IMPLEMENTATION GUIDE FOR COMMUNITY PARTNERSHIP MODEL:

Improving Health Outcomes by Linking Community-based Community Health Workers with Health Systems

Familias en Acción

Kaiser Permanente®
ACKNOWLEDGEMENTS

We would like to thank all members of the Community Partnership Model for the many hours they dedicated to the design and implementation of this program and manual. This project would not have been possible without their commitment to the partnership between Familias en Acción (Familias) and Kaiser Permanente Northwest (KP), who donated countless hours of staff time to complete the project.

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EXECUTIVE SUMMARY

The Community Partnership Model demonstrates a method for linkage between an established Latino-serving Community Based Organization, Familias en Acción, and a Health System, Kaiser Permanente Northwest. Both organizations recognized that each had unique expertise and resources that, working together, could enhance patient services to reach and better serve Latino Medicaid members. The Community Partnership Model was developed to initially serve Latinos and will serve as an important tool for other identified racial, ethnic and immigrant patient populations. Culturally competent care is central to the Community Partnership Model.

Partnering with Community Based Organizations who already employ skilled Community Health Workers/Health Navigators from the identified population (CHW/HN) has been shown to be an effective model for building a more inclusive patient care team. In the Community Partnership Model described here patients are identified by a Health System and referred to a CHW/HN from a Community Based Organization. The CHW/HN becomes a member of the primary care team while continuing to maintain employment affiliation with the Community Based Organization. This effective partnership for culturally competent patient centered care addresses social needs in order to:

- strengthen cross cultural communication with patients
- provide culturally appropriate health information for chronic disease self-management
- enhance health literacy and patient/family engagement
- facilitate patient navigation of the healthcare system
- link patients to supportive community resources to address social needs that may impact their health

The dedication of resources by both organizations resulted in a replicable model that will benefit Health Systems and Community Based Organizations in Oregon, SW Washington and nationally who are poised for such partnerships. This Community Partnership Model Implementation Guide is the result of that partnership and offers practical recommendations with templates and examples for program implementation including contractual and financial agreements, referral processes, mutual training and evaluation. This model can provide the basis to assist Health Systems in reaching Oregon’s Triple Aim of improving the patient experience of care, offering the level of care that brings improved health outcomes and reducing costs.

The Community Partnership Model includes:

1. Implementation Guide for replicating a partnership;
2. Sample contracts and a payment method for CHW/HNs; and
3. Sample metrics for evaluation of clients and the process.
INTRODUCTION

This guide will discuss the rationale and describe the steps to implement a working partnership between Health Systems and Community Based Organizations - from planning through implementation. It is based on lessons learned from other successful programs and from our implementation of the model. It includes resources and samples of agreements, payment methods and forms that we found useful. Knowing that each partner brings their own skills and unique programmatic considerations, we encourage you to use and adapt this guide to build your partnerships.

SNAPSHOT OF THE COMMUNITY PARTNERSHIP MODEL

1. Organizational Internal Planning
   - Identify the need: Select patients with medical needs who experience social needs that impede their utilization of health care.
   - Ensure administrative support and readiness to develop the partnership.

2. Find and Build the Partnership
   - Find appropriate Community Based Organization: Select a CBO that culturally represents, has strong connections to, trust of, and history of serving the identified population, employs and will continue to supervise Community Health Workers/Health Navigators (CHW/HN) who can bridge cultural and community knowledge with understanding of the Healthcare System.

3. Formalize the Partnership
   - Work together to refine the selection of the patient population to be referred.
   - Develop partnership and business contracts.
   - Negotiate payment agreements and select Pathways or another method for payment.

4. Build an Integrated Team
   - Define and develop the referral process and work flow.
   - Clarify roles and job descriptions to successfully embed CHW/HN into patient care teams.

5. Mutual Training and Education
   - Provide orientation and ongoing training of CHW/HN on clinic protocols.
   - Offer training of Health System staff around cultural competence and inclusion of CHW/HN on care teams.

6. Conduct Program Evaluation
   - Collect health care data.
   - Collect narrative data and Patient Activation Measurements (PAM).
## SAMPLE TIMELINES AND MILESTONES FOR COMMUNITY PARTNERSHIP

<table>
<thead>
<tr>
<th>Month</th>
<th>Milestone(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Month</td>
<td>• Health System reviews their needs for culturally specific CHW/HNs and begins to identify targeted patients and locations that need assistance</td>
</tr>
<tr>
<td>Second Month</td>
<td>• Health System identifies and talks with potential Community Based Organizations with capacity to meet their needs</td>
</tr>
<tr>
<td>Third Month</td>
<td>• Health System selects a community partner and signs a partnership agreement. Flexible payment agreement is started at this time for the planning phase</td>
</tr>
</tbody>
</table>
| Fourth Month   | • Identify members of team and leaders  
• Sharing of cultural and organization information from team building process                                                                                                                                                                                                           |
| Fifth Month    | • Identify roles and responsibilities, timeline, workflows, and communication for project  
• Begin communication process within the health organization about CHW/HN                                                                                                                                                                                                         |
| Sixth Month    | • Finalize the client selection, referral process and caseload  
• Identify the evaluation metrics for the partnership  
• Finalize a payment model  
• Complete all internal communications to ensure a warm welcome of the CHW/HN                                                                                                                                                                                                     |
| Seventh Month  | • Begin to integrate new CHW/HN position into clinics  
• Share the workflows on how to identify the social needs of the clients, capture the data and how to address them with the patients                                                                                                                                                                                                 |
| Eighth Month   | • Ensure that all processes are in place to gather evaluation data  
• Review the referral process and adjust the process as needed                                                                                                                                                                                                                                                                           |
| Ninth Month    | • Track volume of clients, referrals and reporting procedures                                                                                                                                                                                                                                                                             |
| Tenth Month    | • Begin first quarterly report process  
• Review and revise the partnership as needed                                                                                                                                                                                                                                                                                           |
1. UNDERSTAND THE PARTNERSHIP MODEL

RATIONALE AND DESCRIPTION

Background: Patients from diverse cultures often face obstacles that can become barriers to quality health care including:

- Fear and/or distrust of the medical system
- Severe, multiple chronic health problems
- Health literacy challenges
- Lack of linguistically and culturally appropriate information or systems
- Unique cultural values
- Lack of knowledge about Health Systems leading to overuse of emergency department or other acute high-cost services
- Social needs that prevent positive health outcomes

Health Systems recognize the disparity of health outcomes for some of their patients. Healthcare providers want the best possible outcomes for all patients yet face obstacles such as lack of time, resources, cultural understanding or language proficiency when caring for patients from diverse cultures. They would like a solution that could be implemented internally, be efficient, cost effective, sustainable and replicable across healthcare settings.

Purpose: Partnering a Health System with an established Community Based Organization (CBO) can bridge that disparity gap. Partnering with a CBO who already employs skilled Community Health Workers/Health Navigators (CHW/HN) from the identified population has been shown to be an effective model for building a more representative patient care team. The Community Partnership Model (CPM) described here utilizes that successful model.

The CPM can provide an effective working partnership in order to offer culturally competent patient centered care that addresses social needs in order to:

- Strengthen cross cultural communication with patients
- Provide culturally appropriate health information for patients
- Enhance health literacy and patient/family engagement

Familias en Acción is excited to be working with Kaiser Permanente because of their enthusiastic commitment to exploring and fully engaging in developing this partnership. We had support from all levels of administration and clinic staff, so that we could effectively plan for all of the necessary elements of the integration of the Community Health Worker. We worked together as a team and sought solutions that benefited all parties of the partnership.

Gail Brownmiller, Executive Director Familias en Acción
• Facilitate patient navigation of the healthcare system
• Link patients to supportive community resources to address social needs that may deter positive health outcomes

This partnership could assist in reaching the Triple Aim of improving the patient experience of care, offering the level of care that brings improved health outcomes and reducing costs.

**Distinctive Project Components:** Many organizations are using CHW/HNs in a variety of ways. This model is unique in that it is a partnership where resources are shared. Rather than hiring CHW/HNs internally, (which requires mid-level management, cultural competence and community contacts) Health Systems can rely on the cultural background, business expertise, and community reputation of a local CBO to provide highly qualified workers.

Services of CHW/HNs are contracted by the Health System. The CHW/HNs remain employees of the CBO that continues to provide supervision, office space, salary and support. The CHW/HNs maintain their position as local community members, stay updated on community resources, receive continuing education, etc.

The CHW/HN, in this model, attends patient care team meetings as a valued, integrated team member of the Health System. Work flow clearly delineates roles, responsibilities, and protocols for care coordination from initial intake to case closure. The Health System provides training on hospital protocol, recordkeeping, communication, etc.

It is important to identify the long term needs of the Health System for serving clients of multiple identified populations. The method described in this guide is designed to work with one or two identified populations per clinic. Thus, one or two CHW/HNs of different ethnic or racial populations might be selected to work in a single clinical setting. If a clinic identified a need to serve four or more identified populations, then we would recommend using the HUB model that is described in the Appendix. This method allows for a centralized contracting agency to provide CHW/HN from multiple populations to offer services simultaneously.

We are aware that the specialized populations we serve face social needs that become barriers to health outcomes. We know that we do not have their trust and that without it we cannot secure good outcomes. Kaiser Permanente has taken steps toward diverse internal hiring but we know that CHWs can reach deeply and with trust into the community. Combine this with the impending decrease in available physicians, we see this as a new route for care delivery and hope to build a model that will be timely and replicable for other Health Systems.


Implementation: To reach the proposed outcomes for both patients and providers it is prudent to enter into a partnership systematically. This document utilizes experience gained from the linkage between Familias en Acción and Kaiser Permanente Northwest to describe systematic processes and tools that can be replicated by other Health Systems in order to provide culturally competent care for specific member populations.
A relationship with a CBO can provide ongoing guidance to the Health System to ensure that the program is grounded in community needs and is culturally competent. The CBO may offer continuing education for Health System staff on culturally relevant services. The CPM is actionable and replicable across other Health System and Community Based Organization partnerships.

THE COMMUNITY PARTNERSHIP MODEL (CPM): LINKING COMMUNITY BASED ORGANIZATIONS WITH THE HEALTH SYSTEM

Initial Stages of Linkage

Familias en Acción, Portland, Oregon and Kaiser Permanente Northwest recognized that both partners had unique expertise and resources that, when linked together, could enhance patient services to reach and better serve Latinos. The Community Partnership Model was built with funding from The Collins Foundation, Meyer Memorial Trust and the Oregon Community Foundation to build a replicable model for integrating CHW/HNs. Kaiser Permanente convened a Planning and Implementation Committee to work with Familias en Acción to develop a strong implementation plan and a payment model that improves health outcomes, is cost effective with clear deliverables and is replicable.

About Familias en Acción

Familias en Acción (Familias) was founded in 1998, in response to the need for a culturally specific organization to promote health for Hispanics. Its mission is to promote empowerment and holistic family well being for Latinos through compassionate community engagement, education, research, and advocacy for social change. Services include: 1- Patient navigator services for Latinos diagnosed with chronic diseases including cancer, diabetes, end stage renal disease and cardiovascular disease; 2- Community health education, a Spanish language support group and chronic disease self-management classes; and 3- Training for Health Professionals. This includes the annual Latino Health Equity Conference and online/in person health professional training with Continuing Education Units.

About Kaiser Permanente

Kaiser Permanente is committed to helping shape the future of health care. It is recognized as one of America’s leading health care providers and nonprofit health plans. Founded in 1945, Kaiser Permanente has a mission to provide high-quality, affordable health care services and to improve the health of its members and the communities they serve. It currently serves approximately 10 million members in eight states and the District of Columbia, including more
than 520,000 medical and 240,000 dental members in Oregon and Southwest Washington. Care for members and patients is focused on their total health and guided by their personal physicians, specialists and team of caregivers. The medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education and the support of community health.

