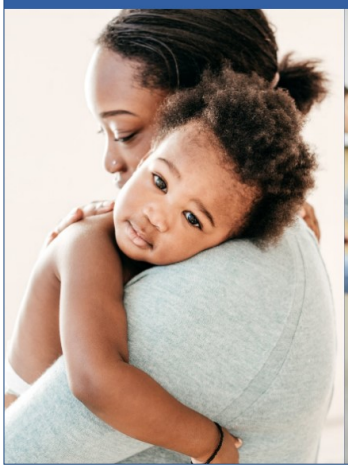
NBHP
Network of Behavioral Health Providers

Greater Houston Pathways Community HUB Planning Initiative

FINAL REPORT & BUSINESS PLAN

December 2021

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Executive Summary

Coordinated care is a necessity for providers, as many clients—particularly the most vulnerable and high-risk—tend to be involved in multiple systems across the health (including behavioral health), social services, and other sectors. This presents challenges not only for the clients who may have difficulty navigating these different systems, but also for the providers who are striving to overcome the "siloed" nature of the system in order to provide care. When providers do seek to address these issues by hiring care coordination staff, they often find that there are few available avenues for reimbursement.

The Pathways Community HUB (PCH) Model, an evidence-based, data-driven, pay-for-performance model of care coordination, has been addressing these challenges for more than 20 years. The PCH is an entity that contracts with Care Coordination Agencies (CCAs) to hire Community Health Workers (CHWs) who meet with high-risk families in their homes and in the community in order to identify and mitigate client risk factors (more than 170 of them) through opening and closing "Pathways."

Pathways correspond to a range of health and social service risk factors, such as food insecurity, lack of a medical home, housing instability, and behavioral health issues. The Pathways Community HUB model goes beyond a "warm handoff" or information sharing through an electronic platform—it details the steps that CHWs should take in order to *resolve* client risks and move them into a level of stability. When these steps are taken and a Pathway is closed, the established PCH can bill payers with whom they have negotiated contracts for the closure of the Pathways. Once the PCH receives payment, it passes on a portion of it to the Care Coordination Agency that employs the CHW that successfully completed the Pathway.

The PCH model addresses whole-person and whole-household social, behavioral, medical, and safety risks. It helps to reduce health disparities by coordinating the care of high-risk clients, connecting them with needed services, and closely tracking the outcomes. It also has the unique benefit of providing a source of reimbursement for care coordination through negotiated outcomes-based contracts with health care and other payers. There are currently 17 certified PCHs and more than 20 under development across the nation in Ohio, Michigan, Texas, Washington, Wisconsin, and several other states.

In the greater Houston area, two pilot projects used the PCH model as the basis for their care coordination efforts—The Network of Behavioral Health Providers' (NBHP's) Community Coordination of Care (c3) pilot project, and the Healthy Women Houston (HWH) pilot project. After recognizing the success of the c3 and HWH pilot projects in mitigating client risks, NBHP and HWH contemplated how the work of the two projects could best be continued and expanded. After several discussions, the groups decided to initiate a planning process aimed at fully implementing the PCH model in greater Houston.

Through this effort, a group of over 30 health, behavioral health, and social service organizations and collaboratives—representing over 100 organizations—met for four months throughout the summer and fall of 2021 in order to develop the framework for local PCH implementation. An overview of that framework, including the proposed PCH structure, staffing, and budget is below.

Proposed Pathways Community HUB Initial Geographic Boundary

- Harris County

Proposed Pathways Community HUB Initial Target Population

- Medicaid enrollees and Medicaid-eligible adults with mental illness or substance use disorder
- Medicaid enrollees and Medicaid-eligible pregnant/postpartum adults with behavioral health risk factors.

Proposed Pathways Community HUB Initial Baseline Measures

- Improvement in depression symptomology for PCH clients
- Percentage of babies of PCH clients born at normal birthweight
- Percentage of babies of PCH clients born with substance dependence
- Percentage of community infant mortality

Proposed Pathways Community HUB Initial Contracting Standards with Care Coordination Agencies

- Contract with a maximum of 6 CCAs with at least 2 CHWs each for a maximum of 12 initial CHWs at 50% minimum time (6FTEs);
- Prioritize CCAs that serve the highest-need behavioral health and maternal morbidity zip codes in Harris County and have a physical presence in these zip codes and/or partner with local organizations that have a presence in these communities (e.g., for space and/or transportation);
- Require care coordinators to be certified as CHWs, with a minimum requirement to complete the 160-hour CHW training;
- Require CHWs to complete additional trainings in behavioral health (e.g., Mental Health First Aid, motivational interviewing, etc.);
- Limit CHW caseloads to no more than 20 per .5 FTE at any given time, pro-rated by the FTE percent committed to the PCH (i.e., 40 per 1 FTE)
- Provide financial support for the CCAs (including CHWs and supervisor time) of up to six months, before scaling down the payments in three-month increments until the CCA is reimbursed strictly upon the completion of Pathways after 12 months;
- Provide incentive payments to CHWs for finding and enrolling clients; and
- Over the first six months, track and share with the CCAs on a monthly basis what the Pathways closure payments would have been had they been paid under the cost reimbursement model.

The Harris County PCH would operate as a program under NBHP with initial staffing of 1.5 FTEs and a proposed three-year budget of $1.36 million. The NBHP membership is expected to consider and vote upon the plan in January 2022.

Pathways Community HUB Model Overview

The Pathways Community HUB (PCH) Model is an evidence-based system of care designed to promote health equity and address the Social Determinants of Health (SDoH) of underserved individuals in communities. It provides a structured, sustainable, and validated how-to guide to help communities work together across sectors in these efforts.

The PCH model was designed and refined over time to address the challenges communities face in supporting their most vulnerable populations. It uses innovative approaches for care coordination, reimbursement, and data collection to address five common challenges, which are detailed in Table 1.

Table 1

Care coordination challenges	How the PCH Model Addresses these Challenges
1. Significant redundancy and inefficiency in many care-coordination approaches.	✓ The local Pathways Community HUB helps local agencies and other care coordination initiatives work together to eliminate redundant efforts. ✓ A single Community Health Worker (CHW) serves as primary contact for individuals as they navigate care and leverage any existing programming.
2. In vulnerable populations, risk factors are interrelated and need to be addressed holistically to fully support an individual and their household. Many care coordination approaches focus on addressing only a subset of these risks.	✓ The national Pathways Community HUB Institute (PCHI) has developed a comprehensive and evidence-based Risk Registry, which defines the spectrum of modifiable risk factors (MRFs) an individual may have. These MRFs span behavioral health, social, and safety risks[1]. ✓ PCHI assessment forms and workflows help CHWs identify all MRFs an individual has across these domains. They also help the CHWs work with the client to prioritize what the individual wants to address in the order that matters to the client. ✓ These MRFs are translated into the 21 PCH Pathways. CHWs assign a Pathway for each MRF that the client is working to address. ✓ Pathways define the steps the CHWs and their clients must work through to eliminate each risk. Pathways include steps on how to validate that the clients' specific risks were addressed in a sustainable way.
3. High risk individuals may not trust the healthcare system and may need encouragement to engage with it. Further, they may be overwhelmed by the complexity of what they need help with.	✓ The PCH model depends on Community Health Workers. CHWs are from the same community as the client and may speak the same language and have the same lived experiences as those they serve. These factors, coupled with ongoing, in-person home visits help CHWs gain their clients' trust over time. ✓ These trust-based relationships can help the client gain confidence and get engaged in their care and take action to address the risks they face.
4. Accountability and sustainable financing are missing in many care coordination approaches.	✓ PCHs must have a Community Advisory Council (CAC) comprised of representatives from all health care and public health sectors in the community, as well as potential PCH clients. The CAC helps identify goals for the PCH and guides its work. The PCH is accountable to the Council for achieving agreed upon goals. ✓ PCHs negotiate with payers to reimburse the PCHs for providing care coordination services. These payments are dependent on Care Coordination Agencies (CCAs)and CHWs achieving measurable outcomes (completing Pathways). ✓ PCHs distribute the reimbursement from the payers to the CCAs that render the services, providing ongoing and predictable income to these front-line organizations to help them be sustainable (The PCH retains a small percentage of the reimbursement to cover their own administrative costs.).
5. There is little transparency, consistency, or evidence of the impact of community care coordination efforts.	✓ The PCH model includes a structured data model, standard data collection forms, Pathways for delivering care, and standard Quality Benchmark Reports and Quality Report cards. ✓ Together, these allow for high levels of consistency, transparency, and data to help quantify the impact of the program.

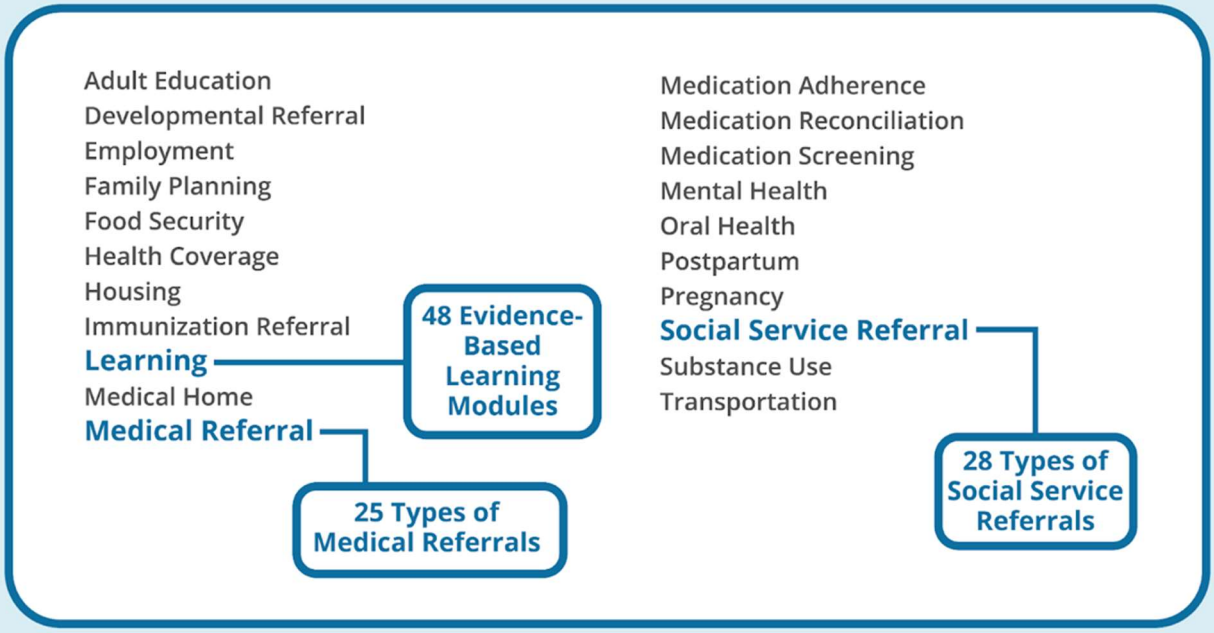
[1] Lynn Falletta, Mark Redding, James Cairns, Mutlaq Albugmi, Sarah Redding, Michael Gittelman, Andrew Beck, Andrew Garner, Ranjeet Arora, Edward T. Chiyaka, Joshua Filla, John Hoornbeek,Embracing the complexity of modifiable risk reduction: A registry of modifiable risks for 0-12 month infants, Preventive Medicine,Volume 137,2020,106118,ISSN 0091-7435 https://www.sciencedirect.com/science/article/pii/S0091743520301420?via%3Dihub.

Serving as a neutral entity, the Pathways Community HUB becomes the nerve center for community-based care coordination. The PCH forms a Community Advisory Council to define the health goals for the community and hold the PCH accountable for achieving these goals. PCHs contract with existing community-based care coordination agencies (CCAs) to hire Community Health Workers (CHWs) who in turn coordinate care for individuals and help to meet their health and social needs. PCHs also negotiate outcomes-based payment contracts with payers and other funders, license any needed technologies, and may also support grant writing on behalf of partner agencies. Streamlining how these organizations collaborate helps reduce duplicative care coordination activities.

Mitigating Risks

Through the model, the PCH assigns high-risk families to the network of CHWs, who identify and work to mitigate risk factors (more than 170 of them) through opening and closing "Pathways". The 21 Pathways correspond to a range of health and social service risk factors, such as food insecurity, lack of a medical home, housing instability, and behavioral health conditions. Each Pathway comprises predefined steps, which include identifying that the risk exists and the date the client indicated they wanted to address it, a series of supportive, non-clinical activities to help the client address the risk, and then a step to validate that the risk was mitigated. The 21 Pathways are listed in Figure 1.

