Welcome!

Enter into the chat:

1) Name, pronouns, organization, and …

2) What comes to mind when you hear the term ‘Community Hub?’

HealthierHere

MTP 2.0: Community Hub

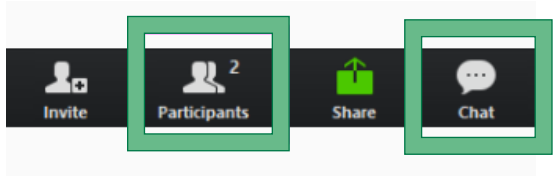
November 17, 2023

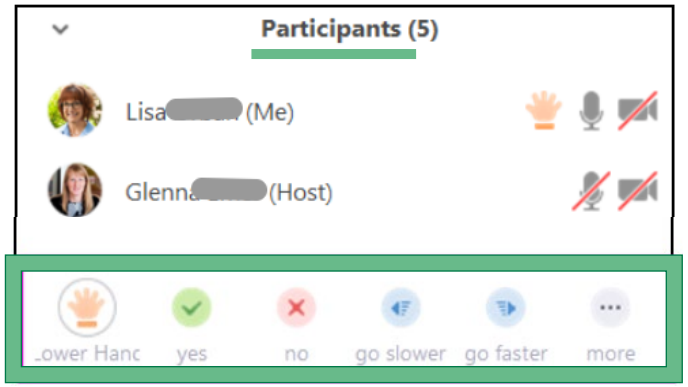
How To Participate

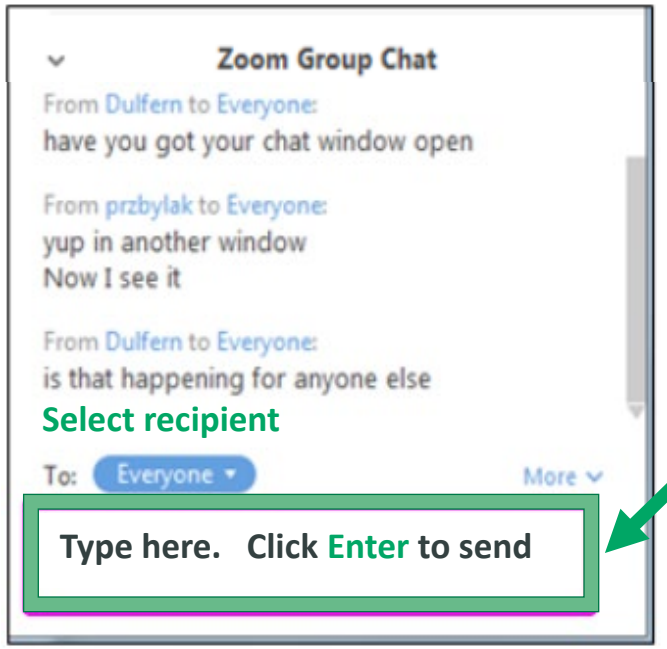
Open Participants and/or Chat Panel

Move your mouse/cursor over the bottom of the Zoom screen.

When the black control panel appears, select the desired panel.







Raise your hand

or provide nonverbal feedback in Participants Panel

(Phone: *9 to raise hand)

Speak

by hovering over the mic next to your name and clicking Unmute in the Participants Panel

(Phone: *6 to un/mute)

Chat

by typing questions and comments in Chat Panel

Agenda

1:00 – 1:10	Welcome, Land Acknowledgement, Objectives
1:10 – 1:40	MTP 2.0: Community Hub
1:40 – 1:55	Becoming a Community Hub Partner
1:55 – 2:00	Timeline & Next Steps
2:00 – 2:30	Questions & Discussion

Land Acknowledgement

https://native-land.ca/

Objectives

- Understand what is coming in Medicaid Transformation Project (MTP) 2.0 and how it is different from MTP 1.0.
- Understand what a Community Hub is, who it will serve, and how.
- Understand what it will look like to partner with HealthierHere in the Community Hub.
- Understand the broad timeline for launching the Community Hub & next steps for interested partners.

