Connecting Those at Risk to Care

A Guide to Building a Community "HUB" To Promote a System of Collaboration, Accountability, and Improved Outcomes

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Prepared for:
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Developed by:
Community Care Coordination Learning Network

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Contents

Introduction and Purpose

This guide is intended to help improve the system by which at-risk individuals within a community are identified and connected to appropriate health care and social services. The audience includes a diverse set of public and private stakeholders involved in coordinating care for at-risk individuals. This guide may be of interest to Federal, State, and local governmental agencies and community-based organizations, such as safety net clinics, hospitals, public health departments, and charitable organizations. It may also interest private practitioners and private businesses.

The guide describes current problems in serving at-risk populations and the implications of these challenges. It then lays out a step-by-step process interested organizations can use to develop the infrastructure within a local community to improve the quality, efficiency, and coordination of services. Wherever possible, this guide includes brief descriptions of initiatives that have built this type of infrastructure, along with links to related tools and resources.

Known as a "Pathways Community HUB," this infrastructure provides tools and strategies needed to ensure that at-risk individuals are served in a timely, coordinated manner. The HUB ensures that a person and populations are connected to meaningful health and social services that produce positive outcomes. HUBs help avoid duplication of effort and keep individuals from falling through the cracks. To accomplish its goals, the Pathways Community HUB provides centralized processes, systems, and resources that allow systematic tracking of those being served and that tie payments to milestones that improve the client's health and well-being.

Those working to develop HUBs within communities have used three overarching principles to guide their efforts, as outlined below:

- **Find:** Identify those at greatest risk.
- **Treat:** Ensure that they receive needed evidence-based health and social services (e.g., prenatal care, immunizations, chronic disease management, parenting education, housing, food, clothing).
- **Measure:** Document and evaluate benchmarks and final outcomes.

These principles are consistent with the fundamentals of high-quality health care and with the principles of public health assessment, policy development, and service assurances outlined by the Institute of Medicine.[1] They also continue to be the driving force behind the work of the 16 communities within the Community Care Coordination Learning Network (CCCLN, sponsored by the Agency for Healthcare Research and Quality or AHRQ), which produced this report.

Background: The System's Difficulty Identifying and Connecting At-Risk Populations to Care

The United States spends significantly more money per capita on health care services than any other nation in the world. Yet the United States lags behind most other developed countries in terms of key outcome measures, including infant mortality,[2] health equity,[3] and patient perceptions of safety, efficiency, and effectiveness. Much of the gap between the level of spending and the outcomes achieved can be attributed to the American health care system's difficulty identifying and serving at-risk populations. Gaps in care occur among many groups, including low-income individuals, uninsured people, racial and ethnic minorities, and those living in rural areas. Problems include:

- **Lack of access to care, leading to poor health outcomes:** Many Americans do not have adequate access to care. In fact, access problems have increased in recent years. In 2007, approximately 20 percent of the U.S. population reported not getting care or delaying needed medical care within the past year, up from 14 percent in 2003.[4] Inadequate access often leads to adverse health outcomes, such as health and functional decline, development of preventable health problems, advanced disease at time of diagnosis, and premature death.[5]
- **Barriers for people who are uninsured:** People without health insurance are less likely to get the right care at the right time in the right place. Too often, having no health insurance leads to preventable hospitalizations, declines in health status, disability, and premature death. Furthermore, the financial impact, particularly for people who are low income and uninsured, can be severe. Those who are uninsured are more likely than those with coverage to drain their savings or go into debt to pay for needed services.[6]
- **Barriers for people who are insured:** Low-income individuals and families with insurance often face barriers to accessing care. These include an inability to navigate the health care system, high copayments and deductibles, lack of sufficient information, lack of transportation, and difficult personal circumstances.[7] All of these contribute to poor health outcomes. In addition, some physicians may not be willing to take patients with certain forms of insurance, such as Medicare or Medicaid. A recent study found that access problems grew significantly in the insured population between 2003 and 2007.[4]
- **Additional barriers for racial and ethnic minority groups:** African Americans, Hispanics, and other ethnic and racial minorities face additional barriers to accessing care, leading to poorer health outcomes. For example, African-American women have substantially higher rates of low birth weight (LBW) babies than do White women,[8] while Hispanics have disproportionate rates of diabetes.[9] In addition, unequal access to care is one factor that leads to poor hypertension control among Hispanic populations.[10] Barriers to care include language and cultural differences, mistrust of the health care system, and financial constraints.
- **Additional barriers for those in rural areas:** Individuals living in rural areas represent 20 percent of the population, yet only 9 percent of practicing physicians work in these areas.[11] Therefore, rural residents often must travel long distances for care and experience long waits at clinics. Many do not receive the care they need in a timely manner.[12]
- **Barriers for other groups:** Other at-risk populations, including (but not limited to) prisoners, adolescents, and those facing large medical debt, also face barriers in accessing care, thus leading to poorer health outcomes.

Not identifying at-risk populations and connecting them to the care they need in a timely manner has two major consequences. First, as made clear by the examples above, health outcomes suffer tremendously. Second, overall health care costs are significantly higher because delays in preventive and primary care result in acute and chronic health issues that lead to expensive emergency department (ED) visits and hospitalizations. At-risk individuals may also visit the high-cost ED for relatively minor conditions that could have been treated in less costly settings (e.g., a primary care clinic). These ED visits occur because of transportation, poverty, and cultural barriers; because no providers will accept them (e.g., if they lack insurance or are underinsured); or because they have not been adequately educated on the appropriate setting in which to seek care. The net result is that those at risk do not connect to the most timely and efficient care. A very small group of at-risk individuals account for the lion's share of all health care costs. Approximately half of all health care expenditures are used to treat roughly 5 percent of the U.S. population,[13] and those at greatest risk represent the greatest weight of our national health disparity.

Inadequacy of Current Efforts

The process of identifying at-risk individuals and connecting them to the care and services they need is generally known as "care coordination." But the current business model for the provision of care coordination services remains inadequate to the task at hand. For example, the traditional system of accountability focuses on "activities" that may or may not be meaningful to and produce a benefit for the recipient of the service. And while more than one organization may provide care coordination services within a given geographic area, generally little or no collaboration occurs across these programs. Individuals fall through the cracks and efforts are duplicated (e.g., a high-risk pregnant woman may have multiple care coordinators who do not interact with each other). As outlined below, three fundamental problems exist with the current approach to care coordination—lack of meaningful work products, duplication of effort, and failure to focus on those most at risk:

- **The work products purchased often have no confirmed benefit to the individual served.** Most care coordination services are purchased through State and Federal government funding streams. These contracts typically purchase "work products" that have no meaning or clear positive impact on the clients being served. There is most often no specific requirement within the contracts to ensure that individuals served are connected to services. Payments are based on the number of individuals on a case list, visits or phone calls made, or notes charted.
- **Efforts may be duplicated or inefficient, leading to payments well above the "market value" of the service provided.** As noted, multiple programs typically exist to serve the same population, with no mandate to minimize service duplication. Thus, some individuals may have many care coordinators while others have none, resulting in wasted funds. In addition, for those with multiple care coordinators, often little or no effort is made to communicate across agencies to coordinate the services delivered. In fact, pooled funding approaches often allow the per-person costs to become quite high, well above the market value of the service provided.
- **There is no requirement or incentive to focus on those at greatest risk.** It takes less time, expense, and cultural competence to serve lower risk populations. Contracts that do not require service to those at greatest risk encourage agencies to "cherry pick" by serving low-risk individuals and avoiding those with the greatest need. For example, a care coordination program

may be charged with ensuring lead testing for 80 percent of a defined population of children. But if 85 percent of these children and their families live in a decent neighborhood with telephones and transportation, they will be easy to reach. However, the 15 percent of children at the greatest risk may have language barriers and live in poor areas without telephones or access to transportation. Serving those at greater risk will require much more time and related financial resources. Given an agency's existing mandate and associated funding streams, any "rational" manager would focus efforts on serving the relatively easy-to-reach, lower risk population.

Fixing these problems requires a fundamental change in the way care coordination contracts are written. Payments need to be scaled to recognize the time, resources, cultural competence, and skill required to effectively serve those at greatest risk. A system of care with incentives to seek out and effectively serve those at greatest risk works better than the current unintentional financial incentives to avoid them.

Health care interventions of prevention and early treatment have an evidence basis for improved outcomes and cost savings. These packages of effective intervention can be delivered to those at greatest risk with cost savings and disparity reduction.

American business has developed many service and product delivery and tracking structures that support accountability, quality, and confirmed service delivery. Airports, package delivery firms, technology firms, and many other business models hold tremendous examples, representing great complexity and variation. American business models and business leaders have been fundamental in ongoing development of the Pathways Community HUB.

Addressing the Problem Through a Pathways Community HUB

A Pathways Community HUB can support the "find-treat-measure" approach outlined earlier by providing the infrastructure to identify those at risk and coordinate and monitor the services provided. The HUB's primary goal is to ensure the timely provision of appropriate, high-quality, cost-effective, evidence-based services that will have a meaningful impact on those served.

By focusing on those at greatest risk, the intent of the HUB is to bring greater equality in service delivery and health outcomes. Those at risk may then achieve a similar level of access and disparity reduction.

The HUB brings public and private community stakeholders—including health and social service providers, elected officials, businesses, and representatives of the at-risk population being served—together to determine local health needs and create the appropriate support, services, and interventions most effective for addressing those needs. Through coordination, communication, and built-in incentives, the HUB strives to increase the effectiveness of care coordination services across multiple programs to ensure that those at risk are identified and connected to care in a timely manner.

To accomplish these goals, the HUB serves as a central clearinghouse that "registers" at-risk individuals and coordinates the care they receive, making sure that biological, psychological, and social needs are met. The HUB does not support any single agency, but rather strengthens and supports *all* health and social service providers in the region. The HUB eliminates duplication and waste and provides needed support services.

A Pathways Community HUB includes a system support structure that helps local agencies work as a team to focus on those at risk, ensure that they connect to both health and social services, and measure outcomes. Tracking important process measures, impact measures (confirmed connection to care), and outcomes across the community system of care supports efforts to improve quality, eliminate duplication, and increase efficiency. The HUB serves as an important part of regional infrastructure to support local agencies and funders in effectively serving those at greatest risk.

Rather than allowing care coordination providers to function in isolated duplicated silos, the HUB focuses them on working together as a team to reach those at greatest risk and ensure that they connect to critical prevention and early treatment, reducing cost and disparity. In short, the HUB connects those who are vulnerable with community resources and holds providers, practitioners, employers, families, and individuals accountable for the outcomes achieved.

A Step-by-Step Guide to Building a Pathways Community HUB

Pathways Community HUB: A Brief Overview of the Phases and Steps

Phase One: Planning the HUB

- Step 1: Form a planning group
- Step 2: Create a new umbrella organization or designate a lead agency
- Step 3: Conduct a complete community needs assessment
  - Determine priority health and social service needs
  - Choose target areas or populations for intervention
- Step 4: Discuss sustainability issues and develop a plan to secure funding

Phase Two: Creating Tools and Resources for the HUB

- Step 5: Build "pathways" or other benchmarks to create accountability
- Step 6: Create supporting tools and documents for care coordinators
- Step 7: Create incentives tied to outcomes
- Step 8: Develop systems to track and evaluate performance

Phase Three: Launching the HUB

- Step 9: Hire HUB staff
- Step 10: Train staff at participating agencies
- Step 11: Conduct a community awareness campaign

Figure 1: The Phases and Steps of Building a Pathways Community HUB

The remainder of this guide provides a three-phase, 11-step process for building a Pathways Community HUB. This process is intended to be a general guide rather than an exact roadmap, as local circumstances should dictate the actual steps undertaken and the correct sequencing of those steps. Regardless of the approach taken, however, it is critical that all Pathways Community HUB functions and services be planned and developed with ongoing input from representatives of the target population (i.e., at-risk individuals) and the care coordinators who regularly work with them and understand their needs. In fact, leaders of the most active Pathways Community HUBs consistently report that the insights and knowledge most critical to effectively serving at-risk individuals come from the clients themselves and those who serve them on a daily basis.

Phase One: Planning the HUB

Phase one involves the steps necessary to plan a Pathways Community HUB. These include identifying and bringing key stakeholders from the community together. This team works together to focus on priority needs and target populations. The issue of sustainability needs to be addressed in this beginning phase as well.

Step 1: Form a Planning Group

Step one involves bringing together key community stakeholders that show an interest in improving the delivery of health and social services to at-risk populations. It is imperative to include representatives from the targeted populations and the care coordinators who work with them. Once the planning group decides to commit to the Pathways Community HUB concept of collaboration, they will need to decide who will be responsible for the HUB. Examples of this step include:

- The Health Partners Initiative (HPI) and St. Elizabeth's Regional Medical Center invited representatives of organizations in the local community (Lincoln, NE) with similar missions to discuss how to address health disparities. Members of the coalition included physicians and representatives of the county health department, insurance companies, and other organizations.
- In central Indiana, representatives of St. Vincent's Health, community-based organizations, and the public at large in four counties came together to discuss the most effective ways to enhance access to care for at-risk individuals in their service areas. Each area had a significant, growing population of Hispanic residents and residents living in poverty.
- In many cases, community stakeholders are joined by representatives of Federal and State agencies. In Ohio, for example, representatives from the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) brought their expertise in evaluation and their familiarity with relevant literature and resources to the table. In addition, in Ohio and New Mexico, State departments of health and Medicaid agencies have been involved in helping with research, data collection and evaluation, and other aspects of this stage.

Key questions to consider in Phase One, Step One:

- Which organizations should be involved in the effort, and how can we get those not involved to come to the table? Candidates should include organizations already involved in care coordination within the community (e.g., health and social service agencies, local funders, policymakers and politicians, local charities, other community-based organizations), along with private businesses. The "net" should be cast wide when considering potential partners, particularly with respect to private companies that may have an interest in helping. It is desirable to have organizations involved with the process as early as possible.
- What are organizations within the group willing and able to contribute to the effort?

Step 2: Create a New Umbrella Organization or Designate a Lead Agency

Depending on the outcome of the initial discussions, a decision should be made as to whether there is a need to designate an existing agency as the lead for the effort, or to create a new, formal umbrella organization. In many cases, an existing organization with experience in building networks and tracking data can be designated to serve as the lead agency or convener. If such an organization does not exist or an agreement cannot be reached on a lead agency, the creation of a new entity likely makes sense. In either case, appropriate governance structures should be set up, typically through an advisory group made up of diverse community stakeholders. Whatever route is chosen, this organization will typically be responsible for providing the common infrastructure and other resources needed by community stakeholders to more effectively serve at-risk populations. Examples of both options exist:

Designated lead agency:

- In Toledo, Ohio, an existing hospital network (CareNet) took on the role of the designated lead agency.
- In Richland County, Ohio, a community-based nonprofit agency (Community Health Access Project) is the lead agency.
- In Texas, the Dallas County Medical Society serves as the lead agency.

New umbrella organization:

- In Indiana, St. Vincent's Health initiated the development of Rural and Urban Access to Health (RUAH). Community roundtables, which include representatives from the local school board, police department, fire department, church federation, Salvation Army, local hospital, free clinics, and social service agencies, serve as an informal board of directors to RUAH.

Step 3: Conduct a Complete Community Needs Assessment

Determine Priority Health and Social Service Needs

Local and regional data are examined to determine the most critical health and social service issues to be addressed by the HUB. Representatives of community-based programs, providers, and agencies should meet with at-risk individuals who are members of the target population to better understand the issues and barriers they face. For example:

- After RUAH chose to tackle access issues for low-income rural and urban residents, they began hosting community meetings. The purpose was to determine what services were currently being provided to these populations, where gaps in care existed, and which community organizations might be interested in partnering to fill those gaps.

- A more indepth example of this step comes from the Muskegon Community Health Project (MCHP), which participates in the local implementation of the Michigan Prisoner Re-entry Initiative, a statewide program designed to help newly released prisoners access services needed to facilitate successful reentry into the community. MCHP convened a small group of individuals—including former prisoners and representatives from hospitals, the county health department, and other agencies that address medical issues for low-income populations—to clarify the barriers to serving newly released prisoners.

Key problems identified during the assessment process included:

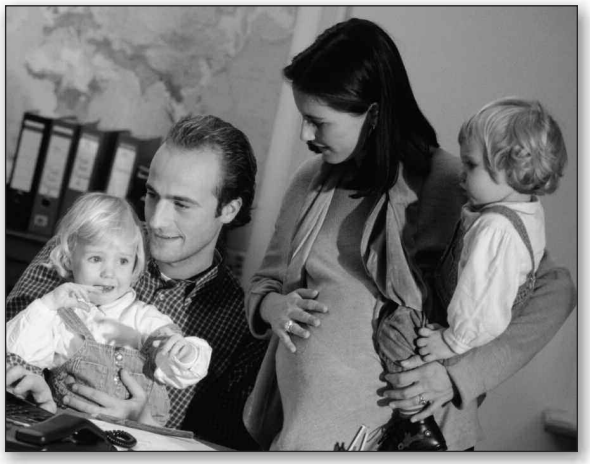
- **Lack of medical home and preventive care:** Newly released prisoners did not have a primary care physician. Therefore, there was no mechanism by which ex-prisoners could receive preventive care. Rather, parolees only sought care (typically from the health department, an ED, or the State-operated indigent care program) in response to an acute medical episode.
- **No medical history:** Newly released prisoners were not given their medical records documenting years of care.
- **No plan for infectious disease care:** Infectious diseases—such as tuberculosis and HIV/AIDS—were not being adequately tracked or addressed, with health department staff unaware of all parolees with infectious diseases. In addition, newly released prisoners often did not know how to locate organizations that provide infectious disease care, such as the local HIV/AIDS clinic.

After identifying these problems and related issues, MCHP staff interviewed experts about prisoner health and men's health to identify models for addressing the health needs of this population. The research revealed that prisoners may not have had appropriate health care before incarceration and may not have had their health needs fully addressed while in prison. Strategies chosen to address these problems included using the period of incarceration to stabilize the health of prisoners, monitoring prisoner health status, and ensuring a continuum of care, including transition of the medical record, once prisoners are released.

Choose Target Areas or Populations for Intervention

In followup to the initial discussions held during Steps 1 and 2, community stakeholders need to continue their conversations and conduct additional analyses designed to further screen the initial priority health and social issues. Then they need to choose specific target areas or populations for intervention. For example:

- Community Health Access Project (CHAP) in Richland County, Ohio, conducted a community needs assessment in partnership with 70 local health and social service agencies. These agencies prioritized the issues identified, agreeing to focus initially on reducing the incidence of low birth weight (LBW) infants. CHAP then used two strategies to identify a target population. First, a process known as "geocoding" was used to identify the highest risk areas for LBW infants (rather



than focusing the effort broadly across the community). CHAP representatives reviewed birth certificates for a 5-year period, plotting the addresses of LBW infants on a county map. This analysis led to the identification of two areas that represented 7 percent of the county's population but accounted for 30 percent of all LBW infants (representing nearly one in four births in this area).[14] Second, CHAP developed specific risk-scoring strategies to evaluate health and social service risk factors facing the population. Based on this work, CHAP decided to target families in these areas who faced significant barriers in accessing health care services. The same strategies can be used for most health and social service issues for which data are being collected.

- The Access Project in Boston, Massachusetts, worked with local stakeholders to determine the level of medical debt in a targeted area, including assistance on which indicators to measure and how to measure them. The Access Project also assisted in surveying the local community to determine the scope of the problem. The goal was to determine the approximate number of individuals who have medical bills or who have accrued medical debt that they are paying off over time.
- St. Elizabeth's Hospital in Lincoln, Nebraska, conducted a county needs assessment and then the Health Partners Initiative (HPI) staff reviewed the findings and invited input from public groups. Based on the assessment and this input, HPI and St. Elizabeth's leaders prioritized the recommendations and decided to focus on disparities in health outcomes (the first priority noted by all groups), especially among African-American women and Hispanic men.
- A group of stakeholders in the Cincinnati, Ohio, area, including health and social service providers, assessed the current level and capacity of care coordination and outreach services offered to high-risk populations. Then they designed a more strategic approach to assisting specific subpopulations in receiving appropriate care. The group jointly decided to target their first project on at-risk pregnant women.

