What is the Pathways Community HUB (PCH)?

The Pathways Community HUB is a nationally certified approach that helps communities work together to support their vulnerable populations in a financially sustainable model. Local community health workers work closely with families to connect to social and medical services to remove barriers to health.

What is the goal of the PCH?

The goal of the PCH is to construct a community solution to address the social determinants of health and link individuals to community resources. Community based care coordination agencies (CCAs) employ community health workers (CHWs) to reach out to those at greatest risk of poor health outcomes. The PCH provides standardization and infrastructure for the CHWs to link and track an individual's risks through to a measurable outcome.

Why is the PCH needed?

Many health interventions are limited in their capacity to account for the influence of social factors (such as low income, employment insecurity, low educational attainment, and poor living conditions) or behavioral practices. The mission of the PCH model is to work across sectors within a community to reach at-risk individuals and connect them to the evidence-based interventions and services that are necessary for positive outcomes.

The current siloes and fragmented approaches to care coordination that exist in service areas often result in duplication of services, ineffective interventions, and uncoordinated care. The PCH provides centralized processes, systems, and resources to allow accountable tracking of those being served, and a method to tie payments to outcomes. The outcomes-based payment methodology is a critical part of the PCH approach.

How does it work?

Once a person is identified and a standardized assessment of risk factors is completed, a specific "Pathway" is assigned for each of the individual's modifiable risk factors. An individual may have multiple Pathways assigned simultaneously. Completion of the Pathway indicates that the person has obtained an evidence-based intervention to address the risk factor. The outcomes are then reported and beneficiaries pay for the coordination of services.

What is the role of the PCH?

The PCH provides a centralized set of processes, systems, and a billing mechanism that enable communities to track individuals being served and provides a way to collect the data for outcome measurement and payment. By tracking referrals made and accomplished, the PCH has the ability to evaluate community capacity and advocate for additional resources for the community.

The PCH also provides standardized training to the community health workers to ensure quality of services as well as contracting and billing with community care coordination organizations and funding partners (government agencies, health plans, hospitals, and others). Finally, the PCH provides the technology platform to track the outcomes of the Pathways and the work the CHWs complete.

How does PCH work with local community-based organization in each community?

The Pathways Community HUB partners with local community-based care coordination agencies (CCAs). A PCH cannot employ CHWs or community-based care coordinators and must contract with organizations that can employ CHWs. A certified PCH must remain neutral within the Pathway community network. The PCH will establish contracts with local community-based organizations that agree to become part of the network and agrees to use standardized data collection tools and Pathways.

Do the payors pay for the cost of the actual community services or the cost of the effort, not just the financial return/outcomes?

It is a requirement of the PCH approach that contracts with payors must be at least 50% tied to completed Pathways (resolved risks). The Pathways Community HUB Institute has developed payment codes and modifiers to track, and invoice completed Pathways. Each Pathway is assigned an outcome-based unit (OBU) based on the average amount of time it takes to complete the Pathway and the realization that not all Pathways started will be completed. The remainder of the payer contract should also compensate for work outside of Pathway completion, including requirements of the PCH around quality improvement, invoicing, and reporting.

What are the 21 Pathways, how were they derived, and how do you measure health outcomes?

The 21 Pathways represent individually modifiable risk factors that can be impacted through community-based care coordination. PCHI has established the Risk Reduction Research Network (RRRN) and partners with researchers studying the impact of the PCH approach. The Pathways directly connect with the risk factors and are used as a tool to measure risk mitigation. Pathways have been used in care coordination work since 2000 and have been updated to reflect improvements in our ability to track individually modifiable risk factors.

How do the partners work together? Who does PCH contract with?

Contracted care coordination agencies (CCAs) become an integral part of the PCH network. Written contracts are developed between the PCH and the CCA. There are specific requirements that the CCA must meet through the PCH certification requirements. For example, the CCA must agree to use the PCHI data collection tools and Pathways, employ at least a .5 FTE community health worker dedicated to working with the PCH, and agree to the outcome-based payment methodology. The PCH does not contract directly with direct service providers or referral partners.

