A call for partners

2018 North Sound ACH Call for Partners

Supplemental Application for Community-Based Care Coordination Agencies (CCA)

North Sound ACH is seeking partners who are currently providing care coordination service in the North Sound region to the populations of focus described within this document, and that would like to serve as a Care Coordination Agency within a Pathways HUB model.

Introduction

The North Sound Accountable Community of Health (North Sound ACH) is a nonprofit organization working with partners from multiple sectors in Island, San Juan, Skagit, Snohomish and Whatcom counties, and tribes, to transform systems that impact health. Launched in 2014, and one of the first ACHs recognized in Washington, North Sound ACH is governed by a Board of Directors who set the strategic direction for the organization.

The North Sound ACH is a partner in the statewide Healthier Washington initiative, which includes an agreement between Washington State and the federal government providing opportunities to support new and innovative approaches to transform health and community services that will: 1) build healthier communities through a collaborative regional approach; 2) integrate the physical and behavioral health payment and delivery system to foster focus on the whole person; and 3) prepare providers for contracts that pay for quality and outcomes rather than quantity. You can learn more about Healthier Washington at this link: (https://bit.ly/2xBa5M0).

North Sound ACH is one of nine region-based ACHs in Washington. As part of the region's commitment to advancing community-based care coordination, we are launching a Community Care Coordination Hub applying the Pathways model to make care coordination more efficient and focused on outcomes. We are looking for agencies interested in joining a network of Care Coordination Agencies (CCA) devoted to linking our initial populations to necessary clinical and social services and resources.

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Initial Population of Focus

The initial population of focus for the Community Hub will be individuals with co-occurring behavioral health and physical health conditions. Specifically, this population will be individuals that have a mental health condition **and** substance use disorder (SUD) **with either** one chronic illness **OR** are of childbearing age. Individuals must **also** be illustrating one of the following additional risk factors: high utilization of care across systems (including EMS and criminal justice), homelessness, or failed attempts linking to other social services.

Depending on responses to this call for CCA partners, the exact pilot population might be a narrower subset of this population including additional segmentation based on (for example) county or specific region.

The startup phase will be small and focused to insure we're learning crucial lessons early on and optimizing HUB operations prior to expanding to include additional populations. Recognizing that there are multiple populations in the North Sound ACH region that could benefit from a Community HUB, we encourage you to view this population of focus as a starting point, and to remain engaged as the HUB scales up to incorporate additional populations over time.

See additional information on the initial population of focus in Appendix B.

Who Should Respond to this Call for Care Coordination Agencies?

Organizations eligible to become a Care Coordination Agency are those which provide some form of care coordination services for Medicaid beneficiaries within the North Sound region. Successful partners will have a trusted presence within the community and are already working with the initial service population in some capacity. These agencies might already utilize community-based care coordinators, community health workers, or outreach workers to connect individuals within the pilot population to social or clinical services (additional care coordinator description below). Agency types might include:

- Community-based organizations
- Behavioral Health organizations
- First responders or EMS agencies
- County resource agencies
- Federally Qualified Health Centers (FQHC)
- Health Home Care Coordinating Agencies

A Community-Based Care Coordinator under the HUB model are those who serve as community care coordinators, including community health workers, social workers, nurses, and case managers. By definition, these individuals spend the majority of their time meeting face-to-face with clients in the community or their home.

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If your organization is not currently providing care coordination services, there are still ways to partner with the HUB outside of becoming a CCA. If you do not think your agency meets the requirements to be a CCA, we will be identifying agencies and individuals during the summer who might best assist the HUB in the following capacities:

- **Referral Partners**: The HUB network relies on agencies that serve as primary referral sources. Referral partners are agencies that interact with the HUB population of focus and are seeking appropriate resources to help individuals remove barriers that may be keeping them from optimal health.

- **HUB Advisory Council:** The HUB will form an Advisory Council that will be made up of members who reflect the community and the North Sound region. This group will inform the direction of the HUB through data analysis, policy development and strategic guidance. Contracted CCA partners, additional community partners and referral sources will be invited to participate on the HUB Advisory Council.

- **Service Provider:** Any organization that provides services which will help a HUB care coordinator complete a Pathway on behalf of a care coordination client. Build out of our referral and provider networks will be an ongoing process throughout the life of the HUB.