### Community Partnership Model Logic Model: Sample Template

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short</th>
<th>Outcomes</th>
<th>Medium</th>
<th>Long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify funding source: Flexible spending account/Medicaid</td>
<td>Identify client need that can be addressed by CHW- Health data analysis</td>
<td>Client selection criteria listed</td>
<td>First Year</td>
<td>- Signed partnership and Pathway payment contract signed to initiate project</td>
<td>- Review &amp; revise the Pathways and their costs</td>
<td>3-5 Years</td>
</tr>
<tr>
<td>Contract for services</td>
<td>Identify appropriate agency based on needs analysis</td>
<td>Agency selected</td>
<td>Second Year</td>
<td>- Serve identified number of clients with selected Pathways</td>
<td>- Review &amp; revise the client selection and referral process</td>
<td></td>
</tr>
<tr>
<td>Community Benefit Funds for Planning</td>
<td>Create a partnership to serve identified clients based on mutual trust</td>
<td>Shared partnership</td>
<td></td>
<td>- Evaluation report on metrics and community capacity at one year</td>
<td>- Review the evaluation metrics and reporting process</td>
<td></td>
</tr>
<tr>
<td>Grants</td>
<td>Verify client criteria and create evaluation metrics</td>
<td>Evaluation metrics selected</td>
<td></td>
<td>- Commitment to measurable triple aim outcomes for target population</td>
<td>- Plan, Do, Study, Act to have an impact on triple aim metrics</td>
<td></td>
</tr>
<tr>
<td>Special Populations Funding</td>
<td>Negotiate partnership contracts and agreements</td>
<td>Completed regulatory and health care compliance contracts</td>
<td></td>
<td>- Improved culturally specific services delivered to clients</td>
<td>- Expand the clients served throughout the Health System</td>
<td></td>
</tr>
<tr>
<td>Health System staff: - Strategic Planning - Medical staff - Data Experts - Administration - Patient support staff/Liaison</td>
<td>Create workflows and integrate CHW/Health Navigator in Care Team</td>
<td>Supervision, workflows, protocols and team meetings completed for integration</td>
<td></td>
<td></td>
<td>- Increased trust with targeted population due to improved relationships</td>
<td></td>
</tr>
<tr>
<td>Community Based Organization: - Administration - CHW/Health Navigator - Pathway support</td>
<td>Develop mutual understanding and culturally specific education with clinical staff</td>
<td>Number of staff receiving culturally specific training</td>
<td></td>
<td></td>
<td>- Reduce costs for targeted population</td>
<td></td>
</tr>
<tr>
<td>Hub for web-based Pathways and/or contracts</td>
<td>Train CHW/ Health Navigator on clinic protocols</td>
<td>Health System trainings completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Select and revise Pathways</td>
<td>Pathways and costs selected</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Create a referral process</td>
<td>Referral process documents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Begin referring clients to CHW/Health Navigator</td>
<td>Referral process implemented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collect metric data for evaluation reports</td>
<td>Evaluation</td>
<td></td>
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</table>
JOSEPHINA’S STORY: AN ILLUSTRATION OF THE PARTNERSHIP

Follow the benefits of the partnership as one Community Health Worker/Health Navigator from Familias en Acción provides services to a patient who is a member of Kaiser Permanente.

Defining The Role Of The CHW/HN

Adam Merecias was chosen by Familias en Acción to be the CHW/HN because of his own cultural expertise and knowledge of the local Latino community. His breadth of experience with patients across medical conditions, knowledge and use of evidence-based best practices, and his ability to work independently and as part of a team, were key elements in working with the Health System.

Adam’s work is different from that of a social worker or hospital patient navigator because of the cultural component:

The families I work with know that I understand and am not judging them. I do not hand them a list of resources and suggest they call. I give them resources that I personally know of and can vouch for. I know the places that speak Spanish. I know what has worked for other Latinos. I know of classes and services that are offered by places not on the usual lists. They trust me and they know I will follow up to help them make the first and the last steps.

A CHW/HN understands the language and culture but is not a medical interpreter:

*It is important that a language interpreter be neutral - I cannot remain neutral if I am to be an advocate.*

A CHW/HN helps the patient understand and receive medical services:

*Moving into specialty care is a place where we lose patients--the system seems too complicated or impersonal. I often go with patients for specialty appointments. I check back later to be sure they understand their medical condition and the next steps.*

Embedding The CHW/HN

After the initial background check, Kaiser Permanente provided internal training so that Adam could work within their system. He learned the EPIC/Health Connect system and has “reading-only” access to the patient’s medical record:
Without needing to make multiple phone calls to multiple providers I can look in the record to see diagnosis, medications, notes from recent visits, ER visits, etc. This helps me identify gaps in a patient’s understanding or following of treatment plan.

I can share my observations, in the chart and at team meetings, about critical issues that can affect a patient’s health. I have found that patients welcome my communicating with their medical providers and that providers gain a deeper understanding of their patients.

Even though most of his work is in the field, Adam was given office space in one clinic for visibility and ease of referral. He understands the value of face to face relationship building and is present if a patient or provider needs immediate support. To explain his role and gain credibility he visits team meetings. Because it is a new service, care team members get periodic reminders from the clinic supervisors about possible patients to refer and how to refer them.

I share an office with a Spanish speaking pharmacist who has become an informal mentor or partner to help me learn about the people, roles, and services available. I have learned so much about what Kaiser Permanente can provide so that I can help patients find what they need and walk them through the process.

**Getting Referrals**

Kaiser Permanente and Familias en Acción spent many hours discussing the type of referrals that would be appropriate for the CHW/HN in this project. A variety of criteria were discussed, such as patients with high usage of the Emergency Department, with multiple chronic diseases, with multiple social needs and chronic diseases, as well as those with only social needs. After much discussion, it was determined that a blend of patients would be selected and that a variety of Kaiser Permanente staff would be able to make the referrals after consulting with the patients and obtaining their approval for the referral.

Kaiser Permanente providers-medical, social work, financial-refer a patient to the “CHW Pool” using the internal email system and indicating specific concerns. The person identified as the “Primary Care Liaison” determines if the referral is appropriate, then faxes it to Adam so he has information he needs to make the initial contact. The liaison roll will vary in each Health System and the levels of support for the CHW/HN will change with various locations and the complexity of care.

**Initial Intake**

Adam meets with a family in their home where they can speak Spanish and are comfortable as they begin to build trust and gather initial information. He uses Motivational Interviewing skills, Teach Back tools and the Patient Activation Measure (PAM) to determine their level of engagement in their health issues and set priorities for working together.
Señora Sanchez and her daughter welcomed me to their home for the initial concern about the daughter’s asthma. She was frightened because the diagnosis of asthma came with new medications that had many warning notices and instructions about how and when to administer them. Because she could not bear to see her child gasp for breath she gave the medicines as often as she could. Instead of getting better her child seemed to be getting worse.

Working Together

Determining the Pathways to Health, which are based on social needs, helps focus the work on the most important problems, track progress, and remain accountable to payers. Most if not all patients in this program will need Pathways for Medication Reconciliation, Health Literacy and Social Service Referral to reduce barriers to care such as food, living situation, transportation and paying for services.

We went through Medication Reconciliation together. She gathered all the medications, prescriptions, teas and anything else the daughter was prescribed or tried on her own. We made a list and coordinated which medication to use for which symptoms and those that are taken according to the clock or day of the week. We role played using the inhaler until both mother and daughter understood when to use it and how.

The Social Service Referral Pathway highlights the social and economic factors that need to be addressed.

As we made our list, it became evident that, not only were the prescription directions written in English, but the mother could not see without glasses. They were not aware that she could get new glasses through her Medicaid coverage. I would help her read through the paperwork and make the application.

Because we met in their home, I was able to observe living conditions that were probably affecting her daughter’s health. She had not spoken to the landlord about the mold on the walls because she worried this would cause trouble for the rest of the family. The extended family was living together; mom and daughter in a makeshift bed in the living room where neither got enough sleep. She was dependent on her own parents for help. Even though many family members worked long hours, there was not enough food. We were able to find food resources. Immigration status is often a topic that is avoided but produces constant stress. Because they can talk with me without fear, I was able to answer their questions and get them started on the process to apply for resident cards.

Patients understandably labeled “noncompliant” become better consumers and patients when these kinds of social barriers are addressed.
Even though the clinic might be calling with important information, the family may not answer their phone because they expect it to be the collection department wanting a payment they didn’t have. This mother might use the ER instead of using a daytime appointment, if she was called to work. Her daughter received acute care but they missed the continuity of information about managing her illness that can happen with an ongoing relationship with a clinic provider. Once transportation was arranged through Medicaid, she missed fewer appointments for her daughter.

**Getting Results**

The CHW/HN can provide the missing piece in the care delivery system. Given the very real constraints providers face in the clinical setting, details about a patient’s life may not arise and certainly cannot be addressed. Yet, it is often those life circumstances that become barriers to following treatment plans and to patients taking an active part in their own health management. The CHW/HN can help patients address those issues, support patients’ understanding of chronic illness and become cultural liaisons between patients and providers. Working together in this way Health Systems will meet their goals of effectively reaching more diverse populations and improving health outcomes.
2. HEALTH SYSTEM ORGANIZATIONAL READINESS AND INTERNAL PLANNING

Before initiating a partnership, it is important for partners to build a culture of readiness and accomplish internal planning.

FACTORS SUPPORTING A CULTURE OF READINESS FOR HEALTH SYSTEMS - AS OBSERVED BY KAISER PERMANENTE

- Experience with or understanding of the role of CHW/HNs.
- Awareness of how ACES (Adverse Childhood Experiences) are strongly associated with increased risk for negative health behaviors and developing chronic diseases later in life.
- Observing the connection between chronic conditions and admission into healthcare systems.
- Desire to understand how social needs affect health outcomes.
- Shift of focus upstream where health care can be more preventative.
- Responding to the future shortage of healthcare providers.
- High level administrative support for serving the targeted population.
- Having sufficient staff that speak the language of the targeted population to provide basic services, while utilizing additional interpreters to assist patients.
- Sufficient funds for training staff and allowing current staff the time to develop the partnership.
- Willingness to make modifications to existing systems and communication workflows.
- Willingness to learn from the partner organization and to teach the partner.

Kaiser Permanente Northwest has already done significant work to develop strategies for partnering with CHWS, including those listed below:

1. Offer learning opportunities for Kaiser Permanente Northwest staff and leaders to understand and differentiate roles.
2. Support community efforts to strengthen the infrastructure for Community Health Workers across our region (such as training, certification, evaluation and payment methods).
3. Implement pilot projects with local community-based organizations to support our members and our community to address specific needs.
4. Integrate community-based Community Health Workers into our services for Medicaid patients.
5. Support the evaluation and research of CHW programs and initiatives so that success is well-defined and understood.
IDENTIFY THE NEED

Define patient population demographics and health needs

Identifying and quantifying the need up front will help focus the model and identify the quantifiable results later. The need for culturally specific patient support can be identified by statistics around healthcare service usage and demographic statistics of the catchment area. This model focused on the Medicaid population because of the Affordable Care Act requirements and potential source of funding for CHW/HNs.

Possible Health System statistics:

- Inappropriate use of ER
- Hospital readmission penalties
- High use of language interpreters (as indication of cultures served)
- Low representation of varied cultures in the work force
- Under-utilization of health services by identified patient population
- High diagnoses of severe chronic illness
- Low patient follow through / high non-compliance rates
- Identification of care gaps
- Need to decrease costs and improve health outcomes without sacrificing quality

“High risk patients” might be identified by social needs that may create barriers to health care, such as:

- Age - children and elders
- Risk factors for severe chronic illness
- Low income
- Non-English speaking or English as second language
- Ethnic or racial minority
- Education level or literacy level
- Environmental conditions (housing, food, transportation, etc.)
- Underinsured and/or uninsured

“Navigators at Kaiser Permanente work on inter-disciplinary care teams of which Community Health Workers are an extension. They work to identify goals and enable members and their families to achieve those goals through identifying local community assets such as CHWs. Navigators are non-licensed. They are highly trained communicators and experts on local community resources/social services. They are skilled in motivational interviewing and person-centered approaches. Community Health Workers are trusted members of a community that work with participants who have similar cultural backgrounds and facilitate linkages to culturally appropriate care, while increasing community capacity.”

Nicole Friedman, Patient Care Navigator Manager Kaiser Permanente
IDENTIFY THE BENEFITS OF PARTNERSHIP

Recognizing the disparity of care and looking for solutions that can happen within existing systems is a solid foundation for developing a partnership. Compare benefits and return on investments between continuing to provide services using current modalities, hiring CHW staff internally, and partnering to bring external CHW services to the Health System.

Tu Porvenir/Your Future: Health for Hispanics in Oregon is a successful model for linking community and Health System resources to improve health outcomes. In 2012, Familias en Acción partnered with the Oregon Medical Insurance Pool (OMIP) to provide culturally specific Community Health Worker navigation to previously uninsured patients with End-Stage Renal failure. Of 90 participants, outcomes showed:

- 78% member engagement rate (compared to 3% for those connected to Nurse Case Managers);
- 59% reduced medical costs;
- 62% reduced inpatient/outpatient/ER costs;
- 23% increased usage of preventive services and
- 62% increase in pharmacy usage (Regence Blue Cross Blue Shield, 2013).