Step 4: Discuss Sustainability Issues and Develop a Plan To Secure Funding

Once the needs of the target area or population are fully understood, the planning group needs to consider how to secure funding to start and maintain the Pathways Community HUB. Financial planning and funding efforts can begin earlier in the process while working through Steps 1 through 3. Often, multiple sources of funding may be available, including:

- Local foundations.
- Local, State, and Federal agencies.
- Third-party payers, such as Medicaid managed care organizations (through contracts with the HUB for services provided).
- Grant funding to finance the initial planning or startup of the venture.
- Payer contracts and other sources that often finance ongoing operations.

Examples of HUBs that have secured startup grant funding include:

- RUAH applied for funding from HRSA's Healthy Communities Access Program (HCAP), receiving a 4-year grant in 2001. (While this grant program is no longer available, other HRSA programs may be.) St. Vincent also formed a partnership with Indiana Health Centers, ADVANTAGE Health Solutions, Inc., Health and Hospital Corporation of Marion County, and the Butler University College of Pharmacy and Health Sciences. This partnership provided additional funding and in-kind assistance to RUAH.
- CHAP began with the support of several organizations, including the Richland County Foundation and the Osteopathic Heritage Foundation, Richland County Job and Family Services (TANF dollars), and an American Academy of Pediatrics Community Access to Child Health grant. These funds helped support the development of services to at-risk individuals in rural and urban areas, along with the development of the Pathways approach (see Step #5 for more details on this model).
- The Dallas County Medical Society applied for and received a HRSA grant to create the Project Access Dallas program. A portion of these funds was used to contract with faculty and staff at the University of Texas Southwestern Medical School's Department of Family Medicine to create an algorithm for program services. This included patient enrollment forms and protocols for communication between participating sites and Project Access Dallas. The Centers for Disease Control and Prevention provided additional funding to study the effectiveness of the program in reducing hospital emergency department utilization.
- The Health Foundation of Greater Cincinnati provided initial grant support for formation of Health Care Access Now (HCAN). HCAN services include: (1) coordinating care for pregnant women and high-risk populations with selected chronic diseases; (2) sharing registration, patient tracking, and reporting for AH100/HCAN "member" organizations and providing other back office support; (3) coordinating access to prescription assistance programs; (4) creating and supporting alternative service delivery arrangements that assist medically underserved persons to find a medical home, such as CincyCare, HealthShare, and Project Access; (5) advocating for health care coverage; and (6) providing community education that targets uninsured and low-income populations with regard to the medical home concept.

Long-term success requires finding an ongoing, stable source of funding, as initial grants usually cover only the startup phase. In some cases, these funds may come from service contracts between the Pathways Community HUB and government agencies (e.g., Medicaid managed care programs) or other organizations that fund services for at-risk individuals. Securing contract provisions that provide such funding requires convincing these organizations of the critical importance of connecting at-risk individuals to the care and services they need, and of the need to hold agencies accountable for doing so. Sharing information on the magnitude of the problem and the potential of the Pathways Community HUB to address it may be helpful in securing such contract provisions.

One example of an organization that has secured such funding comes from HCAN in Cincinnati, Ohio, which signed contracts with Medicaid managed care plans to pay for care coordination and support to pregnant women. HCAN is also working with other HUBs in Ohio to secure State support to pay for a centralized reporting and tracking system of care coordination services provided by State-funded agencies. Future funding sources are being explored with commercial insurance plans that

experience high costs due to inappropriate service utilization by high-risk members (e.g., overuse of the ED or specialist services). Another example comes from CHAP, which receives ongoing funding for operations from social service agencies and Medicaid managed care plans through contracts that tie payments to success in identifying and connecting at-risk individuals to evidence-based care. (See Step #7 for more details.)

Other potential sources of ongoing funding include annual "membership dues" from community stakeholders, with the level of contributions usually varying based on the size and financial resources of the organization. In Oregon, for example, a local health plan and hospital each contributes $10,000 annually to support HUB operations, while the county health department gives $3,000 and a local voluntary clinic pays several hundred dollars each year. Leaders within each stakeholder organization contribute because they recognize the value of the services the Pathways Community HUB provides.

Not-for-profit hospitals, in particular, may be good sources of ongoing funding. They are required to allocate money to community health improvement initiatives and must report such activity to the Internal Revenue Service each year. To meet their "community benefit" obligations, hospitals can provide both cash donations and in-kind support to such activities. For example, they could serve as the fiscal and administrative "home" for a HUB and may pay the salary and benefits of the Pathways Community HUB director. (In these situations, the hospital does not manage the HUB.)

Another option worthy of consideration is use of a local tax levy to support HUB operations. In Albuquerque, New Mexico, the county has approved a tax to fund the program Pathways to a Healthy Bernalillo County. This levy, similar to taxes that fund the local health department and children's services, provides a long-term source of funding that needs to be renewed only every 5 or 7 years. Local governments in many communities have the authority to initiate such taxes.

A final option to be considered is to urge governors, State legislatures, and other government officials to allocate funds to support HUB infrastructure development and ongoing operations. Oregon, for example, passed legislation providing $250,000 over 2 years to an organization known as HealthMatters of Central Oregon to support HUB development. The Ohio legislature is considering legislation that would provide funding to local HUBs as well. In New Mexico, the Pathways Community HUB is using data to petition the State Behavioral Health Purchasing Collaborative and the legislature for additional funding to support a centralized intake and voucher system.

While many promising options for securing sustainable funding exist, long-term success will require convincing those at the highest levels—including State and Federal legislators and the heads of major health foundations—of the critical importance of this work. Stakeholders should educate potential investors of the Pathways Community HUB's ability to eliminate duplication, improve quality, and reduce costs. HUB stakeholders also can push for payment and contract mechanisms that create the right incentives to connect at-risk individuals to the care and services they need.

To achieve sustainability, policymakers and funders must begin to request contractual principles and requirements that encourage agencies and providers to work in collaboration, eliminate duplication, engage at-risk populations, and ensure connection to care with measurable outcomes. This represents a great opportunity in health care system reform.

Phase Two: Creating Tools and Resources for the HUB

Once the planning group has been established, targeted areas or populations for the intervention have been identified, and initial funding has been secured, the next phase is to build the required infrastructure (e.g., tools, resources) to support community-based stakeholders serving the targeted at-risk populations. The overall goal is to remove duplication and improve the effectiveness and efficiency of such services.

Step 5: Build "Pathways" or Other Benchmarks To Create Accountability

In 2001, the Institute of Medicine charged health care organizations, clinicians, purchasers, and other stakeholders with "aligning the incentives inherent in payment and accountability processes with the goal of quality improvement."[15] In response to this report, a movement developed to change the system of accountability within the care coordination component of health care and social services. Approaches included the identification of key work products that represent a positive benefit for clients, the tying of financial incentives to completion of those work products, and the development of "action steps" that help facilitate success.

A variety of approaches exist for creating financial accountability for those serving at-risk populations. The most well-known of these is the Pathways model, developed by the Community Health Access Project. If properly used, this approach can shift the focus of health and social service systems away from activities to outcomes. The model represents the beginning of an effort to demonstrate the specific work products of care coordination. "Pathways" serve as a tool to document the specific work products that lead to a measurable outcome. In addition, Pathways provide the structure to tie financial incentives to outcomes. This encourages care coordinators to work with individuals in the community most at risk to overcome barriers and receive the interventions needed to improve outcomes and reduce costs. In other words, Pathways serve as the documentation and reporting system that captures each of the guiding principles outlined earlier—i.e., finding those at risk, treating them with evidence-based interventions, and measuring the results of these efforts.

Pathways can address many key health and social service issues, such as the following:

- A pregnancy pathway seeks to ensure adequate prenatal care in order to improve birth outcomes, such as reducing the incidence of low birth weight infants and infant mortality.
- A family planning pathway seeks to reduce the number of women with unintended pregnancies.
- A parenting pathway seeks to educate parents using evidence-based techniques to parenting. The goal of this pathway is to reduce parental stress and ultimately child abuse.

- A safety pathway incorporates education and an in-home safety checklist to ensure that all basic safety issues for children are addressed. The goal is to reduce unintended injuries.
- A medical home pathway monitors individuals who do not have ongoing primary care and confirms that they have connected to a patient-centered medical home.

Examples of two "logic models" for a pathway for at-risk pregnant women can be found in the Appendix.

Alternative Models to Pathways

Pathways are not the only model that can be used to track and create accountability for performance. For example, the Bridges to Excellence program (online at www.healthtransformation.net/cs/bridges_to_excellence) pays incentives to physicians caring for patients with diabetes and other chronic diseases based on performance with respect to the provision of specific, evidence-based processes, as compared to benchmarks. Ongoing tracking, incentive payments, and feedback help to promote continuous improvement.

The remainder of this section lays out a step-by-step approach to building a pathway. During this process, it is important to constantly seek input from both targeted at-risk individuals and community care coordinators, in order to understand their culture and environmental context, as well as the issues, barriers, and problems they face in accessing care. The goal is to make sure those being served understand, accept, and support all aspects of the program.

Define the "Completion Step"

Pathway development begins by bringing members of the at-risk community together with stakeholders who have experience and knowledge in serving them to define the desired "success" for the client—i.e., the outcome that successfully resolves the problem being addressed. This outcome should be clearly defined, easy to understand, based on accepted criteria, and measurable. The pathway has not been completed until this step has been achieved, and thus the problem successfully addressed. Examples of completion steps include the following:

- Health coverage: For a pathway designed to secure health coverage, the completion step would be confirmation that the client has insurance.
- Medical home: For a pathway designed to find a medical home, the completion step would be that the client was confirmed for an appointment with the provider serving as the ongoing source of primary care.
- Immunization: For a pathway designed to promote appropriate immunizations, the completion step would be the client being up to date on those immunizations.

Define the "Initiation Step"

The next step is to "go back to the beginning" by defining the "initiation step" or specifically the population that the pathway should serve and the specific problem that the pathway seeks to address. The initiation step helps ensure that the focus remains on a narrowly defined at-risk group or target region. The initiation step should connect clearly to the completion step. In many instances, defining this step is fairly straightforward. For example:

- For a health insurance pathway, the initiation step could be all children under 21 years and expectant mothers in a target area without health insurance.

- For a pregnancy pathway, the initiation step could be any woman in a target area confirmed to be pregnant through a pregnancy test.
- For an immunization pathway, the initiation step could be any child under 6 years of age in a target area behind on his or her immunizations.

In some cases, it may make sense to use established guidelines or standards to help determine the initiation step. For example, a pathway focused on helping better control diabetes, hypertension, or obesity might use established standards to define who qualifies for the pathway (e.g., anyone in the target area with a hemoglobin A1c level above 8 or blood pressure above 140/90). In many cases, it may make sense to further refine the target population to focus on those individuals who are clearly at risk, such as individuals without health insurance, racial or ethnic minority groups, people living in poverty, or people living in a particular geographic area known to face access issues.

Build a Series of "Action Steps" Designed To Achieve Desired Outcome

The final step in building a Pathway is to create the "middle"—i.e., the actions necessary to resolve the identified problem and thus achieve the goal laid out in the completion step. Action steps should be evidence-based interventions that build on each other to reach the desired outcome, as defined by the target population; the typical Pathway has no more than five action steps. Having more than five steps undermines the simplicity of the model and increases documentation requirements (since progress in achieving each step is tracked for every client).

Action steps define the most important interventions that need to occur, but they need not be completed in consecutive steps (i.e., one after the other), as the order can be changed to best fit the needs of an individual client. Often the first action step will be the one that takes the longest to complete or is a necessary prerequisite to other steps being completed, thus representing a "rate-limiting" step that could delay completion. For example, a pathway focused on childhood immunizations might list educating the family about the importance of immunizations as the first action step, since getting parents on board is a necessary prerequisite to moving forward in this area. Addressing the issues that cause these steps to be rate limiting can often improve the production process.

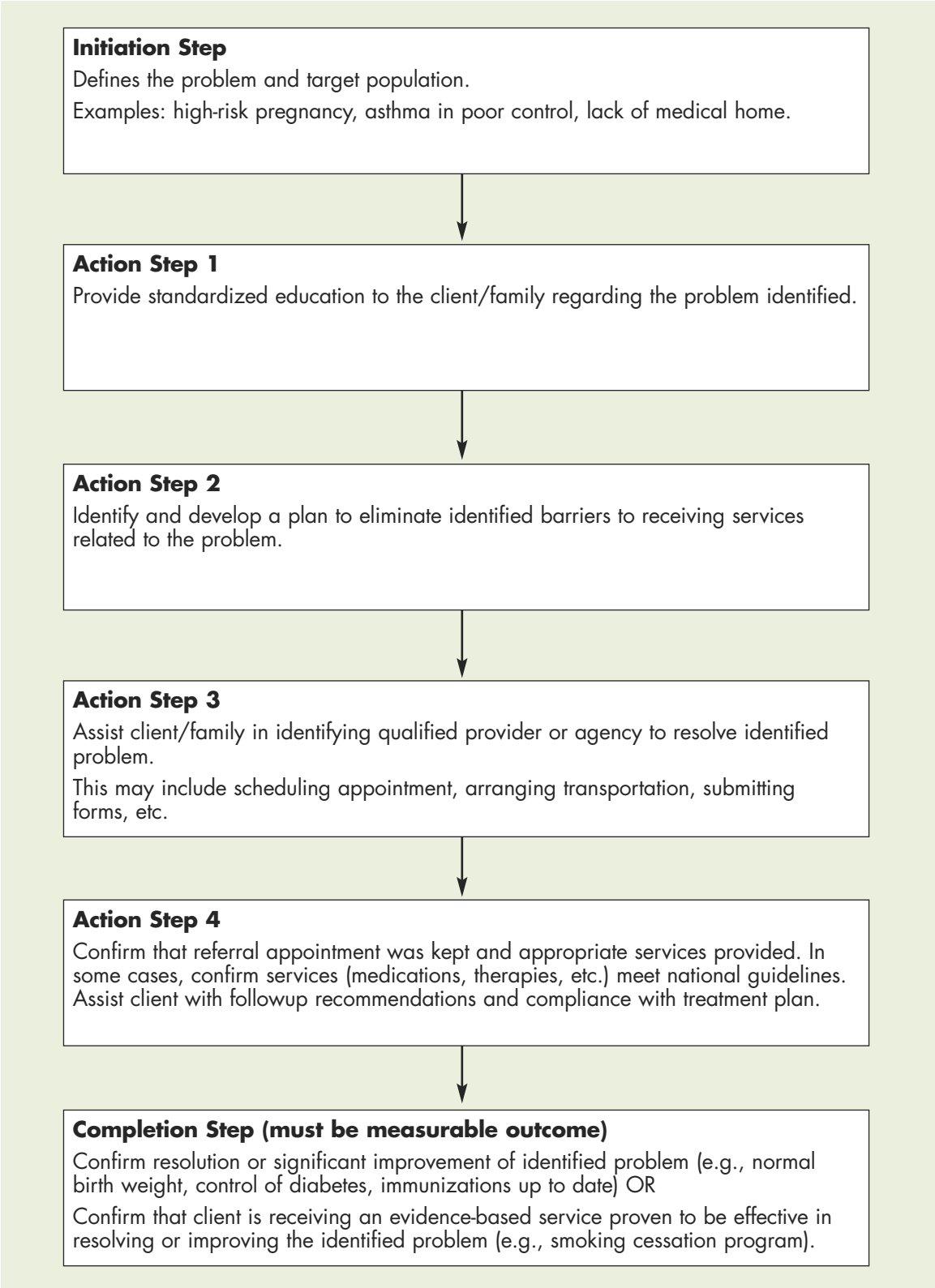
Examples of action steps for an immunization referral pathway (oriented to any child under 6 years of age in the target area behind on his or her immunizations) follow:

- Educate family about importance of immunizations and keeping appointments by reviewing education sheets. Families may also educate workers about their perspectives on immunizations, including any relevant cultural beliefs they may have.
- Identify and eliminate potential barriers to obtaining immunizations; barriers should be documented through specific codes.
- Schedule appointment with provider to provide needed immunizations.
- Confirm with provider that the child kept the appointment, and, if so, record current immunization status using an approved standard log. If appointment is missed, identify, document, and eliminate barriers to keeping the next appointment.

Putting It All Together: Pathway Examples

The chart on the next page provides a common structure on an entire pathway—including the initiation step, action steps, and completion step.

Figure 2. Pathways Common Structure



Examples of specific pathways can be found in the Appendix.

Step 6: Create Supporting Tools and Documents for Care Coordinators

Care coordinators and other individuals working with at-risk individuals need resources and tools to support their efforts. What follows is a brief description of a wide array of paper-based forms that can be used, although use of all of them is by no means necessary.

- **Consent form/notice of privacy practices/release-of-information forms:** These forms confirm that the client is comfortable having his or her information turned in to the central Pathways Community HUB. They also lay out the program's privacy policies (which need to conform with Health Insurance Portability and Accountability Act, or HIPAA, requirements), give permission for the collection of additional key information, and explain the client's rights and responsibilities (including complaint and grievance procedures). Examples of these forms can be found in the Appendix.
- **Intake/enrollment form:** Collaborating agencies should develop a standardized enrollment form that collects initial information that any agency might need, including basic demographic data, name of the agency enrolling the client, and date the information is submitted to the Pathways Community HUB. (The HUB often inputs information from these forms into an electronic database to identify potential duplication of services; see Step #8 for more details.) For example, whenever a partnering agency identifies an "at-risk" individual, a representative contacts the HUB, which reviews the database to determine if any other agency is already working with that client on the issues identified. If so, then the request is denied. Such duplication of effort is common. Two examples of intake forms can be found in the Appendix.
- **Assessment via checklist:** Assuming there is no duplication of services across agencies, the care coordinator works with the client to fill out a checklist that includes "trigger questions"—i.e., questions where a "yes" answer indicates that a pathway should be assigned to the client. The checklist is critical, since many clients will not volunteer important information (e.g., about domestic violence, mental health issues, losing health insurance coverage) unless specifically asked. Examples of checklists can be found in the Appendix. The checklist may also include a list of risk factors that help to determine the level of complexity or risk for each client so that appropriate resources and support can be provided. Such classifications also help in evaluating the performance of agencies and individuals—since expectations for outcome production should vary according to the underlying risk profile of the population being served. An example of a risk factor/barrier list can be found in the Appendix.

- **Care coordination plan and pathway documentation:** The care coordination plan lays out goals and objectives jointly developed by the client and the community care coordinator, with each party signing the form to signal commitment to the plan. The plan, which is driven by the specific pathway being used, is designed to move the client toward the achievement of

results/outcomes rather than processes. Progress toward the plan is reviewed informally at each home visit. After 90 days, progress may be reviewed more formally, with goals and objectives being adjusted as necessary. An example of the forms used to support development of this plan can be found in the Appendix. The care coordination plan may be accompanied by a set of additional forms that help to document the client's progress in completing pathways, such as pathway completion and discharge forms. Some HUBs also use a separate referral form, although frequently this will be a part of the care coordination plan.

In some cases, HUBs may create electronic systems or versions of these forms that can be used by community-based agencies and their staff. For example, care coordinators in Olympia, Washington, have access to software that includes features for identifying problem areas, documenting service needs and referrals, preparing applications for benefits, and maintaining case notes. CHAP has developed and is improving an information technology system that documents the enrollment, checklist, and pathway benchmarks, which tie to both performance and billing. Quality, billing, and overall performance can be measured by agency and across agencies. Dollars are tied to confirmation that those at risk are reached and connected to evidence-based interventions across the network without duplication.