Primary Roles of the Care Coordination Agency and the HUB

The Care Coordination Agency will:

- Use community health workers or community care coordinators who have been trained in the Pathways Community HUB model and its electronic platform;
- Identify unserved and underserved individuals within the initial focus population and enroll them through the HUB;
- Track services to clients using one of twenty Pathways to document progress and outcomes in the HUB's electronic platform;
- Work collaboratively with HUB Advisory Council members to identify community needs, inform HUB initiatives, and evaluate initiative results;
- Support community health workers and care coordinators through:
  - Attendance at required care coordination training sessions hosted by the HUB.
  - Supervision of care coordinators and community health workers, in order to achieve a high standard of care for its clients and high quality of service.
- Work collaboratively with other HUB CCAs and direct service providers around quality improvement activities.

The HUB will:

- Refer clients to an appropriate care coordination agency;
- Offer training to CCA care coordinators in the Pathways Community HUB model and software;
- Develop referral network(s) with providers, clinics, hospitals, and government, as appropriate, to increase the community members served and reached;

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- ❖ Provide quality supervision, data processing, reporting, invoicing, and collection services to the care coordination agency;
- ❖ Support the CCA in performing quality improvement and quality assurance activities;
- ❖ Communicate and report HUB initiative results and achievements to the HUB advisory board, contracted payers and the community.

Payments

The goal of the HUB is to develop contracts with health plans and other funders to support the CCA network, with the HUB acting in a consolidating intermediary role (negotiating contracts and invoicing payers) and in turn paying CCAs.

The North Sound ACH recognizes that becoming a Pathways CCA requires an organization to devote time and resources to development of new workflows, policies, and staff training. North Sound ACH will be supporting all CCA development (start-up) costs for much of the first year while simultaneously leading the effort towards long term HUB sustainability through MCOs and other funding sources. Startup costs covered by the HUB will include Pathways training for CCA staff, as well as reimbursement for CCA staff time dedicated to buildout of Pathways related policies or procedures.

Timeline and How to Apply

If you are interested in becoming a Pathways Care Coordination Agency, please read the following steps to apply. **To be considered during this pilot phase of the Community HUB, applications and attachments must be received by 5:00 pm on June 21, 2018.**

- ❖ **Step One:** Fill out the North Sound ACH Call for Partners.
- ❖ **Step Two:** Review this supplemental packet, including the frequently asked questions and the timeline of population selection.
- ❖ **Step Three:** Fill out the application questions on the next page in a separate document. The total page limit for applications is 6 pages.
- ❖ **Step Four:** Submit (see below).

All applications - whether hard copy or electronic - should be directed to attention of Hillary Thomsen at the North Sound ACH.

By email: Hillary@NorthSoundACH.org
By mail:
PO Box 4256
Bellingham, WA 98227

In person:
1204 Railroad Avenue, Suite 200
Bellingham, WA

For additional questions, contact Hillary at (360) 543-8858 or Hillary@NorthSoundACH.org.

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Application Questions

These questions are meant to be completed in a separate narrative file. Please copy the questions and respond to them in full and submit that file in MS Word or PDF format.

Agency Specific Questions

- **How are you serving the initial pilot population (in any capacity) including via partnership?**
  - Mental Health and Substance Use Disorder population - (describe)
  - Chronic Disease OR women of childbearing age population?

- Do you provide in-home or community-based services, including assessment? Yes No

  - If yes, please describe.

  - In no, would you consider adding this?

Does your agency have experience working with or receiving referrals from:

- Emergency Departments (and other medical providers) Yes No
  - If yes, please describe.

- EMS (Emergency Medical Services) Yes No
  - If yes, please describe.

- Policy Yes No
  - If yes, please describe.

- Courts Yes No
  - If yes, please describe.

- Jails/Prison Yes No
  - If yes, please describe.

- County Resource Centers Yes No
  - If yes, please describe.

- Schools Yes No
  - If yes, please describe.

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- ❖ Churches Yes No
  - ➢ If yes, please describe.

- ❖ Housing providers Yes No
  - ➢ If yes, please describe.

- ❖ 211 Yes No
  - ➢ If yes, please describe.

- ❖ Crisis Centers Yes No
  - ➢ If yes, please describe.