Additional Resources:


Penn Center for Community Health Workers:  http://chw.upenn.edu/
3. FIND & BUILD THE PARTNERSHIP

FIND THE RIGHT PARTNER

FOR HEALTH SYSTEMS: It is important to have established criteria for the Community Based Organization that will become your partner. The Health System can only do that if they have a clear definition of who they will serve and what services are needed. This takes time and planning to identify clear definitions. After that is completed, then the Health System can develop a Request for Proposals (RFP) delineating what they need from a CBO.

The CBO needs to have sufficient infrastructure and stability; the CHWHNs that they hire need to have training, supervision and expertise for the services to be provided. The information in this section can help you know what to look for and what questions to ask.

FOR COMMUNITY BASED ORGANIZATIONS:
Information in this section will help you understand the qualifications that a Health System will be looking for and help you assess whether your organization meets those needs. Each agency has different strengths and programs to offer to a Health System, so not every organization may be appropriate for a particular partnership, even though the CBO serves their community in some manner. Some CBOs may focus on housing assistance or some may focus on mental health services or some other type of service. It is important to determine that the CBO is a good match with the Health System needs before considering the partnership.

QUALIFICATIONS OF A CBO:
Culturally specific community organizations play an important role in health equity for the communities they serve. Although many CBOs serve diverse populations, the programs of culturally specific organizations are created by and for the communities they serve.

Some CBO qualifications to look for:

1. Located within and serving the population who will receive services.
2. Currently provides the type of services that the Health System is seeking.
3. Longevity and sustainability (history, current and future financials, funding sources, etc.).
4. Valued and viewed as successful by the community.

“Organizations providing Culturally Specific Services demonstrate intimate knowledge of lived experience of the community, including but not limited to the impact of structural and individual racism or discrimination on the community; knowledge of specific disparities documented in the community and how that influences the structure of their program or service; ability to describe the community’s cultural practices, health and safety beliefs/practices, positive cultural identity/pride/resilience, immigration dynamics, religious beliefs, etc. and how their services have been adapted to those cultural norms.”
Multnomah County, October 2015
5. Has infrastructure to communicate with Health System and document processes.
6. Hires qualified CHW/HNs who have experience with specific type and depth of services needed along the continuum of care.
7. Provides ongoing supervision of CHW/HN.
8. Uses evidence-based programs.
9. Has a documented method of tracking outcomes and a payment model.

UNDERSTANDING THE ROLE OF A COMMUNITY HEALTH WORKER/HEALTH NAVIGATOR IN THIS MODEL

CHW/HNs do not provide clinical care but rather support the patient in addressing social needs allowing clinicians to focus on clinical care.

They provide dependable communication and may be the point of contact to coordinate services. While not medical language interpreters, they can help patients understand their medical condition, explain treatments and can improve patient follow through. They may offer culturally specific education and support to family members who may be caregivers or who are an integral part of disease management. They can provide cultural mediation that goes both ways between patients and a variety of service systems. They have a network of contacts and knowledge of community services that can provide psychosocial support that mitigate barriers to utilizing health care.

In practice, CHW/HNs may be the ones to:

- Meet a patient at his or her home or go with them to appointments.
- Listen for unmet or undisclosed needs and make referrals to address those needs.
- Explain the full array of services available to the patient.
- Connect patients with practical community supports.
- Break down social determinant barriers that deter desired health outcomes.
- Help patients set and follow through on health goals and disease self-management.
- Offer health education in culturally appropriate ways.
- Support patients to build skills that keep them out of the hospital and help improve their quality of life.

“The CHW/HN role is to identify and support the patient in addressing social needs that are barriers for successful chronic disease management. CHW/HNs, as members of the patient care coordination team, are most effective when they are patient centered rather than disease specific.”
Penn Center for Community Health Workers
There are many job titles describing the Community Health Workers who improve health access for the culture or community they represent. They are each slightly different and provide important, yet often overlapping, roles. This graphic identifies the Health Navigator role used in this partnership with Familias en Acción and Kaiser Permanente. Please note that the Health Navigator in this model has some extra medical training that some CHWs may not have experienced because of the unique medical expertise that Familias Health Navigators bring to this project. This model is slightly different from other models that would show the Health Navigator contained within the CHW circle of expertise.

RECOMMENDED TRAINING OF CHW/HNS

While there are no national certification standards for CHW/HNs at this time, there is a national definition of a Community Health Worker that was developed by the American Public Health Association that is frequently used to explain their role. “A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”

Within the State of Oregon, there are five different “Traditional Health Workers.” In addition to the definitions listed below, there are: Peer Support Specialists, Peer Wellness Specialists and Birth Doulas. This project is focused on Community Health Workers and Personal Health Navigators.
Traditional Health Worker Definitions from Oregon Health Policy Board
Oregon Revised Statutes/ORS 414.025

Personal Health Navigator means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the person’s particular circumstances and in light of the patient’s needs, lifestyle, combination of conditions and desired outcomes. Oregon Revised Statutes/ORS 414.025

Community Health Worker means an individual who promotes health or nutrition within the community in which the individual resides, by:

a) Serving as a liaison between communities, individuals and coordinated care organizations;
b) Providing health or nutrition guidance and social assistance to community residents;
c) Enhancing community residents’ ability to effectively communicate with health care providers;
d) Providing culturally and linguistically appropriate health or nutrition education;
e) Advocating for individual and community health;
f) Conducting home visitations to monitor health needs and reinforce treatment regimens;
g) Identifying and resolving issues that create barriers to care for specific individuals;
h) Providing referral and follow-up services or otherwise coordinating health and social service options; and,
i) Proactively identifying and enrolling eligible individuals in federal, state, local, private or nonprofit health and human services programs.

CHW/HNs at the CBO should have had basic training in:

- Interpersonal communications
- Written and computer communication
- Working on a team
- Outreach strategies
- Patient confidentiality
- Collecting and entering patient data
- Use of evidence-based interventions/programs, e.g. chronic disease self-management programs, motivational interviewing

CHW/HNs have continuing supervision, training and support by the CBO in:

- Community resources
- Maintaining professional boundaries
- Role definition
- Preventing burn out
- Health education

Specific training to work at the Health System will be provided at the Health System.
“Policy developments through the Affordable Care Act are generating new business opportunities for CBOs. CBOs that provide support services through CHW programs are poised to establish contractual partnerships with health care organizations for services such as care transitions, chronic disease management, medication management, family support, palliative care and other services”.
SCAN Foundation, August 2012.

Additional Resources:

Centers for Disease Control and Prevention - Community Health Worker Toolkit

Multnomah County - Culturally Specific Workgroup Recommendations, 10/2015.
https://multco.us/file/48046/download

Oregon Community Health Workers Association
http://www.orchwa.org/

Penn Center for Community Health Workers
www.chw.upenn.edu

The SCAN Foundation
http://www.thescanfoundation.org

Sinai Urban Health Institute - Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings

State of Oregon Office of Equity and Inclusion: Traditional Health Worker Commission
http://www.oregon.gov/oha/oei/Pages/thw-certification.aspx
4. DEFINE CONTRACTUAL AND FINANCIAL AGREEMENTS

THE PATHWAYS TO HEALTH MODEL

This partnership utilizes the Pathways to Health Model, originally developed by Drs. Mark and Sarah Redding of Ohio, to Find, Treat and Measure. For this project, this means to identify appropriate referrals, complete the intervention steps, and measure the activities which define the payment. Each Pathway corresponds to one patient need and outlines intervention steps toward the outcome.

The Pathway model uses CHW/HNs to work with patients on an individual basis, including home visits, to identify social needs and other health assistance that will improve the patient’s health outcomes. For each risk factor identified, a specific standardized Pathway is assigned, and then each Pathway is tracked step by step through completion. An at-risk individual may have many Pathways being addressed simultaneously, reflecting multiple health and social issues identified by the CHW/HN or the health provider. The completion of each Pathway ensures the delivery of one or more evidence-based or best practice interventions to address the risk factor.

“Pathways are the standardized outcome measurement tool. The effectiveness of Pathways used as a single measure and as a comprehensive group of measures has been tested and researched. The model and its impact affirm that like many other effective interventions that require more than one component, more than one risk factor must be addressed to demonstrate changes in health outcomes. The comprehensive nature of the assessment and the use of multiple Pathways are critical to achieving positive outcomes. The measurement of specific items within the Pathways and multiple specific Pathways was conducted by Westat as part of a National Institutes of Health initiative.”


Kaiser Permanente realized early on that they wanted to do more than provide access for one CHW or CBO into one system—that we needed to build in multiple access points. This prevented us from creating a “Pan-Latino program” that would have been insulting to the diversity of Hispanic patients. The Pathways Model offers a universal way to provide needed services uniquely. It is a model for communication, delivery, and currency.

Jefferson J. Mildenberger, Kaiser Permanente
Shown below is a sample of six Pathways (summarized) that are commonly used by Familias en Acción to serve its clients with chronic diseases or cancer. Each Pathway has a trigger point identified in the assessment. If the CHW/HN and the client agree on the need for a Pathway, then it is opened. Each step is completed and documented in a web-based system called CLARA. Once the outcome has been achieved by completing the various steps, then the Pathway is closed. If the patient does not complete the steps or it is not possible to achieve the desired outcome, then the Pathway is marked “incomplete” and the reason is noted in the database. Payment would be based upon the number of steps that were completed.

The next two Pathways are detailed samples of the Pathways designed with Kaiser Permanente for this project. Note that the specific questions and answers used by the CHW/HN are included, as well as timelines for communication. It also shows the Initiation trigger and the definition of Completion. We did not include a sample “social need” Pathway because there are over 20 options and each has its own completion requirements. See the list in the Appendices.
**KAISER PERMANENTE:**

*Health Literacy Pathway*

**Initiation:** If the Participant answers “No” to one or both questions, then s/he is a good candidate for this Pathway: “Do you know where to go for healthcare services?” and “Do you know how to get the care you need?”

<table>
<thead>
<tr>
<th>Step One: Remove Barriers to Care and Provide Resources for Support</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If the Participant is followed by Team Base Care, we will include the contact information for the main point of contact.</td>
<td></td>
</tr>
<tr>
<td>• Did the Participant contact Rockwood Member services representative and receive information regarding their co-pays and benefits?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant have their Health Insurance Identification card?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant understand the information that is printed on their ID card?</td>
<td></td>
</tr>
<tr>
<td>• Do they know how to use the 1-800 number/website/mobile application?</td>
<td></td>
</tr>
<tr>
<td>• Did the Participant receive information about a relevant health care benefit?</td>
<td></td>
</tr>
</tbody>
</table>

**Ask the Participant:**

Call and ask a question, including asking for an interpreter if necessary.

---

**Move to Step Two and follow the questions**

<table>
<thead>
<tr>
<th>Step Two: Higher Level of Care Conversation</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Did the Participant develop a list of involved service providers (Primary Care Provider and Specialists)?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant know which provider to contact for which health issues or conditions?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant understand the importance of making her/his own appointments, letting the provider know the reason(s) for the visit, and cancelling and re-scheduling them?</td>
<td></td>
</tr>
<tr>
<td>• Is the Participant preparing and bringing a list of questions to her/his appointments?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant know how to reorder medication and schedule appointments on KP.org?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant know the difference between Urgent Care and the ED?</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION:** If the Participant has recorded their health information in the Familias en Acción *Senderos Booklet*, has completed all activities, and has demonstrated that they know how to communicate with the Health System, then this Pathway is complete.
**Community Partnership Model**

**KAISER PERMANENTE:**
**Medical Referral Pathway**

**Initiation:** If the Participant has care gaps identified in Health Connect, then the Community Health Worker (CHW) will help the patient make a PCP appointment to address these gaps. If an approved specialty referral is in place, then this Pathway is activated.

<table>
<thead>
<tr>
<th>Step One:</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule an appointment with Primary Care/Specialty Care and attend the appointment with the patient if needed/requested.</td>
<td></td>
</tr>
<tr>
<td>Check with Rockwood member services about Specialty coverage.</td>
<td></td>
</tr>
<tr>
<td>Choose Medical Referral type (see list below).</td>
<td></td>
</tr>
</tbody>
</table>

**Move to Step Two and follow the questions**

<table>
<thead>
<tr>
<th>Step Two: Chek-in with Patient after Initial Visit</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do you feel like your needs were met? Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION:** At the time of Step Two, the Community Health Worker will determine if their needs were met. If the answer is “Yes” then Pathway is complete. If the answer is “No” then a new Pathway is initiated. If this is a continued process in specialty (e.g. longterm chronic disease), this will activate the “Long Term Care Coordination Pathway.” If additional medications are prescribed to Participant, this will activate the “Medication Reconciliation Pathway.”

