North Central Accountable Community of Health

Governing Board Meeting

1:00 PM – 3:30 PM May 7th, 2018

Confluence Technology Center 285 Technology Center Way #102 Wenatchee, WA 98801	Conference Dial-in Number: (408) 638-0968 or (646) 876-9923 Meeting ID: 429 968 472# *Join from PC, Mac, Linux, iOS or Android:* <https://zoom.us/j/429968472>

Time:	Agenda Item:	Proposed Action:	Attachments:	Page
1:00 PM	Introductions - **Barry Kling** • Board Roll Call • Review of Agenda & Declaration of Conflicts • Public Comment	Discussion	• Agenda	1
1:10 PM	Approval of April Minutes - **Barry Kling**	***Motion to Approve:*** • Minutes	• Minutes	2-5
1:15 PM	Pathways Community HUB – Opening of submitted RFP's – **Christal Eshelman**	Information		
1:20 PM	Treasurer's Report - **Sheila Chilson** • Monthly Financial Report	***Motion to Approve:*** • Financial Report	• Financial Report	6-10
1:30 PM	Parkside Update – **Tamara Burns & Julie Rickard**	Information		
1:50 PM	Executive Director's Update - **Senator Parlette**	Information	• Executive Director's Report	11-15
2:00 PM	CHI Update – **Brooklyn Holton, Rosalinda Kibby & Mike Beaver**	Information		
2:15 PM	Budget Amendment & Funding Principles – **John Schapman**	**Motion to Approve:** • 2018 Budget Amendment	• Board Motion Form: 2018 Budget Amendment • Funding Principles	16-18 19
2:30 PM	Staff / Project Updates • **John Schapman** • **Caroline Tillier** • **Peter Morgan** • **Christal Eshelman** • **Sahara Suval**	**Motion to Approve:** • EMS Funding • WPCC Staffing	• Board Motion Form: EMS Funding • Board Motion Form: WPCC Staffing & Supporting Documents • Okanogan County FIMC • Pathways Community HUB RFP Scoring Process • Pathways Community HUB Request for Proposals	20-26 27-31 32-33 34-35 36-79
3:00 PM	Adjourn to Executive Session – ***Governing Board Members Only***			

North Central Accountable Community of Health

4/2/18 Meeting

Monday, April 2, 2018
1:00 PM – 3:30 PM

Introductions - **Barry Kling** • Board Roll Call • Review of Agenda & Declaration of Conflicts • Public Comment	**Board Attendance:** Scott Graham, Michelle Price, Rick Hourigan, Bruce Buckles, Blake Edwards, Shelia Chilson, Barry Kling, Andrea Davis, Brooklyn Holton (part of the meeting), Mike Beaver, Carlene Anders (after Board approval) **Board by phone:** Doug Wilson, Theresa Sullivan, Senator Warnick, Molly Morris **Absent:** Nancy Nash-Mendez, Ray Eickmeyer **Public Attendance:** David Olson, Winnie Adams, Kris Davis, Jackie Weber, Donnie Guerrero, Armando Gonzales, Laura Hernandez, Gail Goodwin, Deb Miller, Kate Haugen **Public Via Phone:** Clarice Nelson, Lisa Shafer, Carly Levitz, Geraldo Perez, Rachael Petro **NCACH Staff:** John Schapman, Sahara Suval, Christal Eshelman, Peter Morgan, Caroline Tillier Teresa Davis, Minutes • No conflicts of interests • No Agenda changes • No Public Comment
Approval of March Minutes - **Barry Kling**	Scott Graham moved to approve the March minutes as written, Michelle Price seconded the motion, no further discussion, motion passed.
Treasurer's Report - **Sheila Chilson** • Monthly Financial Additional Budget Requests – **Christal & John** • SIM/FIMC – line item • Summer Internship – line item • General Budget Approval	❖ **Sheila went through the February Financial Report - Nothing out of the ordinary. Sheila moved to approve the February financials as presented, seconded by Scott Graham, motion passed.** John reviewed the budget • SIM $92,359.95 is the anticipated revenue this year, CDHD has invoiced HCA for this work. • Demonstration Funds: We are moving some of the salary out of the demonstration budget as we are paying out of the SIM Budget. • Some contracts were paid out of the operating funds that we already had. We are going to reimburse the ACH from the Financial Executor for these contract payments. Per Barry, these funds will not be subject to the CDHD hosting agreement fee. • Demonstration Funds (Financial Executor Money) - Funds are held in bank account by Public Consulting Groups for each of the ACH's. It is a non-interest bearing account and we do not pay any fees. SIM and Design Funds accounts do earn interest, • Summer Internship: A University of Washington student approached NCACH about doing a summer internship. Possible ideas to help with are an asset mapping system or workforce development. Looking for a budget approval of $10,000 which includes a salary of $6,000 at $15 an hour plus an additional $4,000 for other expenses. ❖ **Bruce Buckles moved, Sheila Chilson seconded the motion the allocation of up to $10,000 for expenses associated with becoming a University of Washington Masters in Healthcare Administration host site and hiring a summer intern in 2018.** • Specific person in mind is from Wenatchee, • Bruce would want to open it up to all schools and make sure that it is open to everyone. This is the idea and it will be open to everyone in the future. Rick noted that Confluence has had incredible success with their program. No further discussion, motion passed.

North Central Accountable Community of Health

	❖ **Sheila Chilson moved, Judi Warnick seconded the motion to allocate $21,731.16 to provide technical assistance to providers for the transition to FIMC to be spent at the discretion of the Executive Director.** • We have a tentative date of May 15th. Training can be for both Physical and Mental Health providers. Motion passed. ❖ **Sheila Chilson moved, Michelle Price seconded the motion to approve the 2018-19 SIM budget of $92,359.95 and reduce the Demonstration budget by $80,313 because that expense has been transferred to the SIM Budget, no further discussion, motion passed.**
Parkside Update – **Senator Parlette**	Tamara Burns set up a tour and roundtable discussion last week. Those present toured the facility. Julie Rickard, PHD will be the Program Director. There will be another meeting after Julie starts to set a process of who will be transported to Parkside. Expected opening in May, will be hiring 38 FTE (nobody hired yet). Next month Tamara will show a PowerPoint of the facility. ▪ Do we expect that it will pass all of the certifications? ▪ What is the final bill? ▪ Status of licensing? We will have Parkside on the Agenda for the May meeting to answer questions.
Executive Director's Update - **Senator Parlette**	Kick off was a success, staff is gearing up for the Summit on April 20th. Sue Birch, New Director for HCA will be speaking at the Summit and coming a day early to travel the region and end the day with a video conference with locations in all counties for people to attend. A flyer with details will be coming out soon from Sahara.
Board Election – Carlene Anders / Business Seat – **Barry Kling**	❖ **Nominating Committee is nominating Carlene Anders for the Business Community Seat on the Board. Bruce moved to accept the nomination, Scott Graham seconded the motion, discussion: Carlene co-chaired the Carlton Complex fire recovery project and is being nationally recognized for her work. Also owns a daycare center. No further discussion, motion passed.** • Andrea Davis from Coordinated Care is filling the MCO seat to replace Kayla Down.
Presentation: CCHE Stakeholder Survey - **Carly Levitz & Lisa Schafer, Center for Community Health and Evaluation**	Carly Levitz and Lisa Schafer gave a presentation on the Stakeholder Survey that was sent out and completed by stakeholders in December of 2017. Response rate was over 50% of the 172 people surveyed which is above the state average. • Are there targets or benchmarks that we are aiming for? There are not any targets or goals, this is just meant to be snapshot of NCACH. • When you put together the suggestions for improvement, was there anything that surprised you in the comments? Theme around communication and transparency was more called out in NCACH. Stronger theme of broadening engagement beyond the healthcare sector. Given the work we have ahead in 2018 - how can we build on our strengths and address opportunities for improvement? • Sheila - Would like to spend a little time on transparency and the lack of confidence in our governance.

	• Bruce - We can always do better. We need to be able to share with the community on every level. We need a clear marketing plan. • Doug - Thought the presentation was reassuring. But wonders if there are some constituencies that we are not reaching. • Theresa - Communication goes beyond sharing the information and goes into listening as well and taking into account how other organizations are feeling. If you don't feel heard, was the decision already made? • Andrea - From a statewide prospective, this group is so much further along than other ACH's. Concerns seem global around ACH's and the unknown of what they are doing. • Sheila - We have a lot to talk about at the CHI's - our community partners have fallen away. We need to bring them back. Transparency comes down to Data. • Rick - Over the last year we have been in formation, we now have some clarity to move forward. Hopefully we can reengage those people who have fallen away. Now we have that opportunity. • Scott - In the developmental sequence where should we be? It seems that we are ahead. • David Olson - Board needs to cut themselves some slack. This ACH raised the bar and expectations were higher here than other regions. Suggested to reach out to all 172 and inform them of what is going on. • Sheila - Linda is a great advocate for us as an ACH. Would like to have some time for Linda to come have some one on one time to help reconnect those people.
CHI Update – **Brooklyn Holton & Mike Beaver**	**Chelan Douglas CHI - Brooklyn Holton** - Excited to be able to represent on behalf of the CHI. Chelan Douglas has their leadership Council it includes: City government, health, social services, education and migrant. We have a spot on the CHI agenda for a Board update to demonstrating how CHI input was used. They are working to find a way to keep the CHI's going after the transformation is done and finding an opportunity for better collaboration. Next meeting April 11th will be used to give an ACH 101 course. Set up some presentations from other sectors to present to the CHI. **Okanogan CHI - Mike Beaver** -Working on getting the Leadership Council established. Next meeting is the24th of April. Opioid is the main focus of this group. **Grant County CHI - Sahara Suval** - Forming Leadership Council - will be meeting every other month, next meeting April 10th. Planning to have a monthly newsletter and calendar for the CHI. Will be doing a lot of their communication through email and online meetings. Brooklyn went over the Vision, Purpose and Possibilities. There are a lot of cross conversations that have been happening. All three CHI's have participated in the development of this document. This is so helpful to see it through the lens of a community organization, • **Barry moved that the NCACH Board express its appreciation to the CHI leadership council and membership, Sheila seconded the motion, motion passed.**

North Central Accountable Community of Health

Staff / Project Updates • **John Schapman** • **Christal Eshelman** • **Caroline Tillier** • **Peter Morgan**	**<u>Opioid Workgroup - Christal Eshelman</u>** At the last meeting the Board approved the rapid cycle process. WG has created an application for the rapid cycle. Will open on April 9th and close on May 11th. WPCC Members must collaborate with a non WPCC member to apply. As a Board we will be asked to consider the recommendations of the Workgroup. This is a great process and would be something that could become a template for other projects. Andrea also thought the amount seems low. Bruce: Are we looking at other sources of money? We have discussed this internally but it has not taken shape yet. • **Rick moved, Bruce Buckles seconded the motion to approve the attached NCACH Rapid Cycle Application and associated scoring criteria, funding principles, and funding process, no further discussion, motion passed.** **<u>Pathways Community HUB - Christal Eshelman</u>** Workgroup met last week and had a great data presentation. Wrote an RFP on the HUB, RFP will be open until April 27th. The RFP has been widely advertised. There is a TA session that is scheduled for April 9th for anybody interested in applying to be the HUB at CDHD. Workgroup has 23 people, we are developing a smaller core group that will be doing some work outside of the regular meetings. This group helped develop the RFP. June 13th and 14th is a 2 day workshop with Dr. Redding. Question: What is the amount of funding that is going to the HUB? This is something that will be developed at the Board Retreat. **Okanogan FIMC** - Happening January 1st, 2019. Will be looking to the CHI for the Advisory Committee **SDOH Facilitated Discussions happening in all three areas this week.** **<u>Transitions and Diversions - John Schapman</u>** Looking to do the local, ER Diversions, EMS concerns around developing the model. Working with regional EMS. Looking to implement all approaches regionally. Broken each approach into subgroups. Transitional care model is moving faster than the others. Expect a recommendation to the board in the next month or two. **<u>2018 NCACH Annual Summit - Sahara Suval -</u>** Have a full agenda and will distribute a final agenda soon. **<u>WPCC - Peter Morgan</u>** - After two years of talking we are up and running. We had over 100 people from 17 organizations come to the Kick Off. We will be issuing stage one payments by April 20th as long as organizations are registered into the FE Portal.
Adjourn	

NC ACH Funding & Expense Summary Sheet

	SIM/DESIGN FUNDS			FINANCIAL EXECUTOR FUNDS		
	SIM/Design Funds Received	SIM/Design Funds Expended	SIM/Design Funds Remaining	NCACH Funds @ FE	FE Funds Expended	FE Funds Remaining
Original Grant Contract K1437	$ 99,831.63	$ 99,831.63	$ -			
Amendment #1	$ 150,000.00	$ 150,000.00	$ -			
Amendment #2	$ 330,000.00	$ 330,000.00	$ -			
Amendment #3 ($50k Special Allocation)	$ 15,243.25	$ 15,243.25	$ -			
Workshop Registration Fees/Misc Revenue	$ 19,155.00	$ 19,155.00	$ -			
Amendment #4 (FIMC Advisory Comm. Spcl Allocation 2016)	$ 15,040.00	$ 15,040.00	$ -			
Amendment #5*	$ -	$ -	$ -			
Amendment #6** (FIMC Adv Comm Spcl Alloc 2017)	$ 30,300.45	$ 30,300.45	$ -			
Interest Earned on SIM Funds* **	$ 3,223.39	$ 3,223.39	$ -			
Original Grant Contract K2562	$ 24,699.55	$ 3,393.68	$ 21,305.87			
Amendment #1						
Original Contract K2296 - Demonstration Phase 1	$ 1,000,000.00	$ 352,034.60	$ 647,965.40			
Original Contract K2296 - Demonstration	$ 5,000,000.00	$ -	$ 5,000,000.00			
Interest Earned on Demo Funds	$ 27,262.00	$ -	$ 27,262.00			
Finacial Executor Funding -						
*DY1 Project Incentive Funds:				$ 5,151,550.00		$ 5,151,550.00
*DY1 Integration Funds				$ 2,312,792.00		$ 2,312,792.00
*DY1 Bonus Funds				$ 1,455,842.00		$ 1,455,842.00
Totals	**$ 6,714,755.27**	**$ 1,018,222.00**	**$ 5,696,533.27**	**$ 8,920,184.00**	**$ -**	**$ 8,920,184.00**

