Board of Trustees
April 19, 2018

- Review transformation planning and accountability
- Review input for phase 1 funds flow development
- Phase 1 funds flow approval
- Washington State Measure Sets (P4R, P4P, MCO, State)
- Review Pathways Community Care Coordination
Goals

- Review transformation planning and accountability
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Transformation Goals – Where & What?

- Use improvement methodology to work in and across settings to implement key change ideas and standards of care for:
  - whole person integrated care
  - care coordination
  - patient outcomes, provider experiences, and access
Transformation Goals – How?

Identify the sites of care and providers those populations rely most heavily upon for care and infuse resources and supports to transform those settings.

- Quality Improvement Technical Assistance
- Value Based Payment Support
- Workforce Development
- Authentic Community Voice
- Tools and Technology for Population Health Management
- Health Equity Policies, Procedures and Capacity Building, Anti-Stigma Policies
- Community Clinical Linkages/Partnership Development
Transformation Goals – Shared Learning Infrastructure

• Use data to optimize efforts and evaluate the **total community impact** of our work. **Spread effective approaches** to other populations, settings, and providers throughout the region through a **Community-Driven Shared Learning Infrastructure**.
  ➢ Collective Impact Learning Collaborative
  ➢ Robust Monitoring and Evaluation
  ➢ Community Resiliency Fund
  ➢ Health and Equity in All Policies and Systems Changes
ROLE CLARITY SLIDE

Ad hoc committee vs. future investment and waiver committee roles
Funds Flow Guiding Key Principles

**Equitable**
- Balances equity to all partners with an intended impact

**Sustainable**
- Commits to a long-term vision, established by foundational infrastructure that is adaptable over time

**Transformative**
- Builds capacity through collaboration across settings while committed to the long-term vision and remaining adaptable

**Transparent**
- Promotes a simple, easy-to-understand model that is adaptable over time and meets special terms and conditions (STC) requirements

**Locally responsive**
- Meets the needs of the Southwest ACH locality
Four High Level Funds Flow Categories

- **ACH Admin**
  - Administrative operating expenses of SWACH
    - Legal
    - Financial
    - Facilities
    - Equipment

- **Community Resiliency Fund**
  - Funds investments impacting upstream factors and innovative solutions.

- **Regional Capacity Investments**
  - Funds for ACH to make regional investments that support partners for specific purposes including workforce, health IT / HIE, training, and other infrastructure funds.
  - Funds will be used to promote large scale transformation and sustainability across the region.

- **Transformation Plan Implementation**
  - Funds paid directly to partners to plan for and achieve DSRIP goals and overall transformation.
    - Assessments
    - Transformation plans
    - Partnership support
    - Implementation support
### How Many Dollars Are There?

<table>
<thead>
<tr>
<th>Projects</th>
<th>$7.2M</th>
<th>$9.2M</th>
<th>$7.8M</th>
<th>$7.3M</th>
<th>$5.9M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$1.8M</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
</tr>
<tr>
<td>(25%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional Capacity Investments</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td></td>
</tr>
<tr>
<td>Year 2</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
</tr>
<tr>
<td>Year 3</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
</tr>
<tr>
<td>Year 4</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
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<tr>
<td>Year 5</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
<td>$?</td>
</tr>
</tbody>
</table>

#### To support bi-directional integration across Clark, Skamania, and Klickitat Counties

**FIMC**

- **$8.7M**
- Year 1: $1.8M (25%)
- Year 2: $?
- Year 3: $?
- Year 4: $?
- Year 5: $?

**Regional Capacity Investments**

- Year 1: $1.8M
- Year 2: $?
- Year 3: $?
- Year 4: $?
- Year 5: $?

**Partners Transformation Plans/Implementation**

- Year 1: $4M (55%)
- Year 2: $?
- Year 3: $?
- Year 4: $?
- Year 5: $?

