

PATHWAYS COMMUNITY HUB WILLIAMSON COUNTY: 2025 ANNUAL REPORT

The Pathways Community HUB in Williamson County is a collaborative initiative between United Way for Greater Austin and local organizations dedicated to improving maternal health outcomes in Williamson County, Texas, and was fully certified by the Pathways Community HUB Institute in 2025. Partner organizations provide navigation services through certified Community Health Workers. United Way for Greater Austin supports this work by providing strategic program management, training, and data support, ensuring alignment with the Pathways Community HUB Institute's certification standards.

PROGRAM OVERVIEW

The Pathways Community HUB model is a nationally recognized best practice for maternal and child health, endorsed by the Agency for Healthcare Research and Quality (AHRQ) and the Association of Maternal & Child Health Programs (AMCHP), with additional evidence from Texas A&M University and the Episcopal Health Foundation showing improved outcomes for pregnant and postpartum mothers. The Williamson County HUB launched as a pilot in June 2023, transitioned to full implementation in January 2024, and has served 207 total participants through 2025.

Community Health Workers (CHWs) work one-on-one with participants to identify risks across 21 health-related domains ("Pathways"), set goals, and stay engaged until every need is resolved. CHWs begin with a structured assessment that identifies risks across these 21 Pathways:

- Social Service Referral
- Postpartum
- Learning
- Pregnancy
- Food Security
- Health Coverage
- Medical Referral
- Family Planning
- Medical Home
- Employment
- Housing
- Adult Education
- Mental Health
- Oral Health
- Transportation
- Immunization Referral
- Developmental Referral
- Medication Screening
- Medication Reconciliation
- Medication Adherence
- Substance Use

To close each identified gap, CHWs coordinate with local resources and clinical partners by scheduling appointments, arranging transportation, connecting families to benefits, conducting screenings, reinforcing provider guidance, offering basic health literacy education, and advocating during medical visits. Progress is tracked through defined outcomes, and CHWs remain involved until each Pathway is completed. This relationship-based support strengthens engagement in prenatal and postpartum care, stabilizes families, and helps reduce preventable complications.

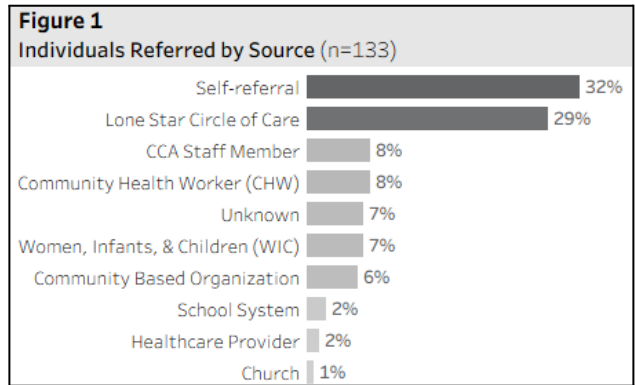
Two Care Coordination Agencies (CCAs) currently manage CHW activities and caseloads. The program primarily enrolls pregnant and postpartum mothers to improve maternal health, with potential future expansion to other vulnerable populations.

DATA PRESENTED IN THIS REPORT

CHWs record data in the HUB Care Coordination System’s secure database at key points throughout enrollment and participation. Data collected during visits related to health risks and access to health care is used to measure social and health improvements over time and can be aggregated to reflect risks in key populations. Data includes participant details, visit documentation, screener results, Pathway progress and completion, and birth outcomes. This report highlights program performance and data collected during calendar year 2025. It summarizes program enrollments, participant demographics, Pathways initiated and completed, and birth outcomes. It concludes with a recap of key events and an overview of strategic initiatives planned for the year ahead.

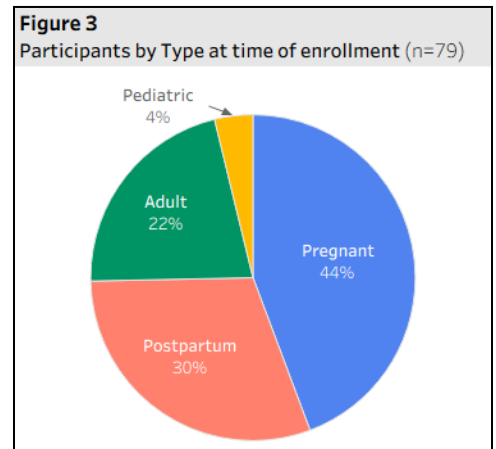
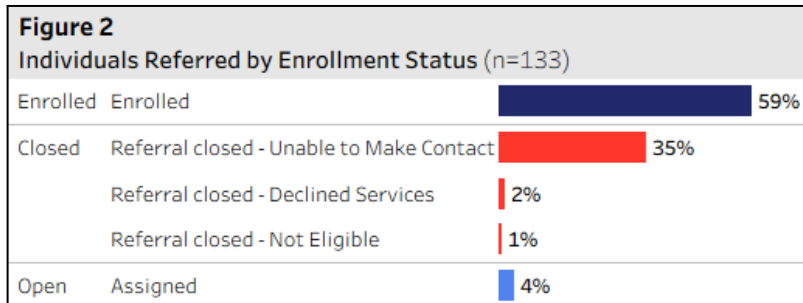
PROGRAM REFERRALS AND ENROLLMENTS