Welcome Message from HealthierHere's CEO, John Kim

MTP 2.0 Renewal Waiver: Community Hub

MTP 2.0: Terminology and Acronyms

- **Health Related Social Needs (HRSN)**
  - *An individual's unmet, adverse social needs that contribute to poor health resulting from their community's underlying SDOH*
- **Community Based Care Coordination (CBCC)**
  - *Locally based supports for individuals and families across the continuum of care that reduces fragmentation, improves access, and meets HRSN needs*
- **Community Hub**
  - *A community-centered entity that organizes and supports a network of contracted case management agencies*
- **"Case Management"**
  - *Refers to designated activities for the purpose of assessing and supporting a client's HRSN needs. Often used interchangeably with care coordination, navigation, and care management*

Bird's Eye View: MTP 2.0

Accelerating care delivery and payment innovation focused on health-related social needs (HRSNs) and equity through:

- ★ *Community based care coordination hubs – aka "**Community Hub**"*
  - *Community-based workforce*
  - *Statewide Tribal Hub (HCA)*
  - *Re-entry for short-term pre and post release services from corrections settings (TBD)*
  - *Health Equity programs (TBD)*

MTP 2.0: What it is and is Not

What it is

An opportunity to partner with HealthierHere to:

- Deliver CBCC services through the Community Hub
- Build capacity/infrastructure for providing CBCC
- Receive workforce support through FTE funding, training/TA, and infrastructure investment
- Contribute to and partner with a network of Hub case management partners
- Serve community members through case management
- Integrate into C2C Network (CIE)

What it is not

Unrestricted, flexible funding to:

- Sustain current care coordination and case management programs that are NOT part of the Community Hub
- Resource community/clinical innovation projects
- Support integrated care efforts
- Initiate workforce or career pipeline programs (unrelated to Community Hub)
- Implement population health management tools

Key Differences between MTP 1.0 and 2.0

- MTP 1.0
  - *Flexible*
  - *Broad scope*
  - *ACHs had broad autonomy to choose projects and approaches, and how to invest the MTP 1.0 funds.*
  - *HealthierHere largely provided flexible funds for partners to invest in capacity building and developing infrastructure with minimal oversight*
  - *Deliverable based contracts*

- MTP 2.0
  - *More prescribed, less flexible*
  - *Narrower focus*
  - *Specific role for ACHs- to be a Community Hub and deliver case management and HRSN services to the community.*
  - *Hub funding will support capacity building for Hub Case Management partners and reimbursement for services provided by contracted HRSN benefits providers*
  - *Contracts for service delivery*

Why Community-Based Care Coordination?

- During the first 5 years of the MTP waiver, HCA identified community-based care coordination (CBCC) as a significant strategy for improving the health of Medicaid enrollees.
- Throughout MTP 1.0, CBCC also emerged as an area of high potential for ACHs to have actionable impact, particularly with the positionality to:
  - *Be a neutral convener*
  - *Build trusted relationships with regional partners*
  - *Steward regional funding*
  - *Provide training, TA, and QI support*
- In MTP 2.0 ACHs have a specific role- to serve as Community Hubs for community-based care coordination and delivery of Health-Related Social Needs (HRSN) services.

How will this benefit our communities?

- Through CBCC services and HRSNs, the Community Hub will help individuals and families in King County more easily connect to supports and resources to achieve their optimal health and wellbeing
- Improved navigation of the health and social services systems
- Access to culturally responsive services for communities by people in their communities
- Improved coordination across sectors
- Improved advocacy for resource and access needs through the availability of robust data
- Large scale community-based workforce support

Broadening HealthierHere's Care Coordination Landscape

DOH Care Connect Hub

Network of community-based care coordinating agencies serving community members who have been **impacted by COVID-19** and who have HRSN

9/2022 - 6/2024

CIE

Designed and driven by community to address barriers that prevent people from finding and receiving care across systems. Uses a collaborative network and technology infrastructure to better connect communities to care

2018 – ongoing

Shared Care Planning

Piloting a coordinated and integrated process for sharing up to date key patient information across care settings to facilitate patient-centered care throughout the continuum of care

2019 – ongoing

MTP 2.0 Community Hub

Network of community-based care coordinating agencies that is supported and managed by HealthierHere

7/2024 - ongoing

Questions?