Bringing in Outside Experts To Facilitate Pathway and Tool Development

Access El Dorado (ACCEL), a countywide collaborative in Placerville, California, focuses on helping low-income parents obtain health insurance, navigate the health care system, and obtain appropriate medical and mental health services for their children. ACCEL developed six pathways with the assistance of Dr. Sarah Redding, cofounder of the model. Dr. Redding attended an ACCEL workshop, held over several days, to help flesh out an initial set of pathways in greater depth. ACCEL then convened smaller workgroups of individuals who finalized the pathways, laying out details on how they would work, who would be responsible for various components, and other issues. Each group designed the pathway on paper and developed referral tools and forms (such as patient consent forms and participant agreements) needed for implementation. Cross-agency representatives met to identify appropriate patient interactions, staff roles and responsibilities, and patient handoff points. These discussions helped in developing standardized work steps and assigning responsibilities to the staff of the various agencies involved in the initiative. In many instances, internal agency work practices had to be amended to adjust for seamless cross-agency patient navigation.

Step 7: Create Incentives Tied to Desired Outcomes

Each collaborating agency in the community should be willing to have at least part of its payments tied to the achievement of meaningful work products and desired outcomes. For those using pathways, a portion of payments will typically be tied to completion of the pathway, although (as is discussed below in more detail) some payments may also be tied to completion of particular evidence-based action steps within the pathway. (The Appendix has a sample consulting agreement between the HUB and a community agency.) The action step that confirms the at-risk individual's connection to an evidence-based intervention is especially critical, since connection to this service can be used to qualify the agency worker for additional payment for achieving an intermediate outcome.

Individual community health workers, social workers, nurses, and others serving at-risk populations should also have a portion of their compensation tied to the achievement of outcomes and intermediate action steps. The goal is to transition the payment system away from process measures that have little or no impact on ultimate outcomes (e.g., phone calls, documentation of client lists). The focus should

be on milestones that represent confirmed connections to needed evidence-based care (e.g., prenatal visits) and desired outcomes (e.g., delivery of a normal weight baby).

In some cases, the HUB may directly contract with government agencies, Medicaid managed care organizations, and other entities and may in turn contract with collaborating agencies or individuals serving at-risk populations. In other instances, the HUB does not serve as the payer, but rather as the reporting structure and quality control function that funders use to ensure achievement of performance benchmarks for participating agencies. In these cases, the agencies can work with their contracting partners to set up the appropriate payment structures.

The following case example from CHAP describes how incentive payments can be tied to desired outcomes.

Background on CHAP

Since 2000, most CHAP contracts with government agencies and other organizations tie payments to the completion of pathways. In other words, CHAP does not get paid for having clients on a list, making phone calls, or providing a certain number of hours of service. Rather, payments are tied to the completion of pathways and to the achievement of meaningful steps for the individuals served. Initially, however, payment mechanisms to individual care coordinators did not change, with each receiving a fixed salary. There was no built-in incentive for care coordinators that excelled at connecting at-risk individuals to care.

To address this issue, CHAP developed a mechanism to tie part of the payments to care coordinators to the number of pathways completed, clients served, and quality assurance points earned (these points are based on chart reviews conducted by supervisors). Payments have been tied to results related to pathways for:

- Pregnancy
- Employment
- Adult education
- Housing
- Medical home

The program remains a work in progress but generally works as outlined below:

- **Competitive base pay:** Recognizing the care coordinators as key business partners in achieving desired outcomes, CHAP gives each worker a competitive base pay and benefits separate from the incentive system.
- **Incentives tied to pathways:** The incentive system rewards those who bring in the most dollars to the organization through the completion of pathways/achievement of desired outcomes. The incentives are paid as follows:
  - Every 2 weeks, a database-generated report documents the number of pathways completed by each care coordinator.
  - Completed pathways are scored based on their complexity and general work requirements. Some completed pathways, such as the one for pregnancy, are worth 10 points, while others, such as ensuring a mother has diapers for her baby, are worth less than 1 point. (See Appendix for a more detailed example of weightings.)

- Care coordinators are paid based on the number and type of pathways completed.
- For some critical pathways that take longer to complete, a portion of the payments are based on the achievement of specific action steps. For example, for the pregnancy pathway, the care coordinators receive an incentive payment based on when they first engage the client (with a higher payment for earlier engagement) and when they confirm the client has connected to prenatal care (since early prenatal care has been proven to produce better outcomes). The largest payment, however, is still tied to completion of the pathway—i.e., the delivery of a normal weight infant.
- Because some CHAP contracts pay the organization in part based on number of clients served and home visits completed, individual workers still receive a small incentive based on these metrics.

More details on this incentive system, along with examples of how incentives have been tied to specific pathways, can be found in the Appendix.

Impact to Date

Linking pay to outcomes continues to be controversial. Yet it clearly has worked at CHAP, which realized an almost 300 percent increase in the number of pregnant women effectively identified and served within several months of initiating the program. CHAP's incentive system has produced a number of other benefits for both individual workers and the organization as a whole, as outlined below:

- The most productive care coordinators have realized substantial yearly income increases ($3,000 to $4,000 a year).
- CHAP has been able to use data routinely collected from the incentive system as an objective tool to measure employee performance during times of financial difficulty when layoffs became unavoidable.

The Importance of Partial Payments

As with American corporations, the Pathways model recognizes that not all outcomes will be positive. When developing contracts and employee incentives, adequate payments should be built in for those pathways that do not reach completion. Creating staged payments with some level of compensation for the achievement of partial success—for example, getting a pregnant woman into prenatal care, even if she ultimately delivers an LBW baby—makes sense. The failure to do this will make it almost impossible for community-based care coordination programs to take on at-risk patients. These programs are often struggling financially. One example of this partial-payment approach comes from HPI, which, as part of its Healthy Birth Pathway, offers community health clinics a $25 payment for enrolling each African-American participant, $50 for successful connection to a medical home, and an additional $25 if a positive birth outcome is produced (i.e., a normal weight baby is delivered).

At the same time, it is critical that contracts and grants secured by the hub—and corresponding incentive systems for individuals—not reward agencies or individuals based on the percentage of clients served. As noted earlier, setting such a threshold—such as screening 80 percent of the population for lead exposure—creates strong incentives for organizations and individuals not to serve those at greatest risk—such as the 5 to 15 percent of the at-risk population that does not have a phone, lives in unsafe or difficult-to-access housing, or faces other barriers that make reaching them difficult.

- Data collected to determine financial incentives have also proven useful in ongoing research and evaluation efforts. (See Step 8 for more information about the evaluation process.)
- CHAP has been able to demonstrate to funders that they are realizing specific, meaningful improvements that have resulted directly from their funding dollars.

Quality Improvement Manual

Pathways to a Healthy Bernalillo County in Albuquerque, New Mexico, developed a detailed Quality Assurance Manual documenting the quality requirements and Pathways to be used by their large university-based multiagency HUB. The manual is available on AHRQ's Web site.

Step 8: Develop Systems To Track and Evaluate Performance

Perhaps the most important functions of the HUB are to:

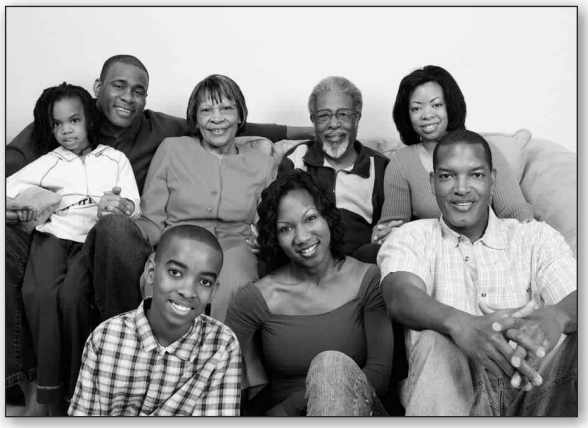
- Centrally track the progress of individual clients (to avoid duplication of services and identify and address barriers/problems on a real-time basis);
- Monitor the performance of individual workers (to support appropriate incentive payments);
- Improve the health of underserved and vulnerable populations; and
- Evaluate overall organizational performance (to support appropriate payments, promote ongoing quality improvement, and help in securing additional funding).

Rather than serving as a central repository for the full client chart, Pathways Community HUBs typically set up an electronic system that captures a relatively limited set of client numbers and identifiers; the typical HUB uses this system to perform the following functions:

- **Register "new" clients through a centralized database to minimize duplications:** As noted earlier, whenever an individual worker identifies a potential new, at-risk client, he or she contacts staff at the central HUB who check to make sure no other care coordinators or organizations are already working with that client. To facilitate this process, a centralized database (preferably electronic) should be kept of all individuals being served by any partner agency. In Richland County, for example, seven care coordination agencies targeting maternal and child health use the Pathways Community HUB to track services to pregnant women in high-risk areas. Care coordinators enrolling a new client first check in with the central HUB to make sure no one else is already working with the client.
- **Monitor progress of individual clients; identify/address barriers:** The database should also provide up-to-date information to the various individuals and agencies involved on how clients are progressing with respect to the relevant pathways or desired outcomes. Some communities have used paper-based processes that allow individuals to enter information on a form, while others are moving to electronic (Web-based) systems that allow for real-time tracking. The availability/practicality of electronic systems in some areas may be limited. Problems include a lack of access to high-speed Internet services, outdated electrical wiring in older buildings, and other problems inherent in underserved communities where care coordination for at-risk individuals takes place.
- **Evaluate performance of individual workers:** The system should allow tracking of the performance of individual community health workers, social workers, nurses, and others

involved in caring for at-risk clients. This information feeds into the incentive payment systems described earlier. See Appendix for a sample performance report for an individual provider.

- **Evaluate and report on organizational performance to stimulate quality improvement:** The system should measure and report on the performance of collaborating organizations in terms of producing positive outcomes (e.g., completed pathways) with a given level of resources. Reports should be accessible to the local HUB and related regional directors. The system should be designed to allow quality assurance staff to analyze all delayed and unfinished pathways to identify any common barriers or roadblocks to boosting "production" of desired outcomes—i.e., interventions, agencies, or action steps that require additional attention. The system should also allow evaluation of each step of the process to determine where production is being slowed or is below standards. The focus should be on finding needed process improvements, not on punishing individuals or agencies. To that end, the Pathways Community HUB works with partner agencies to develop standard production reports that compare outcome production across all involved agencies. Reports show how many pathways are pending or completed by each staff member of each agency, thus allowing the identification of the most productive or successful individuals and organizations. This information assists not only in determining appropriate incentive payments (as described earlier), but also in facilitating the spread of best practices and in identifying any delays or barriers that need to be addressed by an individual, an agency, or the community at large.
- **Monitor community health status:** The information gathered by the Pathways Community HUB can be very useful in helping to track the health status of the targeted population. Working together with the health department, providers, hospitals, and others in the community, the HUB can provide valuable information on what is and is not working in the community.



As part of the quality assurance function, the central HUB can also provide ongoing technical and other support designed to ensure high-quality services and facilitate continuous improvement. For example, the Access Project in Boston helps collaborating organizations build relationships with referral organizations and facilitate relationships between these organizations and local medical providers. It also offers ongoing support to individual counselors when required by case complexity and periodically holds conference calls with program staff

Quality Improvement in Action

CHAP used production reports to identify a key problem—pregnant women commonly had to wait extended periods of time before receiving prenatal care. An examination of the action steps within the pathway found that obtaining health insurance was often a rate-limiting step, largely because a local agency required a physician's confirmation of pregnancy before enrolling a pregnant woman in Medicaid. But the providers in the area would not accept new patients without health insurance, thus creating a "Catch-22" situation for the women involved. The barrier was easily resolved once it was identified, as a local health department physician volunteered to sign the confirmation forms based on the pregnancy test results.

to discuss results, identify trends and patterns related to policy issues that cut across cases, and provide additional technical assistance as needed.

Examples of performance tracking, monitoring, and evaluation systems that have been set up by Pathways Community HUBs include the following:

- **Ohio:** In Richland County and Toledo, Ohio, enrollment, checklists, pathways, and care coordination plans are documented within a Web-based HIPAA-compliant data system. The system helps to identify and eliminate duplication of care coordination services. It also generates reports based on the number of pathways completed and other pathway-related benchmarks to gauge performance. These reports also serve as an invoice, thus making a clear connection between meaningful work products for the client and payment.
- **ACCEL:** In conjunction with the implementation of pathways, ACCEL designed an electronic support system via a Web-based application. To that end, ACCEL assessed and selected a vendor, completed the procurement process, and helped design a configuration for the electronic pathways. Other activities included testing the system, developing training materials, and addressing privacy and security issues by adopting the ACCEL *Notification of Privacy Practices* and related policies. ACCEL went live with the application in February 2008. More recently, ACCEL developed report templates that are programmed into the software, thus allowing the generation of automatic reports to facilitate quality control and improvement through examination of trends in completion rates. An *Enterprise Master Patient Index* has also been developed to support cross-agency patient registration and facilitate the exchange of health information.
- **Access Project:** The Access Project developed a system that tracks the impact of the program on an ongoing basis, including number of clients served, negative consequences of medical debt, amount of debt outstanding, amount of debt resolved, and other indicators.

Phase 3: Launching the HUB

The third and final phase of the process is to roll out the operations of the Pathways Community HUB. This includes hiring dedicated staff for the HUB, training the staff at participating agencies on how to apply the pathways and tools, developing agreements for participating agencies on their relationship to the HUB, and conducting a community awareness campaign to alert stakeholders about the new program.

Step #9: Hire HUB Staff

The Pathways Community HUB typically has only a handful of staff, as most of the work still occurs within the local collaborating agencies. The appropriate timing for the hiring of HUB staff will vary by community. In some situations, staff will be hired earlier to help facilitate and otherwise support many of the activities described in previous steps. In other situations, the staff of collaborating agencies will handle these activities, allowing staffing of the HUB to be delayed until later in the process. Some Pathways Community HUBs might consider forming partnerships with universities to hire graduate students in social work or public health to serve as interns; hospital-based nurses might also be available to assist on a part-time basis as part of outreach efforts.

Examples of Pathways Community HUB staffing appear below:

- **CHAP:** CHAP has a few staff members, including a director and a handful of other individuals responsible for supporting the network of community agencies by maintaining the electronic database, confirming that results are documented in the pathways, and providing reports to monitor quality and contractual payments to the agencies.
- **HPI:** HPI hired an administrator who helped facilitate the development of the pathways; train community health workers on their implementation and use of the care coordination information system; ensure the quality of the data; and perform data aggregation and tracking activities.

Step #10: Train Staff at Participating Agencies

Significant training of relevant agencies and individuals to use an outcomes-based production model (such as Pathways) is required to ensure proper implementation and data collection. The training process for the Pathways model is outlined below:

- **Identify a champion at each agency:** The first step is to identify a "pathways champion" at each participating agency. An expert in the model meets with each champion to review current work processes and incorporate them into the model as practical. The trainer also works with the champion to identify potential roadblocks and answer questions about implementation. This "train-the-trainer" approach helps the champion gain the skills necessary to train the rest of the agency staff.
- **Train agency staff:** Staff members at each agency attend an introductory one-day training session that reviews the common objectives for the community, the benefits of adopting the model, the proper use of individual pathways, and the quality assurance and evaluation processes and systems that will be used. Depending on the scope of effort involved, additional, more intense training modules may be required during implementation of specific pathways. (See examples below for more details.) Some care coordinators may end up specializing in specific pathways, such as those related to pregnancy, housing, or employment. Such specialization can be beneficial as long as the workers also retain the ability to deal with the more general health and social service issues these individuals may be facing.
- **Conduct one-on-one meetings:** As the model is being implemented, the expert trainer and agency champion meet individually with each staff member to make sure he or she understands the model. This review should take place within one week of implementation.

Examples of training programs used by various HUBs are described below:

- **CHAP:** CHAP provides a 12-credit-hour training program through the local community college, with training provided in a culturally and educationally appropriate manner. Training focuses on how to function as part of the health care team serving at-risk patients and promotes team building and networking among community health workers. Training usually consists of 3 weeks of intensive instruction followed by several months of practical instruction provided one day each week.
- **ACCEL:** ACCEL provides formal training and monitoring of community health workers and other participants, using specially developed training materials with universal pathway features as well as pathway-specific requirements. For example, for two insurance pathways, community

health workers received training on topics such as communicating with clients, understanding coverage options, and completing insurance application forms. Staff monitoring is most intense during their first 3 months on the job and occurs periodically thereafter.

- **The Access Project:** The Access Project conducts a 2-day onsite training session for program and partner agency staff members who refer clients to the medical debt resolution program. Training includes a presentation on the prevalence and consequences of medical debt locally and nationally; discussion of specific skills counselors can use when confronting medical debt cases; practical application and practice exercises; and facilitation of actual partnership-building meetings with providers and public programs and other local stakeholders.
- **RUAH:** RUAH trains new care coordinators (known as "health access workers") through a 2-week program that focuses on how to resolve access issues; workers receive additional training by shadowing more experienced staff.

The Appendix provides an example of a training curriculum offered to community health workers (CHWs) in Cincinnati in conjunction with a pathway for at-risk pregnant women, along with a document that details the policies and procedures to be followed by all CHWs in this area. Training sessions include education on these detailed policies and procedures. In addition, the Ohio Board of Nursing has a curriculum for CHWs. Legislation in Ohio designated CHW as a profession. The approved curriculum is available at http://codes.ohio.gov/oac/4723-26-13. Finally, the Minnesota Department of Human Services discusses CHW requirements at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_140357.

Step #11: Conduct a Community Awareness Campaign

Often community members play a critical role in identifying and referring at-risk individuals to the program. Teachers, school nurses, ministers, coaches, and others may be in the best position to know when an individual needs help. (Within the Pathways model, these individuals are known as "finders.") Successful programs, therefore, will conduct a formal community awareness campaign to make sure that all important referral sources know about the program and who might benefit from it, and understand how to refer at-risk individuals. For example, the Dallas County Medical Society advertised its Project Access Dallas program through mailings and presentations at medical society meetings. These efforts highlighted the importance of fulfilling the organization's mission of serving uninsured individuals. The society used interpersonal communications and networking by organizational leaders to solicit the participation of hospitals, clinics, and ancillary providers.

Moving Forward After Implementation

Once up and running, the HUB will use the aforementioned systems to identify and address barriers on a real-time basis and to promote continuous quality improvement through ongoing reporting and feedback on innovative strategies that emerge from within the community. The HUB can also work with local funders to improve the connection between funding and outcomes. The existing HUBs have demonstrated this ability in supporting multiple funding streams to promote unduplicated quality service. Programs effectively reaching those at risk and connecting them to care have realized increases in their funding and service capacity.

Developing a National Learning Network

To further these efforts, existing Pathways Community HUBs are collaborating as part of the above-mentioned 16-member CCCLN, sponsored by AHRQ. This network allows Pathways Community HUBs to share ideas, stories, and strategies with each other on a formal and informal basis. Going forward, members of this network hope to conduct joint research and evaluation to identify and spread best practices across the Nation, including specific strategies for the following:

- Securing upfront and ongoing funding,
- Developing tools and resources to support community stakeholders,
- Identifying and serving at-risk populations, and
- Evaluating the impact of local community-based collaborations.

Working together with leadership and participation at every level, CCCLN members will continue to promote the guiding principles of finding those at risk, ensuring treatment through evidence-based interventions, and measuring the outcomes of these efforts in terms of health improvement and cost savings.

Conclusion

Experience has shown that the health and social service system can become focused on the people it serves and can be an effective and efficient delivery system. People at risk have multiple health and social needs requiring more than one agency and more than one intervention. They currently face silos of services with barriers, inefficiency, and duplication. An effective multiagency, multiservice system of care is needed.

Our Nation has resources, evidence-based interventions, and model systems to learn from. We have innovative community leaders, coalitions, and funders demonstrating success. They are working collaboratively to serve clients most at risk of poor outcomes and are coordinating needed services across community networks in an organized system of care. Their funding is driven by impact measures and outcomes. They are focusing on clients at risk, providing quality services while eliminating duplication and disparities.

Ensuring delivery of prevention, early treatment, and supportive services is the necessary foundation for improving the wellness and success of individuals, families, and populations. The health and economic benefit can reach this generation and the next. Community HUBs can help provide this foundation as health and social service systems move forward in implementing creative methods of delivering care.