Figure 1



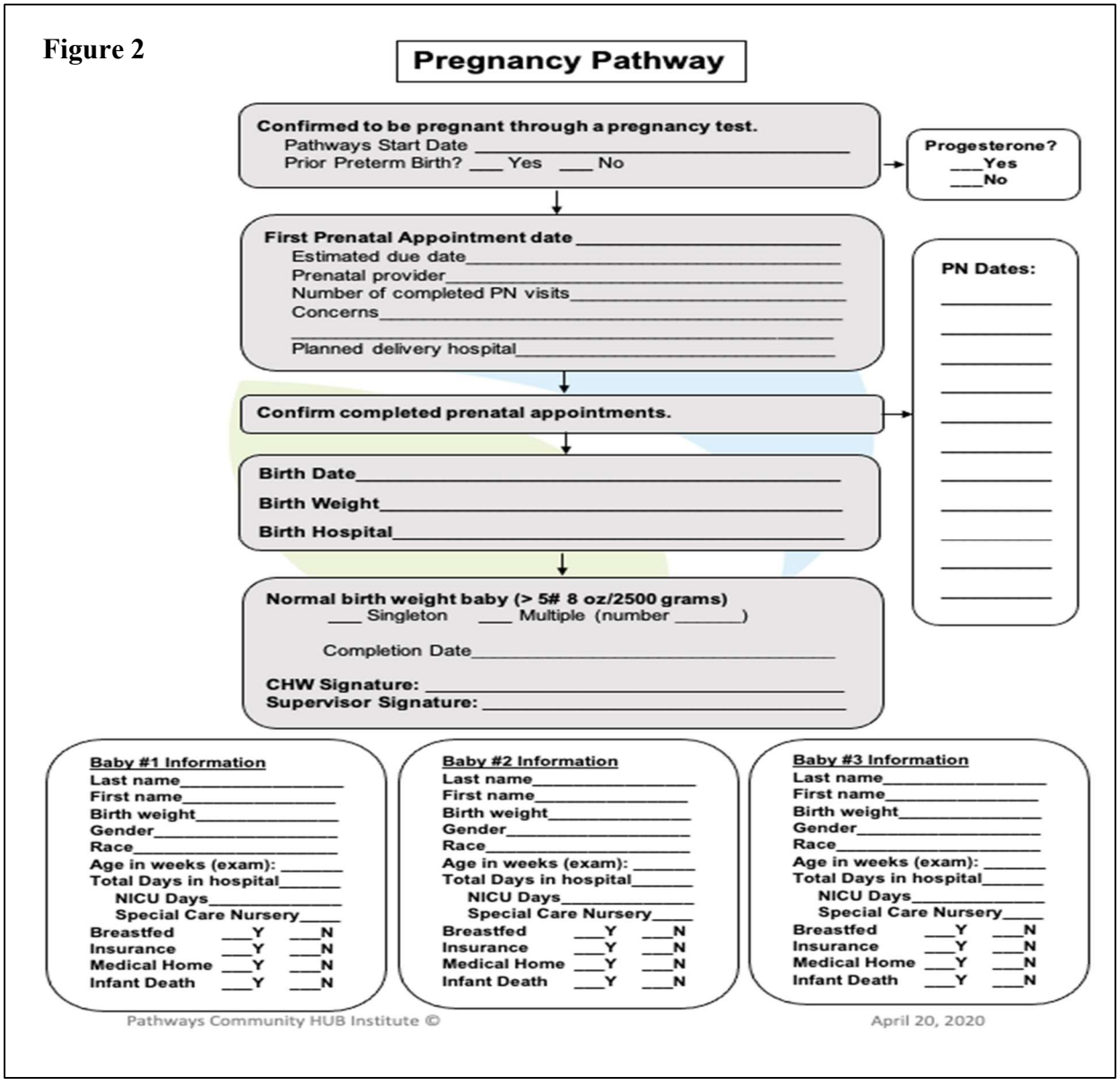
As illustrated in Figure 1, three of the 21 Pathways (Learning Pathway, Medical Referral Pathway, Social Services Pathway) expand to address an extensive range of risks. Mitigating risks associated with the opening and completion of a Pathway goes beyond a "warm handoff"—it details the steps that CHWs should take in order to help clients move to a level of stability in relation to that risk. For example, under the PCH model, someone's risk regarding housing insecurity is considered mitigated only after they have been living in safe and stable housing for at least 30 days; a person's risk related to an inability to obtain treatment for a mental health condition is considered mitigated only after they have

been connected to support services and successfully attended three therapy sessions; and a woman's pregnancy risk is considered mitigated only after she has delivered a healthy, normal birthweight baby.

For all of the above-mentioned risks and outcomes, the CHWs may open several Pathways to address a range of risks with the client. These may include opening Pathways to help ensure a client has adequate access to healthy food once they become housed; to provide transportation and childcare for a client so they can attend needed therapy appointments; or to ensure a woman has the education needed to make sure she understands symptoms of pregnancy complications.

An example of the Pregnancy Pathway can be found in Figure 2. It begins with identifying that the individual is pregnant. Supportive steps include helping the client identify a prenatal provider and supporting her in attending all needed prenatal appointments. The Pregnancy Pathway would be marked "Complete" if the woman delivered a normal birthweight baby. It would be marked "Finished Incomplete" if the woman delivered a low birthweight baby or had a stillbirth or miscarriage. To view additional Pathways, please see Appendices B and C.

Figure 2



Addressing Health Disparities

A main goal of the PCH model is to support underserved populations in reducing health disparities, and it achieves this in several ways. First, the CHWs are from the communities they are serving, and often have shared lived experiences with the clients they serve. In fact, approximately 10% of CHWs employed by PCHs were former PCH clients themselves. A part of the CHW's responsibilities includes going out into the community to identify individuals in need of support. This may include outreach and visits to homeless encampments, food pantries, and a range of other locations underserved individuals may visit, to educate them about the service offerings and work to enroll them in the Pathways program. The CHWs visit clients in person, ideally in their homes, often over a period of months. Delivering personalized care in the client's own domicile serves several purposes. Primarily, it helps the CHWs create caring and trusting relationships with their clients, many of whom are distrustful of the healthcare system. CHWs leverage the relationships they build to help clients reduce their distrust and get engaged in their care. These home visits also help the CHWs identify other issues the clients may face such as a lack of food or heat in the home or the threat of domestic violence.

The PCH model also requires that PCH staff and CHWs attend training on Culturally and Linguistically Appropriate Services, developed by the US Department of Health and Human Services Office of Minority Health. This helps ensure that they are able to relate to and appropriately serve the diverse clients with which they will be engaging.

Finally, the PCH's data-driven focus helps provide transparency about the needs of communities. PCHs track and report on both complete and incomplete Pathways to better understand what is and isn't working within the community. By measuring incomplete Pathways, the PCH can identify gaps in the community's resources. With this data the PCH can show where services are lacking—down to the zip code and census tract level—and where the community may be under-resourced and unable to adequately serve certain populations. In turn, the PCH can work with foundations or investors to seek funding to address these gaps and reduce disparities. For example, one Pathways Community HUB in Ohio used the data from their program to identify that it was taking nearly a year to get housing-insecure pregnant women into secure and stable housing. They used this information to lobby for policy changes, to prioritize pregnant women getting housing, and to lobby to fund more low-income housing.

PCH Growth and Evidence-Base

Pathways Community HUBs are typically small, two-three person organizations. PCHs usually grow over time, serving more clients and working with more CCAs and payers. They may add additional staff over time to support additional funding needed to address gaps in the community's service offerings, as well as the added overhead of the relationships, contracts, billing and reimbursement support, reporting, and research.

The Pathways Community HUB Institute's (PCHI's) research has shown that when all of the components of the PCH model are followed with full fidelity, health outcomes improve, and costs of care are reduced. One study, for instance, conducted by the Buckeye Health Plan, identified that for every dollar spend on PCH activity, there was a savings of $2.35[2]. PCHI conducts regular assessments and certification reviews to ensure PCHs comply with all components of the Model to help ensure that

[2] Lucas, B., Detty, A. "Lower First Year of Life Costs for Babies through Health Plan and Community Hub Partnership." December 2018. BuckeyeHealthPlan.com Presented American College of Obstetrics and Gynecology Nat. Conf. 2019

they achieve the best possible results. An illustration of the inpatient costs savings from the Buckeye Health Plan study can be found in Figure 3.

Figure 3

Buckeye Newborns:
Inpatient Cost Through First Year of Life When Enrolled with Start Smart and Hub Enrollment at Delivery, 2013-2016

Risk Level	Hub Group	Newborn Inpatient PMPM Through 1st Birthday	Enrolled with Hub at Delivery Inpatient PMPM Savings*
High Risk	Enrolled with Hub at Delivery	$301.38	$378.72
	Participated in the Hub, but not through delivery	$186.34	
	Not Enrolled with Hub	$680.10	
High Risk Total		$596.44	

Seventeen communities in five states – Ohio, Michigan, Texas, Washington, and Wisconsin – have achieved national certification by the Pathways Community HUB Institute. Additionally, PCHI is providing technical assistance to communities that want to create certified PCHs or Pathways agencies to meet health equity goals in many states, including California, Illinois, Indiana, Minnesota, Nebraska, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Texas, Virginia, and Washington.

There is currently one certified Pathways Community HUB in Texas—Growing Healthy Together HUB in San Antonio. There are two other PCHs emerging in the state, both of which are Texas Accountable Communities for Health Initiatives (TACHI) funded by the Episcopal Health Foundation. The one that is farthest along in its PCH planning is the Brazos Healthy Communities HUB in Brazos Valley. The other is the Williamson County TACHI site, which is at an early stage of planning.

The Greater Northside Houston TACHI site also is in the early stages of evaluating the PCH model. It is important to note that the Pathways Community HUB model has a number of prerequisites that must be met by a potential PCH in order to pursue certification.[3] One of these prerequisites governs the service area of the PCH and mandates that there be only one PCH in a service area. NBHP has been in communication with the Greater Northside Houston TACHI, and they understand that NBHP is further along in its planning to launch a PCH locally. Should NBHP successfully establish the PCH, they have indicated that they would support these efforts.

[3] PCHI Prerequisites for Pathways Community HUB Certification - https://pchi-hub.com/wp-content/uploads/2021/11/PCHCP-Prerequisites_07.20.2021.docx.pdf.

Background: Early PCH Efforts in Greater Houston

Over the past several years, two pilot projects in Houston have used the PCH model: The Network of Behavioral Health Providers' Community Coordination of Care Pilot Project and the Healthy Women Houston (HWH) Pilot Project.

Community Coordination of Care (c3) Pilot Project

The c3 pilot began with an NBHP initiative that convened over 60 primary care, behavioral health, social service, consumer, governmental, and academic entities to create the blueprint for a coordinated continuum of care that integrates medical, behavioral health, and social services while addressing the social determinants of health. After one year of planning, the group developed a plan for a coordinated care pilot project that aimed to improve client and community outcomes, reduce service duplication, maximize resource efficiency, and generate cost savings.

Funded by the Episcopal Health Foundation, United Way of Greater Houston, and Rockwell Fund, the c3 pilot project launched on September 30, 2019. The pilot targeted low-income children, adolescents, and adults with mental illness and social service needs who lived in the Spring Branch and greater Northeast Houston regions. The pilot project included the following elements:

- A network of 12 primary care, mental health, substance use disorder, and social service providers that made and received referrals and provided services to pilot participants;
- Three community care coordinators who were hired by two contracted community organizations that worked to mitigate risks and remove client barriers that prevented participants from accessing needed services; and
- An electronic platform that allowed participating organizations to share participant data, develop joint care plans, and communicate regarding participant progress.

While the pilot project was based upon the PCH model, it is important to note that due to different constraints, several elements of the model were not implemented. Most notably, the pilot project did not negotiate any outcomes-based payer contracts—thus lacking the incentives and financial sustainability components that are integral to a PCH. In addition, only one of the three care coordinators had been trained as a CHW, while the other two had received traditional training as case managers. Finally, due to the COVID-19 pandemic, in-home and face-to-face visits were suspended for the majority of the pilot project. Such visits, and the trust-based relationships that care coordinators are able to develop through them, are key to getting clients engaged.