What is HealthierHere's Community Hub?

Under MTP 2.0, a Community Hub is a community-centered entity that **organizes** and **supports** a network of **Hub Case Management partners** providing

1) case management services and
2) connecting people to health-related social needs services

A hub **centralizes administrative** and **operational functions/infrastructure** including:

- Contracting with case management partners
- Payment operations
- Managing and assigning referrals
- Service delivery compliance
- Technology infrastructure
- Information security
- Data collection & reporting
- Training/TA/QI support

HealthierHere's Community Hub

Forms and supports a **network** of case management partners

- Community-based, Tribal led/serving, and clinical organizations
- Agencies receive referrals to provide case management services
- Honors & leverages the capacity of local organizations to provide culturally responsive services to community through a reflective workforce
- Fosters cross-sector collaboration across a network of agencies

It is the **centralized** place of coordination for referral to community-based resources

- Central (not single) point of referral
- Role is to connect, coordinate, and collaborate on behalf of people who need support (outside clinical care)
- Provide warm handoff to connect people to clinical care when needed (in partnership with MCOs for their Medicaid enrollees)

HealthierHere's Community Hub

It is **equity centered**

Will **serve the whole community** through case management services (not just the Medicaid population)

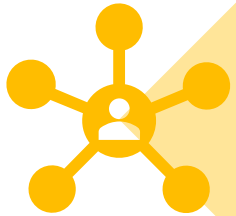
- Many communities aren't Medicaid eligible but still have a need for case management.
- People cycle on and off Medicaid.
- A 'no wrong door' approach is consistent with HealthierHere's values.

Key Functions of HealthierHere's Community Hub

Community & Tribal voice and engagement

Sustainability & business operations

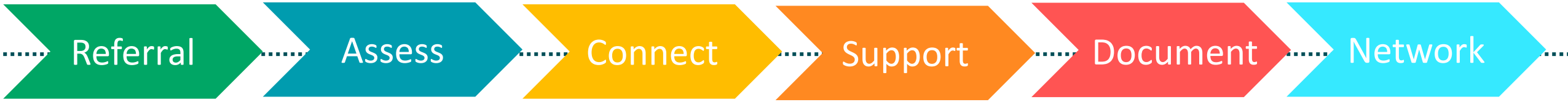
Care coordination operations and reporting



Network management and capacity building

Community-based workforce support

Key Functions of a Case Management Partner



Receive referrals of new clients from the Hub (based on cultural/ language match)

Screening to identify health & social needs

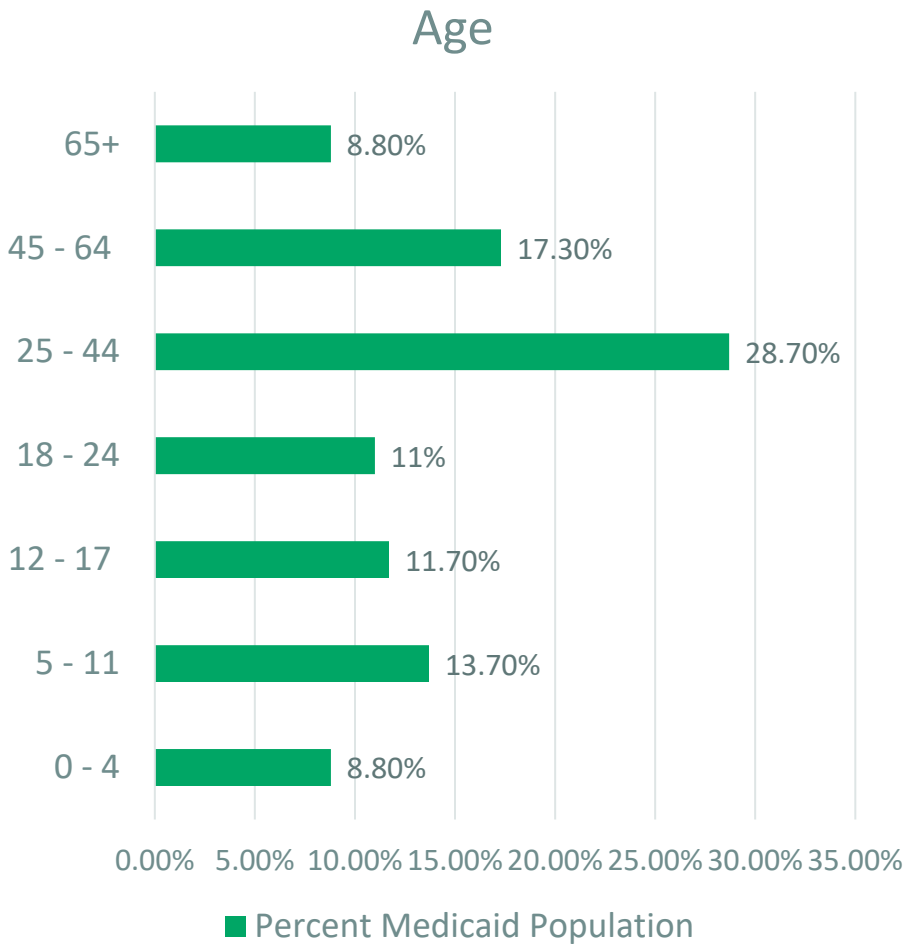
Connect clients to available local resources to meet HRSN needs