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Appendix

Brief Descriptions of Existing Community Hubs

The following are brief descriptions of community hubs that have been developed.

Pathways Community Health Access Project (CHAP), Mansfield, OH

This hub serves high-risk pregnant women, focusing on geographic areas where 30 percent of low birth weight deliveries occur. The hub's primary mission is to increase the number of healthy weight births and to promote healthy pregnancies. This is done by securing access to needed medical and support services for at-risk women, including insurance, food stamps, transportation, employment, and housing. Key outcome measures include the program's impact on birth weights, prenatal visits, and miscarriages. More information is available at http://www.cjaonline.net/Communities/.htm OH_AccessProject.

Lucas County Initiative To Improve Birth Outcomes, Toledo, OH

This hub serves high-risk, low-income pregnant women, with most clients coming from ZIP Codes where the prevalence of low birth weight babies is three times the national average. Most clients are African American. The hub's primary mission is to increase the number of healthy weight births and to promote healthy pregnancies. This is done by securing access to needed medical and support services for at-risk women, including insurance, transportation, and housing. Key outcome measures include the program's impact on birth weights, prenatal visits, and miscarriages. More information is available at http://www.hcno.org/lucas_initiative.htm.

Access El Dorado (ACCEL), El Dorado County, CA

The hub's primary mission is to ensure access to care for children under the age of 19. Key outcome measures include the program's impact on newborn and well-child visits to primary care physicians, immunizations, mental health pediatric consultations, and access to specialty consultations, as well as obtaining and retaining health insurance. More information is available at http://www.acceledc.org/.

Pathways to Health Project – The Health Partners Initiative (HPI), Lincoln, NE

This hub serves low-income minorities in a geographic region that is home to more than 265,000 residents, 7 percent of whom live below the Federal Poverty Level (FPL). The hub's primary mission is to improve the management of asthma by improving access to care and needed support services, including insurance, transportation, and child care. Key outcome measures include the program's impact on blood glucose levels, ED utilization, healthy birth outcomes, and miscarriages.

Project Access Dallas, Dallas, TX

This hub serves Dallas County residents who are insured and have an income below 200 percent of FPL. Many clients are African American or Hispanic. The hub's primary mission is to enhance access to screenings, preventive health services, and diabetes and depression care, and to reduce inappropriate care. Support services include helping to secure access to food stamps, transportation, housing, and child care. Key outcome measures include the program's impact on blood glucose levels, cholesterol, systolic blood pressure, smoking, aspirin use, cancer screenings, ED utilization,

and Beck Scores (a measure of levels of depression). More information is available at http://www.projectaccess.info/tml/about.html.

Care Coordination Programs of CHOICE Regional Health Network (CRHN), Olympia, WA

CHOICE Regional Health Network is a nonprofit community health collaborative formed in 1995 that serves a five-county, primarily rural area of Southwest Washington State. CHOICE serves the region's low-income population (below 250 percent of FPL), providing language and culturally appropriate services to Hispanic and Southeast Asian individuals. Roughly one-third of clients are Hispanic, and most do not speak English. Specific client services have evolved in response to member organizations' needs and priorities, service needs, and programmatic opportunities relevant to health and as a result of the maturation of close working relationships between health and social service providers. As possible within funding and priorities, CHOICE provides clients with assistance in accessing a wide range of resources, including subsidized health care coverage, connection with an affordable medical home, specific health screening and treatment services, prescription assistance, health education, enrollment in food stamps, and screening/referrals for other needs related to food, housing, and income security. CHOICE also provides more intensive care coordination with specific referred populations, including individuals exhibiting high and inappropriate ED utilization and clients of free mental health and chronic care clinics. Key outcome measures include the program's impact on cancer screenings, diabetes referrals/visits, and ED utilization. More information is available at http://crhn.org/www/index.html.

Rural and Urban Access to Health (RUAH), Indianapolis, IN

This hub serves individuals with incomes below 200 percent of FPL in a largely Hispanic community of just over 100,000 residents. The hub's primary mission is to increase access to needed medical and social services (including insurance, transportation, and child care) and to reduce inappropriate care. Key outcome measures include the program's impact on chronic disease management and ED utilization. More information is available at http://www.stvincen.org/about/RUAH/default.htm.

Central Oklahoma Project Access (COPA) Community Health Worker/Health Care Navigator Program, Oklahoma City, OK

This hub serves homeless, underserved, and uninsured populations, particularly individuals with chronic illnesses such as diabetes, hypertension, and cardiovascular disease. Roughly 20 percent of clients do not have insurance, while 16 percent live below the FPL. Just over 15 percent are African American, while 11 percent are Hispanic. The hub's primary mission is to reduce disparities for high-risk individuals by ensuring access to appropriate management of chronic diseases and availability of support services, including insurance, food stamps, transportation, and child care. Key outcome measures include the program's impact on blood glucose levels, ED utilization, diabetes visits, and physician visits. More information is available at http://www.centralokpa.org/.

Healthy Moms & Babes, Cincinnati, OH

A seasoned community outreach agency, Healthy Moms & Babes serves high-risk pregnant women in the Cincinnati area, a region with just under 850,000 residents. Roughly 45 percent of those served live below 300 percent of FPL, and just under one-quarter (24 percent) are African American. The hub's primary mission is to increase the number of healthy birth weight deliveries by securing access to needed medical care and social support services, including insurance, food stamps, transportation, employment, and housing. To that end, the agency serves as the administrative coordinator and lead organization for a pregnancy pathway operated in conjunction with four other social service and public health agencies. As of May 31, 2009, 247 clients were enrolled in the pathway. Key outcome measures include the program's impact on birth weights, prenatal visits, and miscarriages and connection to a medical home for mother and infant. The hub and the pregnancy pathway represent critical service components of the Greater Cincinnati Access Health 100 Initiative and are the first phase of a regional care coordination hub. The hub will expand to serve uninsured, Medicaid, and underinsured populations who earn up to 300 percent of FPL and who experience poor health outcomes due to selected chronic diseases, including hypertension, diabetes, and asthma. More information is available at http://www.healthymomsandbabes.org.

Rio Arriba County Pathways Pilot Project, Rio Arriba, NM

This hub, which includes a broad array of stakeholders (including providers), serves pregnant women with substance abuse problems. The goals are to increase the number of healthy weight births, reduce substance abuse during pregnancy, and promote breastfeeding for at least 60 days. The hub works to increase access to food stamps, transportation, and housing. Key outcomes include the program's impact on birth weight, prenatal visits, and attendance at parenting workshops. Hub activities are funded through a State grant.

Muskegon Community Health Project, Muskegon, MI

This hub serves recently released prisoners from county prisons, primarily men between the ages of 26 and 45; 60 percent of clients served are African American. The hub strives to reduce recidivism rates, use of illegal drugs, and infectious diseases. The hub also helps better manage chronic diseases by facilitating access to pharmaceutical assistance, insurance, food stamps, housing, and career services. Key outcomes include the program's impact on recidivism rates, incidence of hepatitis and HIV, physician visits, and medication compliance. More information is available at http://www.mchp.org.

Access Project Medical Debt Resolution Program, Boston, MA

This hub serves individuals with medical debt by seeking to enhance access to insurance and other assistance programs. Key outcomes include the program's impact on medical debt and insurance enrollment. More information is available at http://www.accessproject.org/medical.html.

Coalition of Community Health Clinics Access and Referral Program, Portland, OR

This hub serves homeless, low-income, and uninsured individuals earning under 200 percent of FPL; the goal is to enhance access to medical and social services, including primary care visits, food stamps, transportation, and housing. Key outcomes include the program's impact on well visits to primary care physicians.

Pathways of Bernalillo County, Albuquerque, NM

This hub serve homeless and low-income individuals in Bernalillo County, New Mexico. The goal is to enhance access to medical and social services, including primary care visits, food stamps, transportation, and housing. Key outcomes include the program's impact on well visits to primary care physicians. More information is available at http://www.berncohealthcouncil.org/.

HealthMatters of Central Oregon, Bend, OR

This hub serves children between 0 and 18 years of age in central Oregon. The goal is to increase access to medical and social services, including well visits to primary care physicians, immunizations, food stamps, transportation, and housing. More information is available at http://www.healthmattersco.org/.

Mid-America Regional Council, Kansas City, MO

This hub serves low-income individuals; the goal is to increase access to medical and social services, including well visits to primary care physicians, immunizations, food stamps, transportation, and housing. More information is available at http://www.marc.org.

"Case Studies" of Organizations Implementing Pathways

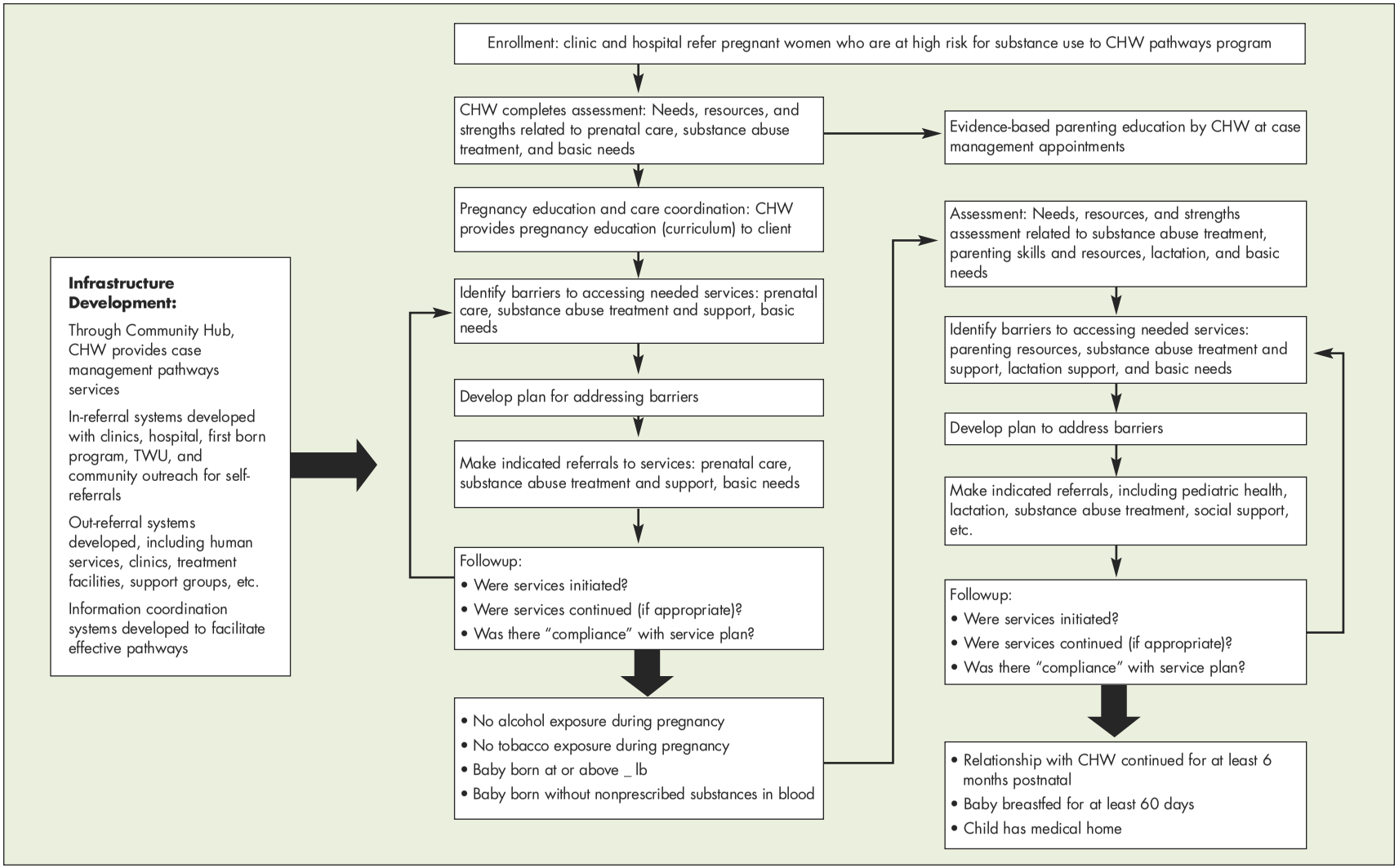
The Agency for Healthcare Research and Quality Innovations Exchange includes eight "profiles" (similar to case studies) of organizations that have successfully implemented pathways. Each write-up includes a capsule summary of the program, a description of the problem addressed, a descriptive summary of key program elements and the results achieved to date, background on the context and impetus for the program, a review of key planning and development steps, and a discussion of considerations for would-be adopters, including lessons related to getting started and sustaining the program. Web addresses for these profiles are provided below:

- Community Health Workers Develop "Pathways" to Facilitate Access to Needed Services For At-Risk Populations, Leading to Improved Outcomes: http://innovations.ahrq.gov/content.aspx?id=2040
- Field-Based Outreach Workers Facilitate Access to Health Care and Social Services for Underserved Individuals in Rural Areas: http://innovations.ahrq.gov/content.aspx?id=1873
- Pathways to Health Project Facilitates Access to Care By Linking At-Risk Groups to Medical Homes: http://innovations.ahrq.gov/content.aspx?id=2151
- Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism: http://innovations.ahrq.gov/content.aspx?id=2134

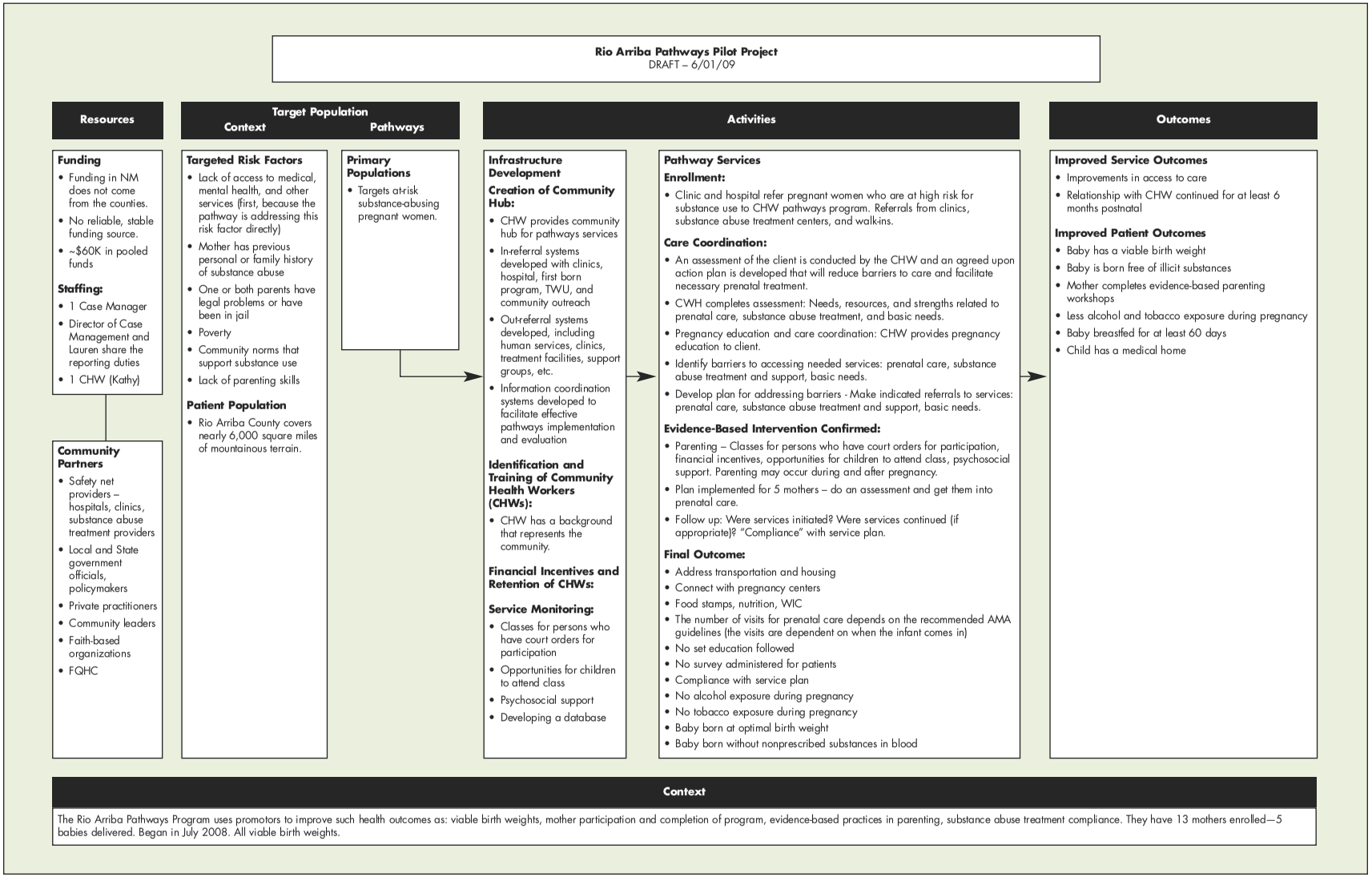
- County-Wide Collaborative Uses Pathways Model to Enhance Access to Insurance, Primary Care, and Mental Health Services for Low-Income Children: http://innovations.ahrq.gov/content.aspx?id=2391
- Pathway Helps Massachusetts Residents Develop and Implement Debt-Reduction Strategies, Leading to 60-Percent Reduction in Medical Debt: http://innovations.ahrq.gov/content.aspx?id=2128
- Community Health Collaborative Reduces Inappropriate Emergency Department Use by Providing Access to Health Care, Social Support for Low-Income Clients: http://innovations.ahrq.gov/content.aspx?id=2197
- Volunteer Provider Network Cares for Uninsured Working Poor, Leading to Lower Utilization and Costs, Better Outcomes, and Positive Return on Investment: http://innovations.ahrq.gov/content.aspx?id=2228

Logic Models

Espanola Pathways Logic Model

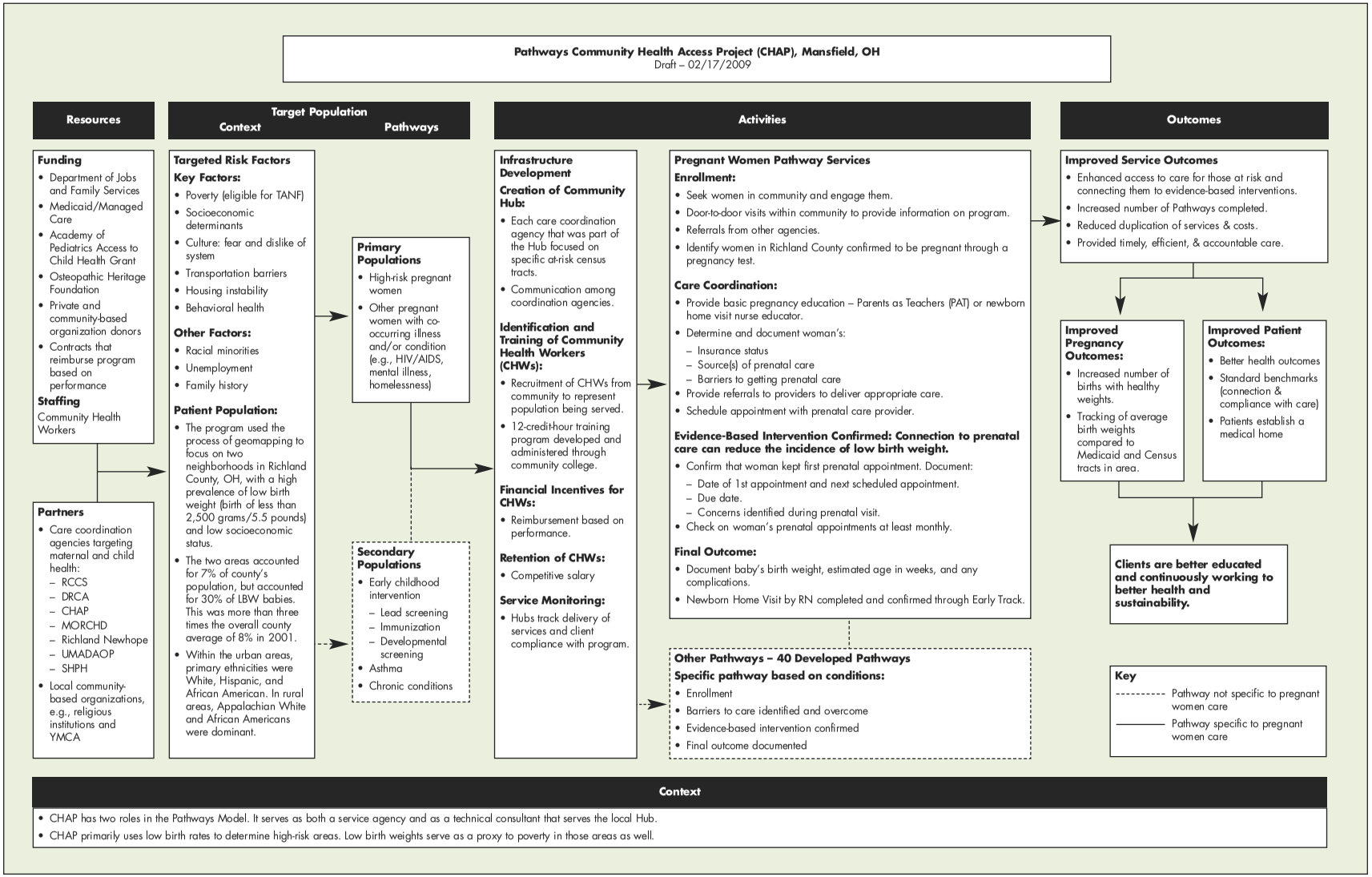


The next model is a more detailed version of the Espanola model, showing Resources; Target Populations, including Context and Pathways; Activities; and Outcomes.



