APPENDIX A

Community Pathways HUB
Certification Prerequisites and Standards

CHAP
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Pathways Community HUB Certification Standards
Background/Rational and Requirements

HUB PREREQUISITES

PREREQUISITE #1
The HUB is an independent legal entity or an affiliated component of a legal entity.

Background/Rationale
The HUB is a legal entity that has legal capacity to enter into agreements or contracts, assume obligations, incur and pay debts, sue and be sued in its own right, and to be held responsible for its actions. The HUB 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;
b. Copy of IRS Determination letter with Tax ID/Employer ID number (EIN); and/or
c. DUNS Number.

PREREQUISITE #2
The Pathways Community HUB has been operating for a minimum of six months using standardized Pathways.

Background/Rationale
The HUB is beyond the planning phases of development and has utilized standardized Pathways within a network of care coordination agencies (see Appendix A).

Review Items to Achieve Prerequisite #2
a. Memorandum of Understanding (MOU), contracts, financial reports, or other formal documentation that substantiates a minimum of six-months using standardized Pathways.

PREREQUISITE #3
The HUB is based in the community and / or region it serves.

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

Review Items to Achieve Prerequisite #3
a. Description of the HUB service area, (i.e., geographic service area - census tracts, zip codes, county, region); and
b. Physical address of the HUB; and
c. Physical addresses of contracted care coordination agencies; and
d. If the HUB covers more than one county (regional), then an explanation of how and why this service area was established.

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
a. List of all communities and / or regions using the Pathways Community HUB model in the state; and, if applicable
b. Identification of any service area overlap with another HUB, an explanation of why an overlap exists, and documentation of how the overlap is addressed.

PREREQUISITE #5
The HUB reviews and / or conducts community needs assessments.

Background/Rationale
A community needs assessment, which includes local data specific to medical, behavioral health, social, environmental, and educational factors, guides the HUB 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 of the HUB's catchment area that includes local data related to the medical, behavioral health, social, environmental and educational needs and opportunities; and
b. Description of how the HUB uses the community needs assessment to identify populations to be targeted for community care coordination services.

PREREQUISITE #6

The HUB coordinates a network of care coordination agencies serving at-risk clients.

Background/Rationale

To promote positive health outcomes and cost savings, the HUB connects those who are at-risk to a care coordinator, and ensures the client receives coordinated medical, behavioral health, social, environmental, and educational services.

Review Items to Achieve Prerequisite #6

a. Contracts, MOUs, or other legal documents (or representative portions thereof) describing the relationship between the HUB and at least two care coordination agency members; and
b. List of all of the contracted care coordination and referral agencies; and
c. List of services provided by each care coordination agency member, and their eligibility requirements; and
d. Attestation that there is *at least* one .5 FTE community care coordinator at each care coordination agency (see Appendix B).

PREREQUISITE #7

The HUB uses standardized Pathways.

Background/Rationale

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

Review Items to Achieve Pre-requisite #7

a. List of all standardized Pathways currently being used by the HUB (see Appendix A).

PREREQUISITE #8
The HUB has contracts with more than one payer.

Background/Rationale
To help ensure comprehensive and sustainable care coordination services, the HUB has diverse and multiple revenue sources.

Review Items to Achieve Prerequisite #8
a. Contracts (or representative portions thereof) with a minimum of two payer(s).

PREREQUISITE #9

The HUB aligns payments with measured outcomes in its contracts with payers and care coordination agency members.

Background/Rationale
Standardized Pathways link billing codes to Pathway steps. Payment for Pathway steps / outcomes is a key component of the HUB model, and promotes accountability, quality, equity, health improvement, and value.

Review Items to Achieve Prerequisite #9
a. Contracts or other financial documents (or representative portions thereof) demonstrating that a minimum of fifty percent of all payments are related to intermediate and final Pathway steps / outcomes.

PREREQUISITE #10
The HUB complies with the Health Information Privacy and Accountability Act (HIPAA).

Background/Rationale
Ensuring strong privacy protections is critical to maintaining individuals' trust in their medical and behavioral 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 HUB comply with the Health Information Privacy and Accountability Act (HIPAA).

Review Items to Achieve Prerequisite #10
a. HIPAA protection policies in the HUB operations manual;
b. Signed HIPAA compliant agreements between the HUB, care coordination agencies, service providers, and others; and
c. Documentation that all HUB personnel 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 certificate of training completion.

PREREQUISITE #11

The HUB is a neutral entity and operates in a transparent and accountable manner.

Background/Rationale

The HUB does not refer clients to any community care coordinator that it may employ. The HUB is responsible for referring clients based on the services, competencies, and capacity of its care coordination agency members, and the needs of the clients. Therefore, the HUB needs a transparent and objective process and criteria to ensure that the referral process is unbiased.