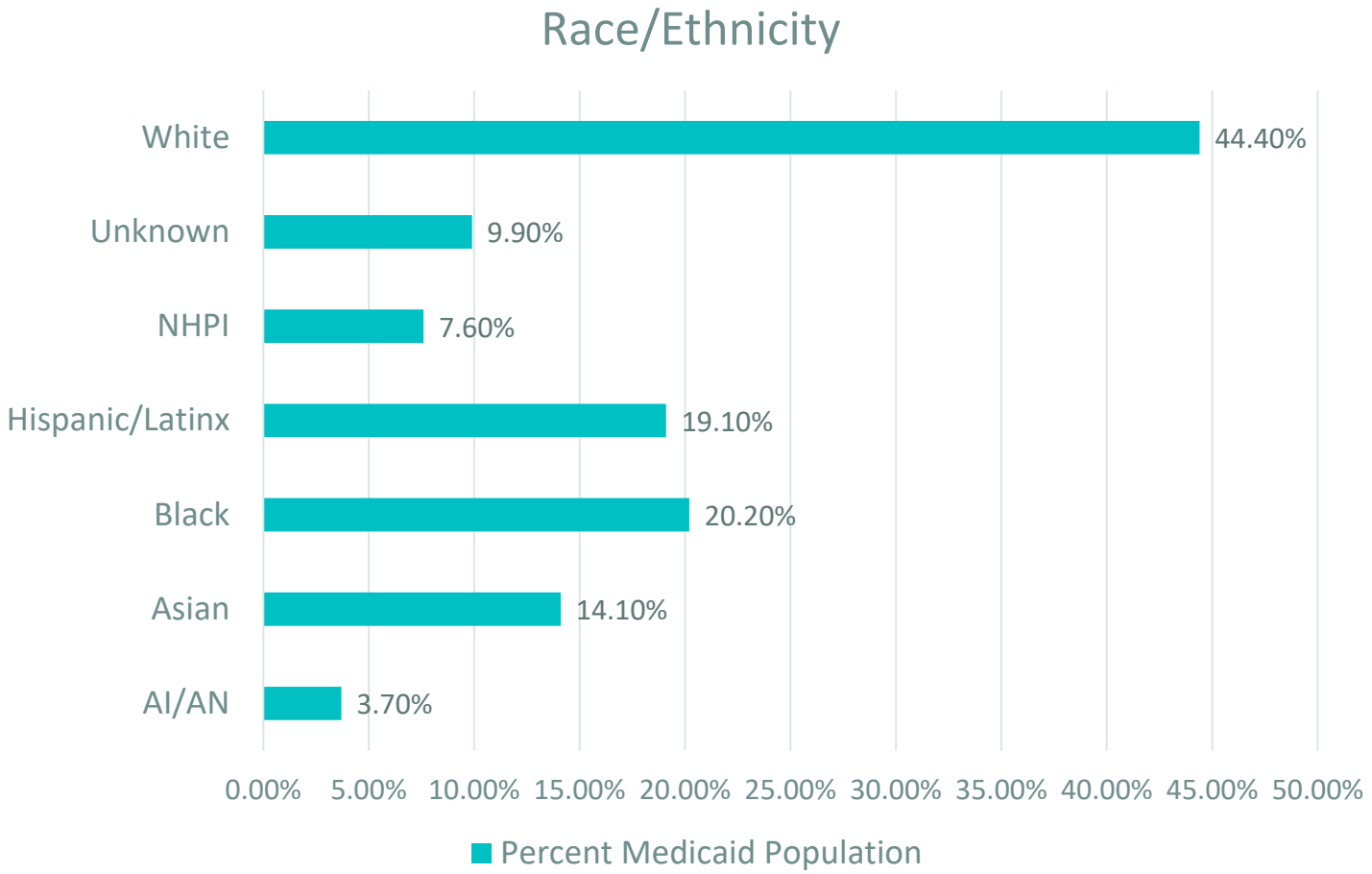
Follow-up to ensure client needs are met and complete warm hand-offs as indicated