Despite these shortcomings and the significant challenges posed by COVID-19, an evaluation report of the pilot project was able to document strong outcomes:

- 70% of Pathways were closed successfully, with risks sustainably mitigated.
- 93% of clients with more than one behavioral health assessment saw improvement in their functional score while enrolled in the program.
- The majority of clients who had been out of the program ***for at least six months*** reported their general health and wellbeing were "Very Good" or "Good."

- Estimated cost savings associated with the reduction in c3 client ER visits ranged from $22k to $55k, but could have been as much as $600,000 if the project had been expanded.

Healthy Women Houston (HWH) Pilot Project

The HWH pilot project is a collaborative that was borne out of a Houston Endowment planning process to develop a comprehensive, community-based, long-term strategy to address and reduce maternal mortality in Harris County. The planning process was overseen by a Steering Committee of community leaders from the health, behavioral health, and social service fields, as well as research, government, and philanthropy.

The resulting *Improving Maternal Health in Harris County: A Community Plan* included several recommendations, including the development of a pilot project aimed at creating a system of care that would improve women's health outcomes in targeted communities. The subsequent pilot project, funded by the Houston Endowment, Episcopal Health Foundation, Cullen Trust for Healthcare, and the Rockwell Fund, kicked off on February 22, 2019.

The HWH pilot project used CHWs and a network of community partners to provide integrated health, behavioral, and social supports for pregnant and post-partum (up to 12 months) women, especially those at higher risk of maternal morbidity and mortality. The targeted geographic locations were the Greater Fondren Southwest and Greater 3rd Ward/Sunnyside communities, which were selected based upon their high incidence of maternal morbidity.

Like the c3 pilot project, the HWH pilot had a number of challenges and constraints—not the least of which was COVID-19, which limited CHW ability to conduct in-home visits. While the pilot project had payer interest, it, like the c3 pilot, did not have any outcomes-based negotiated payer contracts and was completely grant funded. One significant difference between the HWH pilot and c3 is that HWH did not use an electronic platform to store client information. This ended up creating some challenges in data collection and evaluation. The pilot was, however, able to attract CHWs from the local communities in which they were working, which helped to strengthen engagement efforts.

Overall, the HWH pilot was able to:

- Engage over 400 women, while enrolling over 100 women (40% of whom reported a mental illness);
- Create a more seamless process of navigation for clients—who knew their providers were working together—and reduce duplication;
- Complete an estimated 60% of opened Pathways; and
- Ensure almost 100% of deliveries were for normal birthweight

Despite missing key elements of the PCH model, both the Community Coordination of Care and Healthy Women Houston pilot projects demonstrated several positive outcomes. For this reason, NBHP believes that fully implementing a Pathways Community HUB to fidelity in greater Houston would be of significant benefit to both its clients and the community at-large.

Proposed Harris County Pathways Community HUB Framework

The Harris County PCH workgroup kicked off on June 24, 2021, and engaged about 30 community organizations and collaboratives—representing over 100 organizations—throughout the four-month process. A full list of the participating organizations can be found in Appendix A. The workgroup met roughly every three weeks, with occasional meetings from a smaller advisory group in between meetings. The participants: 1) Reviewed information and outcomes from the two PCH-based pilot projects in Houston/Harris County, 2) Received presentations on the PCH model from representatives from PCHI, as well as from certified PCHs in Texas and Ohio; 3) Reviewed information from recently conducted Houston/Harris County community needs assessments and other relevant local data; and 4) Based upon presentations, data, and workgroup expertise, built a framework for PCH implementation in Houston/Harris County.

The workgroup process was designed to ensure that any established PCH would comply with national PCHI prerequisites and standards required for certification. The workgroup systematically walked through the 10 prerequisites for PCH certification and made decisions regarding each relevant prerequisite. Those decisions are explored in greater detail below, as they comprise the framework under which the proposed PCH would operate. For a full listing of all prerequisites and standards for PCH certification, please view Appendices D and E.

Proposed Pathways Community HUB Geographic Boundary

- **Prerequisite #3** - The Pathways Community HUB is based in the community and/or region it serves.
- **Prerequisite #4** – There is only one Pathways Community HUB located within the community and/or region it serves.

The workgroup spent ample time reviewing the geographic boundaries of a potential PCH. The group discussed whether or not serving the entire, multi-county greater Houston region would be too daunting and how the target population could be narrowed in order to address a wider geographic area. The workgroup ruled out starting with a small number of zip codes, however, as both the c3 and HWH pilot projects already demonstrated that, and a smaller geographic region could limit the PCH's reach, as well as payer interest.

The workgroup noted that virtually all of the hospital systems and several other healthcare and social services agencies serve multiple counties in the greater Houston region. The workgroup also discussed the high mobility of many populations, with many patients and clients seeking services across counties, which could necessitate a broader geographic area. However, it also was noted that the CHW staffing level had to align with whatever geographic reason is selected and that having too broad a geographic area would be challenging for CHWs. Excessive travel time that would be required to meet and support clients in person would significantly reduce the productivity and effectiveness of CHWs. This would in

turn result in fewer clients served, fewer Pathways closed, and fewer outcomes-based payments for the PCH and the CCAs.

After much discussion, the group came to consensus on focusing initially on Harris County as a service area, while recognizing that multiple counties potentially could be added to the service area as the PCH grows.

Proposed Pathways Community HUB Initial Geographic Boundary

- Harris County

Target Population & Baseline Measures Defined by Needs Assessments

- **Prerequisite #5** – The Pathways Community HUB reviews and/or conducts community needs assessments.

The workgroup discussed a number of needs assessments that had been conducted across the greater Houston region: the 2020 Harris Cares Report, the 2019 Houston Methodist Hospital Needs Assessment, the 2019 Memorial Hermann Texas Medical Center Needs Assessment, and the 2019 Texas Children's Hospital Needs Assessment, among others. The workgroup also noted that the planning initiative was the result of interest in continuing the work of the c3 pilot project, which served low-income people with mental illness, and Healthy Women Houston, which served low-income pregnant women.

Based upon these needs assessments and populations previously served by the pilot projects, the advisory group initially recommended that the proposed PCH serve children, adolescents, and adults with mental illness; children, adolescents, and adults with substance use disorder; and pregnant women with behavioral health risk factors. Some of the specific data points the workgroup reviewed while considering these populations included:

- An estimated 20% of adults have a mental illness.[4]
- 1 in 6 U.S. children aged 2–8 years (17.4%) have a diagnosed mental, behavioral, or developmental disorder.[5]
- In 2017, roughly 7% of Americans aged 12 or older had a SUD in the past year.[6]
- Among the three largest counties in the Houston metropolitan region, Harris County has the highest percentage of adults reported 14 or more days of poor mental health in a 30-day period (12.3%).[7]

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[4] National Institute of Mental Health, U.S. Department of Health and Human Services, https://www.nimh.nih.gov/health/statistics/mental-illness

[5] Cree RA, Bitsko RH, Robinson LR, Holbrook JR, Danielson ML, Smith DS, Kaminski JW, Kenney MK, Peacock G. Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016. *MMWR*, 2018;67(5):1377-1383.

[6] Reports and Detailed Tables From the 2017 National Survey on Drug Use and Health (NSDUH) | CBHSQ". September 2018. Retrieved from www.samhsa.gov.

[7] Understanding Houston Summary Report. 2019. https://api.understandinghouston.org/wp-content/uploads/2019/11/Understanding-Houston-Summary-Report-2019-1.pdf

- Houston leads the nation in DWI-related fatalities.[8]
- In a community survey, substance abuse and mental health/mental disorders were indicated as the number three and four health issues affecting quality of life in the region.[9]
- Mental/Behavioral health issues and Maternal Health were ranked as number one and four respectively of the top health issues facing the region.[10]
- Harris County's pre-term birth rate worsened to 11.9% in 2019, earning it an "F" rating from the March of Dimes.[11]
- Harris County's low birthweight rate of 8.9% failed to meet the Healthy People 2020 goal of no more than 7.8%.[12]
- African-American babies in Harris County are twice as likely as White babies to have low birthweight. [13]
- The infant mortality rate is over 2.5 times as high for African-American babies as White babies.[14]

Recognizing that the initial target population recommended by the advisory group was broad, the workgroup discussed ways that the population could be further narrowed. Some workgroup members mentioned the difficultly of dealing with minors who have substance use disorder or are pregnant. As a result, the workgroup agreed to initially target adults with the PCH engagement efforts, though in accordance with the model, any identified children or adolescents in the household also would be served.

The workgroup again discussed narrowing the target population by targeting certain zip codes and once again ruled out that idea. The group also discussed the possibility of narrowing the target population by payer source, such as focusing on the Medicaid population, since that would increase the chances that the PCH could be reimbursed for the care coordination activities. Several committee members expressed concern with limiting the participants to only those with insurance due to Harris County's high uninsured rate. The group also discussed limiting participant eligibility according to a percentage of the Federal Poverty Level. After further discussion, the workgroup came to consensus on the following target population, which, in accordance with the PCH model, is expected to be expanded over time.

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[8] Office of National Drug Policy, Houston Investigative Support Center. 2021 Houston High Intensity Drug Trafficking Area Threat Assessment. Retrieved from: https://mcusercontent.com/ccba145279967c59366d85d09/files/c7e8b4ab-7e28-be95-7e04-11149af6ed7d/2021_Houston_HIDTA_Threat_Assessment.01.pdf.

[9] Memorial Hermann - Texas Medical Center 2019 Community Needs Assessment. 2019. Retrieved from https://www.memorialhermann.org/-/media/memorial-hermann/org/files/giving-back/2020-update/cb-mh-tmc-sip-2019-year-1-update-2020.ashx?la=en&hash=2803EEECA65574EC6AC90002C3040794.

[10] Texas Children's Hospital Community Needs Assessment. 2019. Retrieved from: https://www.texaschildrens.org/sites/default/files/uploads/documents/Texas%20Childrens%202019%20Community%20Health%20Needs%20Assessment.pdf.

[11] 2021 March of Dimes Report Card: Supplemental Report. 2021. Retrieved from: https://www.marchofdimes.org/peristats/tools/ReportFiles/PrematureBirth/2021/rc/pdf/SupplementalReportCard-Texas-2021.pdf

[12] National Center for Health Statistics, final natality data. Retrieved from: https://www.marchofdimes.org/peristats/ViewSubtopic.aspx?reg=48201&top=4&stop=43&lev=1&slev=6&obj=1

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Proposed Pathways Community HUB Initial Target Population

- Medicaid enrollees and Medicaid-eligible adults with mental illness or substance use disorder
- Medicaid enrollees and Medicaid-eligible pregnant/postpartum adults with behavioral health risk factors.

The workgroup also discussed several potential measures that could be used to measure the improvement in client/patient outcomes, including:

- Improvement in depression symptomology
- Average # days without relapse/use of substances
- Percentage of rehospitalizations within 30 days
- Percentage babies born at normal Birth Weight
- Percentage of infant mortality
- Percentage of babies born at full term
- Percentage of reduced ER utilization

While all of the above-mentioned measures could be collected, the national certification process only requires two to three specific measurable outcomes for the PCH to collect. The workgroup discussed many of these measures, in addition to those that were aligned with Healthcare Effectiveness Data and Information Sets (HEDIS) measures. Recognizing that the PCH likely will be tracking a number of outcomes for clients, ultimately the group decided to narrow the measures to specific areas representing the proposed target population:

Proposed Pathways Community HUB Initial Baseline Measures

- Improvement in depression symptomology for PCH clients
- Percentage of babies of PCH clients born at normal birthweight
- Percentage of babies of PCH clients born with substance dependence
- Percentage of community infant mortality

Care Coordination Agency Standards & Expectations

- **Prerequisite #6** – The Pathways Community HUB coordinates a network of care coordination agencies serving at-risk participants and has written agreements with its care coordination agency members.
- **Prerequisite #8** - The Pathways Community HUB monitors the caseloads of care coordinators at each care coordination agency.
- **Prerequisite #9** - The Pathways Community HUB aligns payments with measured outcomes in its contracts with care coordination agency members.