**Medical Type:**

- Dental
- Family Planning
- Hearing
- Palliative Care

- Pharmacy
- Primary Care
- Specialty Care
- Speech and Language
- Vision
USING Z CODES IN THE NEEDS ASSESSMENT

One of the methods used to trigger a referral for a social needs Pathway is through a patient needs assessment conducted in the clinic. The needs assessment should include identification of social needs that a patient is facing that are impacting the patient’s health. This could be a social determinant of health screening or some other tool that includes standard language, or codes, to describe some social needs. At Kaiser Permanente, the needs assessment includes “Z codes”, which are supplemental codes in ICD-10. Some of the Z codes are listed below and they often match the Pathways that may be opened by a CHW/HN to assist the client. If another Health System does not use these Z codes, using a similar set of standard codes to describe the social needs and track referrals to a Community Health Worker is recommended. (ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization.)

List of Z codes.
- Caregiver Related Issues Counseling
- Caregiver Stress
- Community Resources Counseling
- Elder Safety Counseling
- Encounter for Educational Counseling
- Fall Risk Assessment and Counseling
- Financial Problem
- Homelessness (aka Lack of Housing)
- Inadequate Material Resources
- Insufficient Social Insurance or Welfare Support
- Medication Safety Counseling in Elderly
- Needs Assistance with Community Resources
- Nutrition and Exercise Counseling
- Parenting Counseling
- Problem Related to Care Provider Dependency
- Problem Related to Lifestyle
- Problems Related to Living Alone
- Unavailability or Inaccessibility of Other Helping Agencies

USING THE PATHWAYS TO HEALTH AS A PAYMENT MODEL

Pathways don’t track completed health outcomes. They track completion of referrals by CHW/ HNs which address barriers to care and the social determinants of health. Each step is paid at an agreed upon amount, with most of the payment coming at the end when the outcome is achieved.

There are potential risks to the CBO which can be addressed. Because payment is linked to outcomes, this provides a clear incentive for both parties to identify appropriate patients and work with the patient until the outcome is completed. The first risk is not receiving sufficient referrals to earn the agreed upon amount in the contract. Establishing a minimum number of referrals that offer the CHW/HNs a reasonable opportunity to generate revenue can mitigate this risk.
For this project, it was determined that a minimum opportunity to generate revenue of $125,000 per CHW/HN would be used because Familias en Acción is a small agency with a limited number of CHW/HN over which to spread the navigator and program costs. A larger agency may be able to function with a lower amount of generated revenue—a range of $100,000 - $125,000 per CHW might be reasonable. Notice that we are focused on the revenue, not the specific cost of one CHW/HN. This is because the success of the partnership relies on the benefits offered by a culturally specific CHW/HN that remains connected to the CBO that employs them. Costs include staffing, support services, classes, community outreach, and administrative overhead.

The second risk is the need for start-up funds during the planning and early referral phase. The early planning and start-up requires a lot of time by current staff, hiring new staff and training them, and time during the first 2 months of operation to meet with clients and complete Pathways that will generate income. The Health System has to provide a way to help fund these costs in order to find a suitable partner.

### Estimated Costs of Pathways - Familias en Acción & Kaiser Permanente

Based on minimum of $125,000 generated revenue per CHW

<table>
<thead>
<tr>
<th>Pathways</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Intake Assessment-2</td>
</tr>
<tr>
<td>X</td>
<td>Medicine Reconciliation-2</td>
</tr>
<tr>
<td>X</td>
<td>Health Literacy</td>
</tr>
<tr>
<td>X</td>
<td>Chronic Disease Self Management/Education</td>
</tr>
<tr>
<td>XXXX</td>
<td>Social Determinant</td>
</tr>
<tr>
<td>XXXX</td>
<td>Health Insurance Application Assistance</td>
</tr>
<tr>
<td>XXXX</td>
<td>Mental Health Referral</td>
</tr>
<tr>
<td>XXXX</td>
<td>Healthcare Medical Home/Specialist</td>
</tr>
<tr>
<td>XXXX</td>
<td>Addiction Services: Drug &amp; Alcohol Counseling</td>
</tr>
<tr>
<td>XX</td>
<td>Long-term Med. Support-2</td>
</tr>
<tr>
<td>$5,850</td>
<td>$5,850 x 22= $128,770</td>
</tr>
</tbody>
</table>

### Average Usage

refers to the Pathways that most clients in each category would use. Some clients may use more.
In this cost estimate, there are multiple components to review.

1. The upper section of the chart identifies different clients and their needs for Pathways. This section would vary with the type of clients selected for services and their estimated Pathways. Notice that under each priority level, there is an estimate of time that a CHW/HN might work with each client. The value of the Pathways is generally the same, except for high priority/difficult clients. Some of the Pathways have a second level of payment due to the complexity of the needs.

2. To determine the average cost per client, there are X’s placed in the column before the Pathway, indicating what the average client might use. As you can see, the more X’s that are listed in the column represent higher needs (Pathways) for that client, generating a higher cost for serving that client.

3. The average number of clients served is based on our best estimates from four years of using the Pathways model. Once we have more data, we will adjust the estimated number of clients served by priority.

We have estimated that a single CHW/HN can serve anywhere from 20 – 65 clients per year, depending upon the needs of the clients. If the client Pathways are closed within 3 months, we would expect about 15-18 clients to be served per quarter with a total of 65 clients served in 12 months. For the very complex clients, a CHW/HN may only take on about 10 clients at a time and keep them for 6-9 months, or longer. Thus, an estimate of 20 clients in 12 months. Identifying the type of client to be served and the length of service will help you estimate the number of clients that can be served per 12 months.

**SAMPLE FUNDING SOURCES**

Once you have identified the clients and Pathways that will be used, it is necessary to identify the sources of potential funding for the project. Here again, you will want to identify whether you need only one or two workers, which could be done through an Independent Contractor method or whether you would consider going through a community Pathways HUB that could contract for multiple workers serving multiple locations or multiple populations.

The HUB model was first developed by the Community Health Access Project (CHAP) in Mansfield, Ohio, with leadership from Drs. Sarah and Mark Redding. The model involves working across organizational silos within a community (CHAP worked with multiple stakeholders in three counties) to reach at-risk individuals and connect them to health and social services that yield positive health outcomes. The model is now part of a national network of community-based initiatives working under a common set of national standards and certification developed by the Pathways Community HUB Institute.
The Portland area has a Hub, which is Project Access NOW. Most Health Systems already work with them on a variety of projects. They have created a Community Pathways Network to serve both social service and medical needs. Two current projects, the Rockwood Pathways Project and the Community Care Connection – Community Assistance Program (C3CAP) offer a variety of community services. The Rockwood Pathways Project is using the Pathways model to provide services to families by a wide variety of agencies.

Either method you select still requires a source of funding. Most of these projects are currently focused on Medicaid patients, so here are some ideas for funding sources.

**Toward Sustainability**

*Stakeholder Health: Insights from New Systems of Health*
*by Teresa Cutts and Jim Cochrane.*

Most CHW programs have depended on grant funding in the past. Narrow categorical guidelines, coupled with discontinuous support, have led to unstable CHW jobs and unpredictable, sporadic access to CHW services. While philanthropic dollars will continue to be vital for start-up costs, research and evaluation, and infrastructure development, more sustainable funding sources for CHW services are needed. A variety of existing and potential funding sources outlined by the National Fund for Medical Education at the University of California San Francisco Center for the Health Professions (now Healthforce Center) at University of California, San Francisco includes grants and contracts, government support, health plan/insurance payment, companies with a diverse workforce and consumer self-pay (Dower, Knox, Lindler, & O’Neil, 2006).

Healthcare reform has also created a variety of CHW payment methods such as federal innovation funds and Medicaid dollars. CHWs show the greatest value in serving low-income populations that are Medicaid eligible. Additionally, around the U.S., Medicaid expansion has extended access to thousands of previously uninsured persons who are now able to obtain coverage. Medicaid policies can drive interest by private payers and a greater number of providers (Rush & Mason, 2015).

As one example, the Michigan Community Health Worker Alliance (MiCHWA) has led efforts to convene payers, providers and state administrators in a series of highly effective stakeholder forums that include CHWs in promoting standardized training, and developing implementation and payment models in tandem with the state’s new requirement that Medicaid managed care hire or arrange for CHWs. Henry Ford Health System, Spectrum Health, St. John Providence and other Michigan Health Systems are also deeply involved in these efforts. Other examples include (Rush & Mason, 2015):

*State Plan Amendments.* Minnesota has CMS authority through a State Plan Amendment (SPA) to provide Medicaid coverage for CHW services specific to diagnostic-related patient education, both individual and group.
**Medicaid Managed Care Organizations.** Several states have taken steps to ensure that Medicaid managed care plans include CHWs in contracting arrangements. As noted, beginning in 2016 in Michigan, the state Medicaid agency requires that all managed care plans maintain a ratio of at least one CHW for every 20,000 enrollees. In New Mexico, CHW services are included in the list of Medicaid benefits, and Medicaid contracts must encourage CHW care coordination.

**Preventive Services Rule.** In July 2013, CMS published a rule change in the Federal Register which allows state Medicaid programs to pay for qualified non-licensed providers such as CHWs to deliver approved preventive services that are recommended by a physician or other licensed practitioner. Some view the Preventive Services SPA as a way for states to sustain CHW initiatives that are initiated with federal and state demonstration funds.

**Medicaid Waivers and Reform Initiatives.** Most state strategies for covering CHW services are through waivers such as 1115a demonstration programs. Exciting health reform initiatives underway in many states through the CMS State Innovation Model (SIM) awards include policy and financial support for CHW models such as Oregon’s Coordinated Care Organizations and Minnesota’s Accountable Communities for Health. Patient-centered medical homes and healthcare homes in many states incorporate CHWs as members of patient centered teams, some with per member per month funding that can help cover CHW care coordination services.

In addition to these ideas, there is at least one example of CHW funding in New Mexico that used a per member per month payment for CHW services. (Journal of Community Health, 2012, 37:563-571) “Community Health Workers and Medicaid Managed Care in New Mexico.”

The chart on the following page is from the University of Texas and it provides a concise summary of the various funding models and payment methods that have been studied. The Pathways to Health would offer another option to consider.
### Project on CHW Policy and Practice
#### University of Texas Institute for Health Policy

**Sustainable Financing of CHW Activities: Three Broad Pathways**

<table>
<thead>
<tr>
<th>Basic Pathways</th>
<th>A</th>
<th>B</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional health care</td>
<td>Population/community-based public health</td>
<td>Patient-centered care systems (emerging hybrid structures)</td>
<td></td>
</tr>
</tbody>
</table>

#### 1. Promising program models
- Emergency room diversion
- "Hot-spotters" (high cost users)
- Prenatal/perinatal coaching
- Primary care based chronic disease management
- Care transitions
- Home/community-based long-term care

**Care coordination**
- Self-management support for chronic conditions
- Referral and assistance with non-medical needs and barriers
- Medication management support
- Patient/family advocacy
- Support and extension of health education
- Patient navigation

**Specific condition-focused initiatives**
- Community development approach (social determinants)

**Patient Centered Medical Homes**
- Accountable Care Organizations
- Health Homes

#### 2. Specific CHW roles in these models
- Care coordination
- Self-management support for chronic conditions
- Referral and assistance with non-medical needs and barriers
- Medication management support
- Patient/family advocacy
- Support and extension of health education
- Patient navigation

**Basic outreach and education**
- Community advocacy/organizing

**Combination of health care and population-based (as at left)**

#### 3. Payment mechanisms for these models
- Fee for service
- Managed care organizations: admin/service dollars; duals
- Medicaid 1115 waivers
- Internal financing
- Prospective payment (FQHCs)

**Medicaid waivers**
- Block grants
- Prevention trust fund (Mass. model)
- Pooled funds from third-party healthcare payers

**Bundled/global/prospective payment**
- Supplemental capitation payment for specific services

#### 4. Options for third-party payers
- CHWs directly employed by payer
- Health care provider contracts/add-ons to hire CHWs
- CBO contracts to employ CHWs
- CHWs as independent contractors

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SELECTING A PAYMENT MODEL

Selecting the appropriate payment model was a challenging part of this project, with the discussion focused on an individual contract versus using a contract with a third-party provider, who has contracted with Familias in the past. Providing health navigation services exclusively to Kaiser Permanente members are expenses many organizations would consider a care delivery expense. In Oregon, health navigation is not currently a billable service. A direct contract would be the preferred method to guarantee that both partners’ needs are met and that the deliverables and expectations are clear and addendums can easily be made to contracts when situations change.