Document all case management activities in accordance with Hub policies and protocols

Participate actively in the Hub network through gatherings, training, and QA/QI activities

Who are we serving?
Medicaid Population as a Baseline





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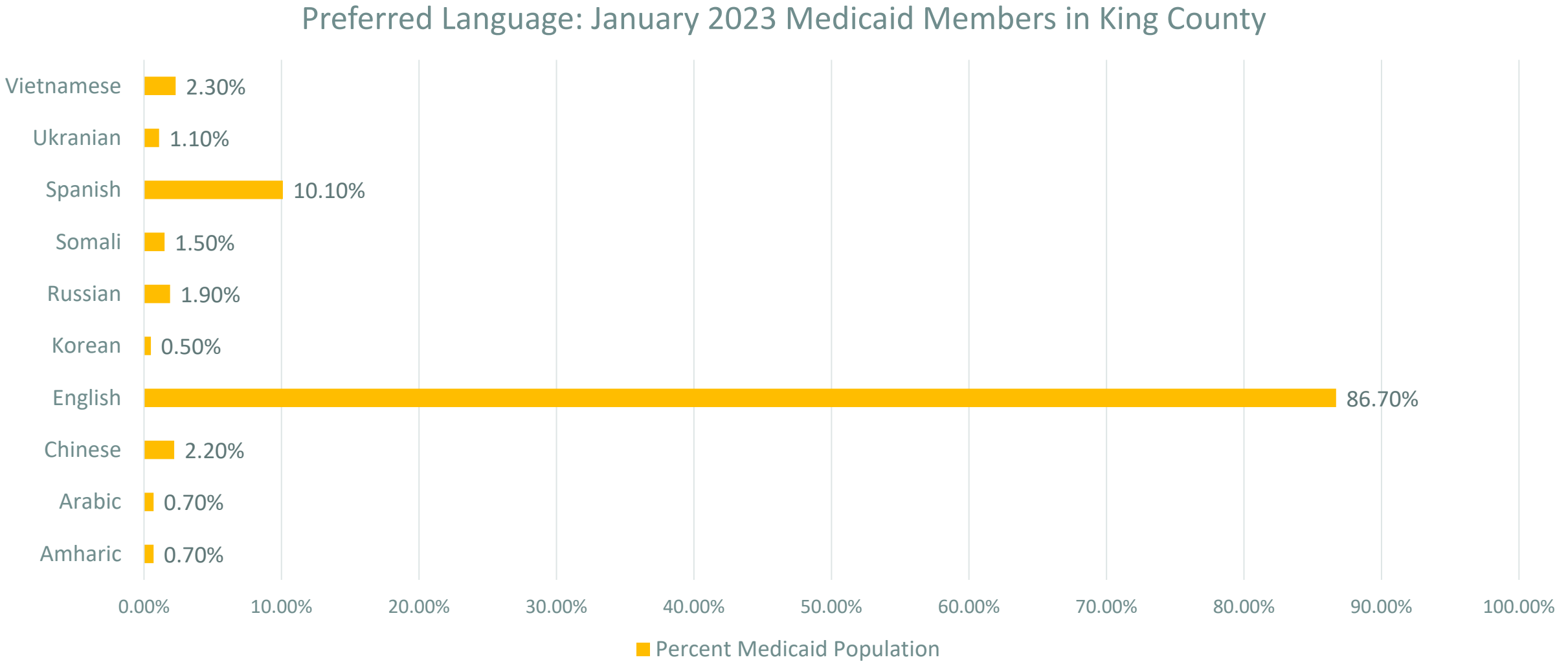