** Funds allocated to NCACH but not yet in FE account*

*** Revenue outstanding. Funding is monthly cost reimbursement.*

*** Only $500 interest on SIM Grant per calendar year can be retained. The rest will be paid back to HCA when directed.*

2015-16 Report		99,831.63	$	99,832.00
2016-17 Report		480,000.00	$	76,736.40
SIM Report	$	107,661.64	$	489,619.00
DEMO Report	$	6,027,262.00	$	352,034.60
	$	6,714,755.27	$	1,018,221.99
Variance	$	-	$	0.01

SIM Funds Report on NCACH Expenditures to Date

Fiscal Year: Feb 1, 2018 - Jan 31, 2019

	Budgeted Allocation	Feb-18	Mar-18	Totals YTD	% Expended YTD to Budget	Comments
Salary & Benefits	**$ 80,313.00**	590.62	369.82	**$ 960.44**	**1.2%**	
Office Supplies				**$ -**	**#DIV/0!**	
Computer Hardware				**$ -**	**#DIV/0!**	
Legal Services				**$ -**	**#DIV/0!**	
Travel/Lodging/Meals				**$ -**	**#DIV/0!**	
Website Redesign				**$ -**	**#DIV/0!**	
Advertising				**$ -**		Job ads.
Meeting Expense				**$ -**	**#DIV/0!**	Mainly meeting room rental costs.
Other Expenditures				**$ -**		WPC speaker expense, stationary printing, office furniture
Misc. Contracts (CORE)				**$ -**	**#DIV/0!**	
Misc. Contracts (CHIs)				**$ -**	**#DIV/0!**	
Subtotal	**$ 80,313.00**	**$ 590.62**	**$ 369.82**	**$ 960.44**	**1.2%**	
15% Hosting fee to CDHD	**$ 12,046.95**	88.59	55.47	**$ 144.07**	**1.2%**	Includes space, computer network & support, fiscal, etc.
Meal Expenses - not charged a hosting fee				**$ -**		
Grand total	**$ 92,359.95**	**$ 679.21**	**$ 425.29**	**$ 1,104.51**	**1.2%**	

Contract K2562 (FIMC Funding)	$	21,731
Amendment #1 (SIM AY4 Funds)	$	70,629
Retained Interest Earned to date		
Total SIM Funds	**$**	**92,360**
Budgeted Amount	$	92,359.95
Total Uncommitted Funds	**$**	**0.21**

% of Fiscal Year 17%

RED = Not yet approved allocations

Demonstration Funds Report on NCACH Expenditures to Date

Fiscal Year: Jan 1, 2018 - Dec 31, 2018

	Budgeted Allocation	Jan-18	Feb-18	Mar-18	Totals YTD	% Expended YTD to Budget
Salary & Benefits	**$ 528,166.00**	$ 48,078.06	$ 48,249.47	$ 46,854.42	**143,181.95**	**27.1%**
Summer Intern Program	**$ 10,000.00**				**-**	**0.0%**
Office Supplies	**$ 18,000.00**	$ 2,462.22	$ 3,804.21	$ 1,081.02	**7,347.45**	**40.8%**
Legal Services	**$ 8,000.00**		$ 1,156.50		**1,156.50**	**14.5%**
Travel/Lodging/Meals	**$ 7,000.00**	$ 1,244.15	$ 1,014.97	$ 929.35	**3,188.47**	**45.5%**
Website	**$ -**	$ 60.86			**60.86**	
Admin (HR/Recruiting)	**$ 7,500.00**				**-**	**0.0%**
Advertising/Community Outreach	**$ -**	$ 456.61	$ 225.00	$ 354.70	**1,036.31**	
Insurance	**$ 5,000.00**				**-**	**0.0%**
Meeting Expense	**$ 7,000.00**	$ 11.30	$ 1,121.05	$ 8,976.45	**10,108.80**	**144.4%**
Other Expenditures	**$ 3,000.00**	$ 1,334.61	$ 700.00		**2,034.61**	**67.8%**
Integration Expenses	**$ 21,731.16**				**-**	**0.0%**
Misc. Contracts (CHIs)	**$ 120,000.00**				**-**	**0.0%**
Healthy Generations	**$ 75,000.00**		$ 12,500.00	$ 12,500.00	**25,000.00**	**33.3%**
OHSU	**$ 150,000.00**			$ 12,754.48	**12,754.48**	**8.5%**
CCMI, CSI	**$ 443,461.00**		$ 44,415.23		**44,415.23**	**10.0%**
Providence CORE	**$ 4,128.00**				**-**	**0.0%**
Subtotal	**$ 1,407,986.16**	**$ 53,647.81**	**$ 113,186.43**	**$ 83,450.42**	**250,284.66**	**17.8%**
					-	
15% Hosting fee to CDHD	**$ 110,309.57**	**$ 8,047.17**	**$ 8,440.68**	**$ 8,729.39**	**25,217.24**	**22.9%**
Grand total	**$ 1,518,295.73**	**$ 61,694.98**	**$ 121,627.11**	**$ 92,179.81**	**$ 275,501.90**	**18.1%**

Funds remaining 2/28/2018	$	5,731,607.93
Interest Earned to date	$	27,265.44
Budgeted Amount (2018)	$	1,518,295.73
Total Uncommitted Dollars	**$**	**4,240,577.64**

% of Fiscal Year Complete 25%

Demonstration Funds Report on NCACH Expenditures to Date

Fiscal Year: Jan 1, 2018 - Dec 31, 2018

	Budgeted Allocation	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Totals YTD	% Expended YTD to Budget
WPCC Stage 1	**$ 1,665,000.00**													**-**	**0.0%**
Opioid Project	**$ 100,000.00**													**-**	
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Grant Total	**$ 1,765,000.00**	$ -	$ -	$ -	$ -	$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	**-**	**0.0%**

Funds Earned (Date TBD)	$ 8,920,184.00
Budgeted Amount (2018)	$ 1,765,000.00
Total Uncommitted Dollars	**$ 7,155,184.00**

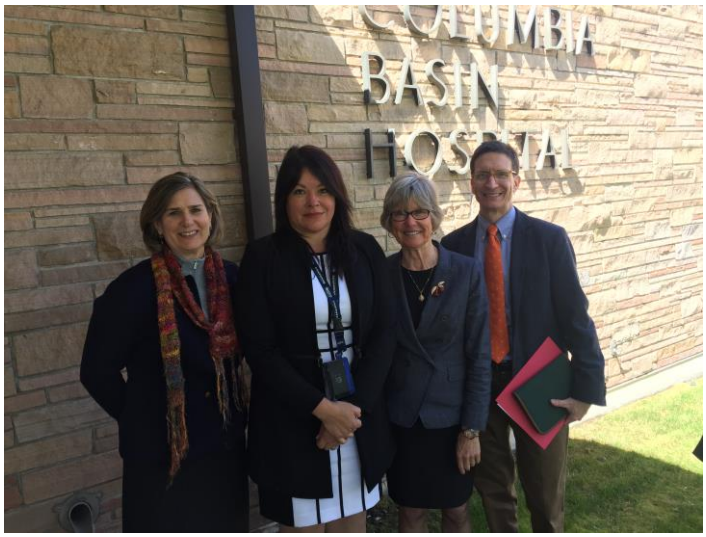
% of Fiscal Year Complete 17%

EXECUTIVE DIRECTOR'S REPORT – MAY 2018

North Central Accountable Community of Health

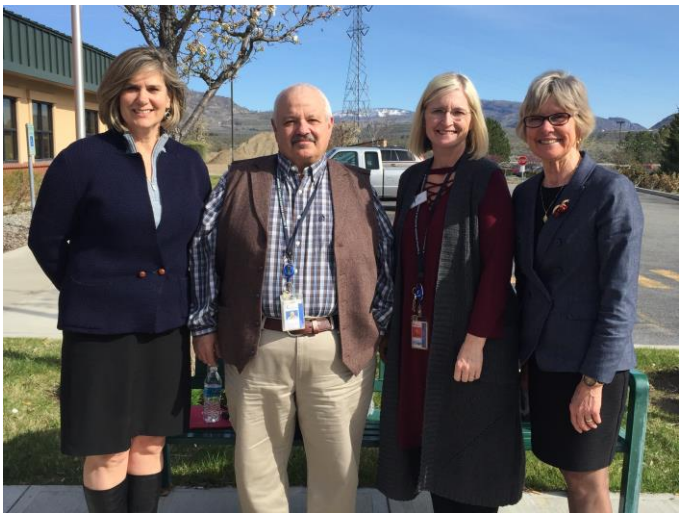
Those of you on our Governing Board and NCACH Workgroups know that healthcare transformation work moves quickly. Between updates and decisions rolling down from the Health Care Authority, decisions at the State legislative level, and our providers on the ground, the Medicaid Transformation Projects are affected by many and can change rapidly. In the midst of all of this activity, I had the chance to sit down with the Director of the Health Care Authority, Sue Birch. We sat for 309 miles, to be exact, as we drove around the North Central Region to visit 7 different clinics and community partners on Sue's first trip to North Central Washington.

Escorted by Governing Board Vice-Chair, Dr. Rick Hourigan, we started in Wenatchee, visiting local community-based organization, Community Choice, before heading to Grant County to see Moses Lake Community Health Clinic, Samaritan Healthcare, and Columbia Basin Hospital.



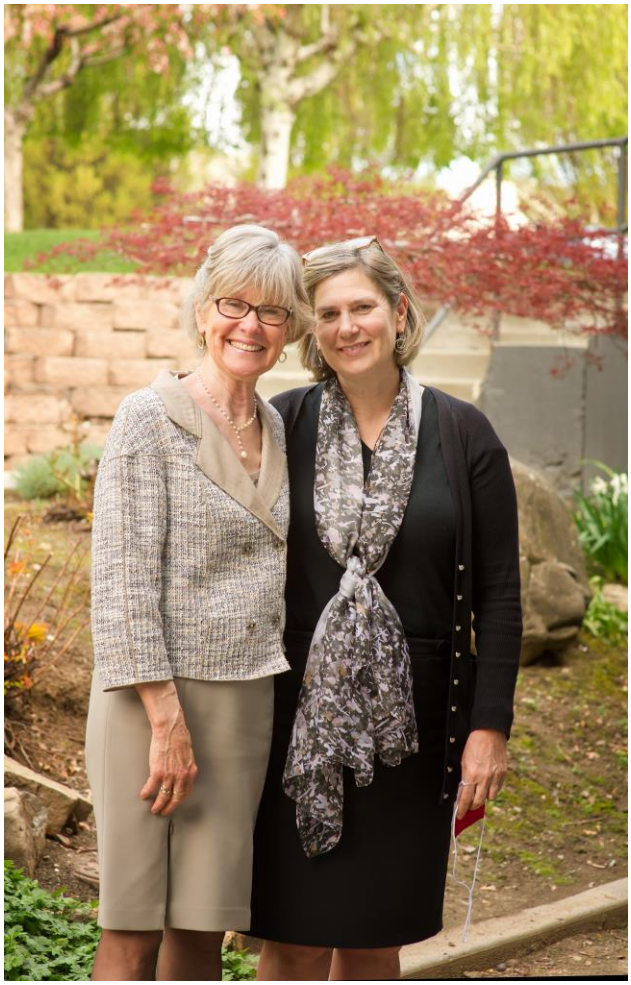
After our morning in Grant County, we headed north to Okanogan County to visit Mid-Valley Clinic and Okanogan Behavioral Health Care. I wanted Sue to really experience the vastness of our region. One of our biggest challenges here in the North Central Region is the distance that our providers, patients, and residents must travel in order to access services and care. As we work to implement the six Medicaid Transformation Projects across the North Central Accountable Community of Health, it is important that we remain mindful of the distance, and the realities of a rural healthcare system and community. The approaches that work in Seattle, or even Olympia, do not work in places like Oroville, Brewster, Mansfield, or Ephrata. It was important to me to show Sue what healthcare services look like in a rural community.

Following our tour of Okanogan Behavioral Health, we stopped at Confluence Health in Omak for Sue to host the teleconference organized for healthcare providers. The teleconference was broadcast to three sites across our region in Omak, Wenatchee, and Moses Lake, and providers had the opportunity to speak with Sue directly.



After the teleconference, it was time to head back to Wenatchee but not before we stopped to visit Three Rivers Hospital along the way. Following our road trip was the 2018 Annual Summit, where Sue got to meet and address over 200 attendees during a very packed day. We are so appreciative of Director Birch for taking the time to really get to *experience* the North Central Accountable Community of Health with us, and for appearing at our Annual Summit. I am hopeful that she will return (after getting some rest!) and will continue advocating for all Accountable Communities of Health across our state.

Charge On!



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STAFF UPDATES

John Schapman

Our Transitional Care and Diversion team has been working with the North Central Emergency Care Council and local EMS providers to develop a work plan and initial planning timeline to help reduce Emergency Department utilization and improve the way patients are transitioned back into home. Three major goals have been developed with specific tactics the EMS Community will take to achieve the goals stated. Planning work on this is slated to start in early June of 2018. The Transitional Care Model Subgroup has been focused on reviewing the assessment tools of the two remaining approaches our region is looking at selecting and is planning to complete a site visit of the locally developed model at Confluence Health in May to getting a better understand the workflow of the model and make final recommendations to the workgroup on which approach to select. Finally, Emergency Departments across the region held their first meeting to discuss specific ED Diversion strategies we will tackle as a region. Specific to program management, NCACH staff spent time at the April Governing Board retreat defining the NCACH region's funding principles, funds allocation process, and workgroup funding projections for the Transformation Project. The Board retreat was a good opportunity to give the Governing Board a good understanding of the current progress each workgroup has made around project implementation and funds development.