Two different methods of direct contracting were considered. The first, a fee for service model, where the Health System would pay the CBO directly for services in either a pre-paid or billed model. The second option considered was a capitated model with the payment being made for the entire population. There are pros and cons to both direct payment methods. Ultimately, it was decided to pursue a third party model based upon the Health System’s previous attempt to integrate CHWs. The Health System had a desire to add additional CHWs from other CBOs that focused on different culturally specific populations. It was hypothesized that a third party model could help to establish a clear, equitable and transparent payment system that other CBOs and Health Systems could use to benefit from this groundwork. The third party model also helped to resolve some issues with consistent documentation of Pathways, centralized data collection and the streamlining of referrals from multiple locations.

Kaiser Permanente Northwest already had a Centers for Medicare and Medicaid Services (CMS) compliant program setup with local hub Project Access NOW (PANOW) that provided services and information to low income patients. PANOW provides both the Health System and the CBO a robust system to request, track and invoice the Pathways and provide many of the desired elements of the HUB model. Another benefit to selecting PANOW was that, much like Familias en Acción, they are well established and respected within the community and have strong relationships with other community-based organizations that employ Community Health Workers. Thus, the potential to grow the program with other agencies after the grant period was appealing. Another benefit to the PANOW solution is that referrals can be collected and tabulated to measure supply and demand within the community, which is essential data for Health Systems and CBOs interested in building capacity within the community.

In the Appendices, there are two sample contracts and a Scope of Work that could be used for contracting with a CBO to provide CHW/HNs to a Health System. The first sample is a Navigation Agency Agreement to be used when contracting with a third-party provider such as PANOW. The Agency Agreement is between the Hub and the CBO and it outlines the roles of each party and the data to be collected. The second document is the Scope of Work that outlines the payments and the health metrics that will be measured. It also specifies that a third-party (PANOW) will process the referrals, the reports and the payments between the
parties. A considerable amount of time has been spent defining the Pathways and their payment amounts in order to arrive at a standardized model that can be used throughout the Portland metro area. These Pathways payments could be adapted in other locations by adjusting the payments up or down to reflect the economy of a local area.

The second sample contract is for an Independent Contractor. This would be a direct contract between a Health System and one CBO. It would include all of the necessary components listed above, but without a third-party provider. This would be used if you have one Health System that wanted to contract with a single agency to provide services.

Additional Resources:

5. BUILD AN INTEGRATED TEAM

Becoming a team requires relationship building and the development of trust. Members of the team all bring their individual and organizational cultural experiences. Team building is a key component of a successful partnership. In this project, team building consisted of sharing the selection of ice breakers and dinámicas, sharing culturally specific food, having site visits and sharing cultural stories.

Learnings from other models such as the Penn Center for Community Health Workers, show that successful integration can hinge on clear job descriptions that outline the scope, expectation, roles and responsibilities for the CHWs and other patient team members. Care team members need to understand that their own roles will be supported and not supplanted by the CHW. It is important to build a working environment where:

- CHWs feel respected for the competence they bring
- CHW skills are understood and utilized as connectors, facilitators, advocates
- Communication protocols keep all members informed
- Team building is encouraged

Kaiser Permanente began this process by creating several committees to address the various components of the project. They included a Planning and Implementation Committee, a Training and Logistics Committee and a Grant Implementation Committee. One of the first steps in developing the partnership with Familias and Kaiser Permanente began with completing a “charter.” This document was completed for each committee involved with the partnership. It took several hours to complete and it included:

- Team Members
- Purpose of the Committee
- Scope of Committee
- Objectives
- Deliverables
- Timeline and Milestones
- Vision
- Performance Measures
- Ground Rules for Decision Making
- Meeting Frequency
- Member Responsibilities

A sample Planning and Implementation Team Charter is included in the Appendices.

It was the role of the Planning Committee to establish the basic guidelines and ground rules for the partnership. Once the charter was completed for the Planning Committee, then a Training and Logistics Committee was formed to focus on the details of integrating the CHW/
The Penn Center for CHWs lists the following (1-5) as important components of an effective CHW program and can be useful for Community Health Workers as they prepare to partner with Healthcare Organizations.

1. HIRE THE RIGHT PEOPLE: Determine the scope and qualifications for the position.
2. DEFINE CLEAR WORK-PRACTICES: A clear job description and expectations is important to ensure the CHW is clear about their roles and responsibilities.
3. SUPERVISE: For the best, most sustainable outcomes, organizations need to integrate CHWs into their operations and finances, and have clear guidelines for supervision.
4. BE PATIENT-CENTERED: Successful CHW programs are patient-centered and can be adapted to different diseases and settings.
5. BE SUPPORTED BY SCIENTIFIC EVIDENCE: CHW models should be supported by high-quality scientific evidence including rigorous evaluations.

HN. It was very important for the Training and Logistics Committee to complete a “charter” process, just as the Planning Committee did, because there were many decisions to be made by this committee. The Scope, Objectives and Deliverables from the Planning Committee Charter helped to define some of the issues that the Training and Logistics Committee needed to address. These issues continued to require regular discussions as the partnership moved forward. One of the key agreements in each of the charter discussions was the agreement to make final decisions by consensus. This required a significant amount of trust by both parties and when the negotiations were underway, this level of trust allowed flexibility on both sides to reach an agreed upon payment for the Pathways and for the referral process.

Listed below are some of the key logistical issues

- Define needs and the process to train CHW/HN on Health System procedures
- Set up electronic medical record support for CHW/HN
  - Determine the level of access allowed--read only or ability to enter case notes
- Clarify how patients receiving CHW/HN services are identified within charts
  - Contact information of CHW/HN located on chart
  - Searchable later to easily retrieve data
- Assign a primary contact person as liaison between CHW/HN and Health System staff for purposes of vetting referrals, communication, questions and answers.
- Introduce CHW/HN as new team member educating staff about CHW/HN background, skills, role on the team. Continue to facilitate inclusion of CHW/HN with reminders, presence at meetings, informal connections.
- Educate staff about the referral priorities and process.
- If possible, set up a mentoring system.
- Although most work is done in the field, define parameters of the physical presence of the CHW/HN within the clinic or setting (office, hours, etc.)
- HIPAA compliance is maintained by each organization using their own Release of Information form and by asking permission of the client before making a referral.

DEVELOPING REFERRAL PROCESS AND LOGISTICS

The Penn Center for CHWs lists the following (1-5) as important components of an effective CHW program and can be useful for Community Health Workers as they prepare to partner with Healthcare Organizations.

1. HIRE THE RIGHT PEOPLE: Determine the scope and qualifications for the position.
2. DEFINE CLEAR WORK-PRACTICES: A clear job description and expectations is important to ensure the CHW is clear about their roles and responsibilities.
3. SUPERVISE: For the best, most sustainable outcomes, organizations need to integrate CHWs into their operations and finances, and have clear guidelines for supervision.
4. BE PATIENT-CENTERED: Successful CHW programs are patient-centered and can be adapted to different diseases and settings.
5. BE SUPPORTED BY SCIENTIFIC EVIDENCE: CHW models should be supported by high-quality scientific evidence including rigorous evaluations.
Developing the referral process may take much longer than anticipated, but it is extremely important because the client services and the money are tied to the referrals. Referrals will go smoothly when there is a clear process, clear criteria and clear responsibilities. For this partnership, the lead Patient Navigator for Kaiser Permanente is the identified contact person on the care team who screens and approves the referrals to be sure they are appropriate. Referrals can be made from medical, social work, or financial staff. They are initiated via a template in the Health System’s email system. They could also be sent via the Staff Messaging function in the EHR. A central “pool” was created for the referrals. That way, throughout the Kaiser Permanente system, there is one place that all the referrals can be sent.

**CPM Referral Process**

**Step 1: Member/Patient Selection Process**
- Phase 1: Begin referrals from a few team members at one primary care clinic (i.e. physician, social worker, care manager/care coordinator)
- Phase 2: Expand to select teams in broader Health System (discharge planning, Primary Care @ Home, High ED hot spotting team)
- Phase 3 and Beyond: Open referrals across the Health System (other primary care clinics, specialty care, community referrals)

**Step 2: Request made via staff message to Referral Pool**
- Referrer will send a staff message in the electronic health record system to the Community Health Worker Referral Pool that expresses patient needs
- Referrers will use a dot phrase that has standardized questions for their request

**Step 3: Referral Coordinator to Review for Appropriateness**
- Community Health Worker referral processor (selected internal health care team staff) to review request for appropriateness
  - If appropriate, move to Step 4
  - If not appropriate, Referral Processor to inform Referrer

**Step 4: Referral Coordinator to Send Referral to Community Organization**
- Referral processor to send referral information over secure e-mail or fax form to partner organization to ensure the request can be initiated in their system
- Community Health Worker to confirm that referral has been received

**Step 5: Community Health Worker to Outreach to Member**
- Community Health Worker to contact member/patient within 2-3 business days
- If not able to contact after 3 attempts, contact referral processor and/or referrer.
ONGOING INTEGRATION

To facilitate ongoing integration between the CHW/HN and the Health System, clinical team meetings should occur weekly for all CHW/HNs and their Health System managers. These are opportunities for ongoing education that can be personalized to the needs of the CHW/HN, the patients, or the Health System staff. The CHW/HN can be invited to in-service training as appropriate. Supervision and continuing education should be provided by the CBO.

For this partnership, the CBO and the Health System discussed the pros and cons of supplying a Health System phone and laptop to the CHW/HN. In this case, because the CBO already provided those items to the CHW/HN, it was decided that the worker would continue to use their existing equipment. The Health System provided access to a work station in the assigned clinic and was given read-only access to the EHR system laptop to connect to specific Kaiser Permanente software.

Shown below is a sample timeline for a health provider to partner with a community-based agency. While the timing of some elements may vary because of staff and current relationships, this timeline does offer a look at the steps that are helpful in establishing a strong partnership.

Defining the need often takes more time than originally planned because moving from a general concept to very specific clients requires talking with a variety of people within the Health System to identify them. Once they are identified, determining the specific services that will be included and those services that will NOT be included needs to be defined. This is a cross-cultural communication between health providers and the administrators of the CBO about the Pathways that might be used and the health metrics used to measure the results.

<table>
<thead>
<tr>
<th>Month</th>
<th>Milestone(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Month</td>
<td>• Health System reviews their needs for culturally specific CHW/HNs and begins to identify targeted patients and locations that need assistance</td>
</tr>
<tr>
<td>Second Month</td>
<td>• Health System identifies and talks with potential partners in the community with capacity to meet their needs</td>
</tr>
<tr>
<td>Third Month</td>
<td>• Health System selects a community partner and signs a partnership agreement. Flexible payment agreement is started at this time for the planning phase</td>
</tr>
<tr>
<td>Fourth Month</td>
<td>• Identify members of team and leaders</td>
</tr>
<tr>
<td></td>
<td>• Sharing of cultural and organization information from team building process</td>
</tr>
<tr>
<td>Fifth Month</td>
<td>• Identify roles and responsibilities, timeline, workflows, and communication for project</td>
</tr>
<tr>
<td></td>
<td>• Begin communication process within the health organization about CHW/HN</td>
</tr>
</tbody>
</table>
Sample Budget:

We have included a sample budget based on the amount of time we estimate that it would take for a Health System and CBO to move through this process, which is about eight months. This is starting from the time of conceptualizing the partnership to full implementation. Some agencies will progress much faster and some will be much slower, but this sample may offer a ballpark of expenses to consider when estimating your own budget. We also offered an estimate of on-going expenses once the partnership is functioning. This does not include the Pathway services, which are shown separately.

<table>
<thead>
<tr>
<th>Month</th>
<th>Milestone(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sixth Month</td>
<td>• Finalize the client selection, referral process and caseload</td>
</tr>
<tr>
<td></td>
<td>• Identify the evaluation metrics for the partnership</td>
</tr>
<tr>
<td></td>
<td>• Finalize a payment model</td>
</tr>
<tr>
<td></td>
<td>• Complete all internal communications to ensure a warm welcome of the CHW/HN</td>
</tr>
<tr>
<td>Seventh Month</td>
<td>• Begin to integrate new CHW/HN position into clinics</td>
</tr>
<tr>
<td></td>
<td>• Share the workflows on how to identify the social determinant needs of the clients, capture the data and how to address them with the patients</td>
</tr>
<tr>
<td>Eighth Month</td>
<td>• Ensure that all processes are in place to gather evaluation data</td>
</tr>
<tr>
<td></td>
<td>• Review the referral process and adjust the process as needed</td>
</tr>
<tr>
<td>Ninth Month</td>
<td>• Track volume of clients, referrals and reporting procedures.</td>
</tr>
<tr>
<td>Tenth Month</td>
<td>• Begin first quarterly report process</td>
</tr>
<tr>
<td></td>
<td>• Review and revise the partnership as needed</td>
</tr>
</tbody>
</table>

Planning & Start Up Budget
(Estimated 8 months)

Sample Positions. Salary only, no benefits included.