Key Services

Case Management

- Resource navigation
- Referral to meet HRSNs (the core of CBCC)
- **For *everyone*** (regardless of Medicaid eligibility)
- HealthierHere will use the PMPM rate we receive for all Medicaid clients (MC and FFS) to pay for these services

HRSN Benefits

- Payment for a service that meets a clinically indicated health related social need (HRSN)
- **Only for Medicaid beneficiaries**
  - Hubs will pay for these benefits for FFS (MCOs will pay for these benefits for managed care)
- Can be provided alongside case management
- Populations, services, and protocols still being finalized by HCA

Reminder: HRSNs are the result of SDoH

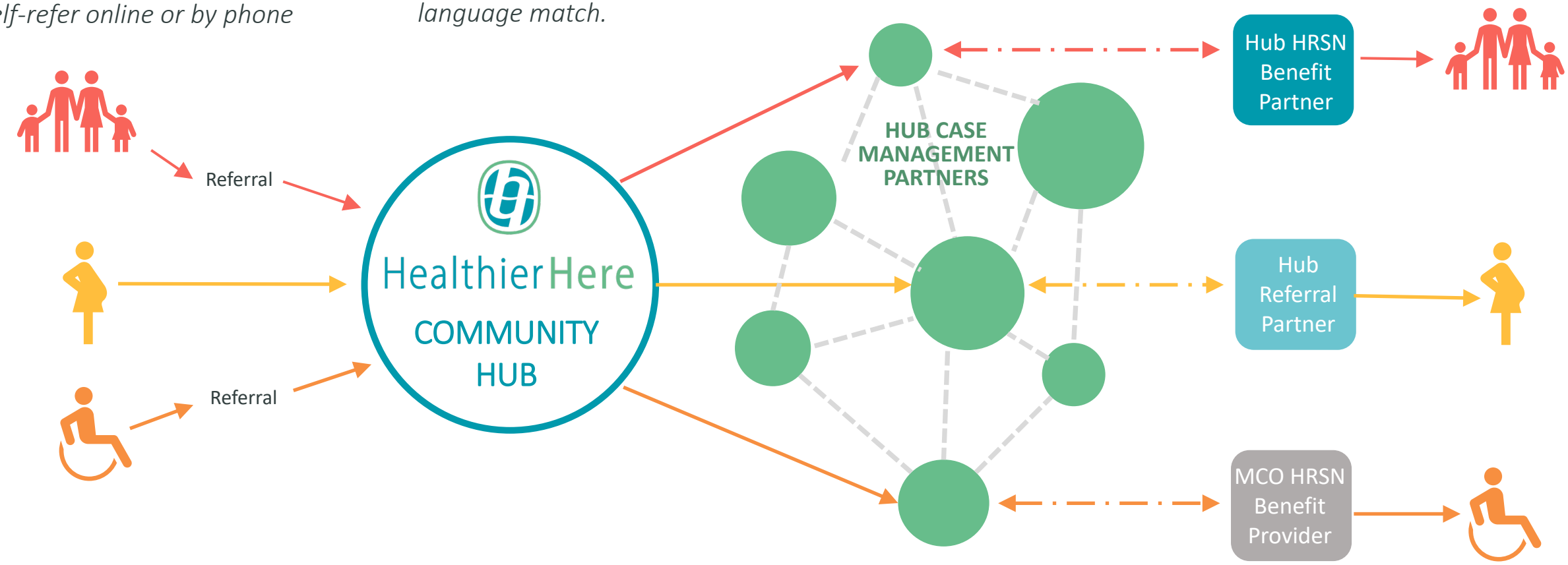
Examples of HRSN services: nutrition supports, housing supports, community transition services, stabilization centers, caregiver respite services, accessibility adaptations/home repairs