In 2025, the program received 133 referrals from various sources (Figure 1). Most individuals were either self-referred (32%) or referred through Lone Star Circle of Care clinics (29%), with additional referrals coming from CHWs, CCA staff members, Women, Infants, and Children (WIC), and other community organizations.



A total of 79 individuals (59% of those referred) were newly enrolled in the program, with another 4% assigned for intake (Figure 2). Most non-enrollment occurred because CHWs were unable to reach the referred individuals. To enroll, participants must be currently pregnant or up to one year postpartum and live in eligible zip codes. In addition to eligible participants, the program also serves adults who are parents of young children referred by rural school districts with limited access to care coordination services. Some adult and pediatric participants are household members of pregnant or postpartum participants with complex health and social needs, reflecting the model’s focus on supporting all members of a mother’s household.

Of the 79 newly enrolled participants, 44% were pregnant at the time of enrollment (Figure 3). Others were postpartum (30%), adult (22%), or pediatric (4%). On average, participants enrolled in 2025 completed their first visit with a CHW within 21 days of the referral.



DEMOGRAPHICS OF PARTICIPANTS SERVED (FIGURE 4)

There were 125 enrolled participants served in 2025. Some participants enrolled in 2024 continued to receive services into 2025. Participants are considered served when they complete at least one visit with a CHW during the year. Demographic characteristics are documented during initial visits and provide valuable insights into the population served, helping tailor services to community needs.

Participant Type

Participants served in 2025 were pregnant at the time of enrollment (53.6%) followed by postpartum (26.4%). Others were adult (17.6%) or pediatric participants (2.4%).

Gender

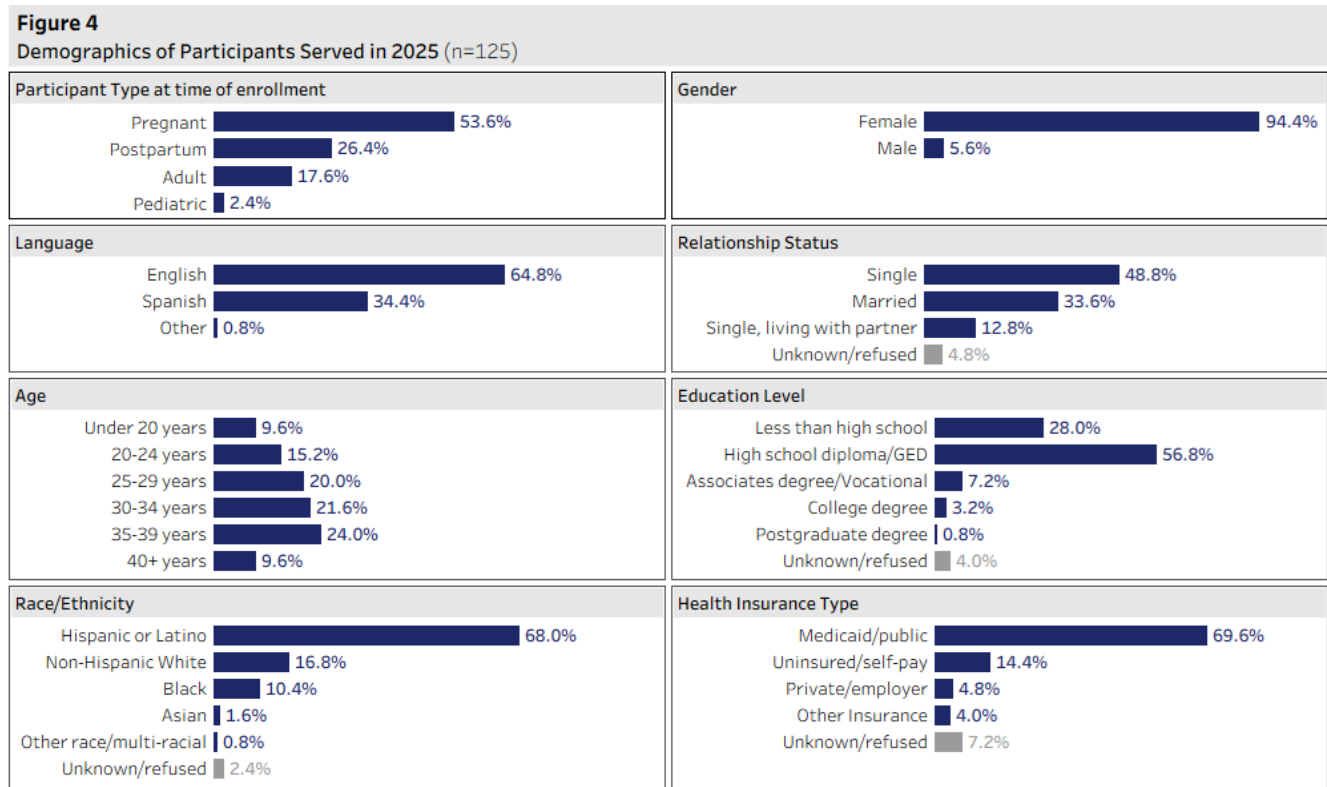
Most participants identified as female (94.4%). The remaining 5.6% identified as male and were adult or pediatric participants.

