**Health Care Access Now (HCAN) was established** in 2009 to develop and deliver partnerships among social service, medical, behavioral health providers and health insurance plans that serve Medicaid consumers. HCAN was initially launched with funding from the Health Foundation of Greater Cincinnati (now Interact for Health) to continue the groundwork laid by a multi-stakeholder leadership group that identified the need to have a better-connected and coordinated network of services for the uninsured and underserved. To date, HCAN has built partnerships with public health, health systems and other nonprofits to serve close to 5,000 adults. Our service approach is collaborative and leverages opportunities to either deliver or subcontract with organizations that have capacity to deliver consistent services using a nationally endorsed model for care coordination. Today HCAN employs 18 full time staff and serves as a practicum site for local college students, and serves as a certified application assistance site to process applications for health insurance enrollment in either Medicaid or the ACA Marketplace plans. HCAN also serves as the Certified Pathways Community Hub with a network of eight Community Care Coordination Agencies with a total of 29 Community Health Workers working in the Maternal and Child Program.

After a careful review of community needs and gaps in service connections for low-income adults, we have prioritized our work to tackle two of the leading health issues facing Greater Cincinnati: infant mortality, poor birth outcomes and chronic disease conditions, such as diabetes, hypertension and congestive heart failure. The 2019 Community Health Needs Assessment completed by The Health Collaborative outlines these needs in our community. Using the standardized processes of pathways, we manage two programs: Maternal and Child Care Coordination Program and Adult Chronic Disease Care Coordination Program. Our focus addresses the social environmental risk factors and barriers that prevent or delay clients from seeking and maintaining a regular timely connection with their medical or behavioral health provider. Barriers such as homelessness, unstable housing, food insufficiency, no transportation or access to public transportation, legal issues, no working utilities, and insufficient personal finances have a significant impact on whether a person can establish behavioral health care, fill prescriptions, address healthcare needs, have healthy food choices or take care of their basic needs. Basic needs become the priority instead of doctor appointments.

Our direct service staff are Community Health Workers (CHWs). Their primary responsibilities are to conduct monthly home visits, accompany clients to medical or behavioral health appointments, arrange for referrals with behavioral health providers, identify and connect clients with community and medical resources and provide important prenatal education and disease self-management education. These individuals are non-medical personnel who have achieved certification as Community Health Workers through the Ohio Board of Nursing. They are the frontline team who do community outreach, recruit clients, develop and maintain a consistent relationship with each client over a designated timeframe. The CHW resolve barriers to care and ensure that better health outcomes are achieved.

CHWs also provide valuable education to our clients to emphasize disease self-management, smoking cessation and topics related to their chronic condition, conduct regular blood pressure and weight checks and medication assessment. HCAN’s model of one-on-one assistance has successfully shown that clients can overcome social and environmental barriers that affect their ability to engage and participate in ongoing consistent care treatment. Our program outcomes demonstrate that the Pathway Care Coordination model gets at the root causes for delaying care, improves adherence to treatment plans, and achieves better communication between the client and their medical provider.