A Visual Representation of the Community Hub

Clients are referred to the HealthierHere Hub by a CBO, Health Care Provider or Social Service Agency or may self-refer online or by phone

Clients are screened and referred to a HUB Case Management Partner based on cultural/ language match.

The Case Manager assesses the clients' needs and available benefits and connects them to Health Related Social Needs (HRSN) providers, then follows up to assure their needs are met.



What We Still Don’t Know

- Which HRSNs will be approved and for which specific populations (phased approach)
- Mechanisms by which case managers and/or the Hub can verify clinical indication for HRSNs
- How HealthierHere will be able to resource organizations for infrastructure needed to participate as a Hub Case Management partner
- Reimbursement for Hub Case Management partner contracts
- How the re-entry program will be structured and administered (2025)

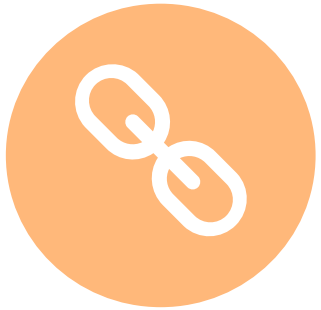
Questions?

Becoming a HealthierHere Community Hub Partner

Becoming a Community Hub Partner

Case management partners – contract with HealthierHere to receive client referrals and provide case management services

HRSN benefit partners – contract with HealthierHere to receive reimbursement for providing HRSN benefits to Medicaid Hub clients



Referral partners – agencies who refer clients to the Hub for services and/or accept referrals from the Hub's case management partners for HRSN services

Case Management Partners

- HealthierHere will be looking for a combination of organizations to become case management partners for Cohort 1 to provide an estimated 40 total FTE of CHWs/case managers (the estimated minimum needed for Hub launch)
- Community Hub services will begin in July of 2024
- Organizations interested in becoming case management partners who are not ready to join Cohort 1 will have opportunities to become case management partners in the future
  - We will add additional cohorts of case management partners to the Hub over time
- Organizations not interested or not eligible to become case management partners may still become Community Hub partners by referring potential clients for intake, accepting referrals from the Hub, and/or becoming HRSN benefit providers

Technology for Case Management Partners

- The Community Hub will be supported by Connect2 Community Network (C2CN), HealthierHere's community information exchange
- HealthierHere will provide the client management system (CMS) for case management partners through C2CN (Connect2 Coordinator)
- Case management partners will adopt Connect2 Coordinator as their CMS for Hub work and will also have the option of integrating their existing technology system over time
- Cohort 1 case management partners will participate in a period of infrastructure/capacity building and integration to prepare for service delivery in July 2024
  - *The opportunity will continue to be available in future years for Case Management partners who join the Hub in future cohorts.*

About Connect2 Community Information Exchange

- HealthierHere's CIE includes a Network of organizations and technology that supports data exchange. These components are referred to as Connect2 Community (C2C) Network.
- C2C Network has been co-designed with community and health care partners
- C2C Network can help you build relationships and access and exchange information so your organization can effectively and quickly coordinate care for your clients across systems
- By joining the C2C Network, Community Hub partners will be able to:
  - *Access the up-to-date resource directory*
  - *Make closed loop referrals*
  - *Share information across health care and social service providers*

Case management partners ready to join Cohort 1 will have some or all of the following characteristics:

- ❑ The organization serves a priority population
- ❑ The organization has expertise in a priority HRSN service area
- ❑ Organizational leadership is willing to commit time and resources to Hub programming and C2C integration
- ❑ The organization has the technical readiness to adopt C2 Coordinator and potentially integrate their existing technology system in the future
- ❑ The organization currently provides services in which information is collected and protected in accordance with HIPAA
  - ❑ The organization has policies and procedures related to privacy and information security, including consent for data collection and sharing, and tracking and responding to information security incidents