Language

Most participants identified English as their primary language (64.8%) followed by Spanish at 34.4%. Few participants spoke another language (0.8%).

Relationship Status

Almost half of enrolled participants were single (48.8%). Others were married (33.6%) or single and living with a partner (12.8%).



DEMOGRAPHICS OF PARTICIPANTS SERVED IN 2025 (CONTINUED)

Age

Participants were most often 35–39 years at enrollment (24.0%), followed by 30–34 years (21.6%) and 25–29 years (20.0%). Others were 20–24 years (15.2%), under 20 years (9.6%), or over 40 years (9.6%).

Education Level

The largest group of participants had a high school diploma or GED (56.8%). Those with less than a high school education followed (28.0%). Others had associates degrees or vocational training (7.2%), college degrees (3.2%), or postgraduate degrees (0.8%).

Race/Ethnicity

Most participants identified as Hispanic or Latino (68.0%). Non-Hispanic White participants accounted for 16.8%, followed by Black participants at 10.4% and Asian participants at 1.6%, while 0.8% identified with another race or multiple races.

Health Insurance Type

Almost three-quarters of participants had Medicaid or public insurance (69.6%). Others were uninsured/self-pay (14.4%), had private or employer-provided insurance (4.8%), or had another type of coverage (4.0%).

PATHWAYS INITIATED AND COMPLETED

In 2025, a total of 1,221 Pathways were initiated across 16 of 21 risk areas. Of these, 75% were successfully completed, while 15% were closed without completion. The remaining 10% are still open with goals underway (Figure 5). Pathways closed as incomplete are most often due to participants either becoming unreachable for continued engagement, exiting the program after reaching broader goals, or moving out of the area.

Notably, Social Service Referral Pathways accounted for almost three-quarters (72.1%) of all completed Pathways in 2025 (Figure 6). Social Service Referrals reflect how connections to community services often support progress on other Pathways. For example, a participant working on a Food Security Pathway will have their referrals to food resources recorded as Social Service Referral Pathways. The community services most frequently targeted included resources for personal and household items, financial assistance, safety equipment, child development, and child care. Social Service Referral Pathways are marked complete once the CHW verifies that the participant has received the item or service, or connected with the service agency. Of the 771 Social Service Referral Pathways initiated, 85% (657) were successfully completed.