The workgroup reviewed how the proposed PCH would interact and contract with Care Coordination Agencies and what the expectations would be for the CHWs that were hired by the CCAs. The workgroup decided that in order to cover the geographic area, the PCH should seek to have contracts covering multiple CHWs with at least 50% of their time dedicated to PCH activities, in accordance with Prerequisite 8. The workgroup discussed certification requirements for the CHWs, as well as other trainings in which the CHWs should engage. There also was discussion around whether or not priority would be given to agencies that are actually located in the high-need areas that the PCH will target so that clients would be able to visit the organization in their local community. The workgroup also discussed the benefits of hiring CHWs who are from the local communities that they serve, as well as those who have lived experiences who could relate to the plights of clients. The hope would be that over time, former PCH clients could eventually be hired as CHWs for the CCAs, which would be beneficial for both clients' progress and workforce development efforts. Finally, the group determined case load limitations for the CHWs. The decisions in these areas are included below.

Proposed Pathways Community HUB Initial Contracting Standards with Care Coordination Agencies

- Contract with a maximum of 6 CCAs with at least 2 CHWs each for a maximum of 12 initial CHWs at 50% minimum time (6FTEs);
- Prioritize CCAs that serve the highest-need behavioral health and maternal morbidity zip codes in Harris County and have a physical presence in these zip codes and/or partner with local organizations that have a presence in these communities (e.g. for space and/or transportation);
- Require care coordinators to be certified as CHWs, with a minimum requirement to complete the 160-hour CHW training;
- Require CHWs to complete additional trainings in behavioral health (e.g., Mental Health First Aid, motivational interviewing, etc.);
- Limit CHW caseloads to no more than 20 per .5 FTE at any given time, pro-rated by the FTE percent committed to the PCH (i.e. 40 per 1 FTE)
- Provide financial support for the CCAs (including CHWs and supervisor time) of up to six months, before scaling down the payments in three-month increments until the CCA is reimbursed strictly upon the completion of Pathways after 12 months;
- Provide incentive payments to CHWs for finding and enrolling clients; and
- Over the first six months, track and share with the CCAs on a monthly basis what the Pathways closure payments would have been had they been paid under the cost reimbursement model.

The workgroup also discussed CCA contracts, which would be in alignment with the payer contracts. In general, the PCH negotiates individual contracts with payers that include a base engagement fee (per member per month), plus negotiated rates based upon Outcomes Based Units (OBUs) for the completion of each Pathway. Each OBU ranges between $30 - $50, and each Pathway is assigned a weighted number of OBUs based upon difficulty for completion. For instance, the 1st Prenatal Visit Pathway is weighted at 3 OBUs ($90 - $150) for completion; the Substance Use Pathway is weighted at 9 OBUs

($270 - $450) for completion, and the Housing Pathway is weighted 15 OBUs ($450 – 750) for completion.

The workgroup also discussed potential ways that Medicaid Managed Care Organizations could finance outcomes-based payments based upon Pathways completion, including the Health and Human Services Commission's Quality Improvement Cost Guidance.

Potential PCH Partners

With the framework for the PCH finalized, the next crucial step was to determine the level of community interest in participating in the PCH in order to ensure that there are viable Care Coordination Agencies, interested payers, and a broad network of community providers who agree to receive referrals from the PCH.

The ultimate goal of the convening was to be able to secure interest from at least two care coordination agencies, two payers, and 15 community partners. Below are the organizations and entities who have expressed initial interest in participating in the potential Harris County Pathways Community HUB:

Care Coordination Agencies

The following organizations, most of whom already have certified CHWs on staff, have indicated their interest in entering into Care Coordination Agency contracts with the potential PCH:

- Catholic Charities
- Santa Maria Hostel
- The Council on Recovery
- the Montrose Center
- The Women's Home

Payers

In addition, two health care payers potentially could participate in an established Harris County PCH, either through entering into negotiated outcomes-based contracts or providing other financial support as necessary:

- Aetna Better Health of Texas
- Community Health Choice

Aetna Better Health of Texas has executed a Letter of Intent to participate in the Harris County PCH should it be established and certified, and Community Health Choice has expressed initial interest pending further exploratory efforts.

Community and/or Referral Partners

Finally, a number of organizations and collaboratives have preliminarily agreed to receive referrals from the PCH, if established, for services for which the PCH clients may be eligible, or to provide other general collaborative support. These include:

- Baylor College of Medicine (HOPES Program)
- Catholic Charities
- El Centro de Corazón
- Health Equity Collective
- Harris Health System
- Houston Food Bank
- Houston Recovery Center
- Legacy Community Health
- Main Street Ministries
- Memorial Hermann
- NAMI Greater Houston
- Santa Maria Hostel
- Spring Branch Community Health Center
- Texas Children's Hospital
- The Council on Recovery
- The Harris Center for Mental Health & IDD
- the Montrose Center
- The Women's Home
- Wesley Community Center

If the Harris County Pathways Community HUB plan is approved by the NBHP membership, NBHP staff will further engage with the community over the next several months and expects that the interested participants in each of these categories will grow significantly.

Proposed PCH Management and Structure

NBHP As The PCH

The Network of Behavioral Health Providers, Inc. (NBHP) is a 501 (c)(3) nonprofit organization that was created in 2004 by the United Way of Greater Houston to provide a forum for the leadership of greater Houston's mental health and substance use treatment providers to come together to work on issues of common concern. The mission of NBHP is to improve the delivery of, and access to, high-quality behavioral health (mental health and substance use disorder) services through education, collaboration, and advocacy.

The 40+ members of NBHP are the CEOs and executives of the behavioral health provider community, representing all aspects of mental health and substance use disorder service provision in greater Houston. Members include public agencies, as well as for-profit and non-profit private organizations, that provide clients with the full range of behavioral health services from prevention to crisis intervention to housing and supports regardless of age, race, religion, gender and gender identity, sexual orientation, and socio-economic status. Since its inception, NBHP's membership has grown in diversity, with the vast majority of its members providing services beyond mental health and substance use treatment, including primary care, specialty care, dental care, and a variety of social services. Cumulatively, NBHP member organizations serve more than 250,000 (duplicated) children, adolescents, and adults each year.

NBHP is one of the few remaining health care collaboratives in the greater Houston area and operates with a small, three-person staff that is independent of its membership organizations and is responsible for carrying out the work of the organization. Over the years, NBHP has gained a reputation as a neutral convener and facilitator of initiatives that address behavioral health and broader health care initiatives. Its works in this area includes:

- The Behavioral Health Affordable Care Act Initiative, which through a partnership with Mental Health America of Greater Houston, provided educational and targeted technical assistance regarding compliance with the Affordable Care Act to behavioral health organizations that provided care to underserved communities;
- The Disaster Behavioral Health Initiative, which convened organizations and collaboratives, including the City of Houston and Harris County health departments and offices of emergency management, American Red Cross, and other organizations to review community needs and gaps in services in order to develop recommendations to improve disaster behavioral health response and recovery efforts in the Greater Houston area; and
- The Community Coordination of Care Initiative, which convened community organizations to create the blueprint for a coordinated continuum of care that integrates primary care, behavioral health, and social services and led to the development of the previously explained c3 pilot project.

NBHP is uniquely positioned to be the PCH for Harris County due to its demonstrated reach across the county, both through its membership organizations and its engagement with the broader community through its collaborative initiatives; its neutral staff that has successfully worked with the PCH model; and its structure as an independent, legal entity.

Proposed PCH Director Credentials

The proposed Director of the Harris County PCH is NBHP Executive Director, Andrea Usanga. Ms. Usanga has spent more than 15 years working on health and behavioral issues in both the private, non-profit and public sectors. Prior to joining NBHP, Andrea led several workgroups and collaboratives to improve the behavioral health care system both locally and across the state. She also has facilitated large-scale collaborations, including the Houston/Harris County School Behavioral Health Initiative (now the Center for School Behavioral Health), which aimed to improve the prevention, identification and treatment of behavioral health issues among students, and the Integrated Health Care Initiative, which aimed to promote the expansion and sustainability of integrated primary and behavioral health care across Texas.

Ms. Usanga's work at NBHP began as the Project Manager for the c3 Initiative, in which she was responsible for convening more than 60 primary care, behavioral health, social service, consumer and academic organizations; leading and facilitating over three dozen workgroup meetings and two half-day retreats; conducting 30 individual interviews with local community leaders regarding care coordination barriers and solutions; conducting five focus groups with 50 patients/clients receiving health, behavioral health and social services; and performing the best practice-based research that led to the selection of the Pathways Community HUB as the care coordination model upon which the c3 pilot project would be based.

Throughout the two-year c3 pilot project, Ms. Usanga participated in biweekly meetings with the care coordination agencies, care coordinators, and partner organizations who provided and received referrals. She also played an integral role in problem-solving client and community partner issues and developing strategies to meet performance outcomes, especially in light of the COVID-19 pandemic.

Upon completion of the c3 pilot project, Ms. Usanga worked with Donna Alexander of Healthy Women Houston to convene community organizations and collaboratives to build upon the work of the pilot projects by establishing the framework upon which the Harris County PCH will be based. She was instrumental in securing the participation of six health care payers throughout the process. She also was responsible for facilitating the workgroup and advisory committee meetings and developing consensus among participants.

With her deep knowledge of and experience working with the PCH model, her broad relationships with community organizations, and her ability to engage and work with diverse populations and stakeholders, Ms. Usanga is well-qualified to lead implementation of the PCH in Harris County.

PCH Structure & Staffing

The proposed structure of the Harris County PCH, which is illustrated in Figure 4, would be set up under The Network of Behavioral Health Providers, Inc. through filing a Doing Business As (DBA), or Assumed Name, with the Texas Secretary of State. The DBA will have its own budget and financial system for tracking revenues and expenditures and also will set up bank accounts that are separate from NBHP.

While the PCH would still be a component of NBHP and governed by the NBHP Board of Directors, in accordance with PCH Standard 4, a separate Community Advisory Council (CAC) will be responsible for advising the PCH. The CAC will be comprised of a diverse group of community leaders that includes representatives from among payers, care coordination agencies, provider organizations, and residents of high-need communities that are served by the PCH. The CAC will be convened on at least a quarterly basis, and the Chair of the CAC also will be proposed as an ex-officio member of the NBHP Board.

In the first year of the PCH, the staff would be comprised of 1.5FTEs: the part-time PCH Director, who will split her time equally between NBHP and the PCH, and a full-time Project Manager. The Director will be largely responsible for:

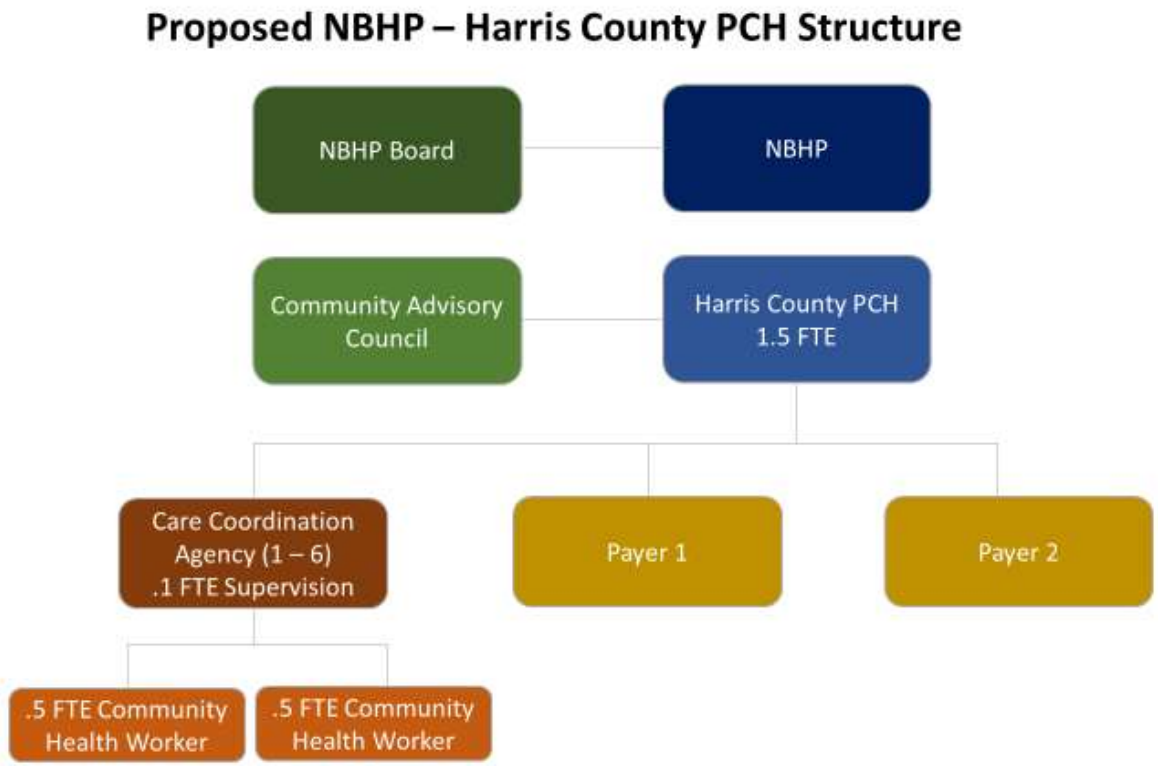
- Overseeing the day-to-day operations of the PCH;
- Managing relationships with the currently contracted Care Coordination Agencies, payers and referral partners;
- Engaging and recruiting new payers and Care Coordination Agencies to participate in the PCH
- Negotiating mutually beneficial contracts for payers and CCAs; and
- Reviewing compiled data and performance outcomes to determine the expansion to new populations and/or geographic regions.