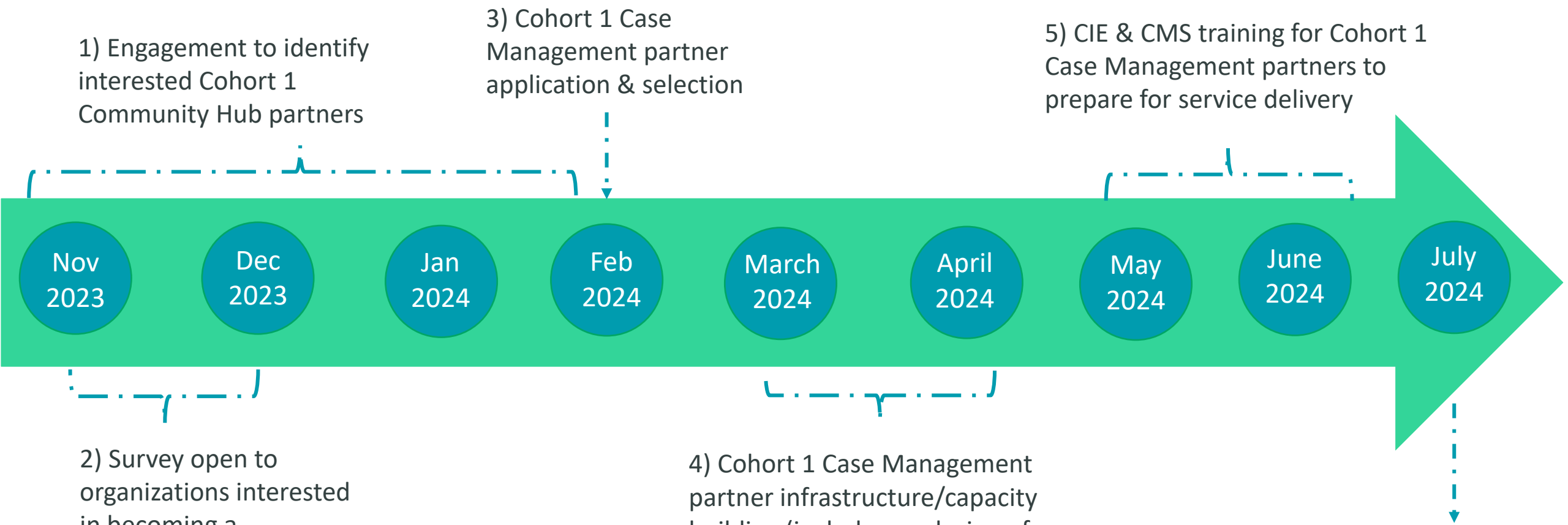
Case Management partners ready to join Cohort 1 will have some or all of the following characteristics (cont.):

- ❑ The organization is a leader in King County, who holds trust with partners and community members
- ❑ Frontline staff are interested and ready to participate
- ❑ The organization's mission and strategic plan align with goals of the Community Hub and C2C Network/Exchange
- ❑ The organization has available case management FTE to dedicate to the Community Hub
- ❑ The organization has experience providing case management services
- ❑ The organization has worked with HealthierHere in the past

Questions?

Timeline

Anticipated Timeline



Next Steps

- Check out our FAQ
- As questions arise about becoming a Community Hub partner, please visit our webpage for updates or email Tavish, tdonahue@healthierhere.org
- For all attendees, please complete the survey that will follow this session. Just 1 submission per organization!
  - *Survey open November 17 – December 11*
- HealthierHere will host hybrid coffee hours to help answer MTP 2.0 questions. Join us at Dubsea Coffee or over Zoom!
- Friday December 8th 10-11am
- Friday January 12th 10-11am
- Friday February 9th 10-11am

Q&A


Thank You
Asante
Shukria
Dhanyavadagalu
Vinaka
Kiitos
köszönöm
Maake
Manana
Dankon
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Kam Sah Hammida
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Grazie
Tack
Taiku
Terima Kasih
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Obrigado
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