further deploy. We appreciate the support of the Commission on Minority Health's funding that supports these efforts to improve birth outcomes for those most at risk.

Mark Redding, MD, FAAP
mark@chaphub.org
419.571-8180