**ACH Admin**

- Year 1 = $721,217 (10%)
<table>
<thead>
<tr>
<th>Year 1 Transformation Plan Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$1.7M Planning</strong></td>
</tr>
<tr>
<td>Assessments</td>
</tr>
<tr>
<td>Transformation Plan</td>
</tr>
<tr>
<td><strong>$2.3M Implementation</strong></td>
</tr>
<tr>
<td>Equity/Stigma Incentive Pool</td>
</tr>
<tr>
<td>Partnership Agreements Incentive Pool</td>
</tr>
<tr>
<td>Implementation Agreements</td>
</tr>
</tbody>
</table>
Settings to Transform

ED/Acute Care
• Partner to improve transitions of care
• Partner with law enforcement and community paramedicine to reduce unnecessary ED utilization
• Implement clinical opioid guidelines and protocols for opioid overdose management
• Acute Interventions
• Telemedicine (BH, Pain, SUD)
• Participate in Pathways HUB (targeted populations)

Emergency Medical Response
• Partner with LE and acute care on ED diversion
• Community Paramedicine crisis management and chronic disease management
• Participate in the Pathways HUB (targeted populations)

SWACH Pathways HUB (targeted populations)
• Provide/partner to deliver integrated BH/PH services
• Participate in community-based care coordination with Pathways HUB for targeted populations
• Partner with patients to prevent and manage chronic disease
• Implement clinical opioid guidelines, provide MAT for OUD
• Partner to improve transitions of care
• Telemedicine (BH, Pain, SUD)
• Oral Health
• Maternal Child Health

Integrated Clinical Health

MCO / Payer

Law Enforcement & Justice Diversion
• Manage PH/BH needs
• MAT in the Jail setting
• Partner with Law Enforcement, the Courts, the Jail Systems for Jail Diversion and Transitions Strategies
• Participate in the Pathways HUB (targeted populations)

Post-acute care
• Partner to improve transitions of care
• Participate in Pathways HUB (targeted populations)

Care Coordination Agencies and CBOs
Provide community-based care coordination services via standardized pathways for targeted populations
Washington Measure Sets

- ACH Pay for Performance (P4P) Measures
- ACH Pay for Reporting (P4R) Measures
- Washington Statewide Accountability Measures (State)
- Managed Care Organization (MCO) Measures
ACHs will earn a portion of their funding based on their performance (aggregate performance for the region) on the P4P measures.

HCA is responsible for calculating ACH performance on P4P measures; the state will not require any additional reporting from participating providers for these measures.

HCA will calculate these measures at the ACH level (and maybe also at the county level), not at the provider / practice level.
### ACH Pay for Performance (P4P) Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Integration</th>
<th>Care Coordination</th>
<th>Opioids</th>
<th>Chronic Disease</th>
<th>State</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause Emergency Department (ED) Visits</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Inpatient Hospital Utilization</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Follow up after ED visit for mental health</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow up after hospitalization for mental illness</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up after ED visit for alcohol or drug dependence</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health treatment penetration</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent homeless</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan All-Cause Readmissions</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Substance use disorder treatment penetration</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child and Adolescents’ Access to Primary Care Practitioners</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*Note: X indicates a measure is included in the respective category.*

---

**ACH Pay for Performance (P4P) Measures**

**SWACH**
**ACH Pay for Performance (P4P) Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Integration</th>
<th>Care Coordination</th>
<th>Opioids</th>
<th>Chronic Disease</th>
<th>State</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam performed</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: HbA1c testing</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management for People with Asthma (5-64 years)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on high-dose chronic opioid therapy</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients with concurrent sedatives prescriptions</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Substance use disorder treatment penetration (opioids)</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ACH Pay for Reporting (P4R) Measures

• ACHs earn incentive payments for successfully completing and reporting on project planning and implementation milestones (e.g. submitting Project Plan, November 2017).

