Care Coordination

1. Your Organization

This inventory form is intended for organizations in the Better Health Together region who are interested in partnering as a Care Coordination Agency with the Pathfinder Hub. This would entail training existing Care Coordinators under the Pathways Model to better align and standardized Care Coordination services for at risk clients. Please fill out this inventory to give us a better idea of your interest and capacity to partner in this work. Feel free to include attachments if that helps, just make sure to clearly note in your answer when a particular question includes an attachment.

This form is due back to BHT by end of day August 4th.

Organization Name:

Key Contacts:

Locations of all sites and services in BHT region:

Area of Focus: (select all that apply)

- [ ] Housing
- [ ] Food
- [ ] Transportation
- [ ] Income
- [ ] Safety
- [ ] Emotional & Community Support
- [ ] Substance Use Disorder
- [ ] Care Coordination
- [ ] Pharmacy
- [ ] Transportation
- [ ] Acute Care
- [ ] Oral Health
- [ ] Specialty and Outpatient
- [ ] Long Term Care
- [ ] Primary Care
- [ ] Mental Health

Other (please describe)

Please briefly describe the mission of your organization:

Please describe any target populations your organization specializes in working with:

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2. Vision

Describe your vision for community based care. Include a vision statement and how the vision advances community needs and priorities:

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3. Approach

"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."
(Health Care Authority, ACH Pilot & Design GOA #14-208)

Describe your current efforts in care coordination, case management, or other services which support care coordination:

Please describe your care coordination work force. For example, what kind of care coordinators do you employ, i.e. social workers, housing specialists, health coaches, etc.? How many care coordinators do you employ? What is their educational background?

What is the typical caseload for your care coordinators?

Describe any relevant trainings or models you require your care coordinators to utilizes. For example, Motivational Interviewing, Community Health Worker Training, sector specific required training etc.

Describe future workforce needs as it relates to community care coordination, and how you will address during the 5-year demonstration period.

Please describe your organization's relationship to local Health Systems, such as hospitals, health clinics, mental or substance abuse providers, long term care facilities, etc?:

Please describe how, your organization engages Medicaid Beneficiaries/clients in program development and design. BHT will be required to demonstrate Medicaid Beneficiaries had multiple opportunities to weigh in the project design process, and we'd like to know your agency's current practice for community engagement.

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4. Opioid Response

BHT is required to implement a regional Opioid Response Project to combat the Opioid Crisis. If your organization works with individuals with a history of opioid abuse, current opioid users or individuals with Opioid Use Disorder, please describe your program efforts related to this population. If you do not work with opioid users you may skip this section.

Please describe your organizations involvement with opioid users and treating Opioid Use Disorder:

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5. Population Health Management

Please describe your current client management system and other systems you use to support bi-directional data sharing, clinical-community linkages, timely communication among program team members, care coordination and management process to enable population health management and quality improvement processes.

Please describe your ability to produce and share baseline information on care processes and health outcomes for population of focus.

Please describe additional investment that would be necessary to meet data needs.

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6. Financial Sustainability

One of the goals of the Medicaid Waiver is to have 90% of all Medicaid contracts moving to value based. To achieve this goal we will emphasize the need to move from fee for service to outcome based partnerships. We envision a need for community based care coordination to be aligned with managed care contracts and health systems. Please describe the current state of your organizations contracts with Managed Care Organizations and Health System to deliver care coordination:

Please identify areas where you need additional training/practice transformation coaching on preparing for Value Based Care:

By 2020, the state has mandated that all regions have transitioned to a fully integrated managed care system. Our region has the opportunity to move to a mid-adopter status by January 2019, and earn an additional $8.7 million dollars.

Will you support our region's efforts to move to Fully Integrated Managed Care?

- ◯ Yes
- ◯ No

Additional Comments of fully integrated managed care:

What kind of in-kind investment are you willing to make in the following capacities:

Data:	
Clinical/Provider:	
Financial:	
Community:	
Program Management:	
Strategic Development:	

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7. Client Population

Please describe the patients you served in calendar year 2016:

Number of unduplicated Medicaid individuals served by your organization in calendar year 2016:

The Pathway model relies on 20 standard “Pathways” which are evidence based care coordination plans to help patients overcome barriers to improving their health. Where applicable, please describe the services your organization offers to support completion of the following pathways, and the total number of individuals served in calendar year 2016 for those services.

Adult Education

Behavioral Health

Development Referral

Developmental Screening

Education (Meaning education around certain subject a care coordinator could provide)

Employment

Family Planning

Health Insurance

Housing

Immunization Referral

Immunization Screening

Lead Exposure

Enrollment in Medical Home

Medical Referral

Medication Management

Postpartum

Pregnancy

Smoking/Tobacco Cessation

Social Service Referral

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8. Demographics

Provide the number of patients/clients in each category below:

Age

Number of clients under 18	
Number of clients 19-64	
Number of clients over 65	

Race

American Indian/Alaska Native	
Asian	
Black	
Multiracial	
Native Hawaiian/Pacific Islander	
White	
Other	

Ethnicity

Hispanic	
Not Hispanic	

Gender

Male	
Female	
Other	

Income:

< $25,000	
$25,000 - $35,000	
$35,000 - $50,000	
$50,000 - $75,000	
$75,000 - $100,000	
> $100,000	

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9. Health Status

Status of your overall client population:

% homeless, living in a home not their own, living in overcrowded home

% children in foster care, alumni of foster care

% unemployed

% with a criminal record

% with Substance Use Disorder

% Opioid Use Disorder

% with serious mental illness/emotional disturbance

% with ACEs score greater than 4

% asthma

% diabetes, obesity, hypertension

Please list the top 5 services provided by your organization:

1

2

3

4

5

Signature of Authorized Representative: