North Central Accountable Community of Health

Community-Based Care Coordination

Board Retreat - January 22, 2021

Acronyms used in this presentation…

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CAA: Community Action Agency

Nonprofit and public groups funded by the Community Services Block Grant (CSBG), as part of the Economic Opportunity Act of 1964 and War on Poverty.

CBCC: Community Based Care coordination

Defined on slide 11 of this presentation.

CBO: Community Based Organization

Generally understood as a nonprofit organization that is representative of community and works on community improvements at a local level.

CCA/O: Care Coordination Agency/Organization

In the context of this presentation, any organization or agency employing community-based care coordinators.

SDOH: Social Determinants of Health

Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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Where We've Been

HUB Community Care Coordination

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The process of identifying at-risk individuals and connecting them to the health and social services they need is often referred to as care coordination. Care coordination is a broad term that is often thought of as a process that occurs within the health care system. The HUB model specifically addresses **community care coordination**, which can be defined as the coordination of services beyond the "walls" of the health care system. A community care coordinator in the HUB model is trained to meet individuals **in their homes or in a community setting** to address all their identified issues. These needs may include help with **housing, transportation, employment, and education** in addition to accessing health care services.

- Excerpt from Pathways Community HUB Manual, p.4

The Theory Behind Pathways HUB Model

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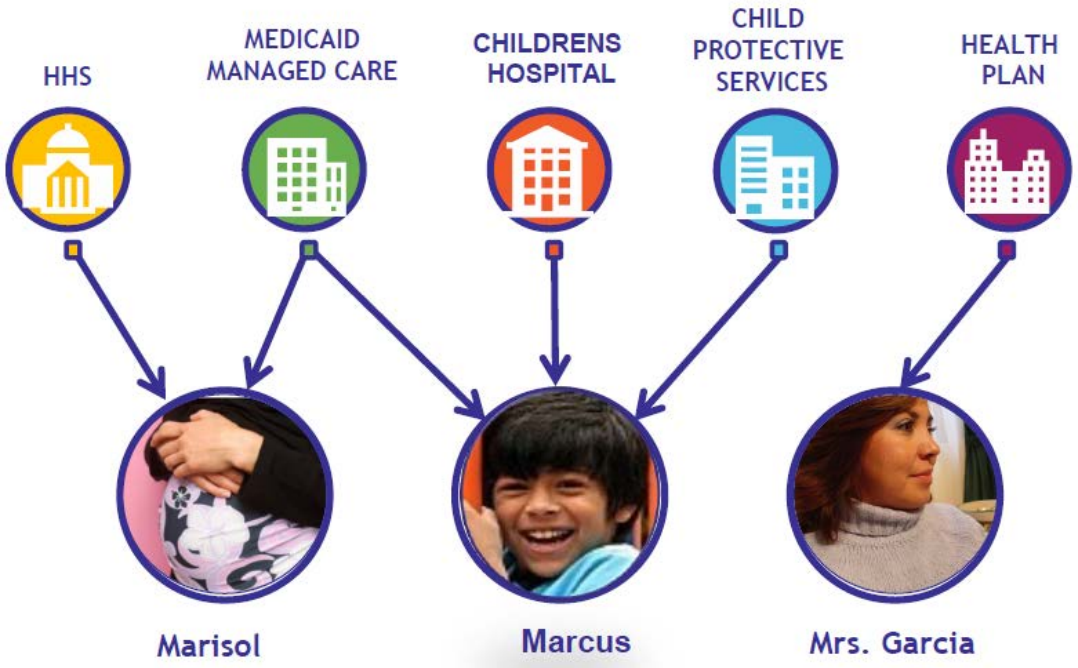
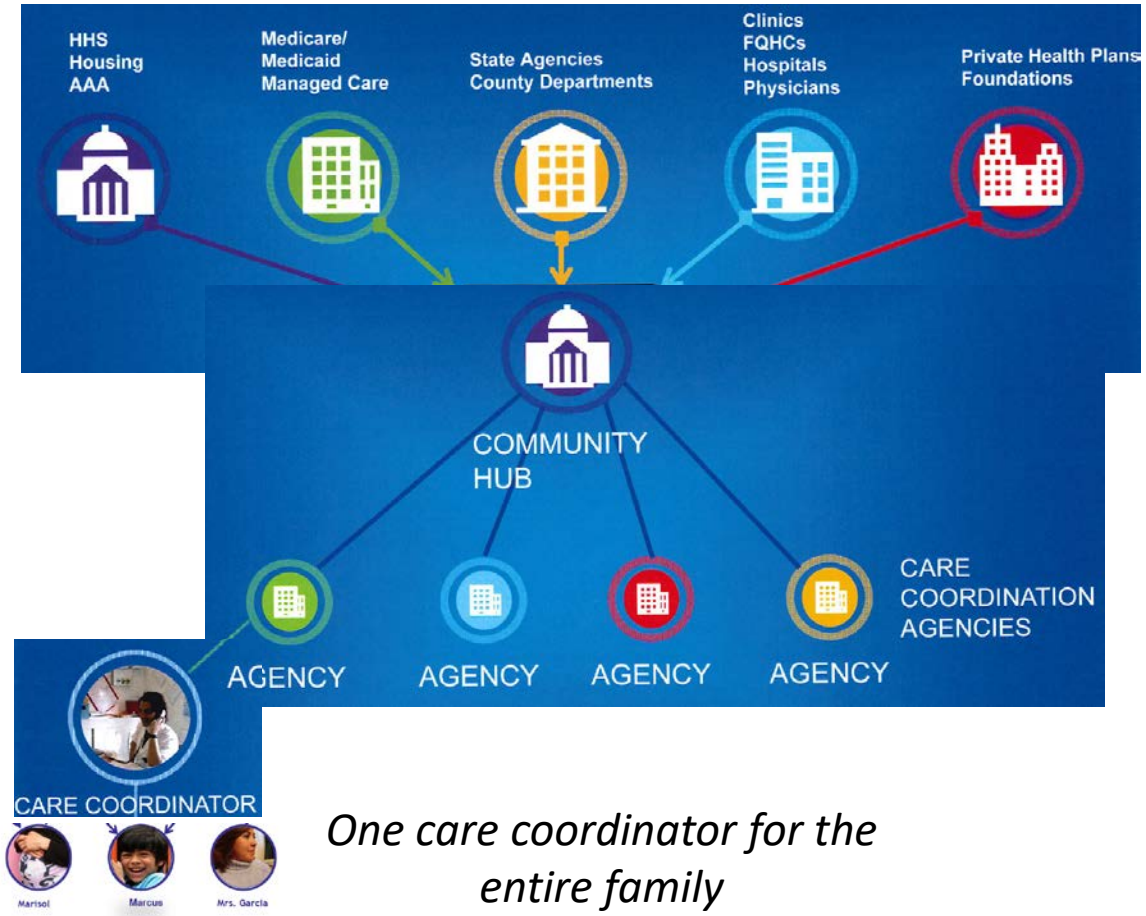
Fragmented System