Larger version available online

Community Health Access Project Logic Model



Larger version available online

Examples of Pathways Used by Various Hubs

Richland Community Hub

Pregnancy Pathway

Initiation Step

Expectant mother identified within targeted "at risk" census tracts.

↓

Pregnancy education process initiated with client and supporting family member (when available).

↓

Barriers identified and plan to eliminate, including:

- Health insurance (Medicaid)
- Transportation
- Culture
- Emergent issues – housing, food, clothing

↓

Confirmation of prenatal visits:

- Assist in scheduling appointment(s) as needed
- Document first and ongoing prenatal visits
- Confirm appointment(s) kept and concerns
- If appointment(s) not kept, identify and eliminate barriers

↓

Continue and document care coordination throughout pregnancy as per protocol.

↓

Completion Step

Healthy infant weighing 2,500 grams or more:

- Document birth weight, EGA, and complications
- Proceed with Safety, Triple P (Parenting), and Family Planning Pathway

Family Planning Pathway

Initiation Step

Woman living in targeted "at risk" census tracts at risk for unintended and/or teen pregnancy.

↓

Family planning education with client and partner (when available).

↓

Barriers identified and plan developed, including:

- Health insurance (Medicaid)
- Transportation
- Culture
- Emergent issues – housing, food, clothing

↓

Confirmation of appointment:

- Assist in scheduling appointment
- Confirm appointment(s) kept
- Document if postpartum or routine GYN visit
- If appointment not kept, identify and eliminate barriers

↓

Completion Step

At one-month followup, client has selected method of family planning and is satisfied with choice.

- Document type of family planning method
- Document pregnancy status at 1, 6, and 12 months

Richland Community Hub

Safety Pathway

Initiation Step

Family with newborn living in the targeted "at risk" census tracts.

↓

Safety education and safety checklist completed with client and supporting family (when available).

↓

Barriers identified and plan developed, including need for:

- Smoke detector
- Home repairs – (holes in floor, chipping paint)
- Appropriate safety items (crib, outlet covers, gates)
- Emergent issues – housing, food, clothing

↓

Completion Step

Confirmation with supervisor that all primary safety issues are addressed.

Community Hub

Triple P – Positve Parenting Pathway

Initiation Step

Expectant mother or mother with newborn identified within targeted "at risk" census tracts.

↓

Triple P Education process initiated with client and supporting family members (when available). Document level of Triple P provided.

↓

Barriers identified and overcome, including:

- Health insurance (Medicaid)
- Transportation
- Culture
- Emergent issues – housing, food, clothing

↓

Triple P visits:

- Assist in scheduling appointment(s) as needed
- Confirm appointment(s) kept
- If appointment(s) not kept, identify and eliminate barriers
- Document if referred for higher level services

↓

Completion Step

Family successfully completed Triple P intervention. Appropriate referrals made if necessary.

*The Positive Parenting Program (known as "Triple P") was developed by Dr. Matt Sanders at the University of Queensland in Australia. This evidence-based program has now been successfully implemented in more than 15 countries. Triple P focuses on giving parents the tools they need to create a positive environment for their children while handling behavioral problems effectively. Triple P is a "communitywide" approach to parenting education – training many providers that come into contact with families on a regular basis. Currently, there are more than 40 trained Triple P practitioners (levels 2 – 5) in Richland County.

Examples of Pathways Used by Various Hubs

Community Hub

Medical Home Pathway

Initiation Step

Child < 21 years old or expectant mother in target area needs a **medical home** (ongoing primary care services by a provider or clinic).

↓

Educate family about the importance of a primary medical home and keeping appointments.

↓

Determine payment source (use codes on reverse).

↓

Identify and eliminate **barriers** to obtaining a medical home (use barrier codes).

↓

Appointment scheduled with primary medical provider or clinic.

↓

Completion Step

Verify with primary medical provider that **appointment was kept.** Document in client's record.

Immunization Referral Pathway

Initiation Step

Any child < 6 years of age in target area behind on immunizations.

↓

1. Educate family about the importance of immunizations and keeping appointments
2. **Education sheets reviewed**

↓

Identify and eliminate potential **barriers** to obtaining immunizations (use barrier codes).

↓

Appointment scheduled with provider for missed immunizations.

↓

Confirm with provider that child kept appointment:

- Record current immunization status using approved standard log
- If appointment not kept, identify and eliminate **barriers** to keeping appointment (use barrier codes)

↓

Completion Step

Child is **up to date** on all age-appropriate immunizations.

Community Hub

Lead Pathway – *Sample*

Initiation Step

Any child **> 6 months** of age

↓

Provide **lead education** to all families with young children.

Give education sheet.

↓

Ask whether child has ever received a blood lead test and **document lab results** in child's chart.

↓

Any child receiving **Medicaid** is required to have blood lead tests at 12 and 24 months of age.

↓

If child does not receive Medicaid, check ZIP Code and refer to high-risk areas for county:

- **High-risk ZIP Code:** child needs blood lead test
- **Low-risk ZIP Code:** use *Risk Assessment Questionnaire* on reverse to determine if child needs a blood lead test.

↓

Identify and eliminate **barriers** to child getting a blood lead test (use barrier codes).

↓

Appointment scheduled with provider to do lead test or to write prescription for blood lead test.

↓

Completion Step

Confirm that appointment was kept and **document** results of blood lead test in client's record:

< 10 µg/dL = not elevated

≥ 10 µg/dL = elevated

1. Refer to public health nursing at local health department
2. Initiate **Developmental Screening Pathway**

Triple P Level 2-3 Behavior Pathway – *Sample*

Initiation

Child identified with behavioral issues.

↓

1. Educate family about the importance of positive parenting
2. Give education sheets

↓

Refer family to community provider trained in Level 2-3 Triple P.

↓

Identify and eliminate potential barriers to family keeping appointment with provider (use barrier codes).

↓

Confirm that family kept initial appointment with provider.

↓

Completion

Family successfully completed Level 2 and/or Level 3 Triple P intervention.

Confirm with family and provider if more intervention is needed and document recommendation.

Examples of Consent Forms

Sample Consent Forms

Greater Cincinnati Pathways Hub Program
Consent to Participate in the Healthy Moms and Babes OIMRI Program

I agree to participate in the Healthy Moms and Babes OIMRI program. I understand the purpose of this program is to help me and my baby get the best care in order to be healthy, have a good pregnancy, and develop strong family bonds.

Participating in this program will provide me with a Home Visitor/Community Health Worker who will:

- Provide regular home visits for me and my family until my child is 2 years old;
- Help me develop a care plan that identifies my family's strengths, my concerns for my child/family/self, and what I want to do to create the best environment possible for my child to grow;
- Share information concerning childbirth, child rearing, child development, and nutrition;
- Provide screenings of my child's overall development and share the results and recommendations to help identify and meet the needs of my child; and
- Link me with available community resources.

To gain full benefit from the program, I will:

- Allow my Home Visitor/Community Health Worker to make home visits on a regular basis and be sure to call to reschedule appointments I cannot keep;
- Develop a care plan with my Home Visitor/Community Health Worker to identify the goals I want to reach;
- Work toward the goals I have identified on my care plan. This plan will be reviewed and updated with my Home Visitor/Community Health Worker on a regular basis;
- Allow the developmental screenings and assessments that assist in identifying strengths and needs and help in planning the best services for my child; and
- Tell my Home Visitor/Community Health Worker if I move or my phone number changes, so she can still reach me.

I understand that Healthy Moms and Babes OIMRI services end when my child reaches 2 years of age.

I understand that this is a voluntary program and I can withdraw from the program at any time.

Parent/Guardian Signature: _____ Date: _____

Rio Arriba Case Management and Outreach Services

I understand that as a condition to my receiving treatment services from **(this provider/at this facility)** _____ **(name/entity)**, _____ may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of the **(office/entity)** _____. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, and which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice by contacting **(name)** to make such a request.

I also understand that I have the right to request **(provider/entity)** _____ to restrict how my treatment information is used or disclosed. (Provider/entity) does not have to agree to my request for the restriction, but if **(she/he)** does agree, (she/he) is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **(provider/entity)** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____ _____

Name Date

Examples of Consent Forms

Samples of Authorization To Release Information

Greater Cincinnati Pathways Hub Program
Healthy Moms & Babes Home Visiting Program

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____("Client") reside at _____
_____. I am the parent of _____
and _____. I authorize appropriate staff of the following agencies:

Healthy Moms & Babes

Department of Job and Family Services (DJFS)

My Prenatal Care Provider _____

My child's Medical Provider _____

to release/ share information regarding services I or my children have received among those same agencies for the purpose of receiving or gaining access to services related to my (or my children's) current or future needs. This authorization includes release of information concerning prenatal and pediatric appointment compliance as well as pertinent information required for processing Healthy Start and the Department of Job and Family Services applications.

This consent may be revoked at any time in writing by informing the agency holding the original form, except to the extent that action has already occurred in reliance thereupon. I understand that I may add other specific agencies to this form by listing and signing below. I further understand that this consent and release will expire in one (1) year and I will need to sign a new release for services to continue.

_____ _____/_____/_____
Client's Signature Date

_____ _____/_____/_____
Parent/Guardian Signature Date

_____ _____/_____/_____
Agency Representative's Signature Date

I wish to add the following specific agency(ies) to this release so that they may release and share information about me:

1. _____
Agency Name

_____ _____/_____/_____
Client's Signature Date

2. _____
Agency Name

_____ _____/_____/_____
Client's Signature Date

Rio Arriba Case Management and Outreach Services

I, (print name) _____, (date of birth), _____, hereby authorize (specific identification of person or entity authorized to make disclosure) _____ to release my treatment information, as specified below, to (specific identification of person or entity authorized to receive the information) _____.

I authorize the following information to be released:

(specific description, including *inter alia*, identification of portions of records to be released, i.e., narrative summary, social work assessment, psychiatric examination, psychological evaluation, progress notes, history and physical, lab results, consultation, and/or time periods of treatment records to be released)

_____

_____

_____

I understand that the information to be released includes:

_____

_____

_____

_____

Except as limited as follows:

_____

_____

_____

This authorization for use/disclosure is for the following purpose:

_____

_____

_____

This authorization will remain effective 90/180 days (circle one) unless an earlier date or condition/event is specified here: _____.
However, I understand that I have the right to revoke/withdraw this authorization, in writing, at any time, and that revocation/withdrawal will be effective except to the extent that (provider/entity releasing the info) _____ has already taken action in reliance upon my authorization. My written statement that I want to revoke/withdraw my authorization should be delivered to (name) _____ at (address) _____

_____.

Rio Arriba Case Management and Outreach Services (Continued)

NOTE: The following statement must accompany the information released. This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. ORC 5122.31, 45 CFR Part 2, and/or ORC 3701.243 prohibit you from making any further disclosure of it without specific informed release of the individual to whom it pertains, their authorized representative, or as otherwise permitted by law. A general authorization for release of information is not sufficient for this purpose.

_____ _____

Individual/Guardian/Personal Representative Date

_____

Print Name

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

_____

_____

FOR OFFICE USE ONLY

Staff person releasing information _____

Signature

_____

Print Name

Date information released: _____

Examples of Consent Forms

Sample Consent Between Agencies

Rio Arriba County Health and Human Services

I, _____, authorize Rio Arriba Case
(Name of Patient)

Management and Outreach Services/_____ to disclose and exchange information necessary to coordinate my treatment and service. The following information may be included:

_____

_____

_____

_____
Nature of Information, As Limited As Possible

The purpose of the disclosure authorized herein is to: **Coordinate my treatment and appropriate services to insure continuum of care and quality of services.**

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
Specification of the Date, Event, or Condition Upon Which This Consent Expires

_____ _____
Client SSN Signature of Participant

_____ _____
Date Signature of Parent, Guardian, or Authorized Representative When Required

Examples of Consent Forms

Sample of Client's Rights, Responsibilities, and Grievance Procedures

Rio Arriba Case Management and Outreach Services

You have the right:

1. To be treated by the staff with respect and dignity.
2. To expect that services will be provided to you without discrimination due to race, ethnicity, gender, religious beliefs, age, sexual orientation, disability, political affiliation or economic status.
3. To voice complaints and to file a grievance regarding your services at RACMOS without fear of reprisal (see Grievance Procedures).
4. That your confidentiality is protected by Federal Confidentiality Rules (42 CFR Part 2) and no information can be released without your written permission unless:
    a. You report incidents of child abuse, abuse of the elderly, etc.
    b. You repeat that you are going to intentionally hurt yourself or someone else.
    c. You commit a crime on program property.
    d. You drive to program obviously impaired.
5. To be informed of program rules and regulations that apply to your conduct as a client.
6. You are encouraged to involve your family in your recovery program.
7. To expect reasonable continuity and coordination of care following discharge from this program.
8. You have the right to informed consent of any proposed services and to be informed of the health and legal consequences of this refusal.
9. To feel safe and secure at RACMOS.
10. To make informed decisions regarding your treatment planning, provider choices and service options.
11. To have access to crisis services 24 hours a day, 7 days a week by calling (505) 753-2203.

You have the responsibility to:

1. Follow plans and instructions for treatment that you have agreed to.
2. Make and attend appointments as well as notify of cancellation within a reasonable time period.
3. To contribute to the healing environment by treating other clients and staff with respect and dignity.
4. Honor and respect the confidentiality of others, "WHAT GOES ON HERE, STAYS HERE!"

COMPLAINT AND GRIEVANCE PROCEDURES

If you believe your rights have been violated or if you have a complaint, please file your grievance in writing to the RACMOS coordinator. If you need assistance, the coordinator will help you with writing your complaint. Be sure to include all the details, including date and times, staff, and/or persons involved, etc.

I. The coordinator will investigate and respond to your grievance within 5 business days of receipt of your complaint.

II. If you are filing a grievance against the coordinator or if you are dissatisfied with the response to your grievance by the coordinator, your complaint will be forwarded to the Director of Health and Human Services. The Director will respond in writing within 10 business days.

_____	_____
CLIENT SIGNATURE	CLIENT SSN
_____	_____
WITNESS SIGNATURE AND TITLE	DATE

Examples of Consent Forms

Sample Privacy Notice

Rio Arriba Case Management and Outreach Services

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You should read this Notice before signing the Consent to the Use and Disclosure of Health Information for Treatment and/or payment.

II. Our Duty to Safeguard Your Protected Health Information.

Individually identifiable information about your past, present, or future health or condition, the provision of health care/treatment to you, or payment for the health care/treatment is considered "Protected Health Information" (PHI). We are required to extend certain protections to our PHI, and to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

We are required to follow the privacy practices described in this Notice, though **we reserve the right to change our privacy practices and the terms of this Notice at any time.** If we do so, we will post a new Notice at 1100 B Paseo de Onate. You may request a copy of the new notice from Rio Arriba Case Management and Outreach Services in Espanola, NM 87532, and it will also be posted on our website at **(web address)** _____.

III. How We May Use and Disclose Your Protected Health Information

We use and disclose PHI for a variety of reasons. For most uses/disclosures, we must obtain your consent. For others, we must have your written authorization. However, the law provides that we are permitted to make some uses/disclosures without your consent or authorization. The following offers more descriptions and examples of our potential uses/disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.** Generally, we must have your consent to use/disclose your PHI.
- **For treatment.** We may disclose your PHI to doctors, nurses, and other health care personnel who are involved in providing your health care. For example, your PHI will be shared among members of your treatment team, or with our central pharmacy staff.
- **To obtain payment.** We may use/disclose your PHI in order to bill and collect payment for your health care services. For example, we may release portions of your PHI to Medicaid, the local ADAMH Board and/or a private insurer to get paid for services that we delivered to you.
- **For health care operations.** We may use/disclose your PHI in the course of operating our Quality Management. For example, we may use your PHI in evaluating the quality of services

provided, or disclose your PHI to our accountant or attorney for audit purposes. Since we are an integrated system, we may disclose your PHI to designated staff in our central office or our Office of Support Services for similar purposes. Release of your PHI to the ADAMH Board and/or the Medicaid agency might also be necessary to determine your eligibility for publicly funded services.

- **Appointment Reminders.** Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.
- **Exceptions.** Although your consent is usually required for the use/disclosure of your PHI for the activities described above, the law allows us to use/disclose your PHI without your consent in certain situations. For example, we may disclose your PHI if needed for emergency treatment if it is not reasonably possible to obtain your consent prior to the disclosure and we think that you would give consent if able. Also, if we are required by law to provide your treatment, we use/disclose your PHI for treatment, payment and operations without obtaining your prior consent.
- **Uses and Disclosure Requiring Authorization.** For uses and disclosures beyond treatment, payment and operations purposes, we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Like consents, authorizations can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Not Requiring Consent or Authorization.** The law provides that we may use/disclose your PHI without consent or authorization in the following circumstances:
  - **When Required by Law.** We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities who monitor compliance with these privacy requirements.
  - **For Public Health Activities.** We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities.** We may disclose PHI to our central office, the protection and advocacy agency or another agency responsible for monitoring the health care system for activities such as reporting or investigation of unusual incidents.
  - **Relating to decedents.** We may disclose PHI relating to an individual's death to coroner, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For research purposes.** In certain circumstances, and under supervision of a privacy board, we may disclose PHI to our central office in order to assist medical/psychiatric research.

- **To avert threat to health or safety.** In order to avoid a serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President.

- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** In the following situations, we may disclose your PHI if we inform you about the disclosure in advance and you do not object. However, if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.
- **Patient Directories:** Your name, location, general condition, and religious affiliation may be put into our patient directory for use by clergy and callers or visitors who ask for you by name.
- **To families, friends, or others involved in your care:** We may share with these people information directly related to your family's, friend's or other person's involvement in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death.

IV. Your Rights Regarding Your Protected Health Information. You have the following rights relating to your protected health information.