How does this fit in with other Care Coordination efforts?

The Pathways Community HUB approach can fit it well with other care coordination efforts. It is meant to streamline and coordinate existing community-based care coordination efforts that already exist in a community or region.

Who pays for the PCH, how much does it cost to implement?

The majority of Pathways Community HUBs begin with financial support from foundations or grants. PCHI advises that a new PCH obtain 2 years of funding before implementing the model. The cost depends on the size and scope of the PCH. It is best to start small and expand the Pathways Community HUB over time. For example, many PCHs start with one priority population or one targeted geographic area and expand to more at-risk individuals or a larger service area after gaining initial experience with the approach. Costs are determined by many factors: which organization takes on the PCH role (existing or new); staff for the PCH; technology solution; training needed for community health workers and their supervisors; and legal expense.

How do the CHWs know who to help and outreach to? Are there marketing efforts in the community? And how do the community members know to trust the CHWs?

Training for CHWs is very important. A certified Pathways Community HUB must show that their CHWs and supervisors meet minimum training requirements to participate in the network. Even if a community has a CHW training program, CHWs need to learn how to use the data collection tools and 21 Standard Pathways with their outreach. One of the key functions of the PCH is to reach out to the larger community and provide information and education on how the PCH operates. Most PCHs do have marketing strategies in place to reach community members, providers, and referral partners.

How does a PCH become Certified?

A PCH becomes certified by meeting the five steps to implementation:

1) Community Engagement and Planning
2) Fulfill the 11 Prerequisites for HUB Certification Eligibility
3) Fulfill PCH Certification Program's 17 Standards
4) Obtain Certification through PCH Institute or certified HUB peers
5) Stay Certified

Please click here for additional information and to see the prerequisites and standards.

Interested in implementing a PCH in your Community?

Contact SJC Core Team Liaison, Betty.Sun@wellness.phi.org.

Through bold, innovative solutions and shared values, we can impact the lives of those who need us the most, removing barriers to quality care and community resources.

PCH Impact

Improved quality of care created by a comprehensive network, delivering coordinated services to vulnerable populations

Lowers agency costs by eliminating redundant and duplicative efforts

Ability to track referrals and outcomes, develop a collective data system and ultimately improve community health outcomes

Promotes efficiency and collaboration among partner organizations

Access to trusted community health worker during evenings and weekends to address barriers

Strengthen and empower families

Glossary

Assessments: A standardized assessment (Visit Form) is used to evaluate a community member's social, medical, and behavioral needs. This assessment is used by all certified PCHs and helps guide the CHW to identify a community member's modifiable risks.

Care Coordination Agency (CCAs): Local organizations who employ community health workers, social workers, Promatoras, community-based care coordinators, navigators and other staff who assist and connect community members to social service, healthcare, and behavioral health providers. CCAs can be community-based organizations, federally qualified health centers, behavioral health organizations, schools, and other organizations.

Community-based Care Coordination: Community-based care coordination is provided by care coordinators located in a community setting. In the PCH approach, CHWs or other community-based care coordinators provide most of their interaction with community members in their home (virtual visits during COVID-19 pandemic). An organization that provides telephonic care coordination or requires community members to come to a location for services would not meet the definition of community-based care coordination. For the PCH approach to work well, it's important for the community-based care coordinators to have strong connections and partnerships with other care coordinators and case managers based in the hospital, health plan or behavioral health systems.

Community Based Organization (CBO): Local community service providers that address a community member's social needs. The community-based care coordinators or CHWs mentioned above will connect individuals to these service providers to close out the Pathways. Example: Food bank, homeless shelter, community health centers.