Multiple care coordinators involved-limited communication

Coordinated System



One care coordinator for the entire family

Pathways HUB Model Functions

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Care Coordination Functions
local

- Specific and standardized comprehensive risk assessment
- Care coordinator addresses risk factors through predetermined Pathway “protocols”
- Tracking and measuring of common metrics & results
- Payment for outcomes promotes sustainability

HUB Functions
regional

- Coordinates standardized training, workflows, and IT platform for care coordinators
- Smart assigns referred clients to care coordinators
- Manages contracts with CCOs
- Centrally tracks and monitors CCO performance
- Builds referral network

Factors that Contributed to Failure

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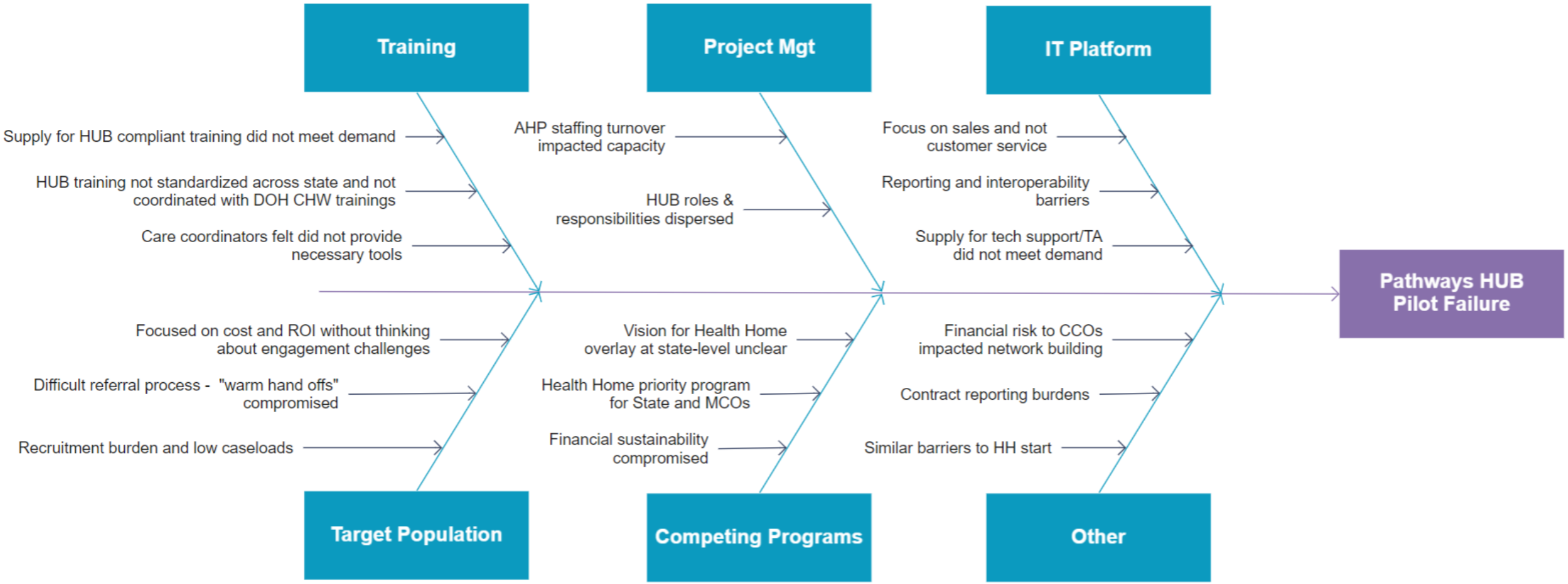

What's Worth Keeping?

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- Community-based workforce
- Emphasis on community-based care coordination
- More coordination (less duplication)

Which regional network coordination functions should we keep?

- Standardized trainings, workflows, and IT platform for care coordinators
- Managing of CCO network and contracts
- Centralized monitoring and support of CCO performance
- Building referral network

Where Are We Heading?

CBCC – Big Picture Goal

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Strengthen the network of community-based care coordination programs across the region so that the network is more cohesive and better able to respond to the needs of North Central residents, especially those with significant behavioral health needs, those utilizing acute healthcare services frequently, and those struggling with incarceration.

Community-Based Care Coordination Defined

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A relational and **person-centered approach** designed to improve access to and coordination of supports for individuals and families in struggle. It involves face-to-face visits with clients at a place of their choosing, and the **deliberate organization of comprehensive social and health care services** done in partnership with clients to facilitate their whole person health. Because it is broader than medical care coordination or case management, it relies on a **community-based workforce** focused on problem solving, advocating and communicating on behalf of and with their clients, across many systems and organizations.

Who is part of a trusted “community-based workforce”?

Trained community-based professionals:

- Community health workers
- Promotores
- Community-based, nongovernmental nonprofit staff and human services providers
- Other trusted community-based professionals (e.g. peer specialists, recovery coaches, doulas)

Note: With specialized training, lay workers or “natural helpers” who live in highly impacted communities can support and join a community-based workforce

- Unemployed residents & retirees
- Students/ recent graduates
- Lay community-based leaders (e.g faith-based leaders, barbershop owners, leaders of neighborhood mutual aid groups)

While skills and roles vary, members of a ”community-based workforce” share common experiences and traits:

- Live in and share culture, language, and life experiences with the members of the communities they serve
- Have earned and enjoy a deep level of trust with peers and neighbors
- Posses strong relational expertise and interpersonal communication skills
- Have relationships with and knowledge of local community-based resources
- Demonstrate a long-standing commitment to living and working in their communities
- Are recognized by CDC and other emergency preparedness experts as an essential component of community recovery capabilities