Review Items to Achieve Prerequisite #11

a. Copy of the conflict of interest policy; and
b. Copy of conflict of interest form template that is signed by HUB personnel, advisors, and Board members; and
c. Copy of a policy that describes the criteria and process to refer clients to care coordination agency members. This policy includes how referrals are distributed when a client meets the eligibility requirements of two or more care coordination agency members; and
d. Confirmation that the HUB does not employ community care coordinators participating in the HUB's care coordination agency network.

HUB STANDARDS

Organizational Infrastructure Standards

1. **The HUB has infrastructure and capacity to fully implement the Pathways Community HUB Model.**

   Background/Rationale
   The HUB must have adequate infrastructure to track and document the delivery of services to those at-risk and must have the capability 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
   a. Copy of the HUB's organizational chart that includes all departments, personnel and reporting structure. If the HUB is an affiliate of a larger umbrella organization, then the relationship should be reflected; and
   b. Copies of job descriptions for each key HUB employee.

2. **The HUB Director possesses the experience and skills to effectively manage the HUB including a commitment to community health and equity as well as strong business and communication skills.**

   Background/Rationale
   The HUB Director must have diverse competencies to ensure the success and sustainability of the HUB. Key competencies include, but are not limited to:
   - Engaging and partnering with community care coordination agencies serving at-risk populations;
   - Developing and maintaining relationships with diverse stakeholders including care coordination agency members, providers, and payers;
   - Developing and managing contractual relationships with payers; and
   - Developing and managing performance outcomes and contractual compliance.

   Review Items to Achieve Standard 2
   a. Copy of HUB Director's job description; and
   b. Copy of HUB Director's resume(s) and / or curriculum vitae; and if applicable,
   c. Additional resume(s) of staff or subcontractor(s) in key positions complementing the competencies of the HUB Director.

3. **All HUB staff receive Pathways Community HUB training.**

   Background/Rationale
   The 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 HUB operates to assure its effectiveness and efficiency.

Review Items to Achieve Standard 3

a. Copy of training outline; and
b. Attestation that all new staff receive comprehensive training about the HUB model with updates as needed (see Appendix B).

Governance & Administration Standards

4. The HUB engages and is advised by a Community Advisory Board.

Background/Rationale

To ensure the HUB understands and meets the needs of those who are at-risk, the HUB 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 HUB.

Review Items to Achieve Standard 4

a. List of Community Advisory Board members, including brief biographies for each; and
b. Description of the roles and responsibilities of Advisory Board members; and
c. Description of how the Advisory Board reflects the community/region that the HUB serves; and
d. Minutes from Advisory Board meetings that occurred within the past six months.

5. The HUB has written agreements with its care coordination agency members.

Background/Rationale

To ensure clarity and transparency of the roles and responsibilities of, and financial arrangements between, the HUB and care coordination agency members, written agreements are needed.

Review Items to Achieve Standard 5

a. Current operational and fiscal agreements (or representative portions thereof) with each care coordination agency member, e.g., contracts, MOU, Business Associate Agreements.

6. The HUB is committed to continual quality improvement.

Background/Rationale

The HUB is responsible for monitoring and improving the quality of care coordination services provided to those who are at-risk. Therefore, the HUB must have Quality Improvement policies and a plan. The HUB 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 HUB Quality Improvement (QI) Plan, that includes but is not limited to:
    1. Description of HUB's mission, program goals, and objectives; and

2. Description of how QI projects are selected, managed, and monitored; and
3. Description of quality methodology (such as PDSA, Six Sigma) and quality tools/techniques to be utilized throughout the HUB and with its members; and
4. Documentation of quality improvement reviews; and
5. Documentation of how identified quality improvement opportunities add to or change existing policy and assure appropriate additional trainings for HUB and care coordination agency members' personnel.

b. Copies of the referral policies and procedures, that include at a minimum:
   1. Required number of attempts to reach the client; and
   2. How the attempts to reach the client are documented; and
   3. Strategies used to reach the client, e.g., phone, mail, email, social media, home visit; and
   4. Time frame for contacting the client; and
   5. Communicating outcome of the referral to the HUB; and
   6. Communication from the HUB back to the referral source.

c. Copies of policies and procedures addressing duplication of services, that include at a minimum:
   1. New client enrollment process; and
   2. How duplication is identified, documented, and eliminated, when appropriate; and
   3. How clients with more than one identified community care coordinator are managed, when this is necessary.

d. Copies of policies and procedures addressing home visits that include at a minimum:
   1. Home visiting frequency; and
   2. How attempted visits are documented; and
   3. How contacts between visits are documented; and
   4. How educational information is chosen and given by care coordinators; and
   5. Safety measures.

e. Copies of policies and procedures addressing supervision, including at a minimum:
   1. Frequency of performance reviews; and
   2. Frequency of caseload reviews; and
   3. Community care coordinator to client ratios to determine maximum caseload per full- and part-time equivalent care coordinators; and
   4. Supervisor to community health worker ratio; and
   5. How a client'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. Timing of supervisor review following the CHW comprehensive assessment; and
   7. Action taken by the CHW and supervisor when urgent issues are identified.

f. Copies of policies and procedures that outline the HUB's role in identifying and addressing performance issues with care coordination agencies.