Christal Eshelman

Social Determinants of Health Facilitated Discussions: We kicked April off by traveling to each of our counties to discuss how the North Central ACH can address social determinants of health through the Medicaid Transformation Project. Chris Kelleher, Program Director at The Center for Evidence-based Policy, joined Teresa and I for these three facilitated discussions focusing on transportation and housing. The results of which were synthesized and potential strategies were developed. These strategies were vetted at our Annual Summit on April 20th. All attendees heard from Chris on the results and potential strategies and had an opportunity to provide feedback and rate the potential strategies. If you missed the Summit, you can view the presentation here. Based on the feedback we got at the Summit, Chris and I will be developing final recommendations to bring to the Governing Board in June.

Pathways Community HUB: The Pathways Community HUB Request for Proposals for a lead agency was issued on March 28th and closed on April 27th. The proposals that were received will be opened during the May Governing Board meeting. I have been working with our technical consultants to develop an RFP scoring process and criteria for the RFP proposals. The RFP evaluation will happen during May with a lead agency being recommendation being brought to the Governing Board in June. North Central has been participating cross ACH discussions around developing a shared services model, in particularly for IT purchasing. I had the opportunity to attend one day of the Washington Community Health Worker Conference in Lynnwood on April 12th. This was a fantastic opportunity to gain a better understanding of Community Health Worker needs and learn from what others are doing around the state.

Opioid Project: The Opioid Rapid Cycle Application opened on April 9th and will close on May 11th. We have been working hard to make sure our community partners are aware of this opportunity. The application review process will take place in May with a slate of applications recommended for funding being brought forward to the Governing Board in June.

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Fully-Integrated Managed Care: We kicked off Okanogan County FIMC transition planning on April 24th with a meeting of County Commissioners, providers, the Health Care Authority, and the North Central Washington BHO. We are planning to utilize the Okanogan Coalition for Health Improvement, which meets every other month, for broad stakeholder input and consumer engagement. In addition, we plan to form a provider group that will meet more frequently and plan for the 2019 Early Warning System and provider IT transition as well as addressing provider concerns and technical assistance needs that arise.

Caroline Tillier

With a successful WPCC Learning Community Kick-Off at the end of March, April was full of activity associated with launching our portal, sending out invitations to our members, and offering our first two webinars for the Change Plan LAN. The purpose of this learning activity is to help our primary care and behavioral health organizations develop a Change Plan that captures their vision for transformation, as well as actionable steps that will guide their work over the coming years. Peter and I are still working with our partners -- who are already incredibly busy -- to shift to using this new portal tool. It is a work in progress for all of us and we are charging forward and fine-tuning as we go, based on what we learn (including what we as staff, can do better/differently). I also continue to work with John and Christal, as the Pathways HUB and TCDI workgroups fine tune their project approaches and target populations. Lots of data was shared with our workgroup partners this month which will inform continued discussions on populations we want to focus on (e.g. behavioral health, people who use the emergency department frequently). The good news is that we are working on amending our data sharing agreement with the Health Care Authority, allowing us to share sensitive data products with our partners at CORE. This will allow us to leverage CORE's skills and do further analyzes based on detailed data products we recently received from HCA. Finally, ACHs across the state received some updates regarding "pay for reporting" (aka P4R) measures that we will be held accountable to, through our Medicaid Transformation projects. In a nutshell, HCA dropped many measures (which all ACHs appreciate) though they made some amendments to metrics (which caused a bit of a stir). These changes came a bit late in the game, in that many of us who have started on a path with our partnering providers and we want to avoid needing to reverse course. I will continue to track and respond to these developments.

Peter Morgan

April was a busy month for the Whole Person Care Collaborative. Following the Kick-off meeting on March 24, the learning collaborative was launched with 8 week learning activity called the Change Plan Learning and Action Network (LAN) to help members build their change plans and also practice collaborating through the webinars. An initial session was held on April 10 with a second on the 24th. Learning Community members are practicing with the Communities of Health portal and beginning building their change plans in the template. Some teams are still forming and some technical difficulties are being identified and corrected as we move along. This initial LAN was meant to be a shakeout cruise and it's proving to be helpful in many ways. NCACH staff are working with our members and with the CCMI/CSI staff to continue to refine the curriculum and the meeting agendas to ensure we're accomplishing what we need.

In May, we will be continuing with the Change Plan LAN and also queuing up a second LAN dealing with Behavioral Health Integration from both a Primary Care Clinic and Behavioral Health agency perspective. We will also be working to set the schedule for other learning activities through the end of the year. We will also

surveying members to clarify their needs and capabilities around Domain 1 projects on Health Information Technology (HIT) and Value Based Payment (VBP) as it relates to the WPCC. We will also be building a coaching assets and needs matrix to identify the coaching needs of our LC members and to match them to resources available.

This is a busy time for LC members as the real work begins and the demands of learning activities on the on already busy staff are integrated into the daily work flow of each organization.

Sahara Suval

April was a blur of activity for the NCACH team! Between the regular meeting cycle of our Workgroups, Coalitions for the Health Improvement, Governing Board, and partners, we hosted a successful Annual Summit with over 200+ attendees, and also managed to attend several community outreach events, including speaking with the Wenatchee Chamber's Community Leadership class. We ironed out an updated version of our "NCACH 101" Presentation, which is available for download on the Coalitions for Health Improvement main page on our website: https://ncach.org/coalition-for-health-improvement/ and are now going to focus on creating some more outreach materials to support our Coalition members as they work to engage others in their communities. Looking ahead, I plan to continue building and refining our suite of outreach materials, tools, and resources for NCACH partners to use as we widen our reach across the four counties. I look forward to an upswing in outreach opportunities as the warmer season approaches, and to continuing to support our Governing Board, Workgroups, and CHIs through communications, on our website, and at community events.

North Central Accountable Community of Health

200 Valley Mall Pkwy

East Wenatchee, WA 98802

www.ncach.org

Contact for Questions:
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Board Decision Form

TOPIC: *Approval of Projected NCACH 2018 Project Funding Allocations*

PURPOSE: *To provide projected funding allocations that NCACH workgroups can utilize in project planning, including implementation timelines, partners, and scope of work to be completed within the projects.*

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

The NCACH Governing Board met on 4/27/18 for a full day retreat to review project specific funding. NCACH staff presented organizational level funding principles, funds allocation decision flow charts, and project-specific funding projections to the Governing Board.

Budget projections through December 31st 2021, broken down by year and workgroup were outlined. Overall projections through 2021 were based on very rough estimates and workgroups plan to provide more detailed annual budget projections to the Governing Board for approval on a yearly basis.

The 2018 Budget projections below outline the anticipated costs for each workgroup from January 2018 – December 2018. Per the NCACH funds allocation decision flow chart, workgroups are required to present detailed project funding recommendations to the Governing Board, prior to release of any funds to partnering providers,. If workgroups recommend funding in excess of the projected costs outlined in the table below, staff will outline the rationale driving any changes to budget projections in the final funding recommendations presented to the Governing Board.

PROPOSAL:

Motion to authorize the following NCACH workgroup funds allocations for the 2018 calendar year as outlined in the table below.

2018 Transformation Project Budget

Budget Item	Total Expenses	Financial Executor Budget	Design Budget
WPCC	**$ 3,163,461.00**	$ 2,685,000.00	$ 478,461.00
TCDI Work	**$ 320,000.00**	$ 320,000.00	
Pathways Hub	**$ 213,000.00**	$ 213,000.00	
Opioid Project	**$ 100,000.00**	$ 100,000.00	
Total	**$ 3,796,461.00**	**$ 3,318,000.00**	**$ 478,461.00**

-

IMPACT/OPPORTUNITY (fiscal and programmatic):

Projected allocations to support the work of our four workgroups and six Medicaid Transformation projects in 2018 total to about $3.8 million. Approving 2018 funding allocations for workgroups will allow workgroup members and NCACH staff to determine how they can work with partners to start implementing projects this calendar year.

Annual funding allocations will also ensure that the Board has a clear understanding of how the funding is going to be distributed across projects and mitigate the potential for certain NCACH projects to not have enough funding to achieve needed outcomes.

Workgroup members and NCACH staff will work within the confines of the budget projections to develop implementation plans and estimated funding amounts for partners. If funding projections change, NCACH staff will outline the rationale for changes in specific funding requests brought to the Governing Board for approval.

TIMELINE:

- May 7th, 2018 – Approval of 2018 Workgroup Funding Allocations
- June 2018 – December 2018 – Based on these general projections, more specific funding recommendations will be brought to the Governing Board

RECOMMENDATION:

Approve above proposal.

Submitted By: NCACH Staff
Submitted Date: 05/07/2018

Board Decision Form Attachment:

Narrative:

Below outlines a detailed summary of 2018 project Costs under each Workgroup. These area all estimates and specific funding request will be brought to the Board throughout 2018.

Table: Detailed 2018 Funds Allocations by Workgroup

Red font highlights dollar amounts that are already approved by the Governing Board

Workgroup	Budget Item	Total	Financial Executor	Demonstration
WPCC				
	Stage 1 Partner Funding	**$ 1,665,000.00**	**$ 1,665,000.00**	
	Stage 2 Partner Funding	$ 1,020,000.00	$ 1,020,000.00	
	CCMI, CSI Contract	**$ 443,461.00**		$ 443,461.00
	Other Contractors	$ 35,000.00		$ 35,000.00
	WPCC Total	**$ 3,163,461.00**	**$ 2,685,000.00**	**$ 478,461.00**
TCDI Work				
	Partner Funding	$ 270,000.00	$ 270,000.00	
	Training Cost	$ 50,000.00		$ 50,000.00
	TCDI Total	**$ 320,000.00**	**$ 270,000.00**	**$ 50,000.00**
Pathways Hub				
	Hub Lead Agency	$ 138,000.00	$ 138,000.00	
	Healthy Generations	**$ 75,000.00**		$ 75,000.00
	Hub Total	**$ 213,000.00**	**$ 138,000.00**	**$ 75,000.00**
Opioid Project	**Total**	**$ 100,000.00**	**$ 100,000.00**	
Total Workgroup Budget		**$ 3,796,461.00**	**$ 3,193,000.00**	**$ 603,461.00**

Board Decision Form

TOPIC: *NCACH Funding Principles*

PURPOSE: *Approval of NCACH organizational level funding principles.*

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

The NCACH Governing Board met on 4/27/18 for a full day retreat to review project specific funding. NCACH staff presented organizational level funding principles, funds allocation decision flow charts, and project-specific funding projections to the Governing Board.

The Governing Board agreed on general funding principles that should be applied the funds that NCACH allocates for work done under the Transformation Project. Those principles will be utilized by NCACH Staff and Workgroups to determine how to design projects and allocate funding to partners.

PROPOSAL:

Motion to approve the following principles that will be utilized to guide how dollars are distributed through our region as part of the Medicaid Transformation Project:

1. Projects that receive funding will outline a path toward sustainability or sustained change.
2. Funding will be distributed to partners for innovative approaches that create new or expand existing capacity and infrastructure, it will not be used to pay for work currently happening.
3. Funding supports linkages between medical providers and social service providers.
4. Partners need to demonstrate a clear way to evaluate impact including data for measurement of success.
5. Projects should show how they address one or more of the six NCACH Project areas

IMPACT/OPPORTUNITY (fiscal and programmatic):

Approval of these funding principles will provide a framework to how each workgroup develops project specific funds allocations to their project specific work. Though all projects will have specific ways that funds are distributed relating to their partners and the work they are completing, each project will look at their project specific funding and how it ties back to the above principles.

TIMELINE:

May: Approval of Funding Principles
June: Approve Decision Flow for Funding Design and Allocation

RECOMMENDATION:

Approve above principles

Submitted By: NCACH Staff
Submitted Date: 05/01/18
Staff Sponsor: John Schapman

Board Decision Form

TOPIC: NCECC Plan For Community Paramedicine with the NCACH

PURPOSE: *Approval of Phase I of the NCECC plan for Community Paramedicine (See attached for full plan)*

BOARD ACTION:

☐ Information Only

☑ Board Motion to approve/disapprove

BACKGROUND:

The North Central Emergency Care Council (NCECC) is a non-profit corporation established in 1991. They work with the Washington State Department of Health and our regional healthcare partners to ensure the continuation of the Emergency Medical Services and Trauma Care system in our communities. The work of NCECC through the Medicaid Transformation Project will be with Emergency Medical Service (EMS) Transportation providers to achieve the following goals:

1. Reduce non-acute ER visits
2. Reduce 30-day Hospital Re-admissions of chronic disease and high risk patients
3. Enhance collection of EMS data and standardize how data is reported across the region

These measures will be achieved by outlined tactics completed by NCECC and its partners through the following three Phases:

1. Phase 1 (June – August 2018): Evaluation and planning of how EMS agencies will achieve the above goals(working with North Central Emergency Care Council).
2. Phase 2 (September – December 2018): Pre-hospital Provider Training and Process Education for all stakeholders of the work plan between the Emergency Care Council and EMS agencies.
1. Phase 3: Go live with implementation Jan 1st 2019.

Details on tactics and deliverables under each phase are listed in the attached pages. The Board motion today is to approve the funding associated with Phase I of the NCECC plan.

Estimated Phase I Cost:

Agency	Dollar Amount
NCECC	$20,000
EMS Agency (10 total)	$50,000 ($5,000/agency)
Total	**$70,000**

PROPOSAL:

The Governing Board motions to allocate up to $70,000 to support Phase I of NCECC's Plan for Community Paramedicine.

- This includes NCECC completing an assessment of other Mobile Integrate Health Service opportunities and incorporate that in the plan that is due in August.

IMPACT/OPPORTUNITY (fiscal and programmatic):

Approving funding for NCECC to complete work over the next 3 months will ensure that NCECC has adequate resources to engage all 10 EMS transport agencies in the process, complete a current assessment of EMS agencies, and create a regional plan to address the goals and tactics outlined in the attached document. The funding for the EMS agencies will ensure these providers can dedicate staff time to develop how each organization will individually engage in the work.