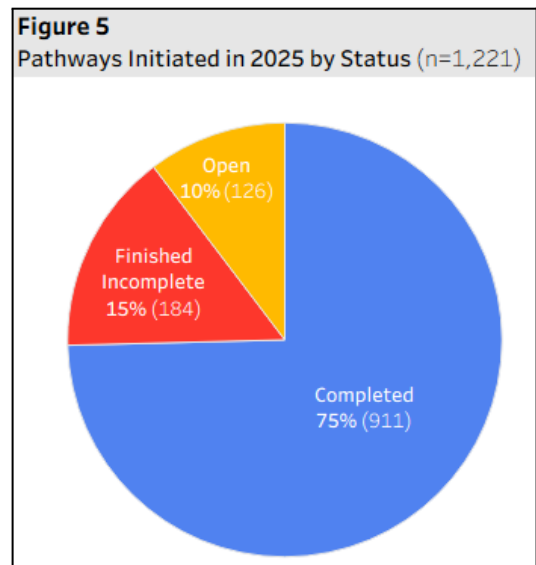


Figure 6

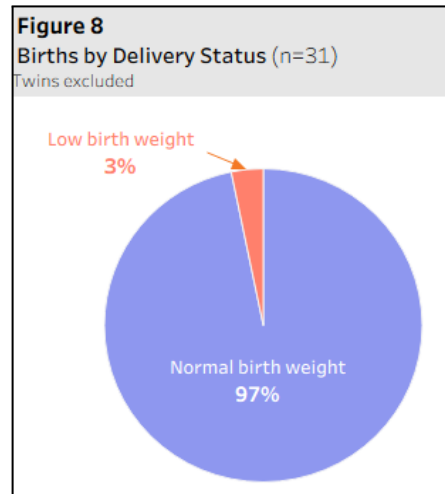
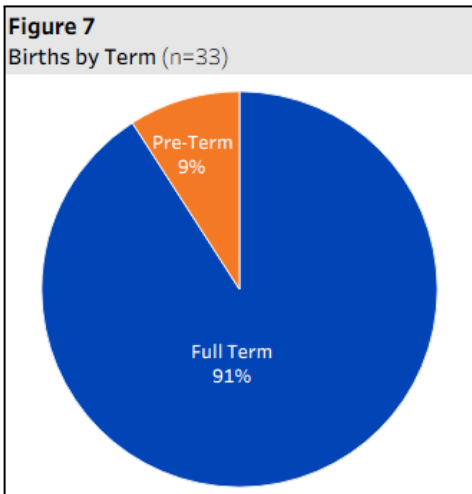
Completed Pathways by Type (n=911)

Pathway	Successful Completion of Pathway	N (%) of Pathways completed in 2025
Social Service Referral	Participant received the needed item or service or attended appointment	657 (72.1%)
Learning	Participant demonstrated understanding of learning materials (during visit)	48 (5.3%)
Medical Referral	Participant attended appointment with medical provider to address referral reason	39 (4.3%)
Postpartum	Participant attended postpartum appointment and answered postpartum information questions	34 (3.7%)
Food Security	Household member(s) had access to adequate food for 30 days without CHW assistance	24 (2.6%)
Pregnancy	Singleton birth weight baby of >2,499 g or twins >35 weeks gestation	24 (2.6%)
Health Coverage	Participant has health insurance coverage in place (i.e., Medicaid, private insurance)	20 (2.2%)
Employment	Participant is still working 30 days from date of hire	16 (1.8%)
Housing	Household member(s) have maintained safe and stable housing for 30 days from move-in date	15 (1.6%)
Family Planning	Family planning completed (i.e., sterilization, long-acting contraceptive, other methods)	10 (1.1%)
Adult Education	Participant completed educational goal (i.e., class, training program, semester)	8 (0.9%)
Mental Health	Participant attended three scheduled mental health appointments	5 (0.5%)
Transportation	Household member(s) had access to adequate transportation for 30 days without CHW assistance	5 (0.5%)
Medical Home	Participant attended appointment with medical provider to establish primary care	4 (0.4%)
Oral Health	Participant attended appointment with oral health care provider	2 (0.2%)

As summarized in Figure 6, Pathway completion typically reflects participants achieving meaningful outcomes related to their health and well-being. For example, 48 completed Learning Pathways involved participants demonstrating understanding of learning materials during visits. In 39 completed Medical Referral Pathways, participants attended appointments after being referred to medical providers. The 24 completed Food Security Pathways were for participants who had access to adequate food for 30 days without CHW assistance.

PREGNANCY PATHWAYS AND BIRTH OUTCOMES

Pregnancy Pathways are initiated for participants with a confirmed pregnancy. CHWs work with participants throughout pregnancy to ensure prenatal healthcare needs are being met and to offer additional support, such as education through Learning Pathways. After delivery, CHWs continue to track outcomes like birth weight. A Pregnancy Pathway is considered successfully completed when the baby is born at a normal birth weight (at least 2,500 grams). In 2025, 33 babies were delivered to participants in the Pregnancy Pathway. Of these, 91% were full-term deliveries (>37 weeks gestation), while 9% were pre-term at 32–37 weeks gestation (Figure 7).