<table>
<thead>
<tr>
<th>Health System Positions</th>
<th>Hours per month – rounded (173.2 per mo.)</th>
<th>FTE</th>
<th>Cost- Rounded Low – High Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health System Administration</td>
<td>17</td>
<td>.10 FTE</td>
<td>$9,200 - $12,000</td>
</tr>
<tr>
<td>Administrative Assistant</td>
<td>26</td>
<td>.15 FTE</td>
<td>$4,200 - $6,200</td>
</tr>
<tr>
<td>Navigator or Program Manager</td>
<td>35</td>
<td>.20 FTE</td>
<td>$10,000 - $14,000</td>
</tr>
<tr>
<td>Navigator Lead/Liaison to PC</td>
<td>35</td>
<td>.20 FTE</td>
<td>$7,200 - $8,600</td>
</tr>
<tr>
<td>Community Benefit Rep.</td>
<td>17</td>
<td>.10 FTE</td>
<td>$5,200 - $7,200</td>
</tr>
<tr>
<td>Clinic supervisor</td>
<td>26</td>
<td>.15 FTE</td>
<td>$10,000 - $11,000</td>
</tr>
<tr>
<td>Clinic Administration (other referring and supporting departments)</td>
<td>4</td>
<td>.02 FTE</td>
<td>$1,300 - $1,500</td>
</tr>
<tr>
<td>Director of Diversity and Inclusion</td>
<td>9</td>
<td>.05 FTE</td>
<td>$4,000 - $4,500</td>
</tr>
<tr>
<td>Legal/Finance/ Administrative - Contracts &amp; Personnel</td>
<td>17</td>
<td>.10 FTE</td>
<td>$6,000 - $7,000</td>
</tr>
<tr>
<td>Total</td>
<td>205 hours per mo.</td>
<td>1.07 FTE</td>
<td>$57,100 - $76,500</td>
</tr>
<tr>
<td>Position</td>
<td>FTE</td>
<td>Cost Range</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>Administration</td>
<td>4</td>
<td>$900 - $1,200</td>
<td></td>
</tr>
<tr>
<td>Navigator/Program Manager</td>
<td>.10</td>
<td>$2,500 - $3,600</td>
<td></td>
</tr>
<tr>
<td>Navigator/Program Liaison</td>
<td>.10</td>
<td>$1,800 - $2,200</td>
<td></td>
</tr>
<tr>
<td>Clinic Supervision</td>
<td>.10</td>
<td>$3,300 - $3,700</td>
<td></td>
</tr>
<tr>
<td>Medical Assistant – Entering Notes</td>
<td>.05</td>
<td>$600 - $700</td>
<td></td>
</tr>
<tr>
<td>Clinic Administration &amp; Finance</td>
<td>.04</td>
<td>$1,300 - $1,500</td>
<td></td>
</tr>
</tbody>
</table>

Additional Resources:
Penn Center for Community Health Workers. [http://chw.upenn.edu/](http://chw.upenn.edu/)
6. MUTUAL TRAINING AND EDUCATION

TRAINING OF CHW PROVIDED BY HEALTH SYSTEM

After the initial background check, the Health System provides internal training so that the CHW/HN can work within their health record system and the clinic. Patients sign Release of Information so that the CHW/HN can share his or her observations in the chart and at team meetings, about critical issues that can affect a patient’s health. The CHW/HN’s contact information is noted in the chart so that Health System staff can contact him/her about a patient as needed. The following list includes training required by the Health System in our model:

- Patient and Family Centered Care
- Motivational Interviewing 1 & 2
- Modules to learn how to use EHR
- Advanced Care Planning
- Team Based Care Orientation (8 hours each day for two days)

TRAINING AND SUPERVISION OF CHW/HN THROUGH CBO

Familias has an extensive process for training its Health Navigators. In addition to obtaining the CHW certification, which is a 90-hour course, the Health Navigators take additional courses in chronic disease management, diabetes management, cancer support education, trauma informed care, Patient Activation Measures (PAM), the Patient Health Questionnaire (PHQ-9), Pathways to Health, and the Empodérate class (developed by Familias en Acción). They also receive extensive training on data entry into the CLARA web-based data system that houses the Pathway data. The Health Navigators are supervised by the Program Services Manager.

Identifying Culturally Competent Evidence-based Tools for Chronic Disease Control

- Community Pathways to Health (Agency for Healthcare and Quality Research Sept 2010)
- Stanford Chronic Disease Self-Management program/Tomando Control de su Salud http://patienteducation.stanford.edu/programs_spanish/tomando.html
- Centers for Disease Control and Prevention Community Health Worker Toolkit http://www.cdc.gov/dhdsp/pubs/chw-toolkit.htm
- Penn Center for Community Health Workers - http://chw.upenn.edu/
CULTURALLY SPECIFIC TRAINING FOR HEALTH SYSTEM TEAM

Many Community Based Organizations can provide in-person training for Health System staff around culturally specific communication with patients. Familias offers in-person training that can be accessed via the website at [www.familiasenaccion.org](http://www.familiasenaccion.org) or online with the California State University Institute for Palliative Care at [https://csupalliativecare.org/programs/latinos/](https://csupalliativecare.org/programs/latinos/).

Familias Culturally Specific Training for Health Professionals and Community Members

**Care of Latinos with Serious Illnesses: A Palliative Approach**

- **In-person** This 4-hour community-based training assists healthcare professionals with culturally specific communication skills that will enhance the interaction and relationships they have with patients. Continuing Education hours are available through California State University Institute of Palliative Care for a fee of $25. This course is available throughout Oregon, Washington, Idaho and Utah through 2017, due to a grant from Cambia Health Foundation.

- **Online** Courses for Healthcare Professionals (4 CE Hours Available)
  This training will assist healthcare professionals in building their skills in caring for their Latino patients. These five, consecutive, one-hour courses are self-paced. Continuing Education is available through California State University Institute of Palliative Care.

**Community Education in Spanish for Latino patients, families, and community members**

- **Empodérate/Health Empowerment** is a 2-hour session that can be held in clinics, churches, schools, homes, and other community settings. Participants are introduced to concepts around patient centered care, are encouraged to take an active role in managing their chronic illness, and gain a beginning understanding of palliative care.

Additional Resources:

- AARP. Mi Registro Personal de Medicación
  [http://assets.aarp.org/rgcenter/general/registro_personal_de_medicacion.pdf](http://assets.aarp.org/rgcenter/general/registro_personal_de_medicacion.pdf)

- AHRQ: Agency for Healthcare and Quality Research. Implementing the AHRQ Health Literacy Universal Precautions Toolkit: Practical Ideas for Primary Care Practices

- ARHQ Spanish Language Patient Action Plan
  [http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/diabetesnetwork/actionplansp.pdf](http://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/final-reports/diabetesnetwork/actionplansp.pdf)

- Centros para el Control y la Prevención de Enfermedades Centro Nacional para la Prevención de Enfermedades Crónicas y Promoción de la Salud. (2010). Controle su Diabetes: Guia
para el cuidado de su salud.

New Health Partnerships: Improving Care by Engaging Patients
7. PROGRAM EVALUATION

Program evaluation will vary tremendously based upon the type of client that is served, the type of health organization and the type of services delivered. The overall goal is to have improved health outcomes for the patient and to save money for the Health System. Working with Medicaid patients, some of the common metrics for this project would be:

- Decrease in inappropriate use of ER
- Decrease in hospital readmits
- Increased use of appropriate medications
- Pathways completed
- PAM scores increased
- Patient satisfaction
- Team process evaluation

Listed below is a chart of Sample Community Partnership Metrics that shows the metric, how it would be measured and how often one might measure the metric. The current project will select several of these metrics to measure over the second year of the project.

**SAMPLE COMMUNITY PARTNERSHIP METRICS**

<table>
<thead>
<tr>
<th>METRIC</th>
<th>HOW MEASURED</th>
<th>FREQUENCY</th>
</tr>
</thead>
</table>
| Patient Activation Tool                     | • % of population that have a baseline and repeat PAM at 3-6 months (85% target).  
• 85% of population will Increase in score from baseline (target to be defined).  
• Data will be captured and reported in CLARA.                                                                                                       | Monthly           |
| Patient Satisfaction                        | • Survey sent with Familias return address on it sent at the end of the grant followed by phone calls.                                                                                                       | Annually          |
| Quality & Chronic Condition – Care Gaps     | • Difference in care gaps pre and post program.  
• Entry date is defined by the first date that Smart Set was used.                                                                                                                                     | Entry into program End of program |
| Number of Members Enrolled in Program       | • Spreadsheet with list of HRNs, date of enrollment, “graduation” date and decline to participate.                                                                                                         | Monthly           |
### METRIC

<table>
<thead>
<tr>
<th>METRIC</th>
<th>HOW MEASURED</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Pathways In Progress, Completed and Incomplete</td>
<td>• CLARA</td>
<td>Monthly</td>
</tr>
<tr>
<td>Medication Compliance for defined population (Teach Back)</td>
<td>• Poly-pharmacy (same metric as complex care pharmacist)</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>• Adherence (fill rate)</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>• (TBD – need to identify specific medications for chronic diseases)</td>
<td>Monthly</td>
</tr>
<tr>
<td>ED Utilization</td>
<td>• 6 month pre and post Program entry</td>
<td>Monthly</td>
</tr>
<tr>
<td>(exclude patients that are part of complex care or intensive case management including KPEDU) (Stand-alone ED visits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction of Social Needs</td>
<td>• Pre and post measurement of Z Codes – Social Needs Assessment Codes within Medicaid</td>
<td>Monthly</td>
</tr>
<tr>
<td>Capacity in the Community</td>
<td>• Narrative report from Familias on capacity created from the Program</td>
<td>Annually</td>
</tr>
<tr>
<td>Number of Referrals TO Community Services</td>
<td>• CLARA</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Number of Referrals FROM the Community</td>
<td>• Spreadsheet</td>
<td></td>
</tr>
<tr>
<td>Care Team Staff Satisfaction with the Community Health worker</td>
<td>• Survey Tools</td>
<td>Annually</td>
</tr>
<tr>
<td>Community Health worker Satisfaction with the Health System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Directives (End of Life)</td>
<td>• Code Report</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

**Additional Resources:**


# 8. APPENDICES

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<td>93</td>
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<tr>
<td>References</td>
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</tbody>
</table>
SAMPLE PLANNING COMMITTEE CHARTER

CPM Planning and Implementation Team

1. Team Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Phone</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Community Health Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Organization Admin Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Organization Operations Lead</td>
<td></td>
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<tr>
<td></td>
<td>Health System RN Team Lead</td>
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<tr>
<td></td>
<td>Health System Navigator Lead</td>
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<tr>
<td></td>
<td>Health System Operations Lead</td>
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<tr>
<td></td>
<td>Health System Physician Lead</td>
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<tr>
<td></td>
<td>Health System Clinical Admin Lead</td>
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<tr>
<td></td>
<td>Health System Medicaid Sponsor</td>
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<tr>
<td></td>
<td>Others as needed</td>
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<td></td>
</tr>
</tbody>
</table>

2. Purpose

Responsible for the development of the Community Partnership and contracts. Governing and oversight of the project and other sub-committees on training and integration of CHW.

3. Scope

<table>
<thead>
<tr>
<th>In-Scope</th>
<th>Out-of-scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removing identified operational barriers</td>
<td>Training of staff</td>
</tr>
<tr>
<td>Reviewing and approving partnership agreements and final documents to ensure cultural competency and sustainability</td>
<td>Business-to-business decisions</td>
</tr>
<tr>
<td>Working as an advisory committee to share results of the partnership</td>
<td>Budget oversight</td>
</tr>
<tr>
<td>Supporting, advocating, and resourcing for partnership funding</td>
<td>Daily operations of partnership</td>
</tr>
<tr>
<td>Communicating with stakeholders within the business entities</td>
<td>Human resource and administration of business entities</td>
</tr>
<tr>
<td>Evaluating success of metrics for partnership</td>
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</tr>
</tbody>
</table>

4. Objective(s)

1. Clearly define the strengths of the care delivery system and community-based organization to maximize partnership for mutual benefit.
2. Facilitate community-based and organizational learning.
3. Identify populations that would benefit from new and emerging culturally-specific models of care that complement health system’s existing care delivery.
4. Evaluate efficacy of adding community-based partners to enhance health system’s ability to respond to social determinants of health.
5. Clearly define and evaluate success metrics for this community partnership.
5. Deliverables

1. Create a culturally-specific partnership with community organization.
2. Evaluate metrics to show improved health outcomes for targeted clients.