CBO Partner Network Building

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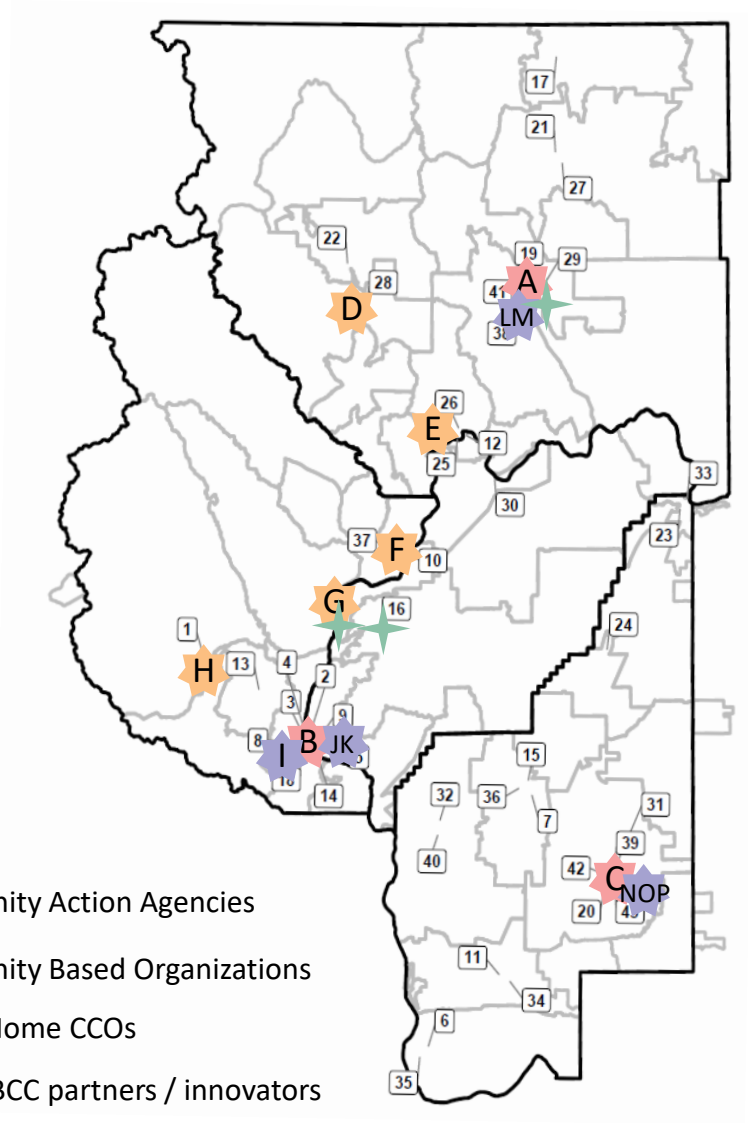

Partnering with CBOs to Strengthen the Network

Mapping of partners for discussion purposes (just a start – not exhaustive or perfectly accurate!)

A – Okanogan County Community Action Council
B – Chelan Douglas Community Action Council
C – Hopesource (HQ in Ellensburg)

D – Room One
E – Pateros Brewster Community Action Council
F – Chelan Valley Hope
G – Entiat Valley Community Services Resource Center
H – Upper Valley MEND

I – Community Choice/AHP
J & L & N – Aging & Adult Care of Central WA
K – Molina
M – Family Health Centers
O – Rural Resources (HQ in Colville, also a CAA)
P – Comprehensive Healthcare (HQ in Yakima)

Legend

- Community Action Agencies
- Community Based Organizations
- Health Home CCOs
- Other CBCC partners / innovators

Assumptions

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- A well-trained trained community health workforce is limited (though expanding) in North Central WA
- A community based workforce is best suited to offer community-based care coordination to various risk populations
- Local CAA and CBO “anchor institutions” who have been working on SDOH for decades are well positioned to leverage community based workforce
- Building a full CBCC caseload for one specific risk population (or program) can be challenging given low population density and large geographic spread
- Serving different risk populations is a strategic (and more person-centered) way to build full care coordinator caseloads
- There is a common fabric to SDOH screenings and outcome tracking for care coordination, regardless of target population
- Having one (or fewer) IT system to track these multiple risk populations and bill variety of payers would reduce administrative burden

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2021 CBCC Plans

CBCC: 2-pronged approach

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1

Strengthen the Health Home program in our region

Our role → work with Health Home leads (e.g. AHP and MCOs) to support their efforts to strengthen the program.