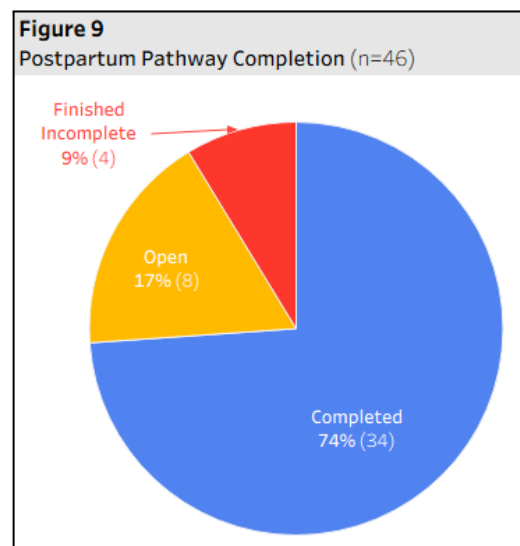


Most babies (97%) born to participants in 2025 were born at a normal birth weight over 2,500 grams, while 3% were in the low weight category between 1,500 and 2,499 grams (Figure 8). Birth weight figures exclude the one set of twins born to a participant in 2025, as twins are not classified by the same birthweight outcomes standards as singleton births.

POSTPARTUM PATHWAYS

Postpartum Pathways are opened for any participant who has recently delivered a baby, including those who delivered prior to enrollment, if they need to attend a follow-up medical appointment.

These Pathways are considered completed when the participant attends their initial postpartum medical appointment between 7-84 days after delivery. In 2025, a total of 46 Postpartum Pathways were opened and 74% were completed successfully. Another 17% remain open, and 9% were closed without completion (Figure 9).



SUCCESSSES THROUGH 2025 AND PLANS FOR 2026

The past year brought deepened collaboration, strengthened infrastructure, and expanded Pathways support for families across Williamson County. Community Health Workers (CHWs) continued to play a central role in connecting participants to essential resources, often leveraging community donations, social media networks, and partnerships to meet urgent needs. CHWs also collaborated across Care Coordination Agencies (CCAs), shadowing one another and mentoring new staff, which strengthened consistency and quality of care across the program.

The program expanded its capacity to meet material needs through partnerships and targeted support. CHWs worked with Austin Diaper Bank to distribute additional diapers and used a no-cost pregnancy and family supply closet. Emergency funding from the Georgetown Health Foundation helped families facing housing and utility crises, and delays in SNAP benefits in fall 2025 were mitigated through H-E-B gift cards to ensure food access.

A new assessment initiative launched in 2025 will help CHWs more consistently assess risks and needs for participants. CHWs began administering the PHQ-9 questionnaire, a standardized tool that helps identify symptoms related to depression; the Patient Activation Measure (PAM), which assesses a participant's knowledge, confidence, and skills in managing their health; and blood pressure screening, reflecting the importance of monitoring maternal health risks during pregnancy and postpartum. While data collection is ongoing, the program plans to share screener outcomes in future reports.

The program's Community Advisory Board provides critical guidance through quarterly meetings, offering a forum to share baseline and outcomes data, gather feedback, and ensure alignment with community priorities.

Looking ahead to 2026, the Pathways Community HUB is positioned for continued growth and regional impact. United Way for Greater Austin is developing a regional Maternal Health CHW Hub spanning Bastrop, Williamson, and Travis counties, creating a unified structure for training, support, and shared learning. The HUB is also progressing toward becoming a Medicaid provider and is in active conversations with local health plans to establish reimbursement pathways to sustain and expand maternal health services.

A regional CHW cohort has been formed to strengthen professional development and peer support across Bastrop, Williamson, and Travis counties. The program will continue its focus on improving maternal health outcomes while exploring opportunities to scale its model to additional vulnerable populations. In 2026, the HUB will also contribute to a regional report led by researchers at Texas A&M University, offering deeper insights into maternal health trends and the impact of coordinated care across Central Texas.

Together, these efforts reflect a maturing, collaborative system increasingly equipped to respond to community needs, strengthen CHW expertise, and advance equitable health outcomes for families in Williamson County and beyond.

MORE INFORMATION ON PATHWAYS COMMUNITY HUB WILLIAMSON COUNTY

Visit our website or email us to learn more about how supporters, agencies, and medical providers can collaborate with [Pathways Community HUB Williamson County: pathwayshub@uwatx.org](mailto:pathwayshub@uwatx.org).

THANK YOU TO OUR PARTNERS AND OUR COMMUNITY ADVISORY BOARD.