- ❖ Other? Yes No
  - ➢ If yes, please describe.

- ❖ What relationships do you have with organizations similar to yours in other communities or regions outside your direct service area?

- ❖ Do you employ, contract with, or are you in the process of hiring community health workers (CHWs)? Yes No
  - ➢ If yes, please describe.

Capacity and Readiness Questions

- ❖ Describe your organization's data infrastructure.

- ❖ Describe your organization's data sharing capabilities.

- ❖ Is your organization willing to take part in an outcome-based model of care coordination, with care coordinator supervision requirements?

- ❖ Identify revenue/funding sources that your organization has to pay for care coordination or outreach today.

- ❖ Identify anticipated revenue/funding sources that your organization may use in the future to pay for care coordination or outreach as the HUB expands (i.e., capacity building capabilities, hiring additional staff).

- ❖ Describe the academic, professional or lay experience of staff providing care coordination services at your agency.

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- ❖ Are you prepared to dedicate time of a staff member to supervision of a Pathways HUB care coordinator?

Awareness of the Pathways Community HUB Model

- ❖ Have you received education or attended information sessions on the Pathways Community HUB model?
- ❖ Do you see your agency fitting into the model? Please describe.
- ❖ The Pathways Community HUB model requires CCAs to enter data into a separate data system for the HUB. What are your concerns or challenges with this?

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Appendix A: Frequently Asked Questions Regarding Pathways Community HUB and Care Coordination Agency Partnership

Q: How would this model be different from others currently underway (Health Homes, or other case management care coordination services offered via various providers and health plans)?

A: "Three fundamental business model problems exist with the current approach to care coordination— lack of meaningful work products, duplication of effort, and failure to focus on those most at risk. The fragmentation and duplication of services and poor outcomes resulting from poor care coordination increase health care costs.[1]"

- *Outcomes as Work Products: Whereas typical care coordination models center on **completion of actions or work products**, Pathways is centered on **completion of outcomes** that will directly mitigate an individual's risks to health. The Pathways Community HUB model is also designed to create direct reimbursement channels between care coordinating agencies and the outcomes they produce with their clients.*

- *Reducing Duplication of Effort: Pathways empowers clients to identify the care coordinator with whom they have developed a trusted relationship, who is then authorized to work across service and funding silos to coordinate care in a comprehensive way. This direct link of payment to outcomes further incentivizes care coordination services to communicate or collaborate with each other, leading to less duplication and inefficiencies.*

- *Focus on Multiple Risks: When a client is referred to the HUB, an initial assessment of risk areas is done across the 20 Pathways, which encompass the many life domains that determine a person's health status. The centralized infrastructure of the HUB model also allows for identification of care breakdowns and resource gaps, and coordinated quality improvement or advocacy efforts to address such gaps.*

- *Regarding Health Homes, this care coordination model pays on a contacted per-member-per-month basis for clients contacted during the month, and the payment rate requires a caseload of 50-55 clients for providers to break even. The incentive is to limit contact for some clients in order to manage a higher intensity of service for other clients. Under Pathways, rates are negotiated with plans on the basis of cost to achieve outcomes, and can be stratified based on intensity of need.*

[1] https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

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Q: What if my agency provides care coordination, but it is not our main service?

A: Organizations eligible to become a Care Coordination Agency are providing some form of care coordination services for Medicaid beneficiaries within the North Sound region. Additionally, it is important to think of this work as not just the HUB + CCAs. The needs of the HUB's population will require varying degrees of partnership within many different sectors and non-typical referral sources. If your agency does not seem to be a good fit for becoming a Care Coordination Agency, the HUB model allows for other partnership opportunities such as:

- **Referral Partners**: The HUB network will rely on a group of agencies that serve as primary referral sources. Referral partners are agencies that interact with the HUB's population of focus, and are seeking appropriate resources to help these individuals remove social barriers that may be keeping them from optimal health.

- **HUB Advisory Council:** The HUB will form an Advisory Council that will be made up of members who reflect the community and the North Sound region. This group will inform the direction of the HUB through data analysis, policy development and strategic guidance. Contracted CCA partners, additional community partners and referral sources will be invited to participate on the HUB Advisory Council.

Q: What is expected of the CCA in charge of employing a care coordinator?