1. **To request restrictions on uses/disclosures:** You have the right to ask that we limit how we use or disclose your PHI. We will consider your request, but are not legally bound to agree to restrictions. To the extent that we do not agree to any restrictions on our use/disclosure of your PHI, we will put the agreement in writing and abide by it except in emergency situations. We cannot agree to limit use/disclosures that are required by law.
2. **To choose how we contact you.** You have the right to ask that we send you information at an alternative address or by an alternative means. We must agree to your request as long as it is reasonably easy for us to do so.
3. **To inspect and copy your PHI.** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your protected health information if you put your request in writing. We will respond to your request within 30 days. If we deny your access, we will give you written reasons for the denial and explain any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed, but may be waived, depending on your circumstances. You have a right to choose what portions of our information you want copied and to have prior information on the cost of copying.

4. **To request amendment of your PHI:** If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (i) correct and complete, (ii) not created by us and/or not part of our records, or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you, and tell others that need to know about the change in PHI.

5. **To find out what disclosures have been made:** You have the right to get a list of when, to whom, for what purpose, and what content of your PHI has been released other than instances of disclosure for which you have given consent (i.e., for treatment, payment, operations, to you, your family, or the facility directory). The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before April 2003. We will respond to your written request for such a list within 60 days of receiving it. Your request can relate to disclosures going as far back as 6 years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

6. **To receive this notice.** You have a right to receive a paper copy of this Notice and/or an electronic copy by e-mail upon request.

V. How to Complain About Our Privacy Practices:

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI, below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at (address) _____.

VI. Contact Person for Information, or to Submit a Complaint: If you have questions about this Notice or any complaints about our privacy practices, please contact: **(name, title/office, address, phone, e-mail) Lauren Reichelt, Director of Health and Human Services, Rio Arriba County, 1100 B Paseo de Onate, Espanola, NM 87532 (505)753-3143.**

VII. Effective Date: This Notice was effective on October 1, 2003.

_____ _____

Client's Signature/Date Witness/Date

Examples of Intake and Enrollment Forms

Rio Arriba County

Rio Arriba County
Health and Human Services Department

Intake Form

Name: _____ SS#: _____

Address: _____ Telephone: _____

Date of Birth: _____ Other Phone: _____

Emergency Contact: Name: _____ Phone: _____

Address: _____

_____

_____

PCP Name: _____ PCP Phone# _____

Diagnosis

Case Management Needs:

Axis I _____ Medical _____

Axis II _____ _____

Axis III _____ Transportation _____

Axis IV _____ _____

Axis V _____ Employment/School _____

Substance Abuse Concerns

Mental Health Concerns _____

_____ _____

Please circle one:

Male Female

Race

White Black/African American
Asian American Indian/Alaska Native
Native Hawaiian/Other Pacific Islander
Asian Other Multiracial

_____ _____

RACMOS Case Manager

Date

Revised on November 6, 2008

Pathways (Toledo)

Initial Client Enrollment Form

(Please print clearly)

Agency Name: _____

Community Health Worker: _____

Date of Enrollment: _____

Where Client Was Found: _____

Client Information

Full Name: _____

Address: _____

_____

(include street, city and zip code)

Date of Birth: _____/_____/_____
(Month) (Day) (Year)

Race/Ethnicity: _____

Risk Factors: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I
☐ J ☐ K ☐ L ☐ M ☐ N ☐ O ☐ P ☐ Q ☐ R
☐ S ☐ T ☐ U

Due Date: _____/_____/_____
(Month) (Day) (Year)

Please fax enrollment form to Pathways Administrator at 419-842-0999.

Examples of Initial Checklists

The following are examples of initial checklists that include "trigger questions"—i.e., questions where a "yes" answer indicates that a pathway should be assigned to the client. The checklist, which is completed with the enrollment form, is critical, since many clients will not volunteer important information (e.g., about spousal abuse, losing health insurance coverage) unless specifically asked.

CHW Pregnancy Checklist

Yes	No	General Health	Q#
		I would like to start off by asking if you have any questions or concerns that you would like to tell me about.	
		Do you need health insurance for yourself? If yes, determine Healthy Start/HF eligibility. 1-Client eligible (Initiate Healthy Start/HF Pathway), 2-Client not eligible.	
		Do you need prenatal care? Consider Referral Pathway.	
		Do you need a primary care doctor? If yes, which services do you usually use? 1-ER, 2-Urgent care, 3-Walk-in clinic. Consider Medical Referral Pathway.	
Yes	**No**	**Home and Transportation**	**Q#**
		Do you need help with transportation to health and social service appointments? If yes, how do you get to appointments now? 1-Bus, 2-Own car, 3-Relative's car, 4-Other.	
		Do you have problems with providing: 1-Housing (1A - About to be evicted, 1B - Homeless), 2-Food, 3-Clothing, 4-Utilities. Consider Referral Pathway(s).	
Yes	**No**	**Nutrition, Safety, and Habits**	**Q#**
		Do you plan to breastfeed?	
		Are you currently taking prenatal vitamins?	
		Do you smoke cigarettes? 1-Less than half pack per day, 2-Half to whole pack per day, 3-One-two packs per day, 4-More than 2 packs per day, 5-Interested in decreasing or quitting. Consider Smoking Cessation Pathway. Please indicate any level of reduction in smoking during pregnancy.	
Yes	**No**	**Employment, Training, Financial Support**	**Q#**
		Are you looking for a job? 1-Need help finding a job, 2-Need help with resume, 3-Need training before getting job, 4-Felony record.	
		Are you currently sanctioned? 1-By DJFS, 2-The courts.	
		Do you have enough money each month to pay all of your bills? Consider Money Management Pathway.	

Yes	No	Emotional Health and Support	Q#
		Do you feel like you are under stress?	
Yes	**No**	**Current Medical Issues**	Q#
		Are you currently being treated for any of the following conditions? 1-Infections, 2-Asthma, 3-Chronic Medical Conditions, 4-Mental Health Problems. Write in type of illness and details.	
		Are you taking any medicines? 1-Prescribed by a doctor, 2-Over-the-counter medications, 3-Herbal or alternative medicines? List all medications currently taking.	
Yes	**No**	**Current Pregnancy**	Q#
		Have you been told by a health care provider that you were in preterm labor during this pregnancy? 1-On medication, 2-On bed rest, 3-Hospitalized.	
		Have you had any infections during this pregnancy? 1-Bladder, 2-Kidney, 3-Sexually transmitted disease, 4-Vaginal, 5-Respiratory, 6-Other (document in chart).	
		Did your health care provider tell you that you have any medical problems with this pregnancy? 1-Diabetes/gestational diabetes, 2-More than one baby, 3-High blood pressure/preeclampsia, 4-Anemia, 5-Inadequate weight gain, 6-Problems with the placenta, 7-Leaking amniotic fluid, 8-Rh negative blood type, 9-Other.	
Yes	**No**	**Signs of Illness**	Q#
		Have you had any: 1-Contractions, tightening or pain in the abdomen, 2-Back/flank pain, 3-Spotting/bleeding, 4-Swelling of hand or face (NOT ankles), 5-Severe headaches, 6-blurred vision. **Immediate notification of supervisor for any Yes answers.**	
		Have you had any: 1-Breathing problems, 2-Pain with urination, 3-Fever or chills, 4-Vaginal discharge, 5-Vomiting, 6-Diarrhea, 7-Excessive tiredness, 8-Other. **Immediate notification of supervisor for any Yes answers.**	

Q# = Qualifier number for question

Examples of Initial Checklists

CHW Postpartum Checklist

Yes	No	General Health	Q#
		I would like to start off by asking if you have any questions or concerns that you would like to tell me about.	
		Do you need health insurance for yourself? If yes, determine Healthy Start/HF eligibility. 1-Client eligible (Initiate Healthy Start/HF Pathway), 2-Client not eligible.	
		Do you need a primary care doctor? If yes, which services do you usually use? 1-ER, 2-Urgent care, 3-Walk-in clinic. Consider Medical Referral Pathway.	
Yes	**No**	**Home and Transportation**	**Q#**
		Do you need help with transportation to health and social service appointments? If yes, how do you get to appointments now? 1-Bus, 2-Own car, 3-Relative's car, 4-Other.	
		Do you have problems with providing: 1-Housing (1A - About to be evicted, 1B - Homeless), 2-Food, 3-Clothing, 4-Utilities. Consider Referral Pathway(s).	
Yes	**No**	**Nutrition, Safety, and Habits**	**Q#**
		Are you breastfeeding? 1-Breastfeeding only, 2-Supplementing with formula, 3-Having difficulty with breastfeeding, 4-Breastfeeding going well.	
		Do you need help childproofing your home?	
		Are you taking vitamins?	
		Do you smoke cigarettes? 1-Less than half pack per day, 2-Half to whole pack per day, 3-One-two packs per day, 4-More than 2 packs per day, 5-Interested in decreasing or quitting. Consider Smoking Cessation Pathway.	
Yes	**No**	**Employment, Training, Financial Support**	**Q#**
		Are you looking for a job? 1-Need help finding a job, 2-Need help with resume, 3-Need training before getting job, 4-Felony record.	
		Are you currently sanctioned? 1-By DJFS, 2-The courts.	
		Do you have enough money each month to pay all of your bills? Consider Money Management Pathway.	
Yes	**No**	**Emotional Health and Support**	**Q#**
		Do you feel like you are under stress?	

Yes	No	Current Medical Issues	Q#
		Are you currently being treated for any of the following conditions? 1-Infections, 2-Asthma, 3-Chronic Medical Conditions, 4-Mental Health Problems. Write in type of illness and details.	
		Are you taking any medicines? 1-Prescribed by a doctor, 2-Over-the-counter medications, 3-Herbal or alternative medicines? List all medications currently taking.	
Yes	**No**	**Reproductive Health**	**Q#**
		Are you sexually active now? 1-One partner, 2-Multiple sex partners.	
		Are you currently using a family planning method? 1-Abstinence, 2-Natural FP, 3-Condoms, 4-Diaphragm, 5-Shot, 6-Pill, 7-IUD, 8-Sterilization, 9-Other.	
		Are you having problems making it to your 6-week checkup? 1-If yes, initiate Referral Pathway.	
Yes	**No**	**Signs of Illness**	**Q#**
		Have you had any: 1-Breathing problems, 2-Pain with urination, 3-Fever or chills, 4-Vaginal discharge, 5-Vomiting, 6-Diarrhea, 7-Excessive tiredness, 8-Abdominal pain, 9-Depression, 10-Bleeding longer than 4 weeks? **Immediate notification of supervisor for any Yes answers.**	

Q# = Qualifier number for question

Examples of Initial Checklists

CHW Pediatric, Birth - 1 Year

Yes	No	General Health	Q#
		I would like to start off by asking if you have any questions or concerns that you would like to tell me about your baby.	
		Do you need a primary care doctor for your baby? If yes, which services do you most commonly use? 1-ER, 2-Urgent care, 3-Walk-in clinic. Consider Medical Referral Pathway.	
		Do you need health insurance for your child? If yes, determine Healthy Start/HF eligibility. 1-Client eligible (Initiate Healthy Start/HF Pathway), 2-Client not eligible.	
Yes	**No**	**Home and Transportation**	**Q#**
		Do you need help with transportation for child to health and social service appointments? If yes, how do you get to appointments now? 1-Bus, 2-Own car, 3-Relative's car, 4-Other.	
		Do you have problems with providing any of the following for your child: 1-Housing (1A - About to be evicted, 1B - Homeless), 2-Food, 3-Clothing, 4-Utilities, 5-Furniture, 6-Car Seat, 7-Crib. Consider Referral Pathway(s).	
Yes	**No**	**Nutrition, Safety, and Habits**	**Q#**
		Is your baby having any problems with feeding? If yes, document in chart.	
		Is your baby breastfeeding?	
		Do you need a working smoke detector? If yes, 1-smoke detector provided and education given.	
		Does baby sleep on his/her stomach? If yes, give detailed information about importance of putting baby on his/her back to sleep.	
		Do you need child care?	
		Did you go over age-appropriate safety information?	
Yes	**No**	**Development**	**Q#**
		Did you discuss brain development and the importance of talking to, reading to, holding, and interacting with the baby?	
		Did you discuss the importance of strengths-based parenting (encouraging your child)?	
		Has your baby been diagnosed with any developmental delays or problems? If yes, 1-screen completed and normal, 2-screen completed and abnormal. Consider Developmental Referral Pathway.	

Yes	No	Disease Prevention	Q#
		Does anyone in your home smoke? 1-Client, 2-Partner/Spouse, 3-Other. Initiate Smoking Cessation Pathway and discuss effects of secondhand smoke.	
		Is your baby missing any immunizations? Consider Immunization Pathway.	
Yes	**No**	**Current Medical Issues**	**Q#**
		Are you giving your baby any medicines? 1-Prescribed by a doctor, 2-Over-the-counter medications, 3-Herbal or alternative medicines, 4-Prescribed by a doctor but cannot afford.	
		Is your baby currently being treated for: 1-Infections, 2-Asthma, 3-Chronic Medical Conditions. Write in type of illness and details.	
Yes	**No**	**Signs of Illness**	**Q#**
		Is your baby having: 1-Difficulty breathing, 2-Vomiting, 3-Diarrhea, 4-Feeding problems, 5-Fever or chills, 6-Jerking of arms or legs, 7-Change in skin color (blue lips, yellow skin), 8-Other. Consider Sick Child Pathway. **Immediate notification of supervisor for any Yes answers**.	

Q# = Qualifier number for question

Examples of Initial Checklists

CHW Adult Male

Yes	No	General Health	Q#
		I would like to start off by asking if you have any questions or concerns that you would like to tell me about.	
		Do you need a primary care doctor? If yes, which services do you most commonly use? 1-ER, 2-Urgent care, 3-Walk-in clinic. Consider Medical Referral Pathway.	
		Do you need health insurance? If yes, determine Healthy Start/Healthy Family eligibility. 1-Client eligible (Initiate Healthy Start/HF Pathway), 2-Client not eligible.	
Yes	**No**	**Home and Transportation**	**Q#**
		Do you need help with transportation to health and social service appointments? If yes, how do you get to appointments now? 1-Bus, 2-Own car, 3-Relative's car, 4-Other.	
		Do you have problems with providing: 1-Housing (1A - About to be evicted, 1B - Homeless), 2-Food, 3-Clothing, 4-Utilities. Consider Referral Pathway(s).	
Yes	**No**	**Nutrition, Safety, and Habits**	**Q#**
		Do you smoke cigarettes? 1-Less than half pack per day, 2-Half to whole pack per day, 3-One-two packs per day, 4-More than two packs per day, 5-Interested in decreasing or quitting. Consider Smoking Cessation Pathway.	
Yes	**No**	**Employment, Training, Financial Support**	**Q#**
		Are you looking for a job? 1-Need help finding a job, 2-Need help with resume, 3-Need training before getting job, 4-Felony record.	
		Are you currently sanctioned? 1-By DJFS, 2-The courts.	
		Do you have enough money each month to pay all of your bills? Consider Money Management Pathway.	
Yes	**No**	**Emotional Health and Support**	**Q#**
		Do you feel like you are under stress?	

Yes	No	Current Medical History	Q#
		Are you currently being treated for any of the following conditions? 1-Infections, 2-Asthma, 3-High Blood Pressure, 4-Other Chronic Medical Conditions, 5-Mental Health Problems. Write in type of illness and details.	
		Are you taking any medicines? 1-Prescribed by a doctor, 2-Over-the-counter medications, 3-Herbal or alternative medicines? List all medications currently taking.	
Yes	**No**	**Reproductive Health**	**Q#**
		Are you sexually active now? 1-One partner, 2-Multiple sex partners.	
		Are you currently using a family planning method? 1-Abstinence, 2-Natural FP, 3-Condoms, 4-Diaphragm, 5-Shot, 6-Pill, 7-IUD, 8-Sterilization, 9-Other.	

Q# = Qualifier number for question

Examples of Risk Factor/Barrier Lists

Lucas County Initiative To Improve Birth Outcomes, Toledo, Ohio

RISK FACTOR CODES

A. African American
B. Drug use
C. Tobacco use
D. No insurance
E. Women with previous birth in last 18 months
F. Late entry into prenatal care (after 13 weeks)
G. No transportation
H. Unaware of the pregnancy
I. Domestic violence
J. Poor living environment
K. Poor health of the mother
L. Noncompliance with medical appointment
M. Personal problems
N. Unwanted pregnancy
O. Mental illness
P. Homeless
Q. Less than 18 years old
R. Unmarried
S. Low income
T. Prior poor birth outcomes
U. Residing in a ZIP Code with a history of a high percentage of low birth weight

BARRIER CODES

1. Financial
2. Transportation
3. Provider limited capacity-can't get an appointment, quota has been reached for medical card, no longer accept patients
4. Provider service not available to the client due to age or disabilities, doesn't accept medical card
5. Child/family in transition (going off Medicaid, etc.)
6. Scheduling-conflict with work/family schedule
7. Child care
8. Mental health of client
9. Cognitive ability of client
10. Beliefs/attitudes of client (low importance, fear, culture, educated/personal choice, etc.)
11. Beliefs/attitudes of others influencing client (low importance, fear, culture, educated/personal choice, etc.)
12. Religious beliefs that affect the decisions of the caregiver for completion of pathway

13. Language
14. Literacy issues
15. Disability of client
16. Chronic Illness
17. Discrimination
18. Criminal record
19. Other

Greater Cincinnati Pathways Hub Program Barrier Codes (2009)

1. Financial _____
2. Transportation _____
3. Housing _____
4. Food _____
5. Language/communication _____
6. Literacy _____
7. Limited access to medical care _____
8. Unacceptable provider _____
9. Scheduling _____
10. Child care _____
11. Lack of support _____
12. Mental health issues _____
13. Attitudes and beliefs _____
14. Domestic violence _____
15. Substance use _____
16. Legal issues _____
17. Other _____

NOTE: Please document barrier codes throughout the Pathway (keep adding them on to the line provided on the Pathway Form).

Sample Case Management/Care Coordination Service Plan

Rio Arriba Case Management and Outreach Services
Case Management Service Plan

Consumer Name: _____

Client SS#: _____

Goal #1: _____ **Date:** _____

Objectives: 1) _____

2) _____

3) _____

Goal #2: _____ **Date:** _____

Objectives: 1) _____

2) _____

3) _____

Goal #3: _____ **Date:** _____

Objectives: 1) _____

2) _____

3) _____

90 Day Review _____

_____

_____ _____

Customer's Signature Date

_____ _____

Case Manager's Signature Date

New Goal: _____ Date: _____

Objectives: 1) _____

2) _____

3) _____

Rio Arriba Case Management and Outreach Services
Notation Form

Date	Goal	Progress Toward Goals	Units

Client:_____ SSN: _____

Example of Pathway Completion and Discharge Forms

Pathway Completion Form (Toledo)

Client Name: _____ **CHW:** _____

Zip Code: _____ **Client Enrollment #:** _____

Race/Ethnicity: _____ **Date Enrolled:** _____

Client's Date of Birth: _____ **Age:** _____ **Estimated Due Date:** _____

Insurance Plan: _____ **Trimester Enrolled:** ☐ 1 ☐ 2 ☐ 3

Primary Care Provider: _____

Pathway Completion		
Insurance	Date Completed: _____	Type of Insurance: _____ Effective Date: _____ Insurance Number: _____
Housing	Date Completed: _____	New Address: _____ _____ Status: ☐ Renting ☐ Living with someone ☐ Bought home
Homeless	Date Completed: _____	Name of Shelter: _____ _____ Duration of Stay Allowed: _____ Barriers:
Social Services Referral	Date Completed:	☐ 1-WIC ☐ 2-Emergency Food ☐ 3-Clothing ☐ 4-Family Supplies ☐ 5-Legal Issues ☐ 6-Child care ☐ 7-Transportation ☐8-Utilities ☐ 9-Help Me Grow Referral ☐ 10-Translation services ☐ 11-Mental health ☐ 12-Substance abuse ☐ 13-Parenting, childbirth, breastfeeding classes ☐ 14-Other: _____ Date of Appointment: _____ Agency: _____ Contact Person:
Smoking Cessation	Date Completed:	Agency: _____ Contact Person: _____ Type of cessation services: ☐ Individual ☐ Group Number of Sessions Attended: _____
Additional Comments: _____ _____		

Please Fax Completed Forms to the Pathways Administrator at 419-842-0999.

