Better Health Pathways HUB

*a program of Better Health Partnership*

# Partner FAQ

The Better Health Pathways HUB supports your clients through our comprehensive Pathways Community HUB model. This FAQ answers the most common questions from referring partners about our services, processes, and collaborative approach to community health.

## About Us

Since 2020, the HUB has connected thousands of Cuyahoga County residents to care and resources and guided them along proven 'pathways' to secure health insurance and coordinate care for addressing medical needs, food insecurity, transportation, housing stability, employment, and more. The HUB receives referrals and assigns them to community-based agencies that employ certified CHWs who outreach referrals to offer care coordination assistance.

## Our Mission

To provide access to a network of community-based services and community health workers (CHWs) capable of assisting individuals with complex health and social needs overcome barriers preventing them from living healthy lives. We measurably improve the health of Northeast Ohio's communities through care coordination, collaborative quality improvement, and data sharing to address clinical and social needs, focusing on outcome-driven results.

## What is a Pathways HUB?

The Pathways HUB is an evidence-based care coordination model that connects individuals facing health and social barriers to community resources. The HUB is certified by the Pathways Community HUB Institute® (PCHI®)—the nation's only certifying body for community-based care coordination for Pathways Community HUBs. We are a results-driven system that improves health, reduces disparities, and ensures accountability by paying for outcomes, not just services. Our trained care coordinators provide personalized navigation, advocacy, and support to help clients access essential services like housing, food security, healthcare, and employment assistance.

## Who We Support

- **Pregnant women and new mothers** needing prenatal, perinatal, and postpartum care coordination
- **Individuals with chronic conditions** such as diabetes, hypertension, and asthma requiring care management
- **Families** experiencing housing instability, food insecurity, or lacking transportation
- **Anyone with complex health and social needs** referred by trusted healthcare and community partners
- **High-risk populations** facing multiple barriers to health and wellness

## Services We Offer

- **Comprehensive needs assessment** and personalized care planning for 21 identified pathways
- **Navigation and advocacy** through healthcare and social service systems
- **Connection to community resources** including food assistance, housing support, transportation, and employment services
- **Health insurance enrollment assistance** and benefits application support
- **Ongoing follow-up and support** until needs are successfully addressed
- **Crisis intervention** and emergency resource connection

# Referral Process & Partnership Details

1

## Submit a Referral

Submit individual referrals in need of care coordination and social service navigation support using BHP's FindHelp program card or contact the HUB team for submitting a group of referrals at the same time.

2

## Initial Outreach

An agency in the HUB receives referrals and assigns them to trained Community Health Workers (CHW) who outreaches within 48-72 hours to introduce services and schedule an initial assessment.

3

## Comprehensive Assessment

The CHW conducts a thorough needs assessment, identifying barriers to health and prioritizing the client's most pressing concerns. Pathways and tools are opened based on need.

4

## Resource Connection

CHWs actively connect clients to appropriate community resources, assist with applications, schedule appointments, provide direct advocacy support.

5

## Ongoing Navigation

Regular follow-up ensures clients successfully access services, overcome barriers, and achieve their health and social goals. CHWs provide support until all identified needs are addressed.

**Important:** All BHP's Pathways HUB services are provided at no cost to clients thanks to our healthcare partners, community funders, and collaborative supporters. There are no fees, income requirements, or barriers to accessing care coordination.

## Why the HUB Model Works

The Pathways HUB is an **evidence-based, nationally recognized** model that puts the person at the center of care. Unlike fragmented service delivery, the HUB provides a single point of coordination across medical and social needs. This approach reduces staff burden on referring partners, prevents members from getting lost between programs, and improves health outcomes through comprehensive, wrap-around support. The model has demonstrated measurable success in reducing emergency department utilization and associated costs, improving birth outcomes, and addressing social determinants of health.

## Our Collaborative Partners

BHP works with healthcare organizations across Northeast Ohio, including major health systems, federally qualified health centers, specialty practices, health plans, and community-based organizations. This extensive network allows us to coordinate care seamlessly, share data to improve quality, and ensure clients receive comprehensive support regardless of where they receive services. Our collaborative model strengthens the entire healthcare ecosystem.

## How to Refer & Learn More

**FindHelp:** https://www.findhelp.org/ *Search for Better Health Partnership or Better Health Pathways HUB*
**Pathways HUB Email**: BHPHUB@metrohealth.org
**Website:** betterhealthpartnership.org/health-pathways-hub
**General Info:** betterhealthpartnership.org/about-us
**Phone:** 216.250.1077

PCHI® Model Certified
Pathways Community HUB Institute®
Full Certification
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*The Better Health Pathways HUB transforms how we serve our most vulnerable community members by coordinating care across traditional boundaries and addressing the social factors that impact health outcomes.*