A: The CCA will designate the staff person to be trained in the Pathways Community HUB model and electronic platform. This training will be provided at no cost to the CCA for the HUB pilot phase. Existing staff of CCAs are candidates to be designated and trained as care coordinators. The HUB model creates the potential for additional sources of reimbursement or funding for the work of existing care coordinators, as well as additional funds for adding care coordinator staff capacity as the HUB network of referrals is developed.

Q: What is the distinction between the eligibility criteria and the application of Pathways? For example, if a risk area is homelessness, are we then only working with clients to address homelessness?

A: The eligibility criteria is defining our initial population for the pilot. Once a client meets eligibility, a care coordinator can and should work through any of the Pathways that are creating barriers to health for the client. When reading the eligibility criteria, we recommend that you ask yourself: "Does my agency see a sizable number of folks with these conditions?" Even if this is not your primary service population, it might be possible that the population is presenting within your system and could therefore be brought into the HUB to work on any of their risk areas.

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Q: What does CCA capacity mean?

A: While the HUB will financially support Care Coordination Agencies in startup funding related to training, staffing, and development of work procedures, it is important that a CCA has other funding and/or funding strategies in mind for sustaining their involvement in the HUB network. The Pathways provide a tool for outcome-based payment directly to a CCA, and the HUB will lead all network sustainability work from the point of contracts with various payer sources for the creation of a robust braided funding model for the HUB. But it is important that the HUB is not viewed as the long term financial backer of the Care Coordination Agency.

Q: What are some of the reimbursement structures that this would entail? I'm concerned about the ROI for my agency and/ or staff to be involved.

A: Many agencies and their staff are already doing the work involved in Pathways, without a strong reimbursement model. As community-based organizations are called upon to tackle an increasing number of risk areas with their clients/patients, the HUB, and completion of Pathways, provides the opportunity to link mitigation of those risks directly to compensation from Medicaid payers and others. The Pathways Community HUB model is designed to be a lean overlay to current care coordination structures, and does not represent a large additional layer to the existing system.

The Medicaid Transformation funding available through the North Sound ACH provides a funding bridge that will allow CCA's to evaluate the future ROI of Pathways-driven care coordination.

Q: Why would Medicaid payers be motivated to contract/ pay for this when they all have other care coordination efforts or programs underway?

A: Pathways populations of focus are being selected based on data that identifies which populations are experiencing poor health outcomes, as well as qualitative feedback from key informants, community-based organizations, clinical providers, and payers serving the region. The pilot population will be one that has been identified by MCOs as one they would support expansion of additional services to. The Pathways HUB model is also based on the idea of leveraging and better coordinating the work of any agency, program or initiatives already providing care coordination services. With MCO leaders at the table in our HUB startup conversations, we are best able to identify those opportunities around overlapping care coordination efforts.

Q: What does it mean if the pilot population is not one my organization currently works with or provides services for?

A: The current best practice in HUB startup requires starting with a small focused population both demographically and geographically, then expanding out and scaling up once the HUB is operational and has worked out some operational and referral issues. If your population of service is not the pilot population we still very much need you as a partner to remain engaged and provide us important

insight into continued areas of need. Recognizing that there are many different populations in the North Sound ACH region that could benefit from a Pathways Community HUB, we want to scope the startup in a way that is manageable to insure we're learning crucial lessons early on and optimizing HUB operations prior to bringing in additional populations.

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Appendix B: Getting to Pilot Population- Selection Process and Approach

Starting Point: Initial Considerations

Best Practice in Pilot Target Population Selection as Identified in the Agency For Healthcare Quality, *Pathways Community HUB Model*:

- Baseline data exists for the targeted population.
- Payers have expressed interest in this population and would consider paying for Pathways outcomes.
- Existing CCAs in the community or region have the capacity to serve this population.
- The HUB and CCAs have staff who can provide culturally and linguistically proficient services to the targeted population.

Additional Considerations:

- Desired initial pilot size of 250-600 patients.
- Qualitative validation that the population has unmet service needs.
- Diagnosis(es) that touch Pay for Reporting (P4R) metrics in Medicaid Transformation Project.
- Payor support and availability of additional funding sources for sustainability.

