CARDI•OH
Ohio Cardiovascular and Diabetes Health Collaborative

CAPSULE

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Connecting Patients with Diabetes to Pathways Community HUBs to Address Social Needs

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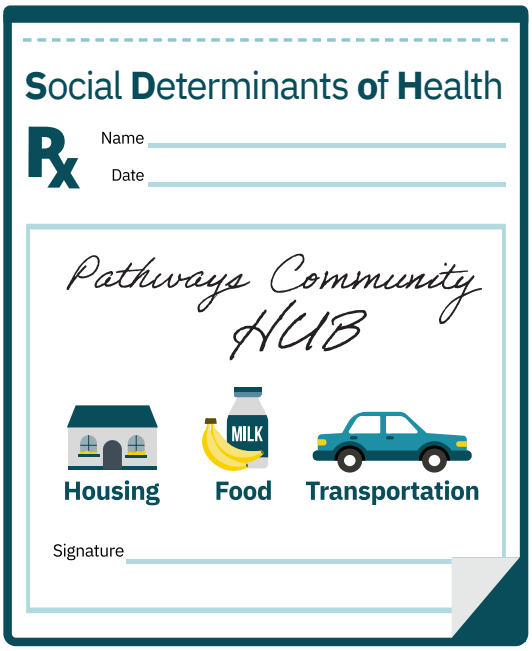
Unmet social needs represent a major barrier to successful diabetes management and control. Many individuals with diabetes experience food insecurity as well as other challenges including transportation and housing instability.[1] Emerging evidence suggests that 80% to 90% of health outcomes are related to social determinants of health and individual health-related social needs.[2]

The Pathways Community HUB model is a promising strategy to address social needs using care coordination by Community Health Workers (CHWs). In Ohio, 10 regionally located certified Pathways Community HUBs support patient needs through the integration of medical practice and community-based organizations.



Simple Referral Process

1. Primary care providers can use a social needs screening tool to assess unmet social needs in patients or otherwise identify an unmet need during a patient visit.
2. Providers can refer patients regardless of insurance status.

Once referred to a HUB, the individual completes a comprehensive risk assessment, and the CHW creates a plan connecting each need to a pathway. The individual and the CHW meet regularly until needs are addressed. Managed Care Plans or other community partners may provide coverage.[3]

To learn more, access Cardi-OH's expanded resource on Pathways Community HUBs.

REFERENCES

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3. Pathways Community HUB Manual: A Guide to identify and address risk factors, reduce costs, and improve outcomes. Agency for Healthcare Research and Quality(AHRQ).2016 AHRQ Publication No. 15(16)-0070. https://www.ahrq.gov/innovations/hub/index.html.

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