6. Timelines and Milestones

<table>
<thead>
<tr>
<th>Month</th>
<th>Milestone(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First &amp; Second Months</td>
<td>- Health Organization reviews their needs for culturally specific CHW’s and begins to identify targeted patients and locations that need assistance</td>
</tr>
<tr>
<td></td>
<td>- Health</td>
</tr>
<tr>
<td>Third &amp; Fourth Months</td>
<td>- Health Organization identifies and talks with potential partners in the community with capacity to meet their needs</td>
</tr>
<tr>
<td>Fifth Month</td>
<td>- Health Organization selects a community partner and signs a partnership agreement. Flexible payment agreement is started at this time for the planning phase.</td>
</tr>
<tr>
<td>Sixth Month</td>
<td>- Identify members of team and leaders</td>
</tr>
<tr>
<td></td>
<td>- Sharing of cultural and organization information from team building process</td>
</tr>
<tr>
<td>Seventh Month</td>
<td>- Identify roles and responsibilities, timeline, workflows, and communication for project</td>
</tr>
<tr>
<td></td>
<td>- Begin communication process within the health organization about CHW</td>
</tr>
<tr>
<td>Eighth Month</td>
<td>- Finalize the client selection, referral process and caseload</td>
</tr>
<tr>
<td></td>
<td>- Identify the evaluation metrics for the partnership</td>
</tr>
<tr>
<td></td>
<td>- Finalize a payment model</td>
</tr>
<tr>
<td></td>
<td>- Complete all internal communications to ensure a warm welcome of the CHW</td>
</tr>
<tr>
<td>Ninth Month</td>
<td>- Begin to integrate new CHW position into clinics</td>
</tr>
<tr>
<td></td>
<td>- Share social determinant needs of clients and how to address them.</td>
</tr>
<tr>
<td>Tenth Month</td>
<td>- Ensure that all processes are in place to gather evaluation data</td>
</tr>
<tr>
<td></td>
<td>- Review the referral process to make sure it is going smoothly</td>
</tr>
<tr>
<td>Eleventh Month</td>
<td>- Track volume of clients, referrals and reporting procedures.</td>
</tr>
<tr>
<td>Twelfth Month</td>
<td>- Begin first quarterly report process</td>
</tr>
<tr>
<td></td>
<td>- Review and revise the partnership as needed</td>
</tr>
</tbody>
</table>

7. Vision (What does success look like? What are the results/outcomes we strive for?)

Strong implementation plan of partnership with improved health outcomes and is cost effective.

8. Performance Measures (How will we assess our progress and performance?)

HEDIS quality metrics (select clinical measures). Visits per member. Pathways data. Quality of life / voice of the member.
9. Ground Rules (How will we conduct ourselves and work with each other?)

1. Decision-making through consensus.
2. Respecting the cultures of the opposite organization.
3. Action items and deadlines.

10. Meeting Frequency and Format

Weekly. 1 hour. Fridays. Expand additional meetings as needed.

11. Member Responsibilities

<table>
<thead>
<tr>
<th>Name</th>
<th>Responsibilities</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Chair of Team.</td>
</tr>
<tr>
<td></td>
<td>Facilitator of Meetings.</td>
</tr>
</tbody>
</table>
### PARTNERSHIP TOOLS

<table>
<thead>
<tr>
<th>Required Items</th>
<th>Helpful Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Payment Model</td>
<td>• Access to EHR for CHW</td>
</tr>
<tr>
<td>• Appropriate match of CHW</td>
<td>• Having a Hub agency</td>
</tr>
<tr>
<td>• Clearly identified need</td>
<td>• Health providers with other roles focused on community engagement and prior experience</td>
</tr>
<tr>
<td>• Active participation from both parties</td>
<td>• Onsite PC clinic team building – Integration orientation</td>
</tr>
<tr>
<td>• Shared drive for electronic communications</td>
<td>• Culturally specific care delivery team</td>
</tr>
<tr>
<td>• Sufficient face to face meetings</td>
<td>• Charters or planning processes</td>
</tr>
<tr>
<td>• Relationship building activities</td>
<td>• Funding for planning process</td>
</tr>
<tr>
<td>• Community organization must already have established trust in community</td>
<td>• Patient story bank</td>
</tr>
<tr>
<td>• Job description and training program for CHW</td>
<td></td>
</tr>
<tr>
<td>• Clearly identified Pathways</td>
<td></td>
</tr>
<tr>
<td>• Patience and confidence in the efforts to achieve health outcomes</td>
<td></td>
</tr>
<tr>
<td>• Measurement system to track outcomes</td>
<td></td>
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<tr>
<td>• Senior leadership support</td>
<td></td>
</tr>
<tr>
<td>• Project coordinator/Manager</td>
<td></td>
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<tr>
<td>• Shared/cooperative leadership</td>
<td></td>
</tr>
<tr>
<td>• Decision making that provides a win-win solution</td>
<td></td>
</tr>
</tbody>
</table>
NAVIGATION AGENCY AGREEMENT

This Navigation Agency Agreement ("Agreement") is between:


Effective Date: XXXX, 201X (the "Effective Date")

RECITALS

A. Project Access NOW and Navigation Agency, along with Kaiser Permanente are participating in a project known as the “Community Partnership Model”, which is testing the use of Pathways to Health as a payment model for Community Health Workers/ Health Navigators (CHW/HN) services at the Kaiser Permanente Mt. Scott Clinic. The main purpose of the Project is to improve health outcomes through the use of a Community Health Worker/Health Navigator assigned to Latino patients and to show that Pathways can be an effective payment model for those services.

B. The Project includes Latino persons ("Clients") who are referred by Kaiser Permanente to Project Access NOW for CHW/Navigator services provided by the Navigation Agency. The referral process and payment of Pathways is delineated in the attached Scope of Work (Attachment A), the list of Pathways, (Attachment B) and Estimated Pathway Costs, (Attachment C.)

AGREEMENT

1. Project Access NOW Responsibilities.

1.1 Administrative Activities: Project Access NOW shall facilitate the referral process between Kaiser Permanente and Navigation Agency, maintain monthly reports and provide payments to the Navigation Agency, as agreed upon in the Scope of Work (Attachment A). Project Access NOW shall also attend regularly scheduled meetings and provide informational support for navigators as necessary. Project Access NOW shall provide regular trainings and or access to trainings about CLARA, the data base for Pathways, and its functions to Kaiser Permanente and the Navigation Agency as needed for participants to fully utilize CLARA.

1.2 Data Platform. Project Access NOW shall contract with a vendor to provide an information technology platform to enable the navigation services for Clients. So long as Navigation Agency complies with applicable requirements, Project Access NOW shall ensure that Navigation Agency has access to the technology platform to perform its services hereunder.

1.3 Records. Project Access NOW shall maintain records sufficient to reflect properly the services it has rendered for the Project and the Clients. Project Access NOW shall provide access to the records for the purpose of auditing and compliance. Such books and records shall be maintained by Project Access NOW for a minimum of five (5) years, or such longer period as may be required by applicable law or grantors.

1.4 Quality Assurance and Auditing. Project Access NOW shall cooperate with Kaiser Permanente in all auditing and quality assurance review relating to the Project.

1.5 Compliance. Project Access NOW shall ensure that the administrative services it delivers are delivered in compliance with all applicable laws and regulations.

2.1 Services. Navigation Agency agrees that it shall provide the following services to Clients:
(a) Navigation services, as listed in Attachment B, provided by Navigators (defined in Section 2.2). The services shall ensure that each Client family is assigned a single Navigator, and that navigation services are trauma-informed, culturally-responsive, and client-centered.

2.2 Participation in Project. Navigation Agency leadership and or appropriate staff shall attend and participate in all Community Partnership Model meetings that are co-facilitated by Kaiser Permanente and the Navigation Agency.

2.3 Supervision. Navigation Agency shall take full responsibility to supervise and employ personnel to function as navigators to Clients (“Navigators”). The Navigators shall possess the skills and competencies to meet expectations of Navigator function, shall be trained by Navigation Agency regarding agency protocol and human resources policies and in compliance with the requirements of this Agreement. Navigation Agency shall ensure that Navigators also attend all trainings offered by Project Access NOW. In the event that Navigation Agency receives a Client complaint, Navigation Agency shall promptly review the case and notify Pathways Program Manager at Project Access NOW and Kaiser Permanente. If those agencies receive a client complaint, they shall notify Navigation Agency and the case will be reviewed.

2.4 Data and Reports. Navigation Agency shall ensure that its Navigators input all data requested by Project Access NOW into the CLARA system within timeframes identified by Project Access NOW. The data shall be correct and inputted properly pursuant to Project Access NOW policies as detailed at the most recent training.

2.5 Quality Assurance and Auditing. Navigation Agency shall cooperate with Kaiser Permanente in all auditing and quality assurance review relating to the Project.

2.6 Compliance. Navigation Agency shall ensure that the services it delivers are delivered in compliance with all applicable laws and regulations.

3. Compensation. Kaiser Permanente is the funding source for both Project Access NOW administrative services and for the Navigation Agency. Project Access NOW will be paid in accordance with its agreement with Kaiser Permanente for start-up costs, ($XXXX) and a monthly service fee of $XXX. Kaiser Permanente will also deposit funds with Project Access NOW to fund the payment of CHW/Navigator services to the Navigation Agency under the terms specified in the Scope of Work, List of Pathways, and Estimated Pathways (Attachments A, B, and C). Should funds become unavailable prior to (date XXX), Kaiser Permanente will provide at least 30 days notice prior to terminating the project.

3.1 Privacy and Confidentiality. Project Access NOW is not a Covered Entity under HIPAA definitions nor is it acting as a Business Associate of Navigation Agency. Navigation Agency is also not a Covered Entity. Navigation Agency shall ensure that it and its personnel, including the Navigators, keep all Client information confidential, except to the extent that such information is lawfully disclosed. Navigation Agency shall be responsible for obtaining any and all Client consents and authorizations legally necessary to allow all information collected by Navigation Agency relating to Clients to be disclosed to Project Access NOW and to Kaiser Permanente. Such consents and authorizations shall refer to Project Access NOW and Kaiser Permanente by name and allow disclosure of all necessary Client information to be disclosed to Project Access NOW and to Kaiser Permanente. Navigation Agency agrees to obtain consent from all clients to allow their information to be shared as follows:

All data collected and stored in the IT Platform will be visible to Project Access NOW for purposes of quality assurance. Project Access NOW by virtue of being the data administrator shall have access to all levels of information stored on CLARA, the IT Platform.
55
Community Partnership Model

Layer I – Available to all Community Partnership Model users and Project Access NOW and includes: name, date of birth, gender, status in Project (active/inactive), Navigation Agency and Navigator as applicable.

Layer II – Available to Kaiser Permanente, Navigation Agency and Project Access NOW, includes participant: address, phone number, race, ethnicity, health insurance status, Pathway status, Pathway step completion dates, and patient engagement survey data.

Layer III – Visible only to the Navigation Agency’s navigator and Project Access NOW and includes: navigator progress notes and observations, correspondence frequency and type, initiated Pathways, Pathway progress and status, tracking of court mandated services, financially related documentation, citizenship documentation status, and domestic violence related services (but only to the extent necessary and without violating any privilege or legal requirements).

In the event that Navigation Agency becomes aware of or suspects that any Client information has been improperly used, disclosed or compromised, Navigation Agency shall immediately notify Project Access NOW’s Executive Director.

4. Liability; Indemnity. Each Party is liable for its own acts or omissions. Project Access NOW shall not be liable for any act or omission of the Navigation Agency or its personnel. Each Party agrees to indemnify, defend, and hold harmless the other Party, and its respective shareholders, directors, officers, agents, and employees from and against any and all claims (including, without limitation, damages, costs, expenses, and attorney fees) including but not limited to those claims arising from the negligence or intentional wrongdoing of the first Party.

5. Publicity/Research. Project Access NOW shall publicize its participation in the Project as agreed upon by Kaiser Permanente and Navigation Agency. Any press release or public statement must first be approved by Kaiser Permanente and Navigation Agency and shall include reference to both parties. Kaiser Permanente and Navigation Agency may refer to Project Access NOW by name in its publicity of the Project. Rights to data for research and publication captured from the Project will be managed by Kaiser Permanente.

6. Term and Termination.

6.1 Term. This Agreement shall commence on the Effective Date and continue until terminated.

6.2 Termination With Cause. This Agreement may be terminated for cause in the event of a material breach that, if curable, is not cured following written notice and a reasonable opportunity to cure.