Pathway Discharge Form (Toledo)

Client Name: _____ **CHW:** _____

Zip Code: _____ **Client Enrollment #:** _____

Race/Ethnicity: _____ **Date Enrolled:** _____

Client's Date of Birth: _____ **Age:** _____ **Estimated Due Date:** _____

Insurance Plan: _____ **Trimester Enrolled:** ☐ 1 ☐ 2 ☐ 3

Primary Care Provider: _____

Resolution of Case Date Case Ended: _____		
Loss to Follow-Up/ Transfer of Care:	☐ Client unable to be located or contacted ☐ Client known to have left area	☐ Client declines further assistance ☐ Client has transferred care to another clinic Which?: _____
Pregnancy Terminated:	☐ Miscarriage at ____ weeks	☐ Abortion
Client Delivers Baby	☐ Prematurely at ____ weeks	☐ Full-term baby
Delivery Date: _____	Weight of Baby: _____ lbs. _____ oz. Where was the baby delivered?: _____	

Pregnancy Complications: _____

Birth Complications: _____

Infant Complications: _____

Status of Mother/Infant at Discharge:		
Has a safe place to live?	☐ Yes	☐ No
Does the mother have a medical home?	☐ Yes	☐ No
Does the infant have a medical home?	☐ Yes	☐ No
Does the mother have insurance?	☐ Yes	☐ No
Does the infant have insurance?	☐ Yes	☐ No
Is mother healthy?	☐ Yes	☐ No
Is infant healthy?	☐ Yes	☐ No
Has the mother been connected to community services to continue addressing current problems?	☐ Yes	☐ No
Is there at least one source for ongoing social support for the mother?	☐ Yes	☐ No
Does the mother have a reliable form of transportation?	☐ Yes	☐ No
Is the mother using a reliable family planning method?	☐ Yes	☐ No

Please Fax Completed Forms to the Pathways Administrator at 419-842-0999.

Example of Referral Form

Rio Arriba County
Health and Human Services

Referral Form

Date: _____

Client Name: _____

Client Social Security #: _____

Referring Agency: _____

Referred To: _____

For the following services:

_____

_____

_____

_____ _____
Client Signature Date

_____ _____
Counselor Date

Please attach a copy of the client's Authorization to Release to Referral form.

Example of Case Management Plan

Rio Arriba County Health and Human Services
Case Management Plan

Client ID _____

Date of requested case management _____

Date of clinical staffing _____

Date of meeting with client _____

Client Referrals

1. Transportation	_____	Date _____	Agency _____
2. Housing	_____	Date _____	Agency _____
3. Schooling	_____	Date _____	Agency _____
4. Job Skills	_____	Date _____	Agency _____
5. Health	_____	Date _____	Agency _____
6. ISD	_____	Date _____	Agency _____
7. Other	_____	Date _____	Agency _____
8. Medical Health	_____	Date _____	Agency _____
9. Employment Income	_____	Date _____	Agency _____
10. Drug Use Treatment	_____	Date _____	Agency _____
11. History of Use	_____	Date _____	Agency _____
12. Legal Issues	_____	Date _____	Agency _____
13. Family Social	_____	Date _____	Agency _____
14. Other Relationships	_____	Date _____	Agency _____
15. Mental Health	_____	Date _____	Agency _____

Notations:

_____

_____

_____

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Case Manager Date

Sample Consultant Agreement Contract Between Hub and Community Agency

Consultant Agreement

THIS CONSULTANT AGREEMENT (the "Agreement") is made and entered into as of the date set forth on the signature page of this Agreement, by and between XXXXXXXXXX and its affiliated entities (hereinafter "XXXXXXXXXX") and XXXXXXXX County Community HUB (hereinafter "Consultant"), an independent contractor, for the provision of services by Consultant to XXXXXXXXXXXXXXXXXXX XXXXXX XXXXXX XXXXXXX XXXXX will be acting as the Fiscal Agent for the XXXXXXXX County Community HUB.

1. Scope of Work. Consultant shall provide care management, outlined in Exhibit "A," services to XXXXXXXXXX under the terms of this Agreement and in a manner consistent with industry standards. If additional detail concerning the scope of work is required, such description shall be included in an exhibit to this Agreement. Any change or addition to the scope of work as described herein may be modified through an addendum to this Agreement.

2. Relationship of Parties. Consultant shall be an independent contractor of XXXXXXXXX. Consultant shall not represent to others that Consultant is an employee or agent of XXXXXXXXXX. Consultant is responsible for all expenses incurred in rendering services under this Agreement, and Consultant agrees to hold XXXXXXXXXX harmless from any such expenses.

3. Compensation. XXXXXXXXXX shall pay Consultant at a rate outlined in Exhibit "A" under Payment. The total amount of fees payable to Consultant during the term of this Agreement shall not exceed $XXX per successfully completed pathway, at XXXXXXXXXX's sole discretion. Consultant shall provide documentation of services rendered as required by XXXXXXXXXX, and payment shall be made within 30 days of receipt of such documentation. If Consultant fails to provide such documentation, XXXXXXXXXX shall not be obligated to make payment to Consultant. Consultant shall reimburse XXXXXXXXXX and XXXXXXXXXX shall reimburse Consultant for payments made in error.

4. Term and Termination. This Agreement shall be effective as of the date set forth on the signature page of this Agreement ("Effective Date") and shall continue in force until the services set forth herein are completed, unless sooner terminated as provided herein. Either party may terminate this Agreement by giving the other party written notice at least thirty (30) days prior to the effective date of termination. Automatic termination shall occur if either party claims bankruptcy or insolvency, as well as death or total disability of Consultant.

5. Confidentiality. Consultant agrees to hold all information concerning XXXXXXXXXX confidential in trust and agrees that such confidential information shall be used exclusively for the provision of services under this Agreement. Information shall not be deemed confidential if such information: (a) is or has become generally known or available to the general public other than by any act or omission of either party; (b) was rightfully known by the other prior to the time of first disclosure; (c) is independently developed without the use of confidential information; or (d) is rightfully obtained

without restriction from a third party who has the right to make such disclosure and without breach of any duty of confidentiality to XXXXXXXXXX. Upon termination of this Agreement, Consultant shall return confidential information to XXXXXXXXXX.

6. HIPAA. If, by performing its obligations under this Agreement, Consultant is a business associate of XXXXXXXXXX, as that term is defined by the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 through 164 and its implementing regulations, Consultant agrees to comply with the terms of the Business Associate Agreement, attached as an exhibit hereto.

7. Compliance with Law; Licensure. Consultant shall, at all times during the term of this Agreement and at Consultant's own expense, comply with all applicable federal, state, and local laws, rules and regulations, and shall maintain in force any licenses and permits required for performance under this Agreement. Consultant certifies that Consultant, its employees and/or agents performing services under this contract are not suspended and/or debarred from doing business with state and/or federal government programs and that Consultant shall abide by and comply with all applicable state and/or Federal False Claims Act, 31 U.S.C. 3729, et seq, requirements and shall report any concerns or allegations of fraud, waste or abuse in accordance with the XXXXXXXXXX Corporate Compliance Plan, a copy of which will be provided upon request.

8. Liability; Insurance; Indemnification. Consultant shall carry adequate insurance (or define appropriate coverage level here) to fully protect Consultant and XXXXXXXXXX from any and all claims of any nature for damage or loss of property or for personal injury, including death, which may arise from or relate to Consultant's performance under this Agreement. Consultant shall notify XXXXXXXXXX not more than ten (10) days after receipt of notice of any reduction or cancellation of such coverage. Consultant shall indemnify XXXXXXXXXX against and hold XXXXXXXXXX harmless from all liability and loss, and against all claims and action, including but not limited to court costs and attorneys' fees, based on or arising out of injury or death to persons, or damage or loss of property, caused by acts or neglect of Consultant in connection with the performance of this Agreement or caused by the breach of this Agreement by Consultant.

9. Notice. Any notice required hereunder by either party shall be in writing. All notices and requests shall be deemed given when postmarked and mailed to XXXXXXXXXX and/or Consultant at the addressees set forth on the signature page of this Agreement.

10. Successors and Assigns. This Agreement shall be binding upon, and shall inure to the benefit of and be enforceable by, the respective successors and permitted assigns of the parties hereto, provided that this Agreement may not be assigned by either party without the prior written consent of the other party.

11. Miscellaneous. Consultant's use of the XXXXXXXXXX name shall only be upon prior written approval or as the parties may agree. Waiver by either party of a breach of any provision of this Agreement shall not operate, or be construed, as a waiver of any subsequent breach. No change, modification, amendment, or waiver of any term of this Agreement shall be valid unless it is in writing and signed by both parties hereto. This Agreement constitutes the entire agreement between the parties hereto and supersedes all prior agreements or understandings between Consultant and XXXXXXXXXX with respect to the subject matter hereof.

12. Governing Law and Venue. This Agreement shall be governed by, and construed and enforced in accordance with, the laws of the State of XXXX without regard to conflict of law of principles. XXXXXXXXXX County XXXX shall be the sole, proper venue of any litigation or proceeding between the parties which arises out of or is in connection with any right, duty or obligation under this agreement. The invalidity or unenforceability of any provision hereof shall in no way affect the validity or enforceability of any other provision herein.

Signatures

In WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the EFFECTIVE DATE. This Agreement may be executed in multiple originals. Each party executing this Agreement represents that they are authorized to execute this Agreement.

EFFECTIVE DATE: _____

XXXXXXXXXX

XXX XXXXX XXXX XXXXXX

XXXXXX, XXXX XXXXX

By:_____

XXXXXX XXXXXX

Title: CBO

Date: _____

XXXXXX County Community HUB

X. X. XXX XXXX

XXX XXXXXX XXXX

XXXXXXXXX, XXXX XXXXX

By: _____

XX. XXXXX XXXXXXX

Title: HUB Director

Date: _____

XXXXXXXXXXXXXXXXXXXX

X. X. XXX XXXX

XXX XXXXXX XXXXXX

XXXXXXXXX, XXXX XXXXX

By: _____

XXX X XXXXXXXXX

Title: Executive Director

Date: _____

XX-XXXXXXX

Federal Tax I.D. Number

Exhibit "A"

Services

To provide outcome focused care management for XXXXXXXXXX. Specific focus includes working to:

1. Develop the Care Management Policies and Procedures Manual. Agencies will utilize this Manual to serve Medicaid Patients enrolled with XXXXXXXXXX. Quality assurance, documentation, Pathways, standardized reporting and other requirements will be established as part of the Manual development.

2. The Care Management Team will begin to collect specific health and social service information from XXXXXXXXXX identified members. An outcome focused care management plan will be established for each member. The care management plan and other required information will be sent for review and approval by the assigned XXXXXXXXXX representative. XXXXXXXXXX shall also review identified members for eligibility (for XXXXXXXXXX coverage) and identify and notify the Care Management Team of any ineligible member.

3. Utilize the outcome production model of Pathways. Provide outreach and care management services to specifically address the health and social service issues identified within the plan and provide periodic care plan updates.

4. Provide written and verbal reporting of outcomes and other specified reporting as established in the Care Management Policy and Procedures Manual. The attached quarterly Care Management Scorecard, Exhibit A-1, is an example of the reports XXXXXXXXXX Management will be receiving.

5. Work with XXXXXXXXXX direct service providers and the inpatient services to facilitate care management of health and social service needs as per the Care Management Policy and Procedures Manual.

   *Care Management as part of this Agreement is defined as the process of client identification, enrollment, health and social assessment, health education, barrier elimination and confirmation of receipt of direct medical services. Care management follow-up is continued until problem resolution and/or patient disenrollment.

6. XXXXXXXXXX shall notify the Care Management Team on a monthly basis of the eligibility (for XXXXXXXXXX coverage) of any individual receiving Services for the purposes of ensuring that only XXXXXXXXXX members are receiving Services that XXXXXXXXXX is obligated to pay for under this Agreement.

7. XXXX will utilize the XXXXXXXX County Community HUB to support and report each step of the work (Pathways) to achieve positive outcomes for each agency (sub-contractors) and each individual served. The Community Hub is the central clearing house which helps agencies work together without duplication, confirming that the Pathways are completed with quality and accountability. Central registration of all individuals served by all the participating agencies will support the identification and elimination of care coordination service duplication. A HIPAA compliant data system is available to achieve this. The Community Hub will work to train and provide ongoing support to each of the involved agencies. Training will specifically focus on the health and social conditions, the Pathways and critical work steps to achieve in the contract, and the use and documentation of results within the data system utilized.

Points of Payment

The contract proposed is almost completely tied to specific areas of performance based on quality benchmarks measured on an individual basis. Prevention and utilization improvements are primary areas of focus.

The following payments are authorized only after referral of the patient from XXXXXXXX and only the Pathways authorized by XXXXXXXXXX for each individual client are initiated. Most individuals will only have one Pathway although with authorization more than one Pathway may be in progress at any one point in time depending on the needs of the client.

Initiation of Care Coordination–Assessment
At the first face to face assessment of the client a complete health, social service and behavioral health assessment will be completed. Following the assessment the appropriate Pathway/Pathways are assigned and a complete care coordination plan developed. The cost for the assessment is in addition to the performance based costs within the Pathways.

Cost for Assessment – $XXX.00

Pathway Payment

Pregnancy Pathway	**- $ XXX.00 (Viable Infant, 2500 grams or greater)**
Family Planning	**- $ XXX.00**
Medical Home	**- $ XXX.00**
Postpartum	**- $ XXX.00**
Developmental Screening	**- $ XXX.00**
Developmental Referral	**- $ XXX.00**
Immunization Screening	**- $ XXX.00**
Immunization Referral	**- $ XXX.00**
Frequent ER Users	**- $ XXX.00 (Includes client stipends for 25%, 50%, or 75% reduction in ER usage)**

Examples of Incentives

Pathway Weighting

The following example shows potential weightings for an array of pathways, with complex pathways such as pregnancy and employment being weighted the highest and relatively straightforward, easier to complete pathways such as sick-child pathways and lice weighted lower.

Pathway Weights							
10	**8**	**6**	**5**	**4**	**3**	**2**	**1**
Pregnancy	Adult Education 1 & 2	Behavior/ Triple P	Behavioral Problems - Home or School	Developmental Referral	Developmental Screening	Lice	Social Service Referral
	Employment	Depression	Chemical Dependency		Immunization Screening	Postpartum	
		Diabetes	Home Eviction		Medical Referral	Preterm Labor	
		Medical Referral	Medical Home		Truancy	Sick Child 0-2 Months	
		Alcohol Referral			Family Planning	Sick Child 3-6 Months	
					Family Violence Referral	Sick Child 7 Months - 2 Years	
					Immunization Referral	Sick Child 3 - 13 Years	
					Healthy Start - Healthy Families		
					Lead	Abnormal Vital Signs 13 Years and Older	
					Smoking Cessation in Pregnancy	Emergency Medical Situation	

Example Incentive System for CHWs

CHAP has two incentive systems. The first provides additional payments based on the percentage of a pathway that has been completed. For example, every time an at-risk pregnant woman is identified, barriers to care are overcome, confirmation of prenatal care is achieved, and a viable normal birth weight baby is born, CHWs receive additional payments (just as CHAP as an organization receives incentives from its contracts).

The second system provides additional payments of up to one dollar per hour for CHWs. The system was developed by the CHAP Quality Assurance (QA) Committee, which routinely provides analysis of work quality and efficiency using standards the committee has developed. Known as the QA Scorecard, this system is based on both quality indicators and overall workload, including number of clients, home visits, and pathways completed. The system allows the highest performing CHWs to achieve

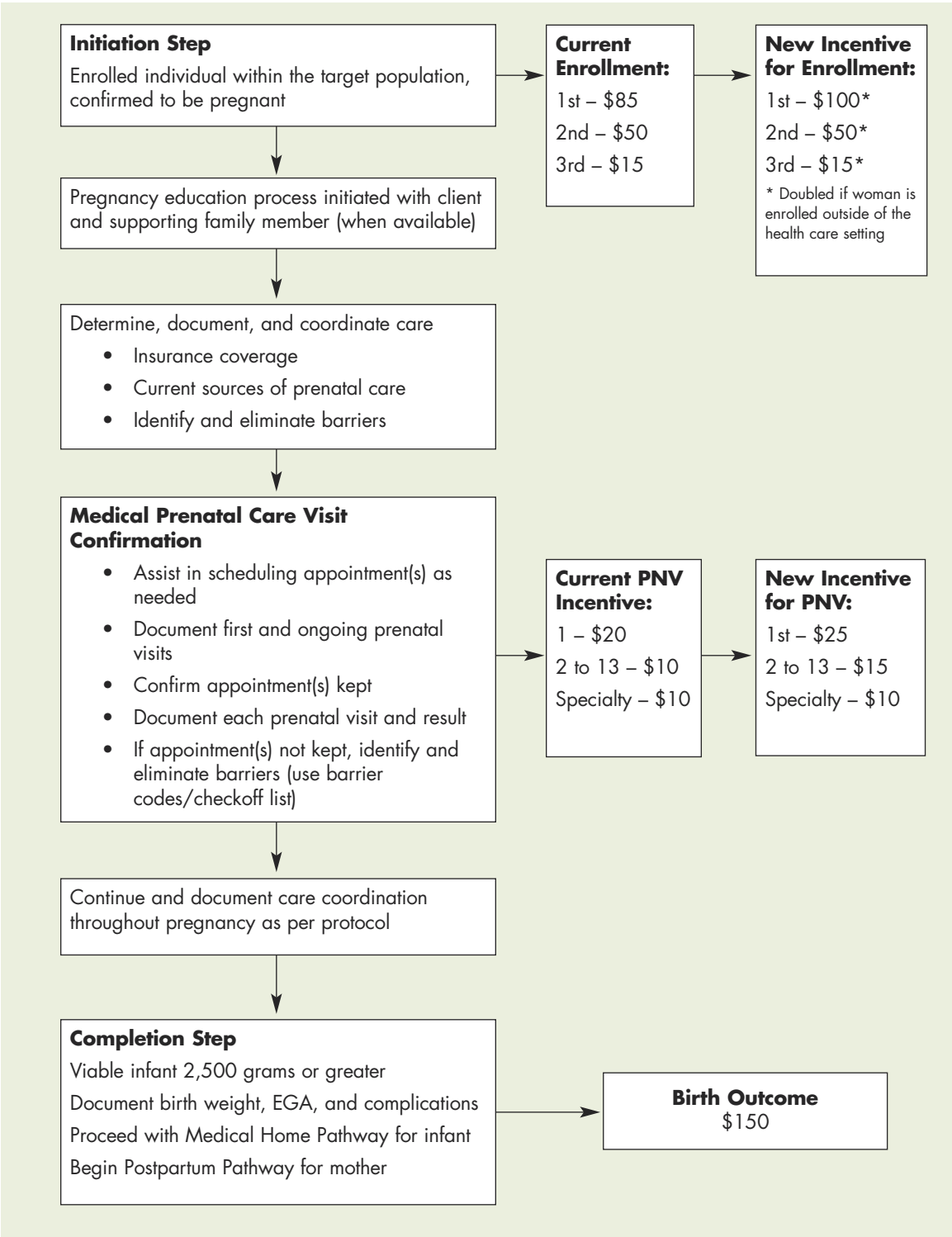
substantially higher pay and benefits consistent with their outstanding work and the additional support they bring to the program.

There are four parts to this incentive system—if a CHW achieves maximum levels for each, he or she receives an additional one dollar per hour for that 2-week pay period.