7. The HUB and its care coordination agency members have effective Human Resource policies and procedures.

Background/Rationale
To ensure equitable and consistent application of HUB policies, procedures and benefits, the HUB's personnel must be knowledgeable of human resources policies and procedures that govern the HUB.

Review Items to Achieve Standard 7

a. Copy of the HUB Human Resource Manual that includes, at a minimum:
    1. Training requirements;
    2. Policies regarding hiring, termination, outstanding performance, dress code, complaint procedures;
    3. Background check information;
    4. Sexual harassment and discrimination policies;
    5. Disciplinary policy;
    6. Problem-resolution process;
    7. Professional boundaries education; and

b. Attestation that each contracted care coordination agency has human resources policies and procedures that include at a minimum the above (see Appendix B).

8. The HUB and its care coordination agency members are culturally competent organizations that provide culturally and linguistically proficient services.

Background/Rationale
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.

Review Items to Achieve Standard 8

a. Copy of the HUB's organizational and workforce development policies and procedures specific to cultural and linguistic competencies; and

b. Attestation that each contracted care coordination agency has organizational and workforce development policies and procedures in place that assures culturally and linguistically competent services (see Appendix B).

Community Care Coordination Workforce Standards

9. Community care coordinators are supported and supervised by a competent professional, working within the scope of their license.

Background/Rationale
Community care coordinators work with clients and the community-at-large to address the needs of at-risk individuals. Supervision of community care coordinators by a licensed professional is a key to providing quality services.

Review Items to Achieve Standard 9

a. Supervisors are licensed professionals working within the scope of their profession; and
b. Resume and / or curriculum vitae for each Supervisor.

10. Community Health Workers are supported by effective and culturally competent supervisors.

Background/Rationale
When a community care coordinator is a Community Health Worker (CHW), it is important that she/he is supported and supervised by a registered nurse, licensed clinical social worker, or another health, social, or behavioral health professional that understands and values the role of CHWs. CHW Supervisors must be culturally competent, attend CHW trainings, and be proficient in supervising CHWs.

Review Items to Achieve Standard 10

a. CHW Supervisor job descriptions; and
b. CHW Supervisor's resumes and / or curriculum vitae; and
c. Documentation that the CHW Supervisor completed the minimum CHW training requirements (see Appendix C).

11. Community Care Coordinators have comprehensive training, education, and support.

Background/Rationale
Education, training, and support for community health workers and non-CHW community care coordinators are essential to achieve improved health outcomes for those at-risk. CHW and non-CHW community care coordinators must meet the minimum training requirements.

Review Items to Achieve Standard 11

a. Documentation that each community care coordinator has completed comprehensive training (see Appendix C).

Scope of Services Standards

12. The HUB ensures care coordination services address the medical, behavioral health, social, environmental, and educational needs of those who are at-risk.

Background/Rationale
The HUB must collect client demographics and other client information to effectively address the medical, behavioral health, social, environmental, and educational risk factors. In order to improve health outcomes, an individualized care plan must be developed to prioritize and address the client's risk factors.

Review Items to Achieve Standard 12

a. Copy of demographic intake form; and
b. Copy of the comprehensive checklists; and
c. List of other tools used to gather information and develop individualized care plans.

13. The HUB assesses and monitors each client's risk status.

Background/Rationale
To ensure an at-risk individual's risk factors are being addressed and that limited resources are being used efficiently—the HUB assesses and monitors the progress of addressing each client's identified risk factors. The HUB aligns the intensity of care coordination services with the client's level of risk.

Review Items to Achieve Standard 13

a. Copies of the policies and procedures that describe how data is used to identify at risk individuals, and how risk factors are addressed; and
b. Documentation of how often and when individual risk assessments occur; and
c. Explanation of how risk measurement translates into intensity of care coordination services.

14. The HUB tracks, monitors, and reports on client services.

Background/Rationale
The HUB and its care coordination agency members must effectively and efficiently serve those at-risk. The HUB must document and report on the status of its clients.