• ACHs will also earn incentive payments for ensuring complete and timely reporting of Pay for Reporting measures to support project monitoring and evaluation.
P4R Overview
Objectives and Key Parameters

P4R metrics provide more detailed information to HCA and ACHs on partnering provider-level implementation progress

Key Parameters

- Set list of metrics for DY 3 through DY 5
- 6 month reporting periods, beginning 2019
- ACHs determine data collection approach that works best for their region
- ACHs report data in a State-provided workbook
- ACHs are not assessed on performance on these P4R metrics – region receives credit based on collection and submission of P4R metric information by the deadline
Evolution of P4R Metrics

HCA has been reviewing metrics to determine applicability, relevance and feasibility and developing additional guidance and a streamlined ACH reporting tool.

Key Changes

✓ Eliminated a number of metrics duplicative to information that may be collected through other efforts
✓ Eliminated “All Project” metrics
✓ Revised 2A metric and aligned with existing Healthier Washington Practice Transformation Hub tool widely in use across the state
✓ Edited several metrics for clarity

<table>
<thead>
<tr>
<th>Metrics (subject to refinement based on pre-testing)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice/Clinic Site—Project 2A</strong></td>
</tr>
<tr>
<td>Assessment of integration of physical and behavioral health care (MeHAF Site Self Assessment tool)</td>
</tr>
<tr>
<td><strong>Practice/Clinic Site—Project 3A</strong></td>
</tr>
<tr>
<td>Providers are trained on guidelines on prescribing opioids for Pain</td>
</tr>
<tr>
<td>Practice/clinic site has EHRs or other systems that provide clinical decision support for the opioid prescribing guidelines</td>
</tr>
<tr>
<td>Mental health and SUD providers deliver acute care and recovery services for people with OUDs</td>
</tr>
<tr>
<td>ED has protocols in place for providing overdose education, peer support and take-home naloxone to individuals seen for opioid overdose</td>
</tr>
<tr>
<td><strong>CBO—Project 3A</strong></td>
</tr>
<tr>
<td>Organization site connects persons to MAT providers</td>
</tr>
<tr>
<td>Organization site received technical assistance to organize or expand syringe exchange programs</td>
</tr>
</tbody>
</table>
Maine Health Access Foundation (MeHAF)

The Maine Health Access Foundation (MeHAF) developed the Site Self Assessment (SSA) Survey to assess levels of primary and behavioral care integration.

✓ Two domains:
  1) Integrated services and patient and family services (12 characteristics)
  2) Practice/organization (9 characteristics)

✓ Each domain has a set of characteristics to rate on a scale of 1 to 10 depending on the level of integration or patient-centered care achieved.

Instructions for Completing the MeHAF Site Self Assessment (SSA) Survey

The purpose of this assessment is to show your current status along several dimensions of integrated care and to stimulate conversations among your integrated care team members about where you would like to be along the continuum of integrated care. Please focus on your site’s current extent of integration for patient and family-centered primary care, behavioral and mental health care. Future-repeated administrations of the SSA form will help to show changes your site is making over time. Organizations working with more than one site should ask each site to complete the SSA.

Please respond in terms of your site’s current status on each dimension. Please rate your patient care teams on the extent to which they currently do each activity for the patients/clients in the integrated site. The patient care team includes staff members who work together to manage integrated care for patients. This often, but not always, involves health care providers, behavioral health specialists, specialty care providers, case managers or health educators and front office staff.

Using the 1-10 scale in each row, circle (or mark in a color or bold, if completing electronically) one numeric rating for each of the 18 characteristics. If you are unsure or do not know, please give your best guess, and indicate to the side any comments or feedback you would like to give regarding that item. NOTE: There are no right or wrong answers. If some of this wording does not seem appropriate for your project, please suggest alternative wording that would be more applicable, on the form itself or in a separate email.