Medicaid-only

Discrete

Near-term

2

Invest in infrastructure that can support all care coordination

Our role → weave together existing parts of care coordination into a more cohesive whole.

All target populations, models & payers

Complex

Long-haul

Objective 1

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Strengthen the Health Home program in the NCACH region

Rationale: The Health Home program was launched in 2013 and is now active across all Washington State counties. It is the Health Care Authority's (HCA) chosen community-based care coordination program for high-risk Medicaid beneficiaries, and has a proven track record and established payment mechanisms. The model is relational and person-centered and could be adapted to meet the needs of populations not meeting Health Home eligibility criteria. While well established, there is room to strengthen the Health Home infrastructure in our region, a prerequisite before expanding the model to other populations.

North Central Health Home Partners

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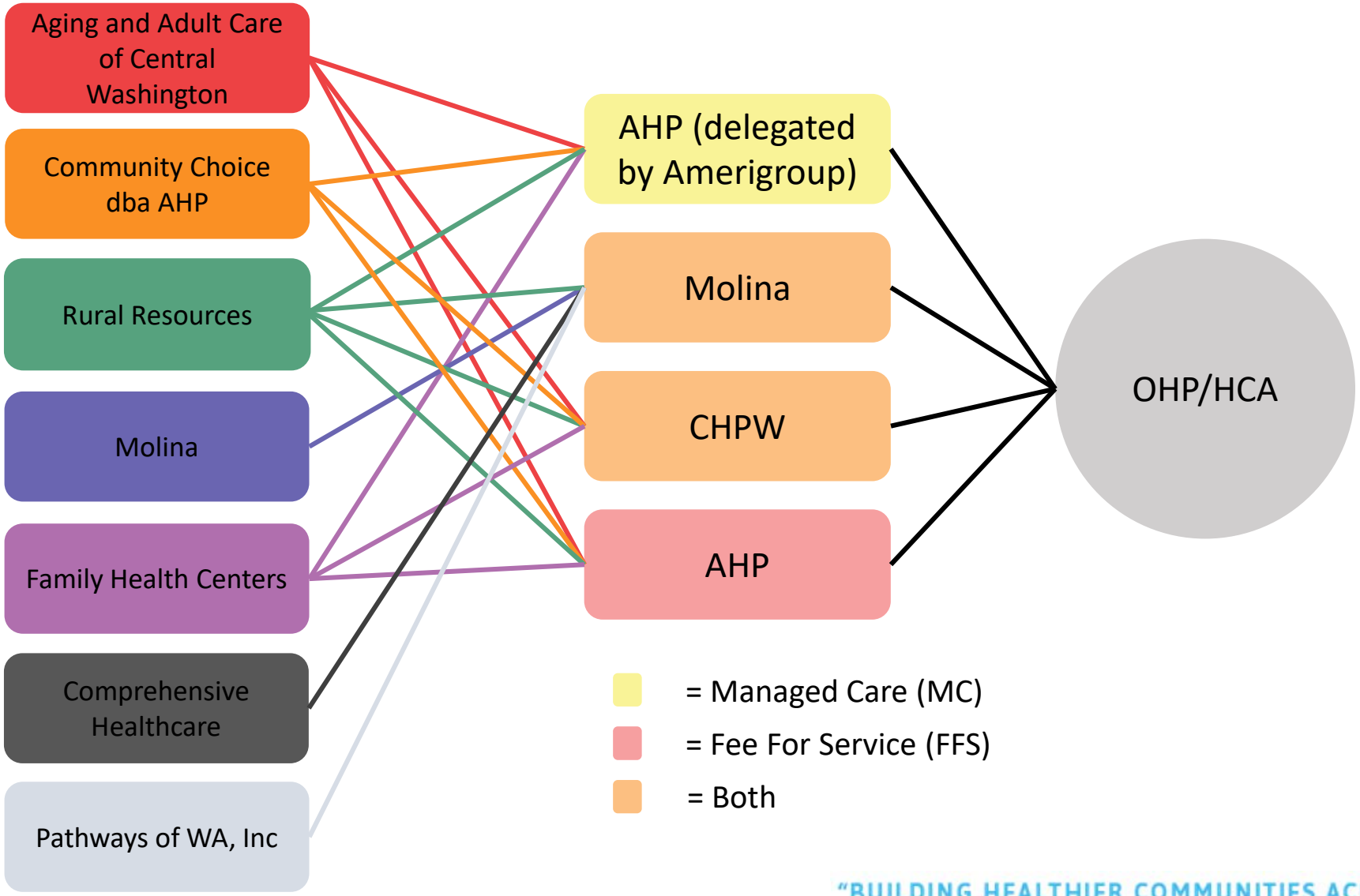