The Project Manager will be responsible for:

- Establishing PCH operational policies and procedures, including workflows, referral processes, and documentation;
- Planning and ensuring completion of required education and trainings for the Care Coordination Agencies' CHWs and supervisors;
- Receiving client referrals and assigning clients to CHWs to avoid duplication;
- Managing CHW caseloads to ensure they do not exceed established maximum limits;
- Tracking and reviewing Pathways completion and generating invoices to payers for completed Pathways;
- Monitoring CHW documentation and ensuring integrity of data entered into the PCH data software;
- Consistently reviewing CCA performance outcomes to ensure continuous quality improvement; and
- Providing monthly quality and outcomes reports to payers and CCAs.

In addition, the PCH will contract with third party organizations for information technology, legal services, and financial reporting. In subsequent years, as the PCH continues to grow in size and scope, the overall staffing will be expanded as appropriate.

Figure 4



PCH Care Coordination Agency and Payer Contracts

Because Harris County is more than 1,700 square miles, the workgroup recognized that maximizing the number of CHWs dedicated to the PCH must be a priority. PCHI Prerequisite 8 requires that CHWs dedicate at least 50% of their time to PCH activities, so the workgroup agreed that the PCH should seek to negotiate Care Coordination Agency contracts for CHWs at .5 FTE rather 1 FTE in order to broaden the potential geographic reach of the CHWs. It is important to note, however, that after reviewing the proposed framework, PCHI recommended that when launching a PCH, having some CHWs who are committed to the PCH full-time helps ensure success. This was not factored into the initial planning but will be strongly considered during the actual PCH development and launch. Budget figures below include the initial workgroup CHW assumptions.

In addition, the workgroup agreed that any CCA that contracts with the PCH must be onboarded with a minimum of two CHWs. This will help to ensure business continuity for the CCA in the event that one of the CHWs leaves. Thus, the PCH initially will seek to contract with up to six CCAs across Harris County that will hire a total of 12 CHWs (6 FTEs). No CHW at .5 FTE will be allowed to carry a caseload of more than 20 clients at any given time. If the CHWs increase their percent of time dedicated

to the PCH, the caseload will be adjusted accordingly, with no more than 40 clients at any given time for 1 FTE.

Another consideration for CCAs is that PCHI Standard 11 requires that all CHWs are appropriately supervised by a professional (e.g., a registered nurse, social worker, or other health professional) who is responsible for signing off on client care plans, home visit documentation, and Pathways completion. General guidelines suggest a ratio of one supervisor per four-five Community Health Worker FTEs. The current plan assumes that each contracted CCA will have an appropriately credentialed supervisor overseeing the work of their hired CHWs.

Regarding payer contracts, PCHI Standard 18 requires that the PCH has at least two contracts with payers, based upon Outcomes Based Units. As will be laid out in more detail in the next section of the report, the proposed PCH expects to have braided sources of funding that include both grants and OBU-based payments for the first several years. However, in the first year, the PCH will seek to negotiate contracts with at least two payers. Due to the proposed target population of adults who currently are Medicaid recipients or are Medicaid-eligible, the PCH will target Medicaid Managed Care Organizations (MCOs) who are operating in the Harris County service area. The opportunity to work with these organizations has expanded due to recently passed legislation at the state level that extends Medicaid eligibility for pregnant women in Texas to six months postpartum. The federal Build Back Better budget reconciliation package, which has passed the U.S. House of Representatives, could further extend the Medicaid coverage period for pregnant women to 12 months post-partum if it is signed into law.

In addition to targeting MCOs, the PCH will engage with hospital systems and other potential entities that would be willing to enter into outcomes-based contracts for indigent populations as the target population is expanded. More information on the expected expenditures and revenues of the PCH are included in the next section.

Financial Plan

Based upon the framework developed by the workgroup, NBHP, in consultation with PCHI, has developed a draft, three-year budget of expected revenues and expenditures that the Harris County PCH may expect to incur. The budget was drafted to cover the work that needs to be accomplished in order to achieve national PCHI Certification.

Like any startup, a PCH can incur significant implementation costs in the first two years as it hires new staff, covers a significant amount of CHW salaries, invests in intensive trainings for CHWs and PCH staff, and develops the PCH platform. The budget assumes significant costs up front, while leveling off by Year 3.

It also is important to note that while the PCH is based upon a pay-for-performance model, the Harris County PCH does not expect that meaningful sustainability based upon successful PCH performance will be achieved in the beginning, but rather over a period of several years (as has been the case for other PCHs across the country). As a result, the budget assumes that the first two years of operation of the Harris County PCH largely will be covered by grant funding. As payer contracts are negotiated and expanded in Year 2, the PCH will expect the level of necessary grant funding to be reduced significantly.

Harris County PCH Proposed Budget Year 1

A significant portion of the expenditures in Year 1 will be the staff costs for the part-time PCH Director and full-time PCH Manager. In addition, NBHP expects that the PCH will be able to onboard a minimum of eight Community Health Workers (4 FTEs) from up to four different Care Coordination Agencies. Based upon the workgroup's framework, the PCH would endeavor to cover the full salary and benefits of the CHWs (up to $60,000 per FTE) for the first six months, 50% for the next three months, and 25% for the remaining three months, contingent upon the CHW/CCA meeting predefined performance metrics. Beginning in the seventh month, presuming payer contracts are in place and the CHWs are closing Pathways, the PCH would additionally phase-in outcomes-based payments to the CCAs for Pathways completion. With these payments, the CCAs will have the incentives to support the CHWs in becoming highly productive in order to cover their full salary costs through Pathway completion.

Other expected costs include training of the CHWs, vendor selection and implementation of a technology platform to support the PCH, technical assistance from the national Pathways Community HUB Institute, general operating costs, and contracting costs related to legal, auditing, IT and other professional services. The full Year 1 proposed budget is detailed more fully below.

Proposed PCH Year 1 Budget Detail

PCH Expenses	Year 1
Ongoing Operating	
PCH Director - .5 FTE Salary & Benefits	$62,500
Project Manager - 1 FTE	$83,000
Ongoing operating costs	$14,550
Software implementation and licensing fees for platform to support the PCH	$100,000
PCHI Certification Fees	$550
Contracted Services	$25,000
One-time costs	
Miscellaneous	$10,000
Technical Assistance from PCHI	$30,000
PCHI Model Training (2 free)	$400
Care Coordination Agency-Related Expenses	**Year 1**
CHW Training for CHWs (@ $2,000/CHW)	$16,000
Agency supervisor salaries (@$10,000 per supervisor in CCA first year of onboarding)	40,000
CHW Salaries (.5 FTE, 8 CHWs year 1, 4 year 2)	$165,000
CCA Incentives (@ $5,000/CCA)	$20,000
Total Expenses	**$567,000**

Harris County PCH Proposed Budget Year 2

In Year 2, in addition to the PCH Director and Manager, NBHP would hope to bring on additional part-time administrative support staff. NBHP also expects that the PCH will be able to onboard an additional four Community Health Workers (two FTEs) from up to two additional Care Coordination Agencies, reaching its goal of 12 CHWs/6 FTEs. As with the initial eight CHWs, the PCH would endeavor to cover the full salary and benefits of the four new CHWs (up to $60,000 per FTE) for the first six months, 50% for the next three months, and 25% for the remaining three months. Reimbursement based upon Pathways completion also would begin in the seventh month. In Year 2, payments to the initial CCAs would strictly be outcomes-based payments for CHW completion of Pathways.

Other expenditures would include continued trainings for the CHWs, PCH platform licensing fees, PCHI consulting fees, general operating costs, and contracting fees related to legal, auditing, IT and other professional services. The costs for national PCHI certification, which is expected to be achieved

in the PCH's second year of operation, also are included. The full Year 2 proposed budget is detailed more fully below.

Proposed PCH Year 2 Budget Detail

PCH Expenses	**Year 2**
Ongoing Operating	
PCH Director - .5 FTE Salary & Benefits	$65,000
Project Manager - 1 FTE	$86,000
Administrative Support Staff - .5 FTE Salary & Benefits	$35,000
Ongoing operating costs	$18,600
Software licensing fees for platform to support the PCH	$60,000
PCH Certification Fees	$3,000
Contracted Services	$25,000
One-time costs	
Technical Assistance from PCHI	$30,000
Care Coordination Agency-Related Expenses	**Year 2**
CHW Training for CHWs (@ $2,000/CHW)	$12,000
Agency supervisor salaries (@$10,000 per supervisor in CCA first year of onboarding)	$20,000
CHW Salaries (.5 FTE, 8 CHWs year 1, 4 year 2)	$82,352
CCA Incentives	$10,000
Total Expenses	**446,952**

Harris County PCH Proposed Budget Year 3

The expenditures in Year 3 are expected to level off, with staffing becoming stabilized, and full salary costs for new CCAs no longer being covered by the PCH. NBHP expects that an additional four CHWs from up to two additional CCAs would be onboarded, with the PCH covering onboarding and supervision costs for the new agencies of up to $10,000. This reduced amount for new agencies is because the initial CCAs bore the brunt of the risk for facilitating establishment of the PCH, assisting with workflow and caseload adjustments, identifying software issues, etc. In Year 3, the PCH should be well-established, and the onboarding process should be far smoother.

The PCH would continue to cover training costs for the CHWs, PCH platform licensing fees, PCHI consulting fees, PCHI certification fees, general operating costs, and contracting fees related to legal, auditing, IT and other professional services. The full Year 3 proposed budget is detailed below.

Proposed PCH Year 3 Budget Detail

PCH Expenses	**Year 3**
Ongoing Operating	
PCH Director - .5 FTE Salary & Benefits	$67,500
Project Manager - 1 FTE	$88,500
Administrative Support Staff - .5 FTE Salary & Benefits	$36,000
Ongoing operating costs	$19,200
PCH software	$60,000
PCH Certification Fees	$3,000
Contracted Services	$25,000
One-time costs	
Technical Assistance from PCHI	$10,000
Care Coordination Agency-Related Expenses	**Year 3**
CHW Training for CHWs (@ $2,000/CHW)	$10,000
CHW Onboarding	$20,000
CCA Incentives	$10,000
Total Expenses	**$349,200**
TOTAL 3-Year Budget	**$1,363,152**

It is difficult to gauge the total expected revenue the PCH will receive over the three-year period without having any negotiated payer contracts in place. In lieu of that, NBHP and PCHI have mapped out potential client profiles, the number of Pathways that could be opened and completed for each profile, and the annualized amount of revenue that could be brought in to the PCH (and, by extension, the CCAs) over the course of a year if sufficient payers contracts have been negotiated. Please note that these numbers are not likely until Years 2 and 3.