TIMELINE: Phase 1: June 2018 – August 2018

NCECC will:

1. Facilitate the process of Community Paramedicine across the Transport Agencies
2. Achieve a current Assessment of EMS agencies by June 30th, 2018
3. Develop a work plan to achieve the above strategies by end of August, 2018.
4. The work plan for EMS agencies shall report;
    - EMS informatics and data plan
    - EMS training needs and costs
    - EMS tactics & timeline

EMS Transport agency (10 total) will:

1. Complete an assessment of current work
2. Develop a work plan to achieve the above tactics (including a timeline when tactics will be completed)

RECOMMENDATION:

Staff recommends that the Board approves Phase I of the NCECC plan. Progress on Phase I of the plan will determine the need for future funding in Phase II and Phase III.

Submitted By:	Transitional Care and Diversion Intervention Workgroup
Submitted Date:	05/01/18
Staff Sponsor:	John Schapman

NCECC Plan for Community Paramedicine with the NCACH

Introduction:

Medicare and Medicaid consider EMS suppliers of transportation and not as providers of emergency and lifesaving medical care. This is EMS 1.0 (back in the Civil War) and Private and Non-Profit agencies are left carrying the weight of caring for and transporting Medicaid patients at a loss.

Below are basic rates from the Medicaid Fee Schedule last updated on December 9, 2016.

Base rate:
For Basic Life Support (BLS)is $115.34
For Advanced Life Support (ALS) is $168.43
Mileage is $5.08/mile

For a 20 mile ALS transport Medicaid pays: $168. 43 for base rate and $101.60 in mileage for total of $270.03. Note this for ALS, meaning a highly trained Paramedic delivering medications and performing lifesaving skills in an ambulance equipped to state standards ~ $200,000 in vehicle and equipment.

One medication alone can cost this much.

Patients are assured that the service is covered because they have Medicaid but don't understand the real cost. The North Central Emergency Care Council (NCECC) provider's plans to provide the NCACH with the data needed to determine the extent of non-emergent transports across the region and work with EMS providers to develop transport protocols to Emergency Departments, Behavioral Health services, or other preventative services. The NCECC has done the work of the Public Health Emergency Preparedness and Response (PHEPER) and has a staff member who administers this work and works closely with all agencies in our region, Chelan, Douglas Grant and Okanogan Counties. NCECC will work with EMS agencies to gather data, develop a work plan template, and be the liaison with the NCACH.

Each agency has agency specific training needs and a protocol must be developed. This will be identified in an agency training needs assessment based on a Community Health Needs Assessment and the agency's ability to perform the duties.

Core Components of the Approach:
The region has identified several priorities that should be included within Transitional Care and Diversion services across the region. Partners who focus on transitional care and diversion work under the Transformation Project should ensure their approaches place an additional emphasis on the following regional priorities:

- Complement what is currently occurring in the region
- Identify high risk patients/utilizer for follow up care
- Coordination of care across spectrum and partners

- Includes better sharing of patient information
- Helps address the needs of those patients with SMI and SUD
- Models need to develop consistency across region and be able to be scaled for each Partner
- Include Patient and Family Engagement

Expected Measures for Transitional Care and Diversion Models Should Target:

Implementation partners should expect Transitional Care and Diversion programs will help improve these quality measures. If it is not feasible for organizations across the region to track specific measures, the workgroup would define proxy measures that could be used to demonstrate improvement in these quality outcomes.

Transitional Care and Diversion Project Metrics		
Year	**Type**	**Metric**
2019-2021	ACH Reported (Pay for Reporting)	• Process milestones/measures will be developed during the planning stages of the timeline and partners who implement the model will be expected to report against those milestones/measures
2019-2021	State Reported (Pay for Performance)	• Outpatient Emergency Department Visits per 1000 member months • Plan All-Cause Readmission Rate (30 Days)
2020-2021	State Reported (Pay for Performance)	• Follow-up After Discharge from ED for Mental Health • Follow-up After Discharge from ED for Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Outpatient Emergency Department Visits per 1000 member months • Plan All-Cause Readmission Rate (30 Days)

Transitional Care and Diversion Intervention Reporting Requirements:

1. NCACH will require periodic written and verbal reports from implementation partners. During the project period, NCACH will expect implementation partners and will share reports/experiences with other organizations that are going through the process.
2. Implementation partner will be required to provide updates at a Coalition for Health Improvement meetings to update other organizations in their region about the work occurring under the Transformation Project
3. Partners will be required to submit written reports electronically through an online portal.
4. Reporting requirements will be detailed in Memorandums of Understanding between the NCACH and each partner.
5. The NCACH Annual Summit takes place in April each year. It is encouraged that partners attend this summit. This will allow community partners to share successes and challenges in implementing these projects and encourage collaboration among partners across our entire NCACH region.

EMS Agency Tactics specific to Diversion and Transitional Care Services:

1. Diversion
    a. **Measure- Reduce non-acute ER visits**
        i. Tactic- Protocol for non-acute patients referred to the HUB or other community based care coordination agency (i.e. Health Homes)
        ii. Tactic- Fall Risk Program
        iii. Tactic- Mental/Behavior Health transport to Parkside
2. Transitional Care
   (with aspects in Whole patient collaborative, HUB, Chronic Disease Management/Care Coordination, Opioid, and Referral to follow services)
    a. **Measure- reduce 30-day Hospital Re-admissions of chronic disease and high risk patients**
        i. Tactic- Patient visitations with review of discharge instructions and medication review post discharge
        ii. Tactic- Patient interviews to assess pathways and social determinants of health
        iii. Tactic- Patient visitations at home with chronic disease measurements and assessments
        iv. Tactic- Reduce opioid overdoses with EMS interventions
3. Enhance collection of EMS data and standardize how data is reported across the region:
        i. Tactic - Create a standardized process to identify the level of acuity for a 911 call
        ii. Tactic – Standardize the process of how/when a patient is a non-transport, non-emergent, and emergent calls across the region.
        iii. Tactic – Link transport data with the level of acuity to identify what kinds of calls are and/or are not being transported
        iv. Tactic – Evaluate current Medical Record systems for providers and evaluate how record systems can better communicate with other providers

Process for Implementing Tactics:

Implementation process is broken into three initial phases.

2. Phase 1: Evaluation and planning of how EMS agencies will achieve the above tactics outlined (working with North Central Emergency Care Council)
3. Phase 2: Pre-hospital Provider Training and Process Education for all stakeholders of 2019 work plan between the Emergency Care Council and EMS agencies.
4. Phase 3: Go live with implementation Jan 1st 2019.

Phase 1: June 2018 – August 2018

1. North Central Emergency Care Council will work EMS transport agencies to refine the steps to achieve the measures in #1 -#3 listed above. This will include the necessary planning need to accomplish work to implement changes.
    a. Funding Mechanism:
        i. $20,000 to NCECC to help facilitate the process of Community Paramedicine across the Transport Agencies in Chelan, Douglas, Okanogan, and Grant counties. This will include achieving a current Assessment of EMS agencies and developing a work plan to achieve the above strategies by July 31st, of 2018. The work plan for EMS agencies shall report;
            1. EMS informatics and data plan
            2. EMS training needs and costs
            3. EMS tactics & timeline
        ii. $5,000 per EMS agency to complete an Assessment of current work and develop a work plan to achieve the above tactics (including a timeline when tactics will be completed)
        iii. EMS Transport Agencies: 10 total ($50,000) + NCACC ($20,000) = Total of $70,000
        iv. Transport Emergency Medical Service Agencies Include:
            1. Ballard
            2. Lifeline
            3. Moses Lake Fire
            4. AMR
            5. LCCH EMS
            6. Aero Methow EMS
            7. Cascade Medical Center EMS
            8. Okanogan County Fire District #15- Brewster EMS
            9. Waterville Ambulance
            10. Protection 1 Ambulance- Quincy
    b. This phase will include developing a budget that outlines the training cost, staff cost, and time away from direct service to complete this work for Q4 of 2018 – to the end of Q4 of 2019
    c. Work plans will be evaluated on a yearly basis with funding needs identified moving forward

Phase 2: September 2018 – December 2019

1) North Central Emergency Care Council will work with EMS agencies to implement the second stage of the process. Funding will be based on 3 main principles
    a. Time needed to offset cost of staff to train in the approaches outlined
    Including training costs to cross-walk work with healthcare stakeholders in the patient care coordination.
    b. Training Cost to region/agency (i.e. Community Health Worker Training Cost/subject matter experts to help EMS agencies work on process improvement)
    c. Support in helping organizations across the region improve collection and reporting of EMS data.

Phase 3: January 2019 – December 2019

1) North Central Emergency Care Council will work with EMS agencies to implement the plan and the work with the community.

    a. Work plans will be evaluated on a yearly basis with funding needs identified moving forward
    b. Reporting and data will be monitored and reported to NCACH as needed.

Board Decision Form

TOPIC: Staffing for WPCC

PURPOSE: Formally approve recommended changes in staffing for the Whole Person Care Collaborative

BOARD ACTION:

- ☐ Information Only
- ☑ Board Motion to approve/disapprove

BACKGROUND:

NCACH staff previewed the following information at the April Governing Board Retreat.

The WPCC is currently staffed by Peter Morgan (.4 FTE) who, as Director, provides oversight of the work, with Caroline Tillier providing staff support (>.5 FTE), and smaller amounts of periodic support from other staff on specific tasks. Peter, who already attempted to retire once, is expecting to phase out of this position in the Fall of this year. He intends to remain active in NCACH work, but clearly this requires an adjustment in the way WPCC is staffed. In addition, the Demonstration-wide data-workload for which Caroline is also responsible will only increase, meaning that she could not simply take on WPCC along with her other duties. Because of the complexity of this project, it would not be effective to delay a change in WPCC staff support until Peter's departure; a transitional approach makes more sense.

The NCACH team believes the launch of the 1st Learning and Action Network and the intent to launch several concurrent LANs in the coming months will drive a management intensity which cannot be well supported by a Director working part time and from a remote location. The staff recommends that a new 1.0 FTE staff should be hired to take on the combined WPCC roles occupied by Peter and Caroline. This would be funded through a transfer of Peter's FTE to this new position and a .6 increase in overall FTE for the ACH. Caroline would continue to provide support to the WPCC during the transition and during peak activity periods for the WPCC and other workgroups. Her unique skills in synthesizing information, communicating, and creating documents and presentations should benefit all projects. Peter is an hourly employee without benefits and would be utilized during the transition to ensure a smooth transition to the new position. Peter's hours would continue to decrease over the transition period as the new position gets established in the community.

A draft job description is attached to this form.

PROPOSAL:

Motion to approve a new 1.0FTE position to adequately support the Whole Person Care Collaborative.

IMPACT/OPPORTUNITY (fiscal and programmatic):

This position would be on par with our current professional positions, representing an increase in staff salary expenses ranging between $57,323 to $73,161 annually, plus benefits. As Peter winds down during this transition, his staffing costs would phase out by the end of 2018. The maximum annual cost for the new position including salary ($73, 161) + benefits ($25,032) = $98,193. If this position starts July 1st, 2018, the overall impact to the 2018 Demonstration budget will be an increase of $49,096 in personnel costs. Note that a well-qualified full-time staff person should be able to gradually assume some of the functions of our consultants from CCMI and CSI, which should lead to less dependence on those contracts in future years.

TIMELINE:

- *May – Request Gov Bd. Approval, and advertise WPCC Position*
- *June – Review resumes and conduct interviews*
- *July - Make offer and hire staff*
- *August-September - Onboard new staff*

RECOMMENDATION:

Approve above motion

Submitted By:	Whole Person Care Collaborative
Submitted Date:	05/07/2018
Staff Sponsors:	Peter Morgan and Caroline Tillier

Whole Person Care Collaborative Manager

Draft Job Description

POSITION OVERVIEW

Salary: $4,776 to $6,096 monthly ($57,323 to $73,161 annually) plus benefits
Hours: 40 hours/week (100% FTE), may include evening or weekend hours
Status: Regular, full-time, with benefits, union membership required
Starting Date: ASAP Closing Date: Open until Filled Work Location: In North Central Region

BACKGROUND

Through a five-year State Medicaid Transformation Project, The North Central Accountable Health Community (NCACH) is implementing 6 projects to address regional health priorities and improve care by providing high-quality, cost-effective care that treats the whole person and improves the well-being of the communities in Okanogan, Chelan, Douglas and Grant Counties. The work of the NCACH is funded by the Washington State Health Care Authority, the Medicaid payer in Washington State.

To this end, the NCACH activities include:

- Convening a broad array of stakeholders to share expertise and experience in improving health including public policy, financing and delivery system redesign across settings and communities.
- Fostering collaboration among stakeholders to improve health.
- Promoting the development and sharing of high quality data and applying data to improve the appropriate utilization of health services.
- Working with local communities to promote high-quality, systemic and sustained services.
- Promoting community engagement as a key component of health improvement.

The Whole Person Care Collaborative (WPCC) focuses on bi-directional care and chronic disease prevention and control, as well as addressing the primary care and behavioral health provider portion of all NCACH selected projects. The WPCC includes three components:

- A Workgroup that advises, plans and monitors activities of the WPCC
- A Learning Community of outpatient primary care and behavioral providers that implements clinical health improvement efforts.
- A broad and inclusive network that connects all of the organizations and individuals who share a commitment to whole person care

MANAGEMENT OF THE WPCC

The WPCC Manager will report to the Executive Director to manage the overall planning, execution and coordination of the WPCC. Job duties include:

- Work with the Collaborative members on the development of meeting agendas and materials.

- Provide staff support and coordination for all WPCC meetings, including preparation and distribution of agendas, member communication, scheduling and logistics, facilitating discussions, documenting discussions and decisions and performing follow-up activities.
- Prepare and distribute monthly updates to members of the Collaborative partners on work related to the WPCC.
- Foster engagement among members, including providing resources, encouraging participation, facilitating connections, and maintaining regular communication.
- Manage staff and consulting resources of the NCACH in a collaborative manner to ensure execution of these duties and responsibilities.
- Collect, synthesize and analyze key data, -- financial and otherwise—from the Collaborative and move towards goals of the Collaborative.
- Work with the Collaborative members to increase participation in Collaborative activities by other stakeholders.
- Work to mobilize members to respond to relevant policy or advocacy issues as they arise.
- Work with the Executive Director and other staff to strategize and implement outreach activities, including development and distribution of materials, handling media inquiries, and engaging others in dialogue and policy development.
- Represent the Collaborative at meetings as necessary.
- In collaboration with Executive Director and other staff, and outside consultants retained for the WPCC, independently monitor and oversee on-the-ground work of funded partners for the purposes of reporting to the Collaborative and State Health Care Authority.
- Manage financial activities, including submitting requests and reports related to funding for the Collaborative.
- Prepare and manage budgets.
- Monitor funded activities, contracts and reporting.