Community-based Care Coordinators / Community Health Worker (CHW) / Promotoras: Trusted community members who have been trained to connect community members to services, these individuals are employed by the Care Coordination Agency (CCA). The PCH model trains these CHWs to work with the individual until their social, healthcare, or behavioral health needs are resolved or the Pathway is completed. These CHWs address any barriers that arise and will follow up with the individual and their family members until their needs are addressed. Depending on location, several PCHs are providing services to Latino communities with Spanish speaking CHWs.

CHW Training: Pathways Community HUB Institute provides CHW training for communities that do not have access to CHW training. Our training weaves the Pathways and data collection tools required in the PCH approach throughout training. The PCHI training is also recognized under the Ohio Board of Nursing as an approved training program for CHW certification in Ohio.

There are minimum training requirements that a certified Pathways Community HUB must meet around CHW training. The PCH can choose any training approach as long as they can meet the minimum training requirements. These requirements include the skills and competencies set forth by The Community Health Worker Core Consensus Project (the national C3 project).

Pathways Community HUB: A Pathways Community HUB is a neutral, transparent, and accountable organization that is based in the community or region being served. PCHs complete a national certification program to confirm fidelity to the PCH approach. The PCH also provides training, technology support, data management, quality improvement, supervision, training, and related services to the network.

Outcome Based Unit (OBU): The Pathways Community HUB Institute has developed Outcome Based Units (OBUs) for all 21 Standardized Pathways. The OBU represents the average amount of effort needed by the community health worker to complete the Pathway and resolve the risk factor. Example: Housing Pathway completion is documented after the at-risk individual has maintained safe and stable housing for 30 days. The Housing Pathway is 15 OBUs.

One of the standards that a certified Pathways Community HUB must meet is to demonstrate outcome-based contracts with a minimum of two payers. Specifically, contracts with the PCH must demonstrate that a minimum of 50 percent of all payments are related to intermediate and final Pathway steps/outcomes using nationally standardized Outcome Based Units (OBUs).

Pay for Outcomes: The Pathways Community HUB establishes financial agreements with funders including managed care organizations (MCOs), local and state government, public health, foundations, grants, and others. The PCH provides payment to the CCAs based on confirmed completion of a Pathway and other contracted work.

Pathways: A specific standardized “Pathway” is assigned for each of the individual’s modifiable risk factors and is used to identify, track, and mitigate the risks. An individual may have multiple Pathways assigned simultaneously. Completion of the Pathway indicates that the person has obtained an evidence-based intervention to address the risk factor. Example: Behavioral Health Pathway: at-risk individual kept and attended 3 scheduled behavioral health appointments in a row.

Pathways Community HUB model: The PCH approach provides an accountable framework for communities who want to build infrastructure for effective community care coordination proven to document both outcome improvement and cost savings. National certification provides health plans, funders, and policy advocates assurance that community networks have met specific operational, health outcome, and cost of care improvement benchmarks that have been demonstrated in peer reviewed research to produce positive outcomes and cost savings.

The Pathways Community HUB (PCH) model focuses on the comprehensive identification and reduction of risk in a culturally connected pay-for-performance approach.

Pathways Community HUB Institute (PCHI):
The Pathways Community HUB Institute (PCHI) is a nonprofit organization that supports the Pathways Community HUB model through national certification and technical assistance to communities. PCHI was launched to assure fidelity to the model through implementation of the national Pathways Community HUB Certification Program supported by the Kresge Foundation.

Risks:
PCHI has partnered with researchers to better understand the medical, social, behavioral health, and safety risks that can be addressed through community-based care coordination. Specifically, the PCH approach looks at risks that are modifiable at the individual and family levels that could be reduced through intervention and broader care coordination efforts. These risks have been translated into Pathways.

Technology Platform:
The PCH utilizes a technology platform to track, collect, and report on assessments and Pathways being completed by the CHWs. These technology platforms need to meet minimum requirements to be certified by the PCHI.