Potential Revenue from Client Profile 1

Medicaid enrollee, pregnant, behavioral risk factors, enrolled in month 5 of pregnancy. Client enrolled 6 months (4 while pregnant, 2 through post-partum visit)

Pathways	# of Completed Pathways	OBU/Activity	Total OBUs
Engagement Fee	6	4	24
Adult Education Pathway	0	10	0
Developmental Referral Pathway	0	5	0
Employment Pathway	0	10	0
Family Planning Pathway	1	6	6
Food Security Pathway	0	7	0
Healthcare Coverage Pathway	0	6	0
Housing Pathway	0	15	0
Immunization Referral Pathway	0	6	0
Learning Pathway	10	0.5	5
Medical Home Pathway	0	6	0
Medical Referral Pathway	2	3	6
Medication Adherence Pathway	0	7	0
Medication Reconciliation Pathway	0	10	0
Medication Screening Pathway	0	5	0
Mental Health Pathway	1	8	8
Oral Health Pathway	0	5	0
Postpartum Pathway	1	7	7
Pregnancy Pathway	1	20	20
Pregnancy - 1st Prenatal Visit	1	3	3
Pregnancy - Prenatal Visit	9	2	18
Social Service Pathway	4	3	12
Substance Use Pathway	0	9	0
Transportation Pathway	1	8	8
Potential OBUs per average client	37		117
Assume 25% closed Incomplete			87.75
Reimbursement per average client profile			$3,510.00
Compensation to CCA	70%		$2,457.00
Compensation to PCH	30%		$1,053.00
Annual Reimbursement per CHW FTE for this client profile (20)			**$70,200.00**

Potential Revenue from Client Profile 2

Medicaid eligible adult with substance use disorder. Client enrolled 4 months, after which time stopped attending substance use disorder treatment appointments and refused CHW visits.

Pathways	# of Completed Pathways	OBU/Activity	Total OBUs
Engagement Fee	4	4	16
Adult Education Pathway	0	10	0
Developmental Referral Pathway	0	5	0
Employment Pathway	1	10	10
Family Planning Pathway	0	6	0
Food Security Pathway	0	7	0
Healthcare Coverage Pathway	1	6	6
Housing Pathway	1	15	15
Immunization Referral Pathway	0	6	0
Learning Pathway	5	0.5	2.5
Medical Home Pathway	0	6	0
Medical Referral Pathway	0	3	0
Medication Adherence Pathway	0	7	0
Medication Reconciliation Pathway	0	10	0
Medication Screening Pathway	0	5	0
Mental Health Pathway	0	8	0
Oral Health Pathway	0	5	0
Postpartum Pathway	0	7	0
Pregnancy Pathway	0	20	0
Pregnancy - 1st Prenatal Visit	0	3	0
Pregnancy - Prenatal Visit	0	2	0
Social Service Pathway	0	3	0
Substance Use Pathway	4	9	36
Transportation Pathway	1	8	8
Potential OBUs per average client	17		93.5
Assume 50% closed Incomplete			46.75
Reimbursement per average client profile			$1,870.00
Compensation to CCA	70%		$1,309.00
Compensation to PCH	30%		$561.00
Annual Reimbursement per CHW FTE for this client profile			**$37,400.00**

Conclusion

The Pathways Community HUB is a proven model that has demonstrated the ability to overcome several challenges in care coordination—mitigating client risks and reducing health disparities through providing holistic care, improving client engagement through trust-based relationships with CHWs, reducing service duplication, ensuring accountability through data and outcomes tracking, and offering a means of sustainable financing.

While the c3 and HWH pilot projects laid the foundation for what is possible with the use of the PCH model in Harris County, NBHP expects even stronger client and community outcomes from full implementation to fidelity—in alignment with the impressive results of PCHs across the country.

The Greater Houston Pathways Community HUB planning process brought together critical community partners from across the health, behavioral health, social service, and payer spectrums in order to develop a framework for the establishment of this model locally. It entailed collaborative review and decision making regarding virtually every facet of the potential PCH in order to ensure broad community support and buy-in once implemented. The level of interest among potential Care Coordination Agencies, payers, and other community partners is significant and growing, and likely will only increase as potential implementation draws near.

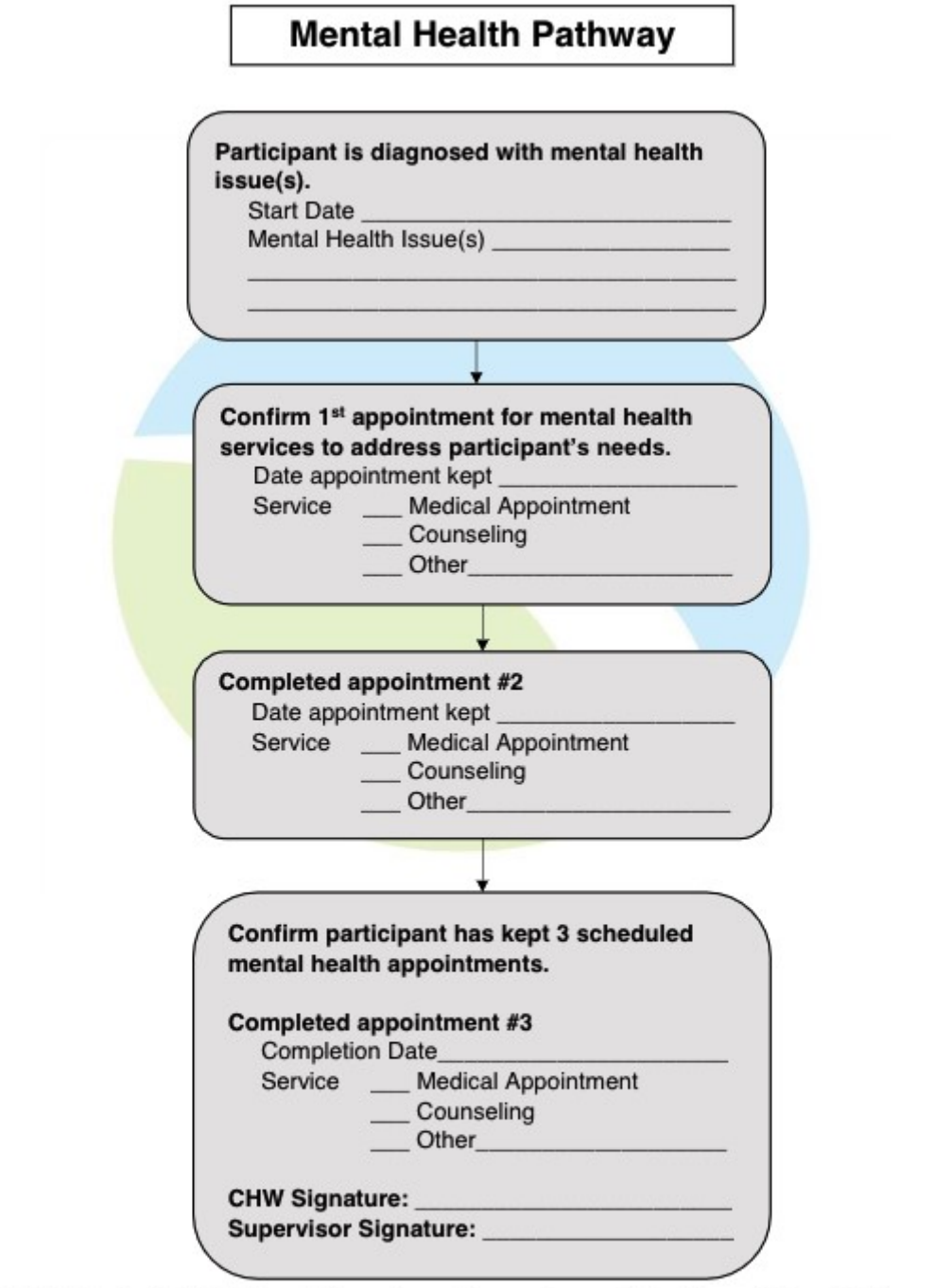
The NBHP membership is expected to consider and vote upon the Harris County Pathways Community HUB plan in January 2022. If approved, NBHP staff looks forward to working with neighborhood and community leaders, a broad array of community-based organizations, payers, and other interested stakeholders in order to usher this important vision into reality.

Appendices

Appendix A: PCH Workgroup Participating Organizations

Aetna Better Health of Texas
Association of Community Assistance Ministries
Blue Cross Blue Shield
Catholic Charities
Community Health Choice
Cypress Creek Hospital
DAG Consulting/Health Women Houston
El Centro de Corazon
Harris County Public Health
Harris Health System
Texas Health and Human Services Commission
Health Equity Collective
Healthcare for the Homeless Houston
Houston Food Bank
Houston Methodist
Houston Recovery Center
Humana
January Advisors
Kingwood Pines Hospital
Legacy Community Health
Memorial Hermann
Mental Health America of Greater Houston
NAMI Greater Houston
Santa Maria Hostel
Texas Children's Health Plan
Texas Children's Hospital
The Council on Recovery
The Harris Center for Mental Health & IDD
the Montrose Center
The Women's Home
UnitedHealthcare
Wesley Community Center

Appendix B: Mental Health Pathway

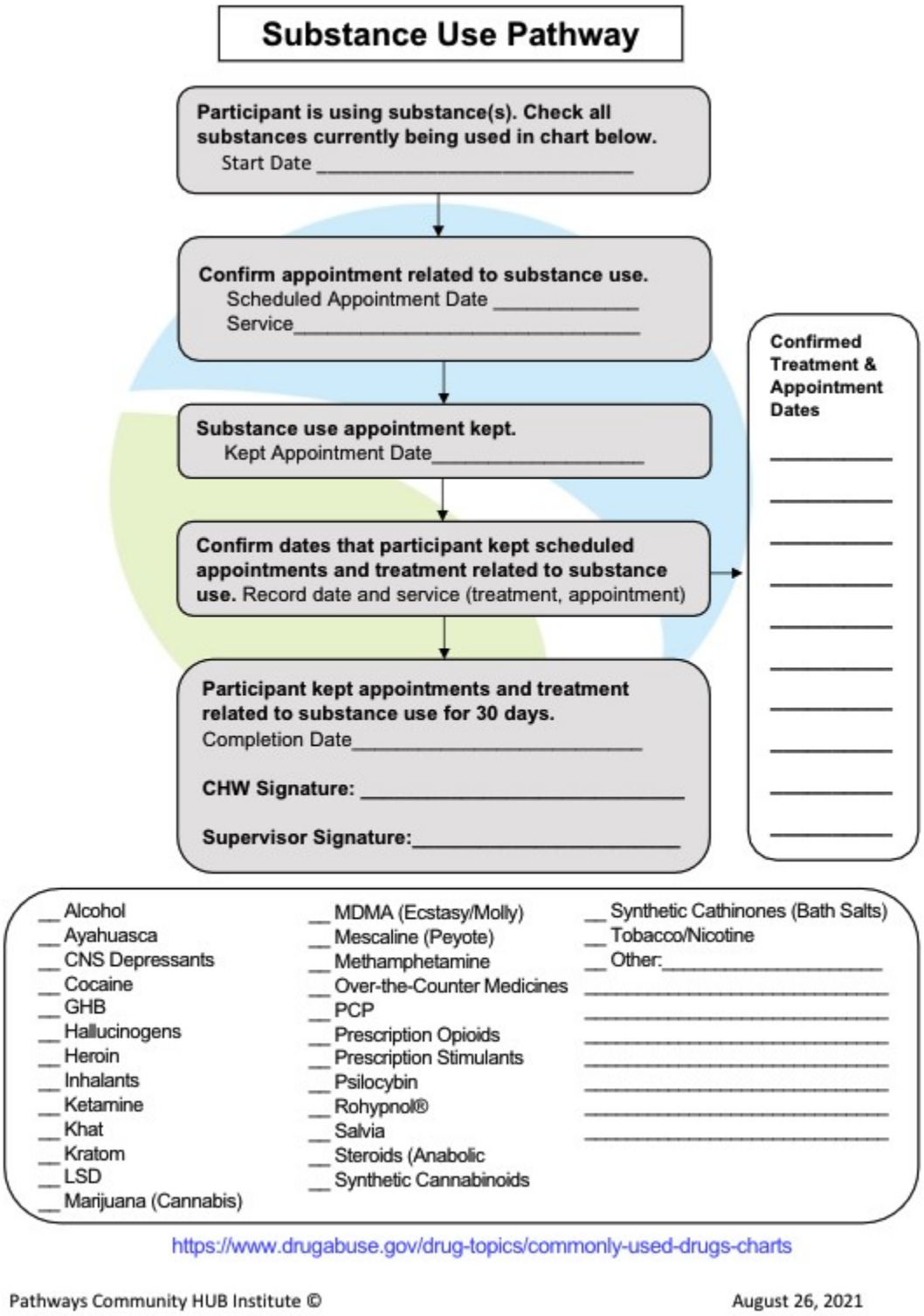


NOTE: Use the Medical Referral Pathway to monitor ongoing mental health appointments that you are helping your participant with.