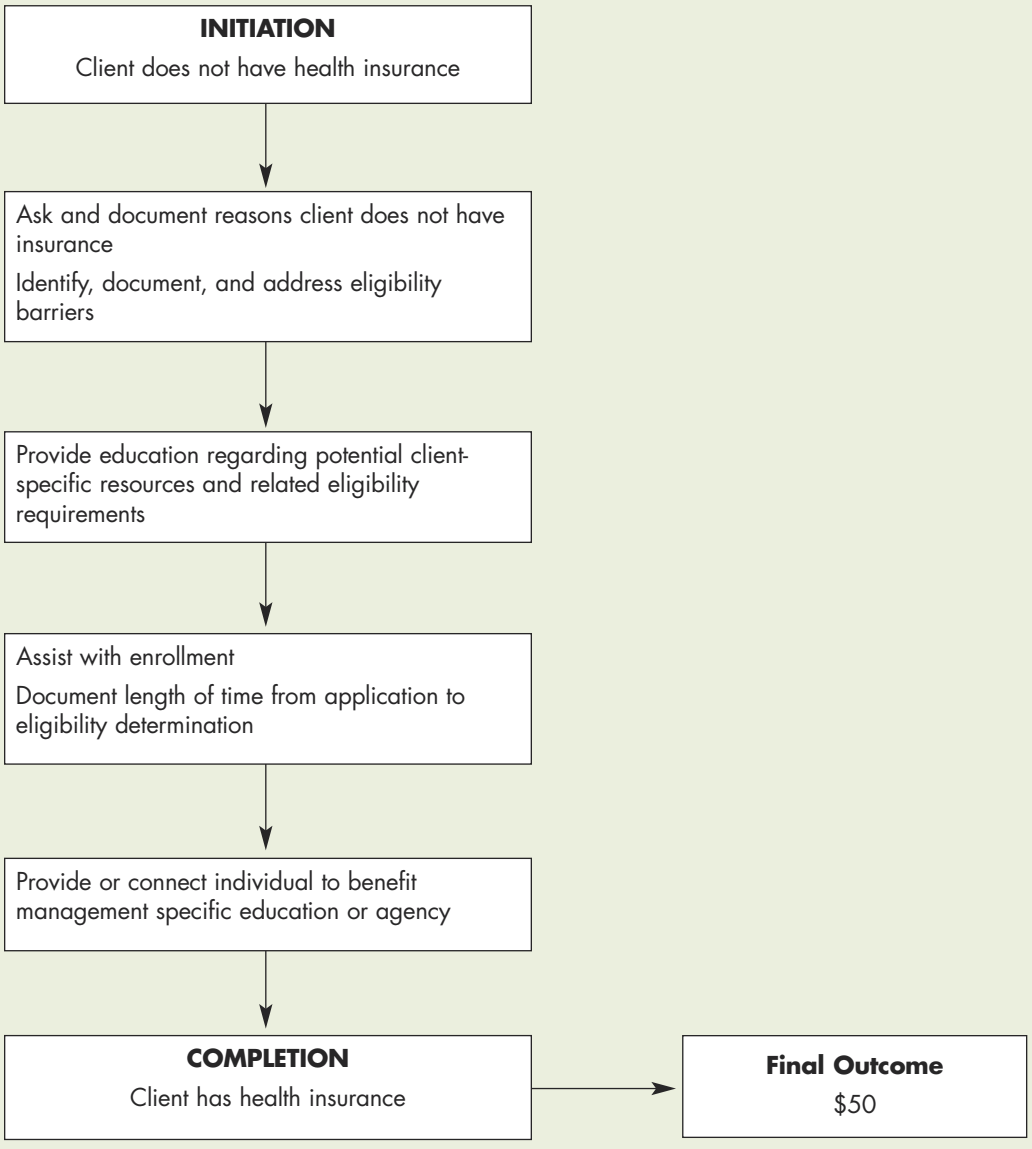
- **Home visit quality (10 percent or 10 cents on the dollar):** After completing a home visit, the CHW fills out a scorecard evaluating the visit that contains questions identified by the QA Committee as being in need of improvement. If all questions are recorded satisfactorily, the CHW receives the full incentive. The incentive is reduced proportionately if not all questions are marked appropriately.
- **Number of home visits (15 percent or 15 cents on the dollar):** The number of home visits is tracked in a database. CHWs completing fewer than 18 home visits do not quality for the incentive. Those completing more than 28 visits receive the full incentive, while those between 18 and 28 receive a proportionate amount. Because some home visits require more time than others (based on the complexity of the client), the QA Committee considered both work time and contracts in setting up the 18-to-28 range.
- **Number of active clients (15 percent or 15 cents on the dollar):** The CHW must have at least 35 clients to receive any incentive from this category and receives the full 15 cents on the dollar additional if they have more than 50 clients. This range was again based on analysis by the QA Committee.
- **Weighted pathways completed (60 percent or 60 cents on the dollar):** CHAP has developed a scoring system to weight each pathway based on importance and the average amount of time it takes to complete. For example, a completed pathway that documents a successful referral counts as 1 point, a completed immunization pathway counts as 5 points, and a completed pregnancy pathway counts as 10 points. Standards for the minimum and maximum total score per 2-week period were developed by evaluating top- and medium-performing CHWs. To achieve the full 60 cents on the dollar, the CHW must score at least 60 points; to achieve 50 percent (or 30 cents on the dollar), CHWs must score at least 40 points. Those achieving between 40 and 60 points receive pro-rated amounts between 30 and 60 cents.

Example of Tying Incentives to Pathways

Toledo Community Hub
Pregnancy Pathway



Toledo Community Hub
Insurance Pathway



Sample Performance Report for Individual Provider

Quarterly Report

Provider _____

Report Period _____ thru _____

	Quarterly	YTD
Total Clients Served		
New Clients		
1st Trimester		
2nd Trimester		
3rd Trimester		
Other		
Number of Home Visits		
Number of Prenatal Visits		
Newborn Babies		
Normal (5 lbs 8 oz or >)		
Low Birth Weight		
Very Low Birth Weight		
Mortality		

Examples of Training Curriculum and Policies/Procedures

Sample Curriculum

Greater Cincinnati Pathways Hub Program
Curriculum Offered at Cincinnati State Community College

Term 1

		Lec	Lab	Clin	CR	Con.
CHW XXXX	Community Health Worker 1	2	0	5	3	7
MCH 4816	Health and Wellness Promotion	2	0	0	2	2
MCH 4805	Patient Care Skills	1	3	0	2	4
		5	3	5	7	13

Term 2

		Lec	Lab	Clin	CR	Con.
CHW XXXX	Community Health Worker 2	2	0	5	3	7
MCH 4884	Cultural Competency for Health and Public Safety Professions	3	0	0	3	3
EMS 4732	CPR-BLS	0	1	0	0.5	1
		5	1	5	6.5	11

Term 3

		Lec	Lab	Clin	CR	Con.
CHW XXXX	Community Health Worker 3	1	0	8	3	9
	Total Hours:	**11**	**4**	**18**	**16.5**	**33**

*Note:

Actual Clinical Lab contact hours: 18 contact/week x 9 weeks = 162 hours

Actual Lecture/Lab contact hours: 15 contact/week x 9 weeks = 135 hours

Total: = 297 hours

The State Board of Nursing requires a minimum of 130 clinical contact hours and 100 didactic hours.

Community Health Worker Program Course Descriptions

CHW XXXX Community Health Worker 1/ 2-5-3

Course Description

This course provides beginning lecture, lab, and clinical practice in community health worker settings, applying concepts defined by the Ohio Board of Nursing Community Health Worker Program. Topics include: health care, data collection, communication in the client setting, community resources, community and individual advocacy, documentation, and reporting.

Prerequisite: Admission into the CHW program

CHW XXXX Community Health Worker 2/ 2-5-3

Course Description

This course provides intermediate lecture, lab, and clinical practice and reinforcement and assessment of skills learned in CHW 1. New topics include: pregnancy, childbearing and neonatal/pediatric special populations health care in adults, geriatric special populations, community health issues related to disabled clients, and family caregivers.

Prerequisite: CHW 1 completed with a "C" or better.

CHW XXXX Community Health Worker 3/ 1-8-3

Course Description

This is the final course in the Community Health Worker curriculum, providing reinforcement and application of topics previously introduced and proficiency assessment of skills learned in the previous coursework. Includes classroom hours for study and reflection of practicum experiences. Students will work in specific community health settings under the supervision of faculty and preceptors.

Prerequisite: CHW 2 completed with a "C" or better.

Sample Policy and Procedure Document

Greater Cincinnati Pathways Hub Policies and Procedures

These policies and procedures are undergoing revision. They are provided here as a sample only and may not reflect current practices.

All Pathways Hub employees/contractual staff will be trained and will implement the following policies and procedures.

Definitions

Pathways Hub = The office located at Healthy Moms & Babes, Inc., 2270 Banning Rd., Suite 200, Cincinnati, Ohio 45239.

Participating Pathway agency = Agencies under contract with the Pathways Hub to enroll, provide, and document care coordination for eligible high-risk clients who are pregnant. (Cincinnati Health Department, Hamilton County Job and Family Services, Healthy Moms & Babes, Inc., Santa Maria Community Services, TriHealth Parish Nurse Program).

a. **Form and Data Collection and Storage – Hard Copy**

The following data is collected and stored (in a locked file cabinet) by the Program Manager or Administrative Coordinator for the Pathways Program:

1. **Participating Agency Meeting Notes.** Notes and agendas for meetings between the Hub and each Participating Agency (by the Program Manager or Administrative Coordinator) are filed in the locked file cabinets in the Hub office. In the files, they are located in each respective agency section in the lead file folder marked with the agency name.
2. **Pathways Agencies Contracts.** These are the contracts that outline the agreements between the participating Pathways agencies and the Hub. These signed contracts are filed in the locked file cabinets in the Hub office. In the files, they are located in each respective agency section in a file folder marked, "ROI – Contract."
3. **Pathways Agencies Release of Information (ROI).** These are the forms that each participating Pathways agency uses when enrolling clients into the Pathways Program. This form documents the client's permission to disclose specific information and to be protected under HIPAA. Client enrollments are not accepted unless accompanied by a signed ROI by each client. The sample forms that each participating Pathways agency uses are filed in the locked file cabinets in the Hub office. In the files, they are located in each respective agency section in a file folder marked, "ROI – Contract."
4. **Referrals.** Referrals from outside organizations (e.g., Amerigroup) that are faxed into the Hub (they cannot be sent electronically/Internet) are filed in the locked file cabinets in the Hub office. In the files, they are located (a) in a file under the specific referring organization (e.g., "Referrals – Amerigroup"), and, (b) in a file in each respective agency section labeled, "Referrals" (with the specific referrals that agency was assigned). Also,

there is a file marked "Return Referrals" behind the specific referring organization file. These are referrals that were unable to be found or enrolled by a participating agency, or that the Hub was unable to verify. (This information is also entered into the Pathways Client database.)

5. **Client Insurance Designation.** The Hub requests each participating agency to track the type of insurance coverage for each Pathways client. This information is faxed to the Hub (it cannot be sent electronically/Internet) by Participating Agencies on a periodic basis and is filed in the locked file cabinets in the Hub office. In the files, they are located in a folder marked "Insurance" in each respective agency section.
   (This information is also entered into the Pathways Client database.)

6. **Participating Agency Audits.** Each Participating Agency must be audited prior to release of any payment by the Program Manager or Administrative Coordinator. These audits are to ensure that compliance with the required documentation on Enrollment and Pathways forms is substantiated. The audits take place at the Participating Agency location and are scheduled. The completed audit on each agency will be filed in the locked file cabinets in the Hub office. In the files, they are located in a folder marked "Audit" in each respective agency section.

7. **Client Enrollment Forms.** These are the forms each participating Pathways agency must use for a potential client to be enrolled into the Pathways Program. This form must be faxed to the Hub (it cannot be sent electronically/Internet). Once accepted or denied, the form (with the required client ROI) is filed in the Participating Agency file in the locked file cabinets in the Hub office. In the files, they are located in each respective agency section in the client enrollment folders, alphabetically. (See Attachment B – Client Enrollment Form.)
   (This information is also entered into the Pathways Client database.)

8. **Completed Client Pathways Forms.** There are currently three Pathways forms:

   a. Pregnancy Pathway (See Attachment C.)

   b. Medical Home Education Pathway (See Attachment D.)

   c. Medical Home Pathway – Infant (See Attachment E.)

In order to receive payment for outcomes, each Participating Agency must submit by fax (they cannot be sent electronically/Internet) completed Pathways forms to the Hub. These forms are filed in the locked file cabinets in the Hub office. In the files, they are matched up with that client's previously filed Enrollment and ROI forms and then filed alphabetically under "Completed" Pathways in each respective agency section in the client folders section. (This information is also entered into the Pathways Client database.)

9. **Client Enrollment Listing.** A current Client Enrollment listing is filed in the locked file cabinets in the Hub office. In the files, it is in a folder marked "Current Enrollments." This listing is used as a cross-reference to ensure that there is no duplication of incoming client enrollments from Participating Agencies. (This information is also entered into the Pathways Client database.)

10. **Denied Enrollments.** When a potential client enrollment is received and denied by the Hub (e.g., the client was currently enrolled or the client does not reside in an eligible census tract/target neighborhood), it will be filed in the locked file cabinets in the Hub office. In the files, it is in a folder marked "Denied Enrollments."

11. **Other Contracts.** All other contracts between the Hub and outside agencies are filed in the locked file cabinets in the Hub office. In the files, they are in folders marked by the type of contract (e.g., "Amerigroup Contract").

12. **Other Information/Files.** Any other information that may be considered confidential will be filed and locked in the locked file cabinets in the Hub office. In the files, this information is in folders that are titled by their content.

13. **CHW Survey Files.** The Community Health Worker Survey (Hamilton County, Ohio/September 2007) documents from confidential phone interviews that took place between April and August 2007 are locked in the locked file cabinets in the Hub office. These documents were the primary collection method for the information that contributed to the CHW Survey report.

b. **Data Exchange With Contractual Partners**

The following data can be exchanged by phone or fax (not electronically/Internet) by the Program Manager or Administrative Coordinator of the Pathways Program with identified contacts of contractual partners with HIPAA agreements in place:

1. **Pathways Information.** Participating Agency, Pathway Coordinator, and Pathway Supervisor. Client name, address, phone, birth date, census tract, neighborhood, race, prenatal/infant clinic and appointment dates, medical home location, birth weight of infant, barriers to getting prenatal/infant care, insurance status and carrier, gestation period, and enrollment date.

2. **Referrals.** Client name, address, phone, birth date, census tract, neighborhood, race, and notes on medical and social issues. Participating Agency and Pathway Coordinator.

3. **Participating Agency Enrollments.** Total numbers, names, and identifying information on clients enrolled in the Pathways program.

4. **Billing.** Contractual partners who are paying for Pathway points and have HIPAA agreements in place will be provided with the following data on designated Pathway enrollees: Name, address, phone, birth date, census tract, neighborhood, race, prenatal/infant clinic and appointment dates, medical home location, birth weight of infant, barriers to getting prenatal/infant care, insurance status and carrier, and gestation period.

c. **Data Storage – Computer**

The following data is entered into the Access database by the Program Manager or Administrative Coordinator for the Pathways Program. This information cannot be transmitted electronically/Internet and is stored in a secured database that can only be accessed by the Program Manager or Administrative Coordinator.

1. **Client Data.** All information from the Pathways forms:

   a. Pregnancy Pathway (See Attachment C.)

   b. Medical Home Education Pathway (See Attachment D.)

   c Medical Home Pathway – Infant (See Attachment E.)

2. **Agency Billing Information.** Participating Agency name, address, contact person, and billing recipient. Billing request with client name/identifier and date. Billing confirmation or explanation, payment release, and date.

3. **Payer Billing Information.** Payer name, address, contact person, total billing amount, and date payment requested. Client(s) designated to billing and related Pathways data. Date payment received.

d. **Data Reporting**

The following data can be reported by the Program Manager or Administrative Coordinator for the Pathways Program. No client identifiers may be present in any reports.

1. **Agency Enrollments and Completions.** Progress and status of Participating Agency client enrollments, client birth outcomes, neighborhoods, client race and age, gestation periods, trimester of enrollments, barrier codes, medical homes, insurance status, and carriers.

2. **Client Data.** Aggregate client birth outcomes, neighborhoods, client race and age, gestation periods, trimester of enrollments, barrier codes, medical homes, insurance status, and carriers.

e. **Data Retention and Destruction**

In accordance with the Sarbanes-Oxley Act, which makes it a crime to alter, cover up, falsify, or destroy any document with the intent of impeding or obstructing any official proceeding, this policy provides for the systematic review, retention, and destruction of documents received or created by the Pathways Hub in connection with the transaction of organization business. This policy covers all records and documents, regardless of physical form, and contains guidelines for how long certain documents should be kept and how records should be destroyed. The policy is designed to ensure compliance with Federal and State laws and regulations, to eliminate accidental or innocent destruction of records, and to facilitate the Pathways Hub's operations by promoting efficiency and freeing up valuable storage space.

1. **Pathways Hub follows the document retention procedures outlined below. Documents that are not listed, but are substantially similar to those listed in the schedule, will be retained for the appropriate length of time.**

   Client Files (all information): 7 Years
   Referrals (all information): 7 Years
   Participating Agency Contracts: 7 Years
   Participating Agency Meetings/Notes: 7 Years
   Payer Contracts (all, including grants): 7 Years
   Participating Agency Billing Information: 7 Years
   Payer Billing Information: 7 Years
   Steering Committee Minutes: 7 Years
   Contracts (after expiration): 7 Years
   Correspondence (general): 7 Years

2. **Electronic Documents and Records**

   Electronic documents will be retained as if they were paper documents. Therefore, any electronic files that fall into one of the document types on the above schedule will be maintained for the appropriate amount of time. If a user has sufficient reason to keep an e-mail message, the message should be printed in hard copy and kept in the appropriate file or moved to an "archive" computer file folder. Backup and recovery methods will be tested on a regular basis.

3. **Emergency Planning**

   Pathway's Hub records will be stored in a safe, secure, and accessible manner. Documents and financial files that are essential to keeping the Pathways Hub operating in an emergency will be duplicated or backed up at least every week.

4. **Document Destruction**

   The Pathways Hub Program Manager or Administrative Coordinator will be responsible for the ongoing process of identifying its records that have met the required retention period and overseeing their destruction. Destruction of financial and personnel-related documents will be accomplished by shredding.

   In addition, any paper documents that will not be utilized or filed will be destroyed by shredding.

   Document destruction will be suspended immediately upon any indication of an official investigation or when a lawsuit is filed or appears imminent. Destruction will be reinstated upon conclusion of the investigation.

f. **Compliance**

Failure on the part of employees to follow this policy can result in possible civil and criminal sanctions against the Pathways Hub and its fiscal agent and possible disciplinary action against responsible individuals. The fiscal agent/chief financial officer will periodically review these procedures with legal counsel or the organization's certified public accountant to ensure that they are in compliance with new or revised regulations.

Glossary of Abbreviations Used in This Report

ACCEL - Access El Dorado (Placerville, CA)

AHRQ - Agency for Healthcare Research and Quality

CCCLN - Community Care Coordination Learning Network

CHAP - Community Health Access Project (Mansfield, OH)

CHW - Community Health Worker

COPA - Central Oklahoma Project Access Community Health Worker/Health Care Navigator Program (Oklahoma City, OK)

CRHN - Care Coordination Programs of CHOICE Regional Health Network (Olympia, WA)

ED - Emergency Department

EGA - Estimated Gestational Age

HCAP - Healthy Communities Access Program

HIPAA - Health Insurance Portability and Accountability Act

HPI - Health Partners Initiative (Lincoln, NE)

HRSA - Health Resources and Services Administration

LBW - Low Birth Weight

MCHP - Muskegon Community Health Project (Muskegon, MI)

RUAH - Rural and Urban Access to Health

TANF - Temporary Assistance to Needy Families

Triple P - Positive Parenting Program

Other Resources

- Pathways: Building a Community Outcome Production Model. Community Health Access Project, Mansfield, Ohio. Available at: http://www.chap-ohio.net/documents/PathwaysManual.pdf.
- 20 Predictors of a Successful Project. In Virginia Health Care Foundation Grant Guidelines, pp. 14-15. Available at: http://www.vhcf.org/grants/documents/GrantGuidelines-updatedaddress.pdf.
- Local Health System Collaborative Readiness and Assessment Tool. This tool helps a community assess its readiness to collaborate on any project.
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Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

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