This form was adapted from similar formats used to assess primary care for chronic diseases.
### Participants Record Item-Level Responses

#### 1. Integrated Services and Patient and Family-Centeredness

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Level of integration; primary care and mental/behavioral health care</td>
<td>. . . none; consumers go to separate sites for services</td>
</tr>
<tr>
<td></td>
<td>. . . are coordinated; separate sites and systems, with some communication among different types of providers; active referral linkages exist</td>
</tr>
<tr>
<td></td>
<td>. . . are co-located; both are available at the same site; separate systems, regular communication among different types of providers; some coordination of appointments and services</td>
</tr>
<tr>
<td></td>
<td>. . . are integrated, with one reception area; appointments jointly scheduled; shared site and systems, including electronic health record and shared treatment plans. Warm hand-offs occur regularly; regular team meetings.</td>
</tr>
<tr>
<td>Levels</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>5 6 7</td>
</tr>
<tr>
<td></td>
<td>8 9 10</td>
</tr>
<tr>
<td>2. Screening and assessment for emotional/behavioral health needs (e.g., stress, depression, anxiety, substance abuse)</td>
<td>. . . are not done (in this site)</td>
</tr>
<tr>
<td></td>
<td>. . . are occasionally done; screening/assessment protocols are not standardized or are nonexistent</td>
</tr>
<tr>
<td></td>
<td>. . . are integrated into care on a pilot basis; assessment results are documented prior to treatment</td>
</tr>
<tr>
<td></td>
<td>. . . tools are integrated into practice pathways to routinely assess MH/BH/PC needs of all patients; standardized screening/assessment protocols are used and documented.</td>
</tr>
<tr>
<td>Levels</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>5 6 7</td>
</tr>
<tr>
<td></td>
<td>8 9 10</td>
</tr>
<tr>
<td>3. Treatment plan(s) for primary care and behavioral/mental health care</td>
<td>. . . do not exist</td>
</tr>
<tr>
<td></td>
<td>. . . exist, but are separate and uncoordinated among providers; occasional sharing of information occurs</td>
</tr>
<tr>
<td></td>
<td>. . . Providers have separate plans, but work in consultation; needs for specialty care are served separately</td>
</tr>
<tr>
<td></td>
<td>. . . are integrated and accessible to all providers and care managers; patients with high behavioral health needs have specialty services that are coordinated with primary care</td>
</tr>
<tr>
<td>Levels</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>5 6 7</td>
</tr>
<tr>
<td></td>
<td>8 9 10</td>
</tr>
<tr>
<td>4. Patient care that is based on (or informed by) best practice evidence for BH/MH and primary care</td>
<td>. . . does not exist in a systematic way</td>
</tr>
<tr>
<td></td>
<td>. . . depends on each provider’s own use of the evidence; some shared evidence-based approaches occur in individual cases</td>
</tr>
<tr>
<td></td>
<td>. . . evidence-based guidelines available, but not systematically integrated into care delivery; use of evidence-based treatment depends on preferences of individual providers</td>
</tr>
<tr>
<td></td>
<td>. . . follow evidence-based guidelines for treatment and practices; is supported through provider education and reminders; is applied appropriately and consistently</td>
</tr>
<tr>
<td>Levels</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td>5 6 7</td>
</tr>
<tr>
<td></td>
<td>8 9 10</td>
</tr>
</tbody>
</table>
Provider Pre-Testing P4R Metrics

HCA is seeking ACHs’ partnership to pre-test P4R metrics and inform additional refinement of P4R metrics by May

1. Identify 2 partnering provider organizations candidates to test P4R metrics by April 20th
   - Across ACHs, seeking interview candidates that will represent diversity of characteristics:
     - **Size/Setting**: Rural, Small, Large/Mixed
     - **Provider Type**: Primary Care, Mental Health Counseling/Treatment, Substance Use Disorder Counseling/Treatment, Community Based Organization
   - Send 2 primary partnering provider organization candidates and 1 back-up partnering provider organization candidate and which characteristics are applicable to medicaidtransformation@hca.wa.gov by Friday, April 20th.