Key Stages in North Sound ACH Pathways Population Selection Process

- **Stage One: January - November, 2017: Information gathering for North Sound ACH Project Plan submission.**
  - Identification of ACH Project Plan partners and key informants.
  - Convening of regional stakeholders via topic specific workgroups, the North Sound ACH Program Council, and partner convenings.
  - Initial scan of relevant data sources illustrating health outcomes and disparities across various geographic and demographic elements.
  - Submission of North Sound ACH final project plan, with high level identification of Pathways population selection criteria.

- **Stage Two: January - April, 2018: Pathways Specific Environmental Scanning**
  - Environmental scan and key informant interviews to build understanding of care coordination activities and populations served across North Sound region. Interviews include:
    - County Resource Centers in Island and San Juan Counties
    - Home Health Care Coordination Organizations
    - The North Sound Behavioral Health Organization

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- Community Based Organizations: Opportunity Council, Compass Health, Planned Parenthood.
- North Sound ACH Leadership: Program Council
- Medicaid Managed Care Plans
- High Utilizer Group initiatives serving Skagit, Snohomish, Whatcom Counties.
- Additional interviews ongoing.

➢ Partner convenings with opportunity to discuss populations of interest: such as the North Sound ACH Program Council, the North Sound ACH Convening of Community-Based Organizations.

➢ Consultation, engagement, and strategic development input of state and national partners in Pathways HUB launch.

❖ **Stage Three: May 2018 until now**

➢ Consultation with Foundation for Healthy Generations in application of best practice to narrow scope of pilot populations.

➢ Development of criteria for Pathways care coordination agencies, including partner readiness assessment questions.

➢ Validation of which populations ring true for MCO payers (MCO Leadership meeting: May 10, 2018), North Sound ACH Program Council (Program Council meeting: May 17, 2018), and community-based organizations (CBO Convening: May 1 2018).

❖ **Stage Four: Final Decision points**

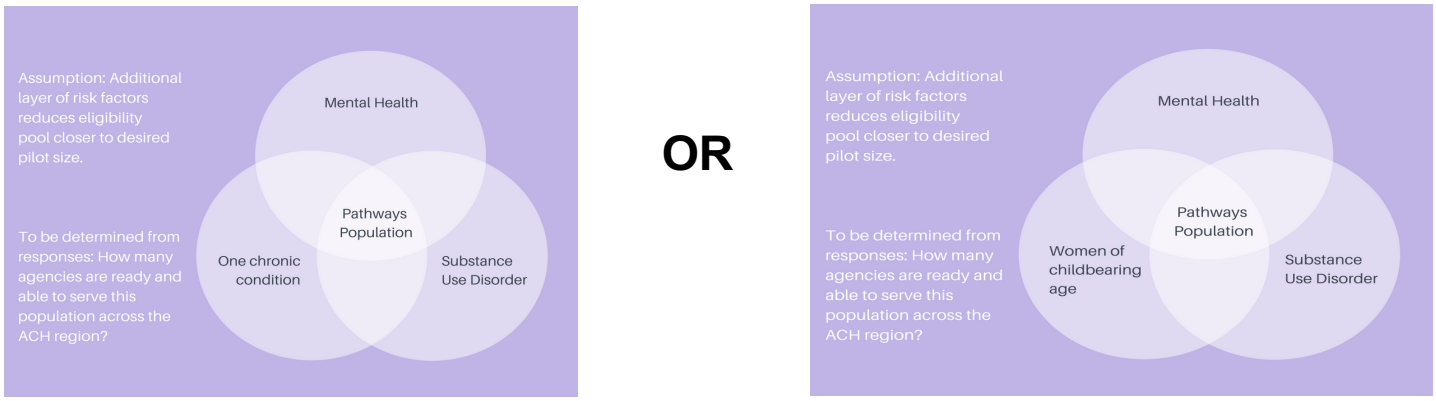
➢ Start with an anchor population, then apply additional layers of segmentation to get to manageable pilot population scope.

➢ The incoming CCA applications will help us refine our population, with final pilot population being determined by the service scope and geographic reach of those agencies that apply.

➢ The applicant's readiness and capacity questions can be utilized to further refine eligible CCAs.

➢ Visual representation below.

Image: A visual representation of Pathways population criteria, showing individuals with mental health and substance use disorder and EITHER 1 chronic disease OR be of childbearing age.



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