Review Items to Achieve Standard 14

a. Copies of reports that include, at a minimum:
    1. Number and type of clients served; and
    2. Risk tracking over time; and
    3. Information by client, care coordinator, agency, and HUB;
        - List of standardized Pathways,
        - Initiated Pathways,
        - Pathways in Process,

- Completed Pathways, and
- Finished incomplete Pathways

15. The HUB promotes collaboration, intersectoral teamwork, and community-clinical linkages.

Background/Rationale
The HUB facilitates team-based multidisciplinary services to help ensure quality and continuity of services that may involve communication and data sharing among multiple practitioners, agencies, community care coordinators, and the client. At a minimum, the client's team includes the client, primary care provider, and a community care coordinator.

Review Items to Achieve Standard 15

a. Description of the mechanism used to communicate with all members of the client's team, e.g., Electronic Health Record, registry; and
b. Samples/screen shots of documents and tools used to communicate information across agencies and among client teams.

Accountability Standards

16. The HUB conducts a cost benefit analysis.

Background/Rationale
In order to sustain community care coordination services and the Pathways Community HUB, a cost-benefit analysis must be conducted to determine the financial impact of HUB services and if service efficiencies, cost savings, and health improvements are achieved.

Review Items to Achieve Standard 16

a. Copy or description of the cost-benefit analysis used; and
b. Documentation that the cost benefit analysis is used to improve the quality and efficiency of the HUB's operations.

17. The HUB communicates its strategies, programs, and progress to the community it serves.

Background/Rationale
The HUB is committed to improving the health of the community, and is responsible to the community. Therefore, the HUB regularly communicates and reports its strategies, progress, and challenges to its funders, policy makers, care coordination agency members, clients, and the community at-large.

Review Items to Achieve Standard 17

a. Copy of most recent report to the community that includes, but is not limited to:
   1. A description of HUB 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 HUB initiatives; and
   3. Future strategies to address unmet needs; and

b. Copy of the HUB's dissemination plan.

APPENDIX

A.

Appendix A -Pathways

B.

Appendix B - Attestation Form

C.

Appendix C - Training Req.

APPENDIX B

Rockville Institute
Certification Costs

Rockville Institute
Research for the Advancement of Social Science

Pathways

Pathways Community HUB Certification Program

Fee Structure

Initial certification ($15,000) requires a comprehensive assessment of HUB compliance with PCHCP Prerequisites and Standards. This process involves application review, technical assistance, document reviews, and site visits. Granting of certification designation is contingent upon HUB compliance with 90% or more of the Standards and all prerequisites.

Desktop Review ($5,500) consists of the same process as conducted during the initial certification, with the exception of a site visit. The desktop review occurs two-years from the date of initial certification. The intent of this two-year review is to assess compliance, identify changes in the HUB's services, and to ensure continuous quality improvements are actively being implemented by the HUB and its network of care coordination agencies.

Re-Certification ($15,000) consists of the a full comprehensive review and includes a site visit. Re-certification remains in effect for 4 years.

APPENDIX C

Project Action Plan
Format and Sample

Project Action Plan Format and Sample

Using the format below, provide each required, numbered goal, numbered SMART objectives, approach (How will you do it?), activities (What will take place), evaluation (Anticipated results, which tools used to collect data), responsibilities (Who will be responsible?), and timeline (Time frame in which each activity will take place.)

Goal 1: Replicate or Expand the Pathways Community HUB

Objective 1.1 By the end of first quarter, ABC Agency will have key staff attend and participate in the Pathways Model and begin the internal process to train all HUB care coordination agencies.

Approach: Agency ABC will require all key staff to attend the training and train HUB care coordination agencies.

Activity: Agency ABC key staff will attend training and will hold HUB model training meetings with care coordination agencies

Evaluation: Sign in sheets of key staff at training and sign in sheets of participating care coordination agencies

Number of key staff and Community Care Coordination Agencies who participate in training.

Responsibility: HUB Program Director

Timeline: Training number one to be held between January 1, 2016 and January 31, 2016

Training number two to be held between February 1, 2016 and February 29, 2016

Objective 1.2 Insert SMART objective here

Approach: List approach(es) here

Activity: List activity(ies) here

Evaluation: Insert evaluation strategy here

Responsibility: Provide names of those who will be responsible for this objective and activities

Timeline: List projected activity dates here.

Objective 1.3 Insert SMART objective here

Approach: List approach(es) here

Activity: List activity(ies) here

Evaluation: Insert evaluation strategy here

Responsibility: Provide names of those who will be responsible for this objective and activities

Timeline: List projected activity dates here.

Continue with each required goal and objective as outlined in the Proposal Narrative – Project Action plan.