Standard #1 - The Pathways Community HUB (PCH) 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 to those 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 reporting structure. 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, and payers; 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 Institute℠ Model.

Rationale/Background

The Pathways Community HUB Institute℠ 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 Institute℠ 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 Institute℠ Model; and
B. Attestation that all new care coordination agency and PCH staff receive comprehensive training about the PCHI℠ Model with 30 days of hire and with updates as needed. **Appendix B**

Standard #4 - The Pathways Community HUB engages and is advised by a Community Advisory 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, for example: 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); and
E. Minutes from the Community Advisory Council meetings that occurred within the past year. It is recommended that the Community Advisory Council meet quarterly, but at a minimum, 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 Council members, 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*. **Appendix B**

**Care coordination service payments are the outcome payments after the PCH retains administrative 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 past year.

C. Documentation of how identified quality improvement opportunities add to or change existing policy.

D. Documentation that staff from both the PCH and care coordination agencies receive training and/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 which include at a minimum:
   1. Document that care coordination agency staff participated 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, secure texting, 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 and submitted for supervisor review.
   6. 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 PCH's role in identifying and addressing performance issues with care coordination agencies.

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

1. Emergency plan addressing the role of the PCH 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 resources policies and procedures that govern the Pathways Community HUB.

Review Items to Achieve Standard #8

A. The PCH's Human Resource Manual which 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. **Appendix B**

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

Rationale/Background

The Pathways Community HUB Institute℠ 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 and Linguistically 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 (**Appendix B**); 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 state and PCH training requirements (**Appendix C**).

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 required components of comprehensive training; and
C. Documentation of expectations for hiring and onboarding of community health workers:
    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 Institute℠ 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 professional that 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 (**Appendix C**) through,
    1. Attendance at foundational CHW training or
    2. Completion of the PCHI Training Template confirming that minimum CHW training requirements have been met.

Standard #12 – The Pathways Community HUB uses PCHI℠ Model 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℠ Model 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 all participants including adult, pregnant or pediatric caregiver. PCHI℠ Model Learning Modules are available to all PCHs applying for certification.

Review Items to Achieve Standard #12

A. Expectation that PCHI℠ Model standard curriculum for Learning Modules is utilized. PCHI℠ Model 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. Learning material:

1. Represents a volume of learning and educational material that will take 10 – 15 minutes for the CHW to provide to the participant, using motivational interviewing techniques, and not simply providing a handout.
2. The learning process includes educational, and behavior change information shared in an Ask-Tell-Ask interaction using open-ended questions.
3. Content is evidence-based and focused on addressing a specific, well-defined, modifiable medical, social, behavioral, or safety risk, as identified in the Publication*, which is relevant to the participant served or the individual(s) that the participant served is caring for (child, disabled family member, etc.)
4. The participant is engaged, and CHW can document the participant's response to the learning information provided.

*(https://www.sciencedirect.com/science/article/pii/S0091743520301420?via%3Dihub)

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℠ Model 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 improve health 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℠ Model approved data collection tools, including:

A. PCHI℠ Model Standard Pathways; and
B. PCHI℠ Model Demographic Form, including enrollment and discharge status; and
C. PCHI℠ Model Visit Form; and
D. PCHI℠ Model 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℠ Model 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℠ Model National Benchmark Report on a quarterly basis and submits aggregate 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 if cost savings are achieved.

Review Items to Achieve Standard #16
A. PCHs going through initial certification need to propose a detailed strategy for conducting 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, Pathways reports, health outcomes, cost savings); and
   2. Description of partnerships, workforce, volunteers, and financing to achieve PCH initiatives; and
   3. Future strategies to address unmet needs.
B. Copy of the PCH's dissemination plan.

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

Rationale/Background

To help ensure comprehensive and sustainable care coordination services, the PCH has diverse and 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 payments are related to intermediate and final Pathway steps/outcomes using nationally standardized PCHI℠ Model Outcome Based Units (OBUs). **Appendix D**