REQUIREMENTS OF THE POSITION

The WPCC Manager should have the following knowledge, skills, abilities, and qualifications:

- Solid record of accomplishing challenging goals in highly professional work environment(s).
- Proven ability to work effectively with people from diverse backgrounds and at different professional levels to accomplish mutual goals.
- Track record of facilitating, collaborating and contributing to the success of interdisciplinary teams.
- Strong organizational skills and attention to detail, given need to promptly follow through on variety of tasks and logistics in a fast-paced environment.
- Successful experience with grants and/or contracts, including budgeting, monitoring and reporting.
- Demonstrated ability to work independently, meet deadlines, manage multiple responsibilities, and prioritize tasks.
- Strong analytic, research, critical thinking and writing and presentation skills.
- Comfortable and articulate when speaking in public.

- Familiarity with the expanded learning collaborative models such as the BreakThrough Series model, Learning and Action Networks, Sprints, Affinity Groups.
- Bachelor's degree in public policy, health, nonprofit management, or related field.
- Supervisory experience in health care and experience with clinical quality improvement preferred.

MEASURES OF SUCCESS FOR THIS POSITION

- Communications – keeping collaborative members well informed and documenting the lessons learned and process of development of the Collaborative.
- Attraction and retention of Collaborative members' interest and participation.
- Increased stakeholder and public awareness and will related to improving the health of our community.
- Improved health indicators (both process and outcome) associated with the WPCC.

Purposed Fully-Integrated Medicaid Contracting Planning Process

Okanogan County 2018

North Central Accountable Community of Health

Chelan, Douglas, and Grant Counties, Jan. 1, 2018 FIMC Transition

- Advisory Committee
- Consumer Engagement Workgroup
- Early Warning System Workgroup
- IT/EHR Workgroup
- Managed Care Rates Workgroup

Purposed Okanogan County, Jan. 1, 2019 FIMC Transition

Okanogan Coalition for Health Improvement:
Broad Stakeholder Input
Consumer Engagement

Okanogan FIMC Provider Group:
Early Warning System
IT/EHR Planning

All Stakeholders:
Physical Health Providers
Behavioral Health Providers
Community-Based Organizations
Managed Care Organizations
Administrative Service Organization
Law Enforcement
Emergency Medical Services
Consumers
Criminal Justice
Ombudsman
Public Health

Providers:
Okanogan Behavioral Health Care
Confluence Health
Family Health Centers
Mid-Valley Clinic
North Valley Hospital
Three Rivers Hospital
Health Care Authority
North Central Accountable Community of Health
Others as necessary

Okanogan County Fully-Integrated Medicaid Contracting Transition Plan

North Central Accountable Community of Health

	2018									2019		
Objective	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Objective 1: Establish a provider group for FIMC												
Task 1.1: Form the provider group												
Task 1.2: Facilitate regular monthly meetings												
Task 1.4: Set agendas, record minutes and make available to provider group members												
Task 1.5: Provide feedback from meetings to HCA, as necessary												
Objective 2: Broad Stakeholder Engagement												
Task 2.1 Establish utilization of Okanogan County Coalition for Health Improvement as mechanizsm for consistent broad stakeholder engagement												
Task 2.2: Facilitate bi-monthly discussions among stakdeholers including MCOs, providers, HCA, and community-based organizations												
Task 2.3: Facilitate communication between Okanogan County Stakeholders, providers, and HCA prior to and during transition												
Objective 3: Community and Consumer Engagement												
Task 3.1: Develop consumer engagement plan												
Task 3.2: Work with HCA to develop communication materials for clients												
Task 3.3: Implement consumer engagement plan												
Objective 4: Development of Early Warning system												
Task 4.1: Establish process for developing Early Warning System												
Task 4.2: Select Early Warning System indicators												
Task 4.3: Work with HCA to collect, analyze, and report Early Warning System indicators												
Objective 5: Smooth IT transition for integration for providers, in particular Behavioral Health providers												
Task 5.1: Behavioral Health Organization conducts Qualis FIMC IT Assessment												
Task 5.2: Behavioral Health Providers Develop IT Transition Plan												
Task 5.3: Identify Technical Assistance Needs												
Task 5.4: Facilitate provision of technical assistance opportunities												
Objective 6: Knowledge transfer to MCOs												
Task 6.1: As necessary, participate in knowledge transfer meetings with Spokane RHO, MCOs, and HCA (Note: HCA will be facilitating these meetings for all regions)												

North Central Accountable Community of Health

Pathways Community HUB Request for Proposals

Scoring Process

Stage 0: Opening

Proposals are due on April 27th, 2018. Proposals will be opened on May 7th, 2018, during the regular scheduled Governing Board Meeting. Notices will be put in the Wenatchee World, Omak Chronical, and Columbia Basin Herald 10 days to prior to the opening of the proposals. All proposals received by April 27th, 2018 at 5:00pm will be kept in sealed envelopes until opened in public on May 7th, 2018. Any proposals received via email, will be printed and placed in a sealed envelope until they are opened on May 7th, 2018.

Stage 1: Screening

Each application will be screened by NCACH Staff to determine it meets the minimum qualifications of the RFP and is complete. Screening will be completed by Thursday May 10th. If information is missing, NCACH may request the missing information and the applicant will have 48 hours to provide a response to the missing information.

Stage 2: Scoring

All reviewers will be given a link to a web form where they will record their reviews. The proposals will be sent electronically to reviewers by 5:00pm on May 11th. Reviewers will be asked to complete reviews by May 22nd, 2018.

Reviewers will be a mix of community stakeholders (selected from the Pathways Community HUB RFP Subgroup) and technical assistance consultants who do not have an actual or perceived conflict of interest. Examples of perceived or actual conflicts of interest include current or future contractual relationships, employees of organizations that have applied, providing letters of support to applicants for this RFP. Additionally all reviewers will be required to sign the NCACH Conflict of Interest Policy prior to reviewing the proposals. There will be an equal number of community stakeholder reviewers as technical assistance consultant reviewers.

If there are three proposals or less, all reviewers will review all applications. If there are more than three proposals, each proposal will be reviewed by two randomly assigned community members and two randomly assigned consultants. The Center for Evidence-based Policy will serve as the review Manager. The Review Manager will be responsible for assigning proposals to the reviewers.

Stage 3: Exchange of Comments

If three or less applications are submitted, the Review Manager will strip scores and share all comments with all reviewers on May 24th, 2018. If more than three applications are submitted, the Review Manager will share all scores and comments with all reviewers on May 24th, 2018. Reviewers will have three business days to review their colleagues' comments and the option to revise their own scores. Final scores will submitted through a similar web form and will be due by 5:00pm on May 30th, 2018.

Stage 4: Score Tabulation

The Review Manager will translate scores into rankings (first place or second place). Proposals with average scores below 68 will be excluded from the ranking process. If one application has more first place rankings than the others, it will be selected. If applications are tied in rank, scores will be totaled to determine the selected agency.

If the application scores are tied after the scores are totaled, an additional reviewer, identified by The Center for Evidence-based Policy, will break the tie. Applications will be considered tied if their average total scores have a three point or less difference.

Stage 5: Governing Board Approval

NCACH maintains the right to not select a successful applicant for the applications received. NCACH may also negotiate with applicants to improve areas where they may be deficient in order to ensure an adequate applicant is selected as the Pathways Community HUB lead agency.

The successful applicant will be recommended to the Governing Board for approval on June 4th, during the regularly scheduled NCACH Governing Board meeting. The Governing Board will be supplied with the average section and total scores of each application along with a summary of the applications and rationale for the selected applicant. Full applications will be available to Governing Board members upon request. The Governing Board may approve, conditionally approve, or reject the recommended applicant.

North Central Accountable Community of Health

Pathways Community HUB Request for Proposals
Proposals Due: April 27, 2018 by 5:00pm

Background

Through cross-sector, regional collaboration, the North Central Accountable Community of Health (NCACH) is working to improve community health in Chelan, Douglas, Grant, and Okanogan Counties. NCACH is one of nine Accountable Communities of Health formed in Washington State through the Healthier Washington initiative. On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Project. The goal of the Transformation Project is to improve care, increase efficiency, reduce costs and integrate Medicaid contracting. To align clinical integration and payment integration within the Transformation Projects, the HCA developed the Medicaid Transformation Project Toolkit describing eight projects from which the ACH can select. One of the six projects that the NCACH has selected is Community-Based Care Coordination. The project objective, as described in the toolkit, is to promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

As described in the Medicaid Transformation Project Toolkit, the NCACH will establish a Pathways Community HUB (HUB) to support a sustainable community-based care coordination system. The HUB model is an evidence-based community care coordination approach that removes duplication through a singular technology system to track care coordinators and outcomes. The HUB model has demonstrated effectiveness within racial and ethnic populations and been endorsed by several federal agencies such as: Agency for Healthcare Research and Quality, Center for Medicaid and Medicare Services, Center for Disease Control and Prevention, Health Resources and Services Administration, National Institute of Medicine and others. Applicants must demonstrate a working knowledge of the HUB model and are encouraged to utilize the following resources to do so: HUB Quick Start Guide (https://innovations.ahrq.gov/sites/default/files/guides/CommHub_QuickStart.pdf) and the HUB Manual (https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf).

In addition, the Kresge Foundation has funded the creation of the Pathways Community HUB Certification Process. The successful applicant is required to pursue certification (note: initial certifications fees will be sponsored by the NCACH). The HUB Certification Prerequisites and Standards are located at (https://pchcp.rockvilleinstitute.org/wp-content/uploads/2017/03/2017-Standards-and-Appendices.pdf).

NCACH's goal in the Medicaid Transformation is to promote and achieve Whole Person Care. NCACH recognizes that much of a person's overall health comes from factors outside traditional healthcare settings. The Pathways Community HUB will connect the healthcare system and social determinants of health partners to achieve the goal of improving population health in the NCACH region. By working with selected target populations through any of the 20 Pathways (Appendix A), the HUB comprehensively reduces and/or eliminates common known risk factors. NCACH has convened a regional workgroup to initiate the planning phase, including defining the target population and target outcomes. The successful applicant will be a part of the workgroup and have input into the initial target

population and target outcomes. The NCACH Governing Board will have final approval of the target population and outcomes during the implementation phase.

Opportunity

The NCACH will select an agency to become the Pathways Community HUB serving North Central Washington (Chelan, Douglas, Grant, and Okanogan Counties). This is a competitive bid process open exclusively to agencies or institutions meeting the eligibility criteria established by the NCACH. The NCACH will not fund the implementation of more than one Pathways Community HUB. The successful applicant will be eligible for non-competitive funding to support the planning, launch, and scaling of a Pathways Community HUB.

Funding

This RFP is for selection of a HUB lead agency to serve the North Central Accountable Community of Health region (Chelan, Douglas, Grant, and Okanogan counties).

Though specific funding amounts are not specified in the RFP, this will be negotiated prior to contract execution. This is because HUB costs are largely dependent on the number of clients served and the target population selection. At this time, neither are known and will need to be selected after the selection of the lead agency. Cost estimates from established HUBs will be discussed during an RFP technical assistance session provided on April 9th, 2018, from 3:30-5:00pm PST.

NCACH is committed to financially supporting the HUB through the initial planning and implementation phases in order to become a viable and sustainable program. Funding for the selected agency will establish the infrastructure for the Pathways Community HUB. The applicant is expected to already have administrative capacity for the HUB (ie. payroll capabilities, HR policies, etc.), however, capacity building specific to the HUB program will be supported by the NCACH. Standard HUBs typically utilize 2-4 full-time staff to manage the HUB operations. NCACH will provide reasonable start-up funding and act as an outcome-based payer for an agreed upon number of clients meeting a specific target population through 2021. NCACH funding will also provide for care coordination services to a minimum number of clients (which will be detailed in the contract). Specific funding commitments will be based on a clear budget and funding plan developed cooperatively by the HUB organization and NCACH. Additional funding may be made available to the successful applicant to subsidize care coordination services provided to clients, on a pay for outcomes methodology, consistent with the HUB model. Funding for the HUB will be contingent on meeting milestones, performance metrics, and outcomes that will be detailed in the contract with the selected applicant.

Eligibility

Applications will be accepted from eligible nonprofit organizations. To receive consideration to serve as the HUB, applicants must:

- Be a public or private nonprofit organization recognized by the State of Washington;
- Be located in Chelan, Douglas, Grant, or Okanogan County;
- Submit a completed application, and;
- Must comply with all current and applicable Washington State laws and regulations.

The following are ineligible for funding consideration:

- Individuals
- National organizations: However, local chapters or affiliates of national organizations may be eligible if they meet the definition of a community-based organization (CBO). As defined by the National Institute of Health, a CBO is public or private nonprofit organization that is representative of a community or a significant segment of a community and works to meet community needs.

Requirements

The NCACH expects the HUB to meet the following requirements:

1. Provide complete accounting of how funds were earned and expended.
2. In the first three years, develop braided funding streams other than NCACH, in order to move toward sustainability by the end of the Medicaid Transformation Project, which ends on December 31, 2021.
3. Attend all pre-arranged mandatory meetings including, but not limited to, the scheduled key initial two-day orientation and Certified Pathways Community HUB training in East Wenatchee, WA on June 13 and 14th, 2018. NCACH will reimburse or provide applicants for travel, meals, and lodging for this orientation.
4. With financial support from NCACH, agree to use the care coordination data system designated by the NCACH.
5. Provide the NCACH access to their data within the care coordination data system to allow for review, analysis, and monitoring of aggregate and disaggregated data and related information, consistent with applicable confidentiality protections.
6. Track, monitor and report on client services and Pathways and provide updates in real time to care coordination data system. The data must be reviewed daily to ensure accuracy. This data report must include, but not be limited to, total clients referred to the HUB, total clients enrolled in the HUB, total and type of Pathways initiated, total and type of Pathways successfully completed, and other measures that will enable progress and status evaluation.
7. Provide quarterly program, fiscal and evaluation reports, including milestones listed the Medicaid Transformation Project Toolkit (link: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf; the relevant section for the Community-Based Care Coordination project can be found in Appendix B) to update the NCACH on program progress and outcomes to date. Continued funding for both the NCACH and the HUB agency is contingent on meeting the milestone and reporting deadlines.
8. Provide semi-annual program evaluation reports to the NCACH including reporting on the Pay-for-Reporting metrics that the NCACH is required to report on (see Appendix B for a list of Pay-for-Reporting metrics for the Community-Based Care Coordination project provided in the Medicaid Transformation Project Toolkit). Continued funding for both NCACH and the HUB agency is contingent on this reporting requirement.
9. Participate in statewide HUB calls with other HUBs in Washington State.
10. Agree to:
    - Participate in HUB model training.