Pathways Community HUB Institute ©

August 11, 2020

Appendix C: Substance Use Pathway



Appendix D: PCH Certification Prerequisites
(Updated July 20, 2021)

Prerequisite #1 - The Pathways Community HUB (PCH) is an independent legal entity or an affiliated component of a legal entity.

Background/Rationale

The Pathways Community HUB (PCH) is a legal entity that has legal capacity to enter into agreements or contracts, assume obligations, incur and pay debts, sue and be sued, and to be held responsible for its actions. The PCH can be an association, corporation, partnership, proprietorship, or trust that has legal standing in the eyes of the law.

Review Items to Achieve Prerequisite #1

A. Copy of most recent IRS Form 990; and
B. Copy of IRS Determination letter with Tax Identification Number/Employer IdentificationNumber (EIN); and
C. Dun & Bradstreet Number.

Prerequisite #2 - The Pathways Community HUB has been operating for a minimum of 3 months using standard Pathways.

Background/Rationale

The PCH is beyond the planning phases of development and has utilized the Standard Pathways within a network of care coordination agencies for a minimum of 3 months.

Review Items to Achieve Prerequisite #2

Formal documentation that substantiates a minimum of three months of PCH operation. Reports of Pathways initiated and completed, and at least one of the following documents must be provided documenting activity since PCH launch:

A. MOUs or contracts with contracted care coordination agencies; or
B. Financial payments to contracted care coordination agencies.

Prerequisite #3 - The Pathways Community HUB is based in the community and/or region it serves.

Background/Rationale

The PCH office and staff are located within the community and/or region it serves. The PCH is established to remove siloes for the population at risk within a specified service area. It is imperative that the Pathways Community HUB have a thorough understanding of capacity of both care coordination agencies and the providers of direct services.

A PCH must clearly describe how the service area was established. A PCH must operate in a defined geographic area made up of neighboring communities or counties. A PCH region cannot be statewide. Ineligible PCH entities include statewide or national organizations. A PCH does not serve individuals who reside in another certified Pathways Community HUB's service area.

It is recommended that, at a minimum, staff from the PCH network (care coordination agencies) be posted within 60 miles of the most distant service recipient in rural areas, and 30 minutes travel time in urban areas.

Review Items to Achieve Prerequisite #3 - Description of the Pathways Community HUB service area:

A. Pathways Community HUB's name and physical address; and
B. Physical addresses of contracted care coordination agencies; and
C. Definition of the PCH service area (i.e., geographic service area – census tracts, zipcodes, county, region); and
D. Explanation of how and why this service area was established:
    1. Documentation of how the PCH gained support from local stakeholders to operate in the service area (meeting minutes or other documentation); and
    2. Priority population served; and
    3. Population size of PCH's service area; and
    4. PCH's plan to serve all priority population residents in the service area; and
    5. Documentation that Community Advisory Council members reflectrepresentation from the entire service area; and
    6. How the Pathways Community HUB operates as a neutral convener.

Prerequisite #4 – There is only one Pathways Community HUB located within the community and/or region it serves.

Background/Rationale

Pathways Community HUB services are coordinated through a single tracking system, allowing for the identification and elimination of duplicative services and the improvement of health outcomes across a defined service area and population.

Review Items to Achieve Prerequisite #4

List of all Pathways Community HUBs in your region; and if applicable, clearly identify the boundaries of adjoining PCHs.

Prerequisite #5 – The Pathways Community HUB reviews and/or conducts community needs assessments.

Background/Rationale

A community needs assessment, which includes local data specific to medical, behavioral health, oral health, social, environmental, and educational factors, guides the PCH in its efforts to improve health and reduce inequities. Hospitals, health departments, and other community partners should work together to assess community health needs and resources and create a shared plan for addressing those needs.

Review Items to Achieve Prerequisite #5

A. A copy of a community needs assessment, conducted no more than three years prior to current certification review, that includes local data related to the medical, behavioral health, oral health, social, environmental, and educational needs and opportunities; and
B. Description of how the PCH uses the community needs assessment and other data to identify populations to be prioritized for community care coordination services; and

C. Baseline measures of key outcomes to be addressed by the PCH.

Prerequisite #6 – The Pathways Community HUB coordinates a network of care coordination agencies serving at-risk participants and has written agreements with its care coordination agency members.

Background/Rationale

To promote positive health outcomes and cost savings, the Pathways Community HUB connects those who are at risk to a community-based care coordinator, and ensures the participant receives coordinated medical, behavioral health, oral health, social, and educational services.

Review Items to Achieve Prerequisite #6

A. Contracts, MOUs, or other legal documents describing the relationship between the PCH and care coordination agency members; and
B. List of all active community care coordinators at each contracted care coordination agency; and
C. Documentation that the Pathways Community HUB has a minimum of two contracted care coordination agencies.

Prerequisite #7 - The Pathways Community HUB uses Standard Pathways.

Background/Rationale

Each Standard Pathway, when completed, represents a specific individually modifiable risk factor that has been identified and addressed. The use of Standard Pathways attracts payers that are interested in funding evidence-based models of community-based care coordination. Additionally, using Standard Pathways allows for further research, evaluation, analysis, and improvement of the model.

Review Items to Achieve Prerequisite #7

Confirmation that the PCH can implement all current Standard Pathways. PCH will need to present paper documentation or database screenshots that confirm all current Standard Pathways are available to care coordinators and Pathways are used as needed (representative of the population being served).

Prerequisite #8 - The Pathways Community HUB monitors the caseloads of care coordinators at each care coordination agency.

Background/Rationale

Each contracted care coordination agency should demonstrate its resourcefulness and benefit to the community by having the capacity to provide services to a reasonable caseload that reflects its efficiency and effectiveness in connecting at-risk populations to appropriate health, behavioral health, and social services.

Review Items to Achieve Prerequisite #8

A. Description of how caseloads are determined for full-time and part-time community care coordinators.
B. PCH's policy for reviewing and analyzing caseloads; and
    1. PCH's plan for caseload correction.
    2. Attestation by the PCH Director that at the time of certification application, the volume ofthe Pathways Community HUB is greater than 50 enrolled active individuals.

C. Confirmation that all active CHWs working with the Pathways Community HUB are dedicated at least 0.5 FTE to PCH work.

Prerequisite #9 - The Pathways Community HUB aligns payments with measured outcomes in its contracts with care coordination agency members.

Background/Rationale

Standard Pathways link billing codes to Pathway completion. Payments for Pathway steps/outcomes are a key component of the PCH model, and promote accountability, quality,equity, health improvement, and value.

Review Items to Achieve Prerequisite #9

Contracts or other financial documents with contracted care coordination agencies demonstratingthat payments are related to intermediate and final Pathway steps/outcomes using nationally standardized billing codes and Outcome Based Units (OBUs).

Prerequisite #10 - The Pathways Community HUB complies with the Health Insurance Portability and Accountability Act (HIPAA).

Background/Rationale

Ensuring strong privacy protections is critical to maintaining individuals' trust in their medical, behavioral health, and oral health providers, and their willingness to obtain needed services. At the same time, circumstances arise where information may need to be shared to ensure individuals receive the best services. Therefore, all those working with the PCH must comply with the Health Insurance Portability and Accountability Act (HIPAA).

Review Items to Achieve Prerequisite #10

A. HIPAA protection policies in the PCH operations manual; and
B. Signed HIPAA compliant agreements between the PCH, care coordination agencies, service providers, and others; and
C. Documentation that all PCH personnel and contracted care coordination agency staff receive and complete HIPAA training upon hire, and annually thereafter.

   Examples of acceptable documentation could include a list of personnel who have completed the training and/or copies of certificates of training completion.

Appendix E: PCH Certification Standards
(Updated July 20, 2021)

Standard #1 - The Pathways Community HUB has the infrastructure and capacity to fully implement the Pathways Community HUB.

Rationale/Background

The PCH must have adequate infrastructure to track and document the delivery of services tothose at risk and must have the ability to document the Pathways process and outcomes, process payments to care coordination agencies, and contract with and invoice payers.

Review Items to Achieve Standard #1

Copy of the PCH's organizational chart that includes all department personnel and reportingstructure. If the PCH is an affiliate of a larger umbrella organization, then the relationship should be reflected.

Standard #2 - The PCH Director possesses the experience and skills to effectively manage the Pathways Community HUB, including a commitment to community health and equity as well as strong business and communication skills.

Rationale/Background

The PCH Director must have diverse competencies to ensure the success and sustainability of the Pathways Community HUB. Key competencies include, but are not limited to:

- Engaging and partnering with community care coordination agencies serving at-risk populations; and
- Developing and maintaining relationships with diverse stakeholders, including care coordination agency members, community members, referral partners, providers, andpayers; and
- Developing and managing contractual relationships with payers; and
- Developing and managing performance outcomes and contractual compliance.

Review Items to Achieve Standard #2

Copy of PCH Director's resume and/or curriculum vitae; and if applicable additional resume(s) of staff or subcontractor(s) in key positions complementing the competencies of the PCH Director.

Standard #3 - All PCH and care coordination agency staff receive training on the Pathways Community HUB Model.

Rationale/Background

The Pathways Community HUB model focuses on identifying and engaging at-risk individuals, documenting risk factors, and addressing those risk factors in a pay for performance, outcome-focused approach. Program and financial personnel must understand the model and how the PCH operates to assure its effectiveness and efficiency. PCHI has developed training on the Pathways Community HUB Model that is available to PCHs applying for certification.

Review Items to Achieve Standard #3

A. Documentation of approved PCHI training provided for all PCH and care coordination agency staff on the Pathways Community HUB approach; and

B. Attestation that all new care coordination agency and PCH staff receive comprehensive training about the PCH Model with 30 days of hire and with updates as needed.

Standard #4 - The Pathways Community HUB engages and is advised by a CommunityAdvisory Council.

Rationale/Background

To ensure the PCH understands and meets the needs of those who are at risk, the PCH leverages existing community resources and seeks to add value to the community. Local leaders, therefore, need to be meaningfully engaged and empowered to guide and advise the strategies of the Pathways Community HUB.

Review Items to Achieve Standard #4

A. List of Community Advisory Council (CAC) members, including brief biographies for each representing what they bring to the CAC; and
B. Representation of key stakeholders on the Community Advisory Council to include, forexample: community members, care coordination agency staff, referral partners, payers,and direct service providers; and
C. Description of the roles and responsibilities of Community Advisory Council members; and
D. Description of how the Community Advisory Council and PCH staff identifies, and addresses issues identified in the community through analysis of PCH data (i.e., gaps,resources, etc.); and
E. Minutes from the Community Advisory Council meetings that occurred within the pastyear. It is recommended that the Community Advisory Council meet quarterly, but at aminimum, twice a year.

Standard #5 – The Pathways Community HUB is a neutral entity and operates in a transparent and accountable manner.

Rationale/Background

The PCH is responsible for referring clients based on the services, competencies, and capacity of its care coordination agency members, and the needs of the participants. Therefore, the Pathways Community HUB needs a transparent and objective process and criteria to ensure that the referral process is unbiased.

Review Items to Achieve Standard #5

A. Copy of the PCH's conflict of interest policy and conflict of interest form template; and
B. Signed conflict of interest forms by PCH personnel, Community Advisory Councilmembers, and Pathways Community HUB Board members; and
C. Copy of a policy that describes the criteria and process to refer clients to care coordination agency members (Referral Policy). This policy includes how referrals are distributed when a client meets the eligibility requirements of two or more care coordination agency members; and
D. Attestation that the PCH does not refer clients to any care coordination agency where the PCH is the final recipient of care coordination service payments*.

**Care coordination service payments are the outcome payments after the PCH retainsadministrative and quality management fees.*

Standard #6 – The Pathways Community HUB is committed to continual quality improvement

and has a written Quality Improvement Plan.

Rationale/Background

The PCH is responsible for monitoring and improving the quality of community-based care coordination services provided to those who are at risk. Therefore, the PCH must have a Quality Improvement Plan. The PCH must regularly evaluate its services as well as those services provided by care coordination agency members.