2. Outreach to 2 partnering provider organizations candidates to test P4R metrics by April 27th
   - Manatt will share provider outreach materials with ACHs
   - Manatt may ask for your support in identifying additional, specific types of organizations to ensure representation of the characteristics listed above across ACHs

3. Participate in provider interview
   - Manatt will facilitate provider interviews, summarize findings and identify areas for clarification and refinement
   - HCA will further refine P4R metrics based on feedback
**Medicaid Transformation Demonstration Waiver project requirements**

**Health Systems & Community Capacity Building**

- These required elements are the foundation for transformation projects:
  - Financial sustainability through value-based payment (VBP)
  - Workforce development related to specific initiatives
  - Systems for population health management

**Care Delivery Redesign**

- Required project:
  Bi-directional integration of care and primary care transformation

Choose at least one:
- Community-based care coordination
- Transitional care
- Diversion interventions

**Prevention & Health Promotion**

- Required project:
  Addressing the opioid use public health crisis

Choose at least one:
- Maternal and child health
- Access to oral health services
- Chronic disease prevention and control
Community Care Coordination

- care coordination provided in the community
- confirms connection to health and social services.

A Community Care Coordinator:

- Finds and engages at-risk individuals
- Comprehensive risk assessment
- Confirms connection to care
- Tracks and measures results
Foundation of the Model

Step 1: Find
Comprehensive Risk Assessment

Step 2: Treat
Assign Pathways

Step 3: Measure
Track/Measure Results (Connections to Care)
One Care Coordinator for the Entire Family
Find: Comprehensive Risk Assessment

Standard Data Collection:
- Release of Information (ROI)
- Client Intake
- Initial Checklist (enrollment)
- Ongoing Checklist at each face-to-face visit
Find: Comprehensive Risk Assessment

Standard Data Collection:
- Release of Information (ROI)
- Client Intake
- Initial Checklist (enrollment)
- Ongoing Checklist at each face-to-face visit
20 Core Pathways – National Certification

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral
- Behavioral Referral
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy
- Postpartum
Treat: Risk = Pathways (PW)

20 Standard Pathways:
• One risk factor at a time
• Outcome achieved = finished PW & Payment!
• Outcome not achieved = finished incomplete PW
“Typical” Family at Risk

Marisol, 28
- Pregnancy PW
- Housing PW
- Social Service Referral PW – Transportation
- Employment PW

Marcus, 6
- Medical Home PW
- Medication Assessment PW
- Tool – Asthma Action Plan
- Social Service Referral PW – Education support

Mrs. Garcia
- Medical Referral PW
- Education PW
- Employment PW
- Education PW - Diabetes
- Smoking Cessation PW
One Care Coordinator for the Entire Family
## Distinctions between Pathways & HUB

<table>
<thead>
<tr>
<th>Pathways</th>
<th>Community HUB</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Patient-centered, care coordination tool</td>
<td>– Tracks Pathways (outcomes) across agencies</td>
</tr>
<tr>
<td>– Identifies and “translates” patient risks</td>
<td>– Eliminates duplication</td>
</tr>
<tr>
<td>– Measured outcomes</td>
<td>– Streamlines referrals</td>
</tr>
<tr>
<td>– Payments for measured Pathway outcomes</td>
<td>– Provide infrastructure for community-based care coordination</td>
</tr>
<tr>
<td></td>
<td>– Involve braided funding – Pathways can be purchased by different funders</td>
</tr>
</tbody>
</table>
Regional Organization and Tracking of Care Coordination

COMMUNITY HUB

Agency A
Agency B
Agency C
Agency D

CARE COORDINATION AGENCIES (CCA)

- Demographic Intake
- Initial Checklist -- assign Pathways
- Regular home visits – Checklists and Pathways completed
- Discharge when Pathways completed (no issues)
# Measure

**Track and Measure Progress with Pathways**

**By Community Care Coordinator**

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW A</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>CHW B</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CHW C</td>
<td>9</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>

**By Agency**

<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency A</td>
<td>50</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Agency B</td>
<td>64</td>
<td>17</td>
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<tr>
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- Care Coordinator
- Agency
- HUB
- Community
- Region
- Etc…
Key Points to Building a HUB

- The HUB must be a neutral entity in the community and cannot employ its own care coordinators.

- There is only one Pathways Community HUB in a community or region.

- The HUB must be an independent legal entity or an affiliated component of a legal entity.

- The HUB must be based in the community or region it serves.

- There must be a Community Advisory Board made up of members reflecting the community or region the HUB serves.