- Implement recruiting and hiring of staff, if necessary.
- Utilize Community Health Workers (CHWs) to help achieve improved health outcomes for the identified target population and must ensure (through sharing and facilitating of CHW education opportunities) that each CHW meets the minimum training requirements as outlined in Appendix C.
- Ensure that contracted Care Coordination Agencies maintain qualified staff to supervise the work of care coordinators as required by the HUB Certification Prerequisites and Standards.
- Perform quality monitoring and improvement activities.
- Adopt and implement the Pathways Community HUB model.
- Begin the certification process within 6 months of Pathways Community HUB model service implementation.
- Provide a one-year follow-up on clients who received HUB services.

11. Comprehensively address reduction/elimination of known risk factors to the target population through the eventual implementation of all 20 Pathways, and monitor these risk factors through a quality improvement program and data submission in the required data system. Please note, the number of Pathways initiated should be correlated with the need demonstrated among the target population.
12. Participate in the NCACH Annual Summit. This regional event is held each year in an effort to share learnings and engage partners.
13. With respect to care coordination services, the HUB must be a neutral entity and operate in a transparent and accountable manner.
14. Create and maintain a Pathways Community HUB Advisory Board which is meaningfully engaged and empowered to guide and advise the strategies of the HUB.
15. Ensure HUB staff complete HIPAA compliance training and conduct security compliance measures and reviews to attain third-party HIPAA compliance.

Public Record Notice

It is expressly understood by the parties that the Chelan-Douglas Health District is the backbone agency of the North Central Accountable of Health and therefore is subject to the Washington Public Records Act, RCW 42.56. Upon receipt of a public records request, NCACH is required to provide prompt inspection or copies within a reasonable period of time of responsive records that NCACH determines, in its sole discretion, are public records subject to release.

If your organization chooses to include in your application what is considered a proprietary trade secret they must complete the following statement and submit it the NCACH on your agency letterhead:

*NCACH agrees not to disclose, without giving prior notice, any specific information that (**organization**) has previously identified as proprietary trade secret. In the event that a person seeks that information through a public records request, NCACH will notify (**organization**) in the course of NCACH's legal review to give (**organization**) an opportunity to establish to the satisfaction of NCACH that the information constitutes a proprietary trade secret that is exempt from disclosure under the Public Records Act. If NCACH does not find that the information constitutes a proprietary trade secret, NCACH will notify (**organization**) of its intention to disclose the information in accordance with law. (**Organization**) may*

choose to seek appropriate legal action, including injunctive relief, to prevent disclosure of the information at issue.

Application Deadline and Proposal Preparation

Applications must be received by 5:00 PM, April 27, 2018. Applications may be mailed or emailed (in PDF format) to the address below:

North Central Accountable Community of Health
Attn: Christal Eshelman
200 Valley Mall Parkway
East Wenatchee, WA 98802
Email: christal.eshelman@cdhd.wa.gov

Suggested word counts are provided for each section. These are suggestions and the applicant will not be penalized in the scoring process for a word count above or below the suggestion.

Proposal Preparation

A Pathways Community HUB RFP Technical Assistance Session will be provided in person at the Chelan-Douglas Health District with an option to participate remotely.

April 9th, 2018 at 3:30-5:00pm PST

Registration Link: https://www.eventbrite.com/e/ncach-pathways-community-hub-rfp-technical-assistance-session-tickets-44618712771

Questions regarding this RFP should be submitted to Christal Eshelman at christal.eshelman@cdhd.wa.gov. Questions and answers will be posted on our website (https://ncach.org/care-coordination/) within five business days of receiving them.

Proposal Review and Selection

Responses to this RFP, which are determined to be complete and in compliance with the requirements of this RFP will be reviewed by NCACH. Proposals that do not provide all of the requested information, or do not meet all the requirements specified in the RFP, will be determined incomplete and will be disqualified. The applicants will be ranked based on the quality of the application and qualifications of the agency. If necessary, NCACH will contact applicants for clarifying information or if there are additional questions. The applicant with the highest rank will be selected to serve as the HUB. NCACH reserves the right to re-issue the RFP and/or not select a HUB lead agency from the pool of applicants if it is deemed that no applicants demonstrate the required qualifications, skills, and/or capacity to serve as the HUB.

North Central Accountable Community of Health

Pathways Community HUB Application
Proposals Due: April 27, 2018 by 5:00pm

Applicant Information

Applicant Agency/Organization:_____

Complete Mailing Address:_____

_____

Federal Tax I.D. Number:_____

Executive Director:_____

Phone:_____

Email:_____

Project Director (if known):_____

Phone:_____

Email:_____

Fiscal Officer:_____

Phone:_____

Email:_____

Certification: The applicant understands and agrees to the following conditions:

1. This RFP is for selection of a HUB lead agency to serve the North Central Accountable Community of Health region (Chelan, Douglas, Grant, and Okanogan counties).
2. NCACH is committed to financially supporting the HUB to become a viable and sustainable program. NCACH will provide startup funding and act as an outcome based payer for an agreed upon number of clients meeting a specific target population through 2021. NCACH will negotiate an initial start-up contract and payer contracts with the successful applicant.
3. Funding to the HUB will be contingent on meeting milestones, performance metrics, and outcomes that will be detailed in the contract with the successful applicant.
4. All project records will be made available to NCACH upon request for review or audit and will not be disposed of without written authorization from NCACH, and that a copy of all audits of project funds will be submitted to NCACH.
5. We certify to the best of our knowledge and believe that the information contained in this application is true and correct and that the document has been duly authorized by the applicant organization.

Signature of Agency Director:_____ Date:_____

Signature of Auditor or Fiscal Officer:_____ Date:_____

Narrative Responses

For submission, please attach narrative responses to the completed Applicant Information form (page 6).

Project Participation Requirements

Please provide an attestation that the organization meets and/or meet all requirements as described in the Requirements section of the Request for Proposals.

Proposal Narrative – Description of the Agency

Description of the Applicant Agency

1. Provide a description of the applicant agency including but not limited to current programs, agency's mission and vision, size of staff, organization chart (included staff that will need to be added to support the HUB), description of staff roles, locations and hours, size of operating budget, general financial status, and composition of board of directors.
2. Provide a statement of competencies including
    a. Why the applicant is best suited to implement and achieve the project goals;
    b. The applicant's connection to the North Central region and the communities served;
    c. Evidence of the applicant's ability to lead community interventions to improve health. Evidence of this ability may include documentation of past efforts to lead community interventions to address health disparities; reports of improved indicators by population, age, socioeconomic status; and published articles, public reports or documents specific to improvement in health status, and;
    d. Examples of the organization's talent and capacity to contract for long term and/or innovative services.
3. Provide a description of the applicant's areas of expertise, key personnel, credentials of proposed staff, job technical experience, and unique capabilities. Applicants should include key staff job descriptions and resumes of staff assigned to the project (to the extent this is known).
4. Provide a description of the plan to hire or retain a HUB Director who possesses the experience and skills to effectively manage the HUB including a commitment to community health and equity as well as strong business and communication skills.
5. Provide a description of the proposed HUB's infrastructure, and its capacity to fully implement the Pathways Community HUB model, including a description of the organizational infrastructure and key staff to support necessary HR, fiscal, and IT functions.
6. Describe the agency's plan to ensure that assigned program staff are culturally and linguistically competent.
7. Provide a description of the existing or proposed HUB's mechanism or plan to communicate its strategies, programs and progress to the North Central ACH region.
8. Describe the HUB's plan to coordinate the network of care coordination agencies serving our target population. Provide a general description of the proposed HUB's plan to promote collaboration, inter-sectoral teamwork and community-clinical linkages for a target population. Though the target population is not yet identified, to answer this question, please provide an example of an approach you would take for one target population of your choosing (examples of

target populations include opioid use disorder, frequent Emergency Department utilization, and mental health disorders).

9. The HUB may start with services in one city or county, but must expand services to all four counties by the end of 2021. Provide a growth/expansion plan detailing the strategy, efforts and timeline to expand coverage to all four counties (Chelan, Douglas, Grant, and Okanogan counties), if the applicant agency is not currently in all four counties.

Model Adoption

Provide a narrative describing the applicant's ability to adopt the Certified Pathways Community HUB model. The explanation should include:

1. Participation in ongoing mentoring calls and face to face sessions.
2. Capacity to adopt the model.
3. Provide a description of the HUB's mission, program goals, and objectives.
4. Provide a description of the plan to ensure that staff of the HUB and HUB care coordination agencies receive cultural and linguistic training and provide culturally and linguistically proficient services.
5. Explain who the HUB may contract with to act as a payer for care coordination outcomes (excluding the NCACH).
6. Provide a description of how the proposed HUB is a neutral entity and how it operates in a transparent and accountable manner. HUB organizations are not usually allowed to become certified if they also provide care coordination services. If the applicant provides such services, please describe how the HUB operation will be financially and administratively separated from care coordination services provided by the applicant, including confirmation that the HUB will not refer to any community care coordinators that it may employ. Additionally, list any current contractual relationships with care coordination agencies, potential payers, Managed Care Organizations, or other relevant organizations.
7. Document the applicant's understanding that funding provided by NCACH specific to establishing a Pathways Community HUB should not be used to fund other programs in the agency.
8. The capacity to achieve HUB certification is a key requirement of the HUB organization. Provide a description of how the agency meets or plans to meet HUB certification prerequisites and standards (https://pchcp.rockvilleinstitute.org/wp-content/uploads/2017/03/2017-Standards-and-Appendices.pdf).

Continuous Monitoring and Improvement

Continuous monitoring and improvement is both quantitative and qualitative and assesses the degree to which intended objectives are achieved by clients or the agency. Organizations must demonstrate the ability to implement quarterly clinical and non-clinical measures to evaluate program effectiveness. Please remember, the number of Pathways initiated correlates to the needs of the high-risk population served. Each Pathway that is deemed necessary must be opened without delay as the need is determined and reported on in each quarter.

1. Describe the methods that will be used to determine whether the established standardized Pathways goals and objectives are being met by the HUB and whether the expected outcomes are being achieved.
2. Provide a brief proposed continual quality improvement plan that will impact service delivery.
3. Provide experience your organization has had with applying the PDSA (Plan, Do, Study, Act) cycle or a similar process for continuous monitoring and improvement.

Letters of Support

[Optional] Attach relevant and specific letters of support for your agency specific to this RFP from care coordination agencies, community partners, the agency's Board of Directors, and others as appropriate. You are encouraged to provide at least two letters of support from care coordination agencies that would be willing to contract with your organization as a Care Coordination Agency as described in the Pathways Community HUB model.

Appendices

Appendix A	Core Pathways
Appendix B	Community-Based Care Coordination section of the Medicaid Transformation Project Toolkit
Appendix C	Community Health Worker minimum training requirements and supervisory requirements

APPENDIX A

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Adult Learning

Initiation
Client identifies adult learning need(s). Date _____

Partner with client to establish and review educational and/or career goals. Document goal(s) and desired outcome(s).
Goals: _____

Assist client in registering for training or educational course:
□ Gather necessary documentation for registration.
□ Determine if client needs to take an assessment or placement exam & schedule exam date.
□ Use Education Pathways as appropriate.

Confirm that client is registered in class or training program and attends first class. Date _____

Monitor client's progress with educational program. At a minimum of every 2 weeks confirm that client is attending classes and document progress in client record.

Progress Checks:
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____

Completion
Confirm that client successfully completes stated educational goal:
- Course / class completed
- Training program completed
- Quarter / semester completed

Date _____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Behavioral Health

Initiation
Client with diagnosed behavioral health issue(s).
Date _____

↓

Document behavioral health issue(s). _____
_____
Use Education Pathways as appropriate.

↓

Schedule initial appointment for appropriate level of behavioral health service based on client's need.
Date _____

↓

Completed Appointment #1: Date _____
Service _____
Completed Appointment #2: Date _____
Service _____
Completed Appointment #3: Date _____
Service _____

↓

Completion
Client has kept three scheduled behavioral health appointments.
Date _____

Monitor any follow-up appointments with the Medical Referral Pathway after this Pathway is completed.

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Developmental Referral

Initiation

Child with suspected developmental delays.
Date _____
Reason for referral _____
_____

↓

□ Explain Part C services and review family's rights.
□ Explain agency options available to obtain a developmental evaluation.

↓

□ Obtain parental/guardian consent for evaluation.
□ Partner with primary care provider to obtain a prescription and assist family with scheduling developmental evaluation.

↓

Schedule developmental evaluation appointment.
Date _____
□ Educate caregivers about the importance of keeping appointment. Use Education Pathways as appropriate.

↓

Completion

Document the date and results of completed developmental evaluation.
Date _____
Results _____
_____
_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Developmental Screening

Initiation
Any child up to 5 years of age. Child should be screened at a minimum of every 6 months using the age appropriate ASQ or ASQ-SE. Date _____

↓

□ Educate the family about the importance of developmental milestones. Make sure to document appropriate Education Pathways.
□ Obtain verbal consent from parent/guardian to do developmental screening.

↓

Completion
Child successfully screened using the age appropriate ASQ or ASQ-SE. Record test and results. Date _____

↙ ↘

No developmental concerns identified. Discuss findings with caregivers. Record date for next developmental screen. Date _____

Developmental concerns identified and discussed with caregivers. Start Developmental Referral Pathway.