Review Items to Achieve Standard #6

A. Copy of the PCH's Quality Improvement (QI) Plan, that includes, but is not limited to:
   1. Description of how QI projects are selected, managed, and monitored; and
   2. Description of quality methodology (such as PDSA, Six Sigma) and quality tools/techniques to be utilized throughout the PCH and with its CCA members; and
   3. Documentation of who is responsible for conducting QI reviews; and
   4. Frequency of QI reviews: and
   5. Description of how the PCH uses QI findings to improve the quality of community-based care coordination services provided to those who are at risk.
B. Documentation of quality improvement reviews that have been completed over the pastyear.
C. Documentation of how identified quality improvement opportunities add to or changeexisting policy.
D. Documentation that staff from the PCH and care coordination agencies receive trainingand/or resources based on quality improvement recommendations. Provide written documentation of trainings and attendance sheets from trainings.

Standard #7 – The Pathways Community HUB is committed to continual quality improvement and has a written manual outlining all PCH policies and procedures.

Rationale/Background

The PCH is committed to continual quality improvement to assure that community members are receiving the highest quality community-based care coordination services. All PCH policies and procedures must be written and shared with PCH and care coordination agency staff. The manual must be updated annually, at a minimum.

Review Items to Achieve Standard #7

A. Description of PCH's mission, program goals, and objectives.
B. Referral Policies and Procedures, that include at a minimum:
   1. Document that care coordination agency staff were involved in developing the referral process to be fair and transparent; and
   2. Document how referrals are provided in a HIPAA compliant way from the PCH to CCAs (electronically, phone call, etc.); and
   3. Required number of documented attempts to reach the client; and
   4. Document strategies used to reach the client (e.g., phone, mail, secure email, securetexting, home visit); and
   5. Document number of days client is expected to be contacted from receipt of referral; and

6. Document the specific time frame and process for communicating outcome of the referral to the PCH; and

7. Document the specific time frame and process for communication from the PCH back to the referral source regarding outcome of the referral.

C. Policies and procedures addressing duplication of services that include at a minimum:

1. Document the new client enrollment process; and
2. Document how duplication is identified, documented, and eliminated, when appropriate; and
3. Document how clients with more than one identified community care coordinator are managed when this is necessary.

D. Policies and procedures addressing home visits that include at a minimum:

1. Document home visiting frequency expectation (minimum monthly); and
2. How attempted visits are documented; and
3. How contacts between visits are documented; and
4. Document expectation that 75 percent of overall visits should occur in participants' homes or at minimum, in a community setting. Documentation must be provided if visits are not completed in the home setting (safety reasons, participant preference, etc.). Visits should not occur on a regular basis in an office environment (clinic, agency, etc.); and
5. CHW documentation for home visits must be completed within two business days
6. and submitted for supervisor review.
7. Document safety measures for home visits.

E. Policies and procedures addressing supervision, including at a minimum:

1. Document frequency of performance reviews; and
2. Documentation that caseload reviews occur at least monthly; and
3. Document community health worker to client ratios to determine maximum caseload per full- and part-time equivalent care coordinators; and
4. Document supervisor to community health worker ratio; and
5. Document how a participant's comprehensive assessment and plan of care that is provided by a community health worker is reviewed and signed off by their supervisor; and
6. Document that supervisor review and sign-off occurs within five business days from home visit date; and
7. Document timeline and action taken by the CHW and supervisor when urgent issues are identified.

F. Policies and procedures that document the HUB's role in identifying and addressing performance issues with care coordination agencies.

G. Policies and procedures that outline how the HUB will respond in emergency situations (Natural disasters, pandemics, etc.).

1. Emergency plan addressing the role of the HUB and CCAs that is reviewed and
2. updated annually; and
3. Training for CCA staff on how to protect themselves during an emergency; and
4. Training on strategies to provide learning modules and resources for participants (Connecting to telehealth, safety, etc.).

Standard #8 - The Pathways Community HUB and its care coordination agency members have effective Human Resource policies and procedures.

Rationale/Background

To ensure equitable and consistent application of Pathways Community HUB policies, procedures, and

benefits, the PCH's personnel must be knowledgeable of human resourcespolicies and procedures that govern the Pathways Community HUB.

Review Items to Achieve Standard #8

A. The PCH's Human Resource Manual, that includes at a minimum documentation of:
   1. Training requirements; and
   2. Policies regarding hiring, termination, outstanding performance, dress code,complaint procedures; and
   3. Travel policy to allow individuals to meet job requirements; and
   4. Background check information; and
   5. Sexual harassment and discrimination policies; and
   6. Disciplinary policy; and
   7. Problem-resolution process.

B. Attestation that each contracted care coordination agency has human resources policies and procedures that include at a minimum the above plus professional boundaries education for community care coordinators on an annual basis.

Standard #9 - The PCH and its care coordination agency members are culturally sensitive organizations that provide culturally and linguistically appropriate services.

Rationale/Background

The Pathways Community HUB model of care coordination focuses on improving health, advancing health equity, improving quality, and eliminating disparities. Consequently, it is vital to provide effective, equitable, understandable, and respectful quality services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy,
and other communication needs. PCHI has developed training on the National Culturally and Linguistically Appropriate Services (CLAS) Standards that is available to PCHs applying for certification.

Review Items to Achieve Standard #9

A. The PCH's organizational policies reflect the adoption of the National Culturally andLinguistically Appropriate Services (CLAS) Standards; and

B. Attestation that each contracted care coordination agency has organizational policies that reflect the adoption of the National CLAS Standards; and

C. Documentation that the PCH provides training to PCH and care coordination agency staff at least every 2 years on how to provide culturally and linguistically appropriate services reflecting the population served:
   1. Provide training overview that incorporates an understanding of the different needs and backgrounds of populations served and how care coordination staff are sensitive and responsive to those unique needs; and
   2. Training activities should include a focus on diversity and inclusive practices; and
   3. Sign-in sheets documenting those in attendance; and
   4. Plan for staff that do not attend training.

Standard #10 – Community health workers have comprehensive training, education, and support.

Rationale/Background

Education, training, and support for community health workers (CHWs) is essential to achieve improved health outcomes for those at risk. CHWs and other community-based care coordinators must meet the minimum PCH training requirements.

Review Items to Achieve Standard #10

A. Description of training that community health workers have completed; and
B. Documentation that each community health worker has completed all requiredcomponents of comprehensive training; and
C. Documentation of expectations for hiring and onboarding of community healthworkers:
    1. CHW job description used by care coordination agencies; and
    2. Background check completed before hire; and
    3. Documentation that CHW foundational training begins within 30 days of hire; and
    4. Minimum training requirements before CHWs interact with clients:
        a. Pathways Community HUB model and Standard Pathways
        b. Mandatory reporting requirements
        c. Safety during home visits
        d. HIPAA requirements; and
    5. Onboarding checklist for CHWs at each care coordination agency.

Standard #11 – Community health workers are supported by effective and culturally competent supervisors working within the professional scope of their license.

Rationale/Background

All community health workers should be supported and supervised by a registered nurse, licensed clinical social worker or another health, social, behavioral, or oral health professionalthat understands and values the role of CHWs. Experienced CHWs may function in a supervisory role when part of a care team. CHW supervisors must be culturally competent, attend CHW trainings, and be proficient is supervising CHWs.

Review Items to Achieve Standard #11

A. CHW supervisor job descriptions from each care coordination agency on agency letterhead; and
B. CHW supervisors' current resumes and/or curriculum vitae; and
C. Documentation that the CHW supervisor completed the minimum CHW training requirements through:
    1. Attendance at foundational CHW training or
    2. Completion of the PCHI Training Template confirming that minimum CHWtraining requirements have been met.

Standard #12 – The Pathways Community HUB uses PCHI approved participant curriculum with the Learning Pathway.

Rationale/Background

Each Standard Pathway, when completed, represents a specific individually modifiable risk factor that has been identified and addressed. Many modifiable risks in community-based care coordination can

be addressed through learning and behavior change. The PCHI participant curriculum incorporates one or more risk factors within each learning module. The learning modules are tracked with the standard Learning Pathway and can be used for participants of allcategories including adult, pregnant or pediatric caregiver. PCHI learning modules are available to all PCHs applying for certification.

Review Items to Achieve Standard #12

A. Expectation that PCHI standard curriculum for learning modules is utilized. PCHI learning modules are documented within the Learning Pathway; and
B. Process that the PCH uses to approve other evidence-based materials used with the Learning Pathway. Each Learning Pathway should be tied to a specific medical, social, or behavioral health risk factor that can be mitigated and addressed with learning and motivational interventions. Learning materials used outside of the PCHI standard curriculum for learning modules must represent a similar level of effort, time commitment, and expertise in delivery towards a measurable learning outcome.

Standard #13 - The Pathways Community HUB ensures care coordination services address the medical, behavioral health, oral health, social, environmental, and educational needs of those who are at risk. The PCH uses approved PCHI data collection tools.

Rationale/Background

The PCH must collect demographic and other information to effectively address the medical, behavioral health, oral health, social, environmental, and educational risk factors. To improvehealth outcomes, an individualized care plan must be developed to prioritize and address the participant's risk factors.

Review Items to Achieve Standard #13

The Pathways Community HUB uses PCHI-approved data collection tools, including:

A. PCHI Standard Pathways; and
B. PCHI Participant Profile, including enrollment and discharge status; and
C. PCHI Visit Form; and
D. PCHI Progress Form to summarize client's individualized Pathways-based care plan; and
E. Other data collection items and tools unique to the PCH can be added as needed.

Standard #14 – The Pathways Community HUB must use the PCHI Data Model.

Rationale/Background

Implementation of the PCHI Data Model is fundamental to improving the evidence-based effectiveness of the PCH and its ongoing development and improvements. Benchmarking comparisons and research evaluations involving more than one PCH requires standardization of data, data entry, and relationships established between data items.

Review Items to Achieve Standard #14

A. PCHs using information technology systems are required to use PCHI Certifiedtechnology vendors.
B. PCHs using paper documentation must demonstrate appropriate use of data collection tools and assimilation of the data/reporting.
C. PCH data entry and reporting must be consistent with PCHI Data Model data definitions.

Standard #15 – The Pathways Community HUB tracks, monitors, and reports on participant services.

Rationale/Background

The Pathways Community HUB and its care coordination agency members must be able to produce regular quality and performance reports to effectively serve those at risk.

Review Items to Achieve Standard #15

A. PCH prepares the PCHI National Benchmark Report on a quarterly basis and submitsaggregate data to PCHI within 30 days of the completion of the quarter (submission dates: **April 30, July 31, October 31, and January 31**).
B. Document how the PCH leadership uses analytics to inform and support community policy and decision makers in the implementation of community-level strategies to address population level needs such as poor-quality housing, food insecurity, and access to care where there are high concentrations of at-risk residents.

Standard #16 – The Pathways Community HUB conducts a cost benefit analysis.

Rationale/Background

To sustain community care coordination services and the Pathways Community HUB, a cost- benefit analysis must be implemented to determine the financial impact of PCH services and ifcost savings are achieved.

Review Items to Achieve Standard #16

A. PCHs going through initial certification need to propose a detailed strategy forconducting a cost benefit analysis.
B. PCHs that have been in operation 2 or more years must:
    1. Complete a cost benefit analysis; and
    2. Describe how the cost benefit analysis is used to improve the quality and efficiency of the PCH's operations.

Standard #17 – The Pathways Community HUB communicates its strategies, programs, and progress to the community it serves.

Rationale/Background

The PCH is committed to improving the health of the community and is responsible to the community. Therefore, the PCH regularly communicates and reports its strategies, progress,and challenges to its funders, policymakers, care coordination agency members, participants,and the community at large in partnership with the Community Advisory Council.

Review Items to Achieve Standard #17

A. Copy of the most recent report to the community that includes, but is not limited to:
    1. A description of PCH initiatives (e.g., community needs assessments and health improvement plan, demographic information of those served, Pathway reports, health outcomes, cost savings); and
    2. Description of partnerships, workforce, volunteers, and financing to achieve PCHinitiatives; and
    3. Future strategies to address unmet needs.

B. Copy of the PCH's dissemination plan.

Standard #18 – The Pathways Community HUB has contracts with more than one payer.

Rationale/Background

To help ensure comprehensive and sustainable care coordination services, the PCH has diverseand multiple revenue sources.

Review Items to Achieve Standard #18

A. Summary of annual funding sources to support the PCH; and
B. Outcome-based contracts with a minimum of two payers. Contracts or other financial documents with the PCH demonstrating that a minimum of 50 percent of all paymentsare related to intermediate and final Pathway steps/outcomes using nationally standardized Outcome Based Units (OBUs).