6		
LEAD	FFS	MC
AMG		✓
CC AHP	✓	
CHPW**	✓	✓
CCW**	✓	✓
MHC	✓	✓

Budget Projections

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1 Strengthen the Health Home program in the NCACH region

Budget Item	Amount	Details
Health Home expansion	$225,000	Seed funding to bring on additional Health Home care coordinators (focus on Okanogan and Grant counties).
Platform Costs	$200,000	New Health Home platform for Action Health Partners.
Platform Development and Training	$125,000	Action Health Partners staff time for platform migration, development and training of CCO partners.
TOTAL	**$550,000**	

Objective 2

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Deepen awareness and understanding of regional care coordination efforts

Rationale: Addressing low awareness and understanding of care coordination services across our region will promote connections and coordination, while building shared assumptions and understanding of our current (and evolving) state.

Objective 3

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Expand reach of community-based care coordination models to rising risk populations

Rationale: The need for community-based care coordination far exceeds the current capacity and restrictions of the Health Home program. Based on an April-June 2020 snapshot, 545 NCACH residents were engaged in Health Home services, a fraction of our resident population. As healthcare partners increasingly screen for SDOH, they continue to need community partners who can assist with significant social determinant needs. Prioritize programs that employ a community-based workforce (e.g. CHWs and peers).

Objective 4

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Strengthen common resource inventory tools that can benefit all care coordination agencies across our region

Rationale: The ability to quickly identify local resources is critical for residents and any care coordinator, community health worker, case manager, responding to a crisis. In the absence of an accurate and comprehensive database, organizations and programs spend valuable resources creating and updating their own siloed resource inventories. Focusing investments on 211 builds on an existing platform, while recognizing their place in a national infrastructure and our statewide care coordination infrastructure.

Objective 5

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Strengthen data collection and sharing mechanisms across care coordination network

Rationale: Some programs, especially those managed by community-based organizations, may not have robust systems to track their work and impact. Others may have existing platforms, but may not track social determinants of health data. Regardless of target population and model, community-based care coordination is likely to draw on similar methods and touch on similar social determinants of health. Providing technical assistance and promoting trusted information technology tools can promote consistency across programs. This is an important strategy that will help funded partners build their path towards sustainability, since being able to share qualitative and quantitative program data is necessary when securing government and foundation funding.

Objective 6

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Organize continuing education opportunities to promote broad-based community health workforce development

Rationale: Many social service partners lack the resources to sponsor or send their staff to high-quality trainings. In addition, many trainings are offered outside of our region. Sponsoring trainings for our region's partners is a workforce development opportunity that also serves as a networking and relationship-building opportunity. Bringing partners together who serve similar roles and functions (regardless of target population, titles and sectors) is an important cross-sector network strengthening strategy.

Objective 7

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Work with potential future funders and advocate for funding mechanisms to sustain CBCC programs

Rationale: NCACH has lots of discretion and flexibility as it chooses how to disburse earned MTP funds. This flexibility gives us a unique opportunity to provide seed funding and build capacity for community-based care coordination without imposing funding restrictions that get in the way of person-centered services. It also allows us to entertain start-up costs that community based organizations are often asked and unable to absorb. Because our funds are limited, however, we should proactively work with funded partners to build their path towards sustainability, including identifying and securing longer-term funding opportunities.

Budget Projections

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2 Invest in infrastructure that can support all care coordination

Budget Item	Amount	Details
Recovery Care Coordinators	$300,000	Seed funding to expand capacity for CBCC to recovery population.
WA 211	$100,000	Development costs for improved functionality of 211 web interface.
NCW 211	$100,000	Invest in 211 resource management capacity, and prioritize staffing footprint in our region.
CBCC Programs - Rising Risk	$500,000	Seed funding to expand capacity for CBCC to rising risk populations (proposals coming through the CHI community initiatives process.)
Platform Costs	$100,000	Cover costs for CBCC partners who are interested in using trusted platforms.
TOTAL	**$1,100,000**	