Circle ASQ Screen used: 2 4 6 8 9 10 12 14 16 18 20 22 24 27 30 33 36 42 48 54 60

____ Communication ____ Gross Motor
____ Fine Motor ____ Problem Solving
____ Personal-Social

Circle ASQ-SE Screen used: 2 6 12 18 24 30 36 48 60 Total Score _____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Education

Initiation

Education Pathway initiated by community care coordinator. Date _____

↓

Document the HUB approved evidence-based education provided.

_____

_____

↓

□ Document required assessments, education format, and pre- and post-tests as appropriate to the topic.

↓

Completion

All required components are completed and documented. Date _____

Education Format (circle): Handout Talking Points Video Slides Other _____

Pre-Test Score _____

Post Test Score _____

Assessment _____

Date Finished Incomplete _____

Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Employment

Initiation
Client is requesting assistance in obtaining a job.
Date _____

↓

□ Education and work history
- Previous work experience _____
  _____
  _____
- Educational level completed_____
- Employment goals (special training needed for desired job) _____
  _____
  _____
  _____

□ Identify barriers to employment (felony record, financial constraints, etc.) Document Education Pathways as appropriate.

↓

Care coordinator works with client to confirm that résumé is completed. Date _____

↓

Care coordinator works with client to monitor job applications at least every 2 weeks and record. →

Progress Checks:
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____

↓

Confirm date of hire and place of employment.
Date _____ Place _____

↓

Completion
Client has found consistent source of steady income and is employed more than 30 days from date of hire.
Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Family Planning

Initiation
Client has requested help with getting a family planning method. Date _____

↓

□ Document HUB approved education about family planning with the Education Pathway.

↓

Schedule appointment for family planning.
Date _____

↓

Completion 1 (Permanent or LARC)
Confirm that client kept appointment and document family planning method. Date _____
Method _____

Pathway is complete if tubal ligation, Essure, vasectomy, IUD, implant, shot or other form of long-acting reversible contraceptive (LARC) is obtained.

↓

Completion 2 (Individual Control)
Confirm that client kept appointment and document family planning method. Date _____
Method _____

If client has chosen a method other than a permanent method or LARC, then Pathway is complete when client has successfully used the method for more than 30 days from the start date.
Follow-up date _____
Confirmation that family planning method is still being used ___ Yes ___ No

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Health Insurance

Initiation
Client needs health insurance. Date _____

↓

□ Assist client and/or family in completing forms as directed and submit to agency. Document Educational Pathways as appropriate.

↓

Confirm with agency that all forms have been received and completed properly.
Date _____

↓

Completion

Arrange follow-up within 2-6 weeks of application submission to **confirm acceptance or denial** of insurance.

- If **denied, record reason** in client's record and refer client to other community resources.
- If **accepted, document status** – including insurance number – in client's record.

  Insurance _____

  Number _____

  Date _____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Housing

Initiation
Client needs affordable and suitable housing. Date _____

Check all reasons why housing is required:

□ Eviction	□ Safety Issue(s)
□ Homeless	□ Too many for living space
□ Domestic Violence	□ Financial
□ Poor rental history	□ Discrimination
□ Fire/Natural Disaster	□ Disability
□ Self-imposed (pets)	□ Lead
□ Poor location to access services	□ Other _____

Partner with client to contact appropriate housing organization and schedule an appointment. Date _____

Housing organization_____

□ Help client remove barriers and document Pathways used.

Confirm that client kept appointment. Date _____
Name and phone number of contact person if client is placed on a waiting list. Phone _____
Name_____

□ Follow up with housing contact person at least bi-weekly to monitor housing progress and record in client's chart. Document completion of related Educational Pathways with client.

Progress Checks:

Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____

Document date client moves into housing unit. Date_____
Address_____

Completion
Confirm that client has moved into and maintained a suitable and affordable housing unit for more than 30 days from the move-in date. Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Immunization Referral

Initiation

Immunization record reviewed, and child is confirmed to be behind on immunizations or no record is available. Date_____

Confirm appointment scheduled with provider or clinic to update immunization status.

Provider: _____

Appointment Date: _____

Educate family about the importance of immunizations and maintaining an up-to-date record. Check educational tool(s) used:

Ages 0-10	Ages 11-18
□ *Your Child Thanks You*	□ *Immunization is the Best Protection*
□ *Why Risk It*	□ *HPV Did You Know?*
□ *What Is Your Reason*	

Completion

Child is up-to-date (UTD) on all age-appropriate immunizations.
Monitor immunization status at all visits. Date_____

□ UTD on all
□ UTD without influenza

Document how records were obtained and reviewed.

□ Family's record □ Health care provider
□ ImpactSIIS □ Health department
□ Other electronic registry □ Other_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Immunization Screening

Initiation

Any child less than 18 years of age. Date_____

↓

Determine immunization status by using the child's immunization record:

- If record is available, use "***Checking a Vaccine Record***" Tool or document confirmation from ImpactSIIS registry.
- Document how records were obtained and reviewed.
  - □ Family's record □ Health care provider
  - □ ImpactSIIS □ Health department
  - □ Other electronic registry □ Other_____

↓

Educate family about the importance of immunizations and maintaining an up-to-date record. Check education tool(s) used:

<u>Ages 0-10</u>

- ❑ *Your Child Thanks You*
- ❑ *Why Risk It*
- ❑ *What Is Your Reason*

<u>Ages 11-18</u>

- ❑ *Immunization is the Best Protection*
- ❑ *HPV Did You Know?*

↓

Completion

Immunization record reviewed and documented.

1. Child is up-to-date (UTD) on all age-appropriate immunizations. Date_____
   - ❑ UTD on all
   - ❑ UTD without influenza
2. Child is behind on age-appropriate immunizations. Document reasons why and start Immunization Referral Pathway.
3. Document that no records are available, and the steps taken to get records, and open the Immunization Referral Pathway.

Date Finished Incomplete _____

Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Lead

Initiation

Any child between 12 – 72 months of age. Children are recommended to be tested at 12 and 24 months (check one).

□ 12 months
□ 24 months

or

□ Lead testing status unknown (12 – 72 months)
□ Lead testing not done (12 – 72 months)
□ Other _____

↓

□ Provide lead education to all families with young children and/or expectant mothers. Use Education Pathway.

↓

If available, provide date and result of most recent lead test.
Date_____ Results_____

↓

Check all that apply:

□ Child is on Medicaid
□ Child lives in high risk zip code area

If child is not on Medicaid, and does not live in high risk zip code area, then complete Lead Assessment Tool:

□ Assessment is positive
□ Assessment is negative

↓

Schedule appointment for blood lead screening.
Date_____

↓

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

□ Elevated: ≥ 5 µg/dl → Refer to health department.
□ Non-elevated: < 5µg/dl

Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Medical Home

Initiation
Client needs an ongoing source of primary care.
Date_____

↓

Determine and record client's payer source:
- □ Medicaid
- □ Medicare
- □ Private Insurance
- □ Self Pay
- □ Other _____

↓

1. Identify provider _____
2. Assist client in scheduling appointment.
   Date_____
3. Document Education Pathways as appropriate.

↓

Completion
Confirm that appointment was kept. Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Medical Referral

Initiation

Client needs a health care appointment or service.
Document type of service needed – use codes.
Date _____ Code _____

□ **Educate** client about the importance of regular health care visits and keeping appointments. Document education with appropriate Education Pathway.

Appointment scheduled for health care service.
Date _____ Provider_____
Service _____

Completion

Verify that appointment was kept. Date _____

Code Numbers for Type of Medical Referral:

1. Advanced Directives
2. Behavioral health services
3. Breastfeeding services and support (classes, pump, etc.)
4. Dental
5. Disease management and support services, including education
6. Equipment assistance
7. Family Planning and reproductive health
8. Hearing
9. Home Health services
10. Immunizations
11. Labs
12. Medication assistance
13. Nutritional services
14. Occupational therapy
15. Physical therapy
16. Primary care _____
17. Procedures (Ultrasound, MRI, x-ray, etc.)
18. Rehabilitation (cardiac, pulmonary, etc.)
19. Sexually transmitted infections
20. Specialty care _____
21. Speech and Language
22. Substance abuse services (detox, medication assisted treatment, sober housing, etc.)
23. Treatment (chemotherapy, radiation, etc.)
24. Vision

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Medication Assessment

Initiation
Client is taking prescribed medication(s).
Date_____

□ Complete the Medication Assessment Tool with your client and/or client's caregiver:

1. Include all medications your client says he/she is taking right now (prescription, over the counter, herbal, alternative, etc.)
2. Record what your client says about the medication in his/her own words – even if it is different from the label.

Send completed Medication Assessment Tool to client's primary care provider or pharmacist. Date_____

Verify with primary care provider that Medication Assessment Tool was received. Date_____

□ If medication issues are identified by health care provider, then initiate Medication Management Pathway.

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Medication Management

Initiation
Client is not taking medication(s) as prescribed.
Date_____
Referral Source _____

↓

Schedule appointment with prescribing provider to complete medication reconciliation and patient education.
Date_____

↓

Care coordinator schedules follow-up appointment in the home. Date_____

↓

Medication Assessment Tool completed in client's home and sent to provider.
Date_____

↓

Provider reviews Medication Assessment Tool:
□ Medication correct
□ Medication is not correct – Schedule appointment with provider. Date _____

↓

NOTE: Medication Assessment Tool and provider visits are repeated until provider confirms that medication is correct. (Steps 2 – 5)

↓

Completion
Verify with primary care provider that client is taking medications as prescribed. Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Postpartum

Initiation
Client has delivered and needs to schedule a postpartum appointment. Date_____

Appointment scheduled with provider.
Date_____

NOTE: Complete Family Planning Pathway and Education Pathways as appropriate.

Confirm that postpartum appointment was kept.
Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Pregnancy

Initiation
Any woman confirmed to be pregnant through a pregnancy test. Date_____

NOTE: Document all pregnancy related education with Education Pathways.

Confirm first prenatal appointment with prenatal provider. Provider_____

- First prenatal appointment date_____
- Estimated due date_____
- Number of completed prenatal appointments to date (including 1st prenatal) _____
- Concerns_____
  _____

Confirmed **completed** pregnancy-related appointments that happen after the Initial Checklist.

Prenatal appointments:

Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____
Date:_____

Completion
Healthy baby ≥ 5 lbs. 8 ounces (2500 grams)

Birth date_____ Weight_____
Gestational Age_____

Check one: Singleton_____ Twins_____ Triplets+_____

***Please remember to complete the Birth Information Tool.**

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Social Service Referral

Initiation
Client needs a social service. Document type of service needed - use codes. Date_____ Code_____

↓

□ Provide education as needed to keep appointment. Document Education Pathway(s) as appropriate.

↓

Appointment scheduled with social service provider or to receive other services. Date_____
Provider/Service_____

↓

Completion
Verify that client kept scheduled appointment and/or received services. Date_____

Code Numbers for Type of Service

1. Child care services
2. Child development services (Part C, Help Me Grow, Head Start)
3. Child or elder abuse services
4. Clothing – ongoing resource for clothing
5. Citizenship – resource to obtain citizenship
6. Day care/respite services
7. Educational services and supports (not using Adult Learning PW)
8. Employment –employment resource (not on Employment PW)
9. Family crisis services (emergency shelter, red cross, etc.)
10. Fatherhood program and support services
11. Financial support – resource to financially assist with identified risk factor
12. Food stability – ongoing resource for food stability
13. Household items, including furniture
14. Housing services –housing resource (not on Housing PW)
15. Identification services (birth certificate, driver's license, ID, etc.)
16. Intimate partner violence support services
17. Legal services
18. Literacy – intervention and educational services
19. Medical debt support
20. Parenting education classes and support
21. Phone – resource to obtain phone services
22. Safety equipment – (Examples: cribs, safety equipment for elders, car seats, locked cabinets for guns, bike helmets, fire extinguisher)
23. Translation services – ongoing resource for translation services
24. Transportation – ongoing resource for transportation
25. Utilities – ongoing resource for utility support

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

Client Name _____ Birth Date _____

Care Coordinator _____ Agency _____

Tobacco Cessation

Initiation
Client states that he/she is a tobacco user.
Date_____

↓

Provide HUB approved tobacco cessation Education Pathways.

↓

Use the 5 A's to guide discussion:

1. **Ask** - Identify and document tobacco use status at every visit.
2. **Advise** - In a clear, strong, and personalized manner, urge client to quit.
3. **Assess** - Is the client willing to make a quit attempt at this time?
4. **Assist** - For the client willing to make a quit attempt, refer for counseling and pharmacotherapy to help him or her quit.
5. **Arrange** - Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.

Date_____ Referral_____

↓

Review 5 A's. Ask about reduction in tobacco use at each home visit. Document any reduction in use:

□ No reduction
□ 25% less Date_____
□ 50% less Date_____
□ 75% less Date_____
□ Quit Date_____

↓

Completion
Client has stopped using tobacco products for one month.
Date_____

Date Finished Incomplete _____
Reason _____

Supervisor's Signature _____ Date _____

APPENDIX B

Community-Based Care Coordination Project
Excerpt from:

MEDICAID TRANSFORMATION PROJECT TOOLKIT

Revised October 2017

Full Document available at: https://www.hca.wa.gov/assets/program/project-toolkit-approved.pdf

Project 2B: Community-Based Care Coordination

Project Objective: Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.

Target Population: Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), or mental illness/depressive disorders, or moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

Evidence-based Approach:

- Pathways Community HUB https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf.

Reference the "Project Implementation Guidelines" for additional details on the project's core components, including Domain 1 strategies and evidence-based approaches, to guide the development of project implementation plans and quality improvement plans.

Project Stages

Stage 1 – Planning

Milestone	**Proof of Completion**	**Timeline** ***(complete no later than)***
• Assess current state capacity to effectively focus on the need for regional community-based care coordination	Completed current state assessment	DY 2, Q2
• Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	Completed Financial Sustainability, Workforce, and Systems for Population Health Management strategies, as defined in Domain 1, reflective of support for Project 2B efforts	DY 2, Q2
• Select target population and evidence-based approach informed by regional health needs	Definition of target population and evidence based approach	DY 2, Q2

• Identify project lead entity, including: o Establish HUB planning group, including payers. o Designate an entity to serve as the HUB lead.	Identified lead and binding letter of intent from HUB/lead entity	DY 2, Q2
• Identify and engage project implementation partnering provider organizations, including: o Review national HUB standards and provide training on the HUB model to stakeholders o Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers, and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB o Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB lead entity	Identified implementation partners and binding letters of intent	DY 2, Q2
• Develop project implementation plan, which must include: o Description of pathways, focus areas, and care coordination service delivery models, o Implementation timeline o Roles and responsibilities of implementation partners o Describe strategies for ensuring long-term project sustainability	Completed implementation plan	DY 2, Q3
Stage 2 – Implementation		
Milestone	**Proof of Completion**	**Timeline *(complete no later than)***
• Develop guidelines, policies, procedures and protocols	Adopted guidelines, policies, procedures and/or procedures	DY 3, Q1
• Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / pathways	Completed and approved QIP, reporting on QIP measures	DY 3, Q2
• Implement project, which includes the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ: o Create and implement checklists and related documents for care coordinators.	Estimated number of partners participating and if applicable,	DY 3, Q4

○ Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach. ○ Develop systems to track and evaluate performance. ○ Hire and train staff. ○ Train care coordinator and other staff at participating partner agencies. ○ Conduct a community awareness campaign.	the number implementing each selected pathway.	

Stage 3 – Scale & Sustain		
Milestone	**Proof of Completion**	**Timeline** ***(complete no later than)***
• Increase scope and scale, such as adding partners, focus areas or pathways	Document Stage 3 activities in Semi-Annual Reports.	DY 4, Q4
• Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required		DY 4, Q4
• Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion		DY 4, Q4
• Identify and document the adoption by partnering providers of payment models that support the HUB care coordination model and the transition to value based payment for services.		DY 4, Q4

Project Metrics

Year	Metric Type	Metric	Report Timing
DY 3 – 2019	**P4R – ACH Reported**	• Report against QIP metrics • Number of partners trained by focus area or pathway: projected vs. actual and cumulative • Number of partners participating and number implementing each selected pathway • % PCP in partnering provider organizations meeting PCMH requirement • % partnering provider organizations using selected care management technology platform • % partnering provider organizations sharing information (via HIE) to better coordinate care • % of partnering provider organizations with staffing ratios equal or better than recommended	Semi-Annual

		• Number of new patients with a care plan • Total number of patients with an active care plan	
	P4P – State Reported	• Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration	Annual
DY 4 – 2020	**P4R – ACH Reported**	• Report against QIP metrics • Number of partners trained by focus area or pathway: projected vs. actual and cumulative • Number of partners participating and number implementing each selected pathway • % PCP in partnering provider organizations meeting PCMH requirement • % partnering provider organizations using selected care management technology platform • % partnering provider organizations sharing information (via HIE) to better coordinate care • % of partnering provider organizations with staffing ratios equal or better than recommended • Number of new patients with a care plan • Total number of patients with an active care plan	Semi-Annual
	P4P – State Reported	• Follow-up After Discharge from ED for Mental Health • Follow-up After Discharge from ED for Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration	Annual
DY 5 – 2021	**P4R – ACH Reported**	• Report against QIP metrics • Number of partners trained by focus area or pathway: projected vs. actual and cumulative • Number of partners participating and number implementing each selected pathway • % PCP in partnering provider organizations meeting PCMH requirement • % partnering provider organizations using selected care management technology platform • % partnering provider organizations sharing information (via HIE) to better coordinate care	Semi-Annual

		• % of partnering provider organizations with staffing ratios equal or better than recommended • Number of new patients with a care plan • Total number of patients with an active care plan • VBP arrangement with payments / metrics to support adopted model	
	P4P – State Reported	• Follow-up After Discharge from ED for Mental Health • Follow-up After Discharge from ED for Alcohol or Other Drug Dependence • Follow-up After Hospitalization for Mental Illness • Inpatient Hospital Utilization • Mental Health Treatment Penetration (Broad Version) • Outpatient Emergency Department Visits per 1000 member months • Percent Homeless (Narrow definition) • Plan All-Cause Readmission Rate (30 Days) • Substance Use Disorder Treatment Penetration	Annual

Project Implementation Guidelines: This section provides additional details on the project's core components and should be referenced to guide the development of project implementation plans and quality improvement plans.

Guidance for Project-Specific Domain 1 Strategies

- **<u>Population Health Management/HIT</u>:** Current level of adoption of EHRs and other systems that support relevant bi-directional data sharing, clinical-community linkages, timely communication among care team members, care coordination and management processes, and information to enable population health management and quality improvement processes; provider-level ability to produce and share baseline information on care processes and health outcomes for population(s) of focus.
- **<u>Workforce</u>:** Capacity and shortages; incorporate content and processes into the regional workforce development and training plan that respond to project-specific workforce needs such as:
  - Shortage of Mental Health Providers, Substance Use Disorder Providers, Social Workers, Nurse Practitioners, Primary Care Providers, Care Coordinators and Care Managers
  - Opportunities for use of telehealth and integration into work streams

- Workflow changes to support integration of new screening and care processes, care integration, communication
- Cultural and linguistic competency, health literacy deficiencies

- **Financial Sustainability:** Alignment between current payment structures and guideline-concordant physical and behavioral care, inclusive of clinical and community-based; incorporate current state (baseline) and anticipated future state of VBP arrangements to support integrated care efforts into the regional VBP transition plan. Assess timeline or status for adoption of fully integrated managed care contracts. Development of model benefit(s) to cover integrated care models.

APPENDIX C

STANDARDIZED COMMUNITY HEALTH WORKER CORE COMPETENCIES		
Core Competency 1: Health		
Content Area	***Specific Skills***	***Minimum Instruction***
Physical, mental, emotional and spiritual impacts on health	Explaining internal and external basic life resources; social determinants of health; stress and health	2 hours
Basic anatomy and physiology of major body systems	Explaining the basic body system functions and major organs: 1. Cardiovascular 2. Pulmonary 3. Nervous 4. Endocrine 5. Gastrointestinal 6. Urinary 7. Muscular-Skeletal 8. Integumentary 9. Female & Male Reproductive 10. Immune	8 hours
Acute and chronic illnesses including but not limited to heart disease, cancer, stroke, diabetes, and lung disease	Explaining signs and symptoms of: 1. Coronary Heart Disease 2. Hypertension (High Blood Pressure) 3. Heart Failure 4. Asthma 5. Emphysema 6. COPD 7. Pneumonia 8. Ear & Sinus Infection 9. Stroke 10. Alzheimer's disease	8 hours

	11. Diabetes 12. IBS 13. Kidney disease 14. Ulcers 15. Cancer 16. Arthritis 17. HIV/AIDS	

Behavioral health	Recognizing and making appropriate referral for: 1. Depression (including screenings) 1. Anxiety Disorder 2. Bipolar Disorder 3. Schizophrenia 4. Referral agencies and reporting processes	2 hours
Vital signs	Understanding and explaining blood pressure, pulse, and temperature readings	1.5 hours
Basic cardiopulmonary resuscitation skills	Current American Red Cross Basic CPR certification	As required
Medical terminology	Explaining basic medical terminology in use with healthcare teams and clients	1.5 hours

Core Competency 2: Community Resources		
Content Area	***Specific Skills***	***Minimum Instructional***
Community resources & referral processes to assist various target population groups	Understanding and utilization of: 1. Information and referral (I & R) systems 2. Community agencies for health, social service, education, and legal aid 3. Referral and reporting processes for these agencies Collaborating and streamlining services with agencies	2 hours
Entitlement programs	Understanding and utilization of local, state and federal public entitlement programs (funding, eligibility and referrals)	1 hour

Core Competency 3: Communication Skills		
Content Area	***Specific Skills***	***Minimum Instructional***
Interpersonal communication skills	Knowledge and effective usage of : 1. Verbal and nonverbal communication 2. Compassionate communication 3. Language register and discourse patterns 4. Active Listening and Interpersonal skills	5 hours
Interview techniques	Knowledge and effective usage of basic interviewing and verbal response techniques; Motivational Interviewing	4 hours
Written communications to health care and service care providers	Knowledge and effective utilization of reports, summaries, memos, and email in professional communication while avoiding common errors	1 hour
Telecommunication techniques	Utilization of effective and appropriate telecommunication techniques, including voicemail and texting	1 hour

Core Competency 4: Individual & Community Advocacy		
Content Area	***Specific Skills***	***Minimum Instruction***
Diversity & the CHW role in an interdisciplinary team	Recognition of diversity and equality; the CHW role as part of a healthcare team	1 hour
Self-care skills in various target population groups	Supporting development of client self-care with recognition of inter-cultural, -generational, and socioeconomic differences	3 hours
Skills to assure that different target population groups receive needed services		
Liaison between target population groups and local agencies and providers	Methods of serving as an agency collaborator and advocate for clients	2 hours

Core Competency 5: Health Education		
Content Area	***Specific Skills***	***Minimum Instruction***
Teaching strategies	Utilization of effective adult learning strategies (for example, Mediated Learning) Consideration of client in Behavior of Change Model	2 hour
Group education and classes	Plan and lead classes on health issues	1 hour
Client/patient medication and appointment compliance	Reinforce importance of medication and appointment compliance	.5 hour
Healthy lifestyle choices to reduce health risk factors	Educating on nutrition, exercise, and stress management skills	2 hours
Adverse health consequences of smoking, drinking; and drugs of abuse; Recognizing and making appropriate referral for signs of addiction	Understanding and educating on: 1. Addiction 2. Legal Substances: alcohol, tobacco, prescription medications 3. Illegal Substances – heroin, cocaine, marijuana 4. Referral agencies and reporting processes	2 hours
Oral health care	Educating on the importance of oral health care across the lifespan	.5 hour
Prevention and wellness	Explaining basic and age-appropriate prevention and wellness safety	1 hour
Family violence, abuse and neglect	Recognizing and reporting signs of family violence, abuse and neglect; establishing safety plans	1 hour
Safety/ and injury prevention techniques	Explaining age-appropriate safety/injury prevention techniques	1 hour
Causes of morbidity and mortality by age group	Understanding and educating on top causes of morbidity and mortality by age group	.5 hour

Core Competency 6: Service Skills and Responsibilities		
Competency Area	***Specific Skills***	***Instruction Time***
Care coordination	Knowledge and ability to help individuals navigate the healthcare system by addressing the physical, social, geographical, and other barriers to personal care	4 hours
Safety of the CHW	Strategies for safe community visitation	1 hour
Gathering and reporting client information	Providing effective screenings, health assessments, documentation	3 hours
Time management	Demonstration of ability to utilize work time effectively	1 hour
Basic clerical, computing, and office skills	Demonstration of basic clerical, computing, and office skills	1 hour
Professional and personal development	Development of a plan for professional and personal improvement	1 hour

Core Competency 7: Healthcare Needs Across the Life Span		
Content Areas	***Specific Skills***	***Minimum Instruction***
Concepts and theories of human development	Understanding basic theories of physical, cognitive, and psychosocial development of humans	2 hours
<u>Childbearing Years</u>: (a) Health education (b) Related anatomy, physiology, and appropriate health care (c) Family planning	Ability to educate on anatomy, physiology, family planning, and appropriate health care during the childbearing years	3 hours

Pregnancy: (a) Basic anatomy, physiology, and normal signs related to pregnancy (b) Recognition of warning signs during pregnancy requiring immediate reporting to the registered nurse supervisor (c) Health education related to pregnancy, labor, and postpartum care	Ability to educate on basic anatomy, physiology, and normal signs related to pregnancy, labor, and postpartum care Ability to recognize and immediately report warning signs to a registered nurse supervisor or appropriate physician during pregnancy	5 hours
Newborn, Infant, Young Child: (a) Routine infant feeding & newborn care (b) Recognizing and reporting problems that can occur in early infancy (c) Immunization schedules & information regarding referral to appropriate health care facilities and practitioners (d) Basic methods to enhance typical child development	Ability to educate on: 1. Routine infant feeding 2. Newborn care 3. Basic methods to enhance typical child development Immunization schedules and information regarding referral Ability to recognize and report problems that can occur in early infancy	5 hours
Children with disabilities	Ability to refer clients for appropriate disability screenings and professional services	1 hour
Adolescence: (a) Age appropriate health education (b) Acute and chronic illnesses including, but not limited to asthma, obesity and eating disorders (c) High risk behaviors	1. Ability to educate on adolescent health issues, including acute and chronic illnesses, but not limited to asthma, obesity and eating disorders, and high risk behaviors 2. Ability to recognize signs of and make appropriate referrals for adolescent health issues, including acute and chronic illnesses	4 hours
Adults and Seniors: (a) The aging process (b) Prevention strategies (c) Recommended screenings (d) Adults caring for aging parents (e) Adults with disabilities	Ability to educate on and make referrals related to: 1. The aging process 2. Prevention strategies 3. Recommended screenings 4. Adults caring for aging parents 5. Adults with disabilities	4 hours

Core Competency 8: Community Health Worker Profession		
Content Area	***Specific Skills***	***Minimum Instruction***
Healthcare, Public Health	Ability to understand and define public health and resources	1 hour
History of CHWs	Ability to understand and explain history of CHWs in the United States	1 hour
CHW Identity	Ability to understand and explain CHW definition, roles, workforce profile, core values	1 hour
Ethical Code of Principles	Ability to understand and apply confidentiality standards and informed consent	2 hours
Professional Boundaries	Ability to understand the emotional dynamics of care coordination and establish appropriate boundaries with clients	2 hours

Core Competency 9: Clinical Practicum		
Content Area	***Specific Skills***	***Clinical Hours***
Agency/Clinical Experience	Ability to work in a clinical practicum setting and meet aforementioned competencies as assessed through: 1. Completion of an agency case study (purpose, client eligibility, outcome assessment, funding) 2. Development of clinical experience goals 3. Interviewing Skills Evaluation 4. Home Visitation Evaluation 5. Site Supervisor Interview and Report	72-80 130

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