6.3 Termination Without Cause. This Agreement may be terminated by either Party after (date XXX), upon thirty (30) days’ prior written notice to the other Party.

7. General.

7.1 Amendment. This Agreement may be amended by the Parties only in a writing referencing this Agreement and signed by the Parties.

7.2 Waiver. A provision of this Agreement may be waived only by a written instrument executed by the Party waiving compliance. No waiver of any provision of this Agreement shall constitute a waiver of any other provisions, whether or not similar, nor shall any waiver constitute a continuing waiver. A failure to enforce any provision of this Agreement shall not operate as a waiver of such provision or any other provision.

7.3 Compliance with Law. All Parties shall comply with all federal, state, county, and local laws,
ordinances, and regulations applicable to this Agreement.

7.4 Third-Party Beneficiaries and Successors. Nothing in this Agreement gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons.

7.5 Counterparts. This Agreement may be executed in counterparts, both of which when taken together shall constitute one agreement binding on both Parties, notwithstanding that both Parties are not signatories to the same counterpart. Each copy so executed shall constitute an original.

7.6 Survival. Expiration or termination of this Agreement shall not extinguish or prejudice any Party’s right to enforce this Agreement with respect to any breach or default in the performance of the terms and conditions of this Agreement.

7.7 Assignment and Delegation. This Agreement may not be assigned by either Party without the prior written consent of the other Party.

7.8 Entire Agreement. The Agreement contains the entire agreement between the Parties with respect to the subject matter hereof and supersedes all oral understandings, representations, prior discussions, and preliminary agreements.

7.9 Attorney Fees. If either Party brings any action or proceeding against the other relating to the validity, interpretation or enforcement of this Agreement, then the prevailing party shall be entitled to recover all costs incurred by them, including reasonable attorneys’ fees.

7.10 Independent Contractor. Navigation Agency is an independent contractor for Project Access NOW in connection with the services it provides under this Agreement, and nothing in this Agreement is intended to create or shall be construed as creating an employer-employee relationship or a partnership, agency, joint venture, or franchise, nor is any employee or contractor of Navigation Agency an employee or contractor of Project Access NOW by virtue of this Agreement.

PROJECT ACCESS NOW

By:
Name:
Title:
Signature Date:

Familias en Acción (Navigator Agency)

By:
Name:
Title:
Signature Date:
SCOPE OF WORK AND PAYMENT MODEL

A. Description of Project and Partnership

The purpose of this partnership between Kaiser Permanente, Familias en Acción and Project Access NOW is for a Community Health Worker/Health Navigator (CHW/HN) to deliver services to specifically identified Kaiser Permanente patients using the Pathways to Health model to address social determinants and to assist the client in accessing their health care services by using a HUB model for tracking the referrals and Pathways.

1. Roles:
Kaiser Permanente will select Latino patients at the Mt. Scott Clinic based on specific criteria that have been agreed to by Kaiser Permanente and Familias prior to starting this project. They will make referrals to Project Access NOW, who will refer them to Familias. Kaiser Permanente is funding this project.

Familias en Acción will provide one CHW/HN to provide services to approximately XXX clients from (date) to (date), using the Pathways to Health model. These Pathways have been discussed and agreed to by all parties. The Pathways are defined with an initiation point, work steps and a completion point, as well as costs to be paid at each step and the completion. The list of Pathways and costs are attached as Attachment B. All data will entered into CLARA, Pathways data base.

Project Access NOW (PANOW) is the Hub for this payment model. They have the contract with Kaiser Permanente to receive the referrals and the funding. They will forward the referrals to Familias en Acción in a timely manner, track the Pathways, prepare reports for Kaiser Permanente and pay Familias en Acción on a monthly basis, based upon the Pathway steps completed. The CLARA data base or other documents will be used to track all information and payments.

The goal of the partnership is to improve the health outcomes for the Latino patients by using community health workers and for Kaiser Permanente to see some reductions in overall costs and/or health improvements.

B. Description of Training Process

Training and sharing of knowledge about serving Latino clients using the Pathways model will take place between all three agencies. Kaiser Permanente will provide whatever training is required to insure that the Community Health Worker is operating safely and effectively within the Kaiser Permanente system. In addition, they have offered to include Motivational Interviewing and End of Life Discussions (Gunderson model) for the CHW/HN. PANOW will provide training to all parties, as needed, to effectively use the CLARA database to enter data or review data. Familias will provide navigation and HIPAA training to its staff and will share Latino cultural insights with Kaiser Permanente staff during regular staff meetings or huddles, as needed.
C. Description of Referral Process and Client Criteria

Step 1: Member/Patient Selection Process Phase 1: Begin referrals from a few team members at one primary care clinic (i.e. physician, social worker, case manager/care coordinator). Phase 2: Expand to select teams in broader Health System (discharge planning, Primary Care @ Home, High ED hot spotting team). Phase 3 and Beyond: Open referrals across the Health System (other primary care clinics, specialty care, community referrals)

Step 2: Request made via staff message to Referral Pool Referrer will send a staff message in the electronic health record system to the Community Health Worker Referral Pool that expresses patient needs. Referrers will use a dot phrase that has standardized questions for their request.

Step 3: Referral Coordinator to Review for Appropriateness - Community Health Worker referral processor (selected internal health care team staff) to review request for appropriateness. If appropriate, move to Step 4. If not appropriate, Referral Processor to inform Referrer.

Step 4: Referral Coordinator to Send Referral to Community Organization Referral processor to send referral information over secure e-mail or fax form to partner organization to ensure the request can be initiated in their system. Community Health Worker to confirm to PANOW and Kaiser Permanente that referral has been received.

Step 5: Community Health Worker to Outreach to Member - Community Health Worker to contact member/patient within 2-3 business days. If not able to contact after 3 attempts, navigator will contact referral processor and/or referrer.

Clients may have a mixture of low to high needs on two scales. The first is their medical care for one or more medical conditions. The second scale describes their social needs for assistance, such as transportation, child care, rent payments and many more issues. The clients will have a combination of needs that will determine the rate of Pathway payments. Certain high need clients will require more time to address their needs, thus the payment is higher. (See attached list.)

D. Description of Pathway to Health services delivered by navigator and documentation

Based upon the negotiations between the three partners, we have agreed upon Pathways that specifically address social needs or some type of health need. In addition, there are two levels for the Intake Assessment, depending on the amount of time that is required due to the complexity of the client. Each Pathway has a clearly defined initiation, work steps and a completion step. Depending upon the needs of the clients, we have estimated that most clients will be served within 3-6 months. If they require long term assistance of 9 months or longer, then there are Pathways designed for the long term client. Each step is listed in the CLARA database and a date is required to complete the step and move forward.
E. Description of Pathway Payment process

The current agreement is based on the CHW completing enough Pathways to generate about $ XXXX from (date) to (date). A start up payment of $ XXX from Kaiser Permanente is due to Familias at the beginning of the project. This funding will be “earned” back through tracking the Pathways and subtracting those funds from the amount owed to Familias during the first 2-3 months of services.

To generate $ XXXX it will require about XX active clients, depending on the mixture of clients who are referred. The process begins with about XXX referrals per month from Kaiser Permanente, to generate XX active clients each month that will accept the CHW/HN services. (Expect about a 25-30% decline rate of total referrals if the client was informed of the referral.) Pathways are paid upon completion of individual steps within each Pathway. PANOW will pull a report each month of the completed steps and will bill Kaiser Permanente and pay Familias based on the report. All clients that decline services are recorded, as well as their reason for declining services. Billing and payments should be completed by the 21st day of the month.

If Kaiser Permanente does not make sufficient referrals to generate at least X active clients within a particular month, then it would still be billed for a minimum payment of $ XXX for that month to continue provider services.

F. Evaluation Metrics and Reporting Requirements

The evaluation metrics may vary with the type of client selected and the services provided. At minimum, Familias and PANOW will track the following data on a monthly basis, with a data report due on the 15th of the following month:
1. Number of clients referred, accepted and declined in CLARA;
2. Reason for declined services;
3. A patient engagement/activation measure using the PAM or some other instrument, as agreed with Kaiser Permanente;
4. Number of Pathways open, completed, in progress and incomplete for each accepted client;
5. Familias will provide a narrative report discussing any community impact and the implementation of the program, plus a client story; and
6. Other data as agreed upon, with survey tools provided.

Kaiser Permanente will choose from the following list, which evaluation metrics are appropriate for the clients and make such data available to Familias and PANOW on a quarterly basis:
1. Quality and chronic Condition Care Gaps;
2. Medication compliance;
3. ED Utilization;
4. Reduction of Social Needs using Z codes;
5. Use of Advanced Directives;
6. Satisfaction surveys for staff, CHW or patients; and
7. Cost savings per clients.
G. Start-Up payments and Required Documents

Upon the signing of:
1. The Memorandum of Understanding between Familias and PANOW;
2. The Business Agreement between Kaiser Permanente and Familias; and
3. The signing of the Agreement between Kaiser Permanente and PANOW for the funding of the project;
4. Familias shall request a $XXX start–up payment to begin the project and begin accepting referrals.

H. Continuation of Project

(Insert language for the projected length of the project and possible growth.)

I. Legal Requirements

All legal requirements regarding HIPAA, insurance, indemnity, modification and termination are included in the MOU or Business Agreement, to which this document is an Attachment.

____________________________            _____________________________
Signature/ Date Familias           Signature/Date PANOW
Title:____________________   Title:_____________________
Familias en Acción               Project Access NOW
2710 NE 14th Avenue              P.O. Box 10953
Portland, OR 97212               Portland, OR 97296-0953
503.201.9865                     503.345.6720
**SAMPLE SINGLE AGENCY AGREEMENT - KAISER PERMANENTE**

**PROFESSIONAL SERVICES AGREEMENT**

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<th>Agreement Start Date:</th>
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<tr>
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<th>Agreement End Date:</th>
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<table>
<thead>
<tr>
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<table>
<thead>
<tr>
<th>Kaiser Permanente Administrative Contact</th>
<th>Contractor Primary Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
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<td>Title:</td>
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<tr>
<td>OneLink Approver E-mail: @kp.org</td>
<td></td>
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<tr>
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</tbody>
</table>

**KP Customer Name:**

**HIPAA COMPLIANCE:**  
Check below if a HIPAA Business Associate Agreement is required for the Services under this Agreement*:
- [ ] Yes - Contractor will have access to PHI*
- [ ] No - Contractor will **not** have access to PHI*

*PHI - Protected Health Information under HIPAA

**HEALTH SCREENING:**  
Are health screenings required for the Services under this Agreement?**
- [ ] Yes or [ ] No

**Required if Contractor personnel is assigned to work in a hospital or medical office building**

**Cost Information**

<table>
<thead>
<tr>
<th>The Agreement Total Dollar Amount $:</th>
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</thead>
<tbody>
<tr>
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</table>
This Professional Services Agreement ("Agreement"), which includes a statement of work for the services described herein (the “Services”), shall be governed by the Kaiser Permanente Terms and Conditions, which are available for review at http://xnet.kp.org/compliance/supplier/formsreqs/index.html (the “Kaiser Permanente Terms and Conditions”) and incorporated herein by this reference. For the avoidance of doubt, as used in the Kaiser Permanente Terms and Conditions, the defined term “Contractor” shall also mean “Consulting Firm,” “Vendor” or “Supplier” and the defined term “Purchaser” shall also mean “KP Customer”, “Kaiser”, “KP” or “Kaiser Permanente” as used in this Agreement.

This Agreement constitutes a separate and independent agreement between the Contractor and KP Customer identified above (also referred to herein as “Kaiser Permanente” or “KP”).

1.0 MODIFICATIONS, IF ANY, TO THE KAISER PERMANENTE TERMS AND CONDITIONS:

The parties have agreed that the following modifications to the Kaiser Permanente Terms and Conditions shall apply to this Agreement (if applicable):

1.1 Reports. Contractor shall submit all written progress and other reports to Kaiser Permanente in accordance with the schedule specified in the Scope of Work, or if no schedule is specified in the SOW or Award, then as reasonably requested by Kaiser Permanente, but in any event no less than annually. Contractor shall timely provide financial status and other reports and data in the format requested by Kaiser Permanente in order to meet reporting requirements.

1.2 Confidentiality. During the term of this Agreement and thereafter, either party, its employees, agents, subcontractors or affiliates shall not disclose Confidential Information received from the disclosing party without the disclosing party’s prior written consent or use such information for any purpose other than as intended under this Agreement. “Confidential Information” shall include but is not limited to the planning information, client data, and materials and information concerning either party, or developed as a result of performing the project, as applicable. Confidential Information shall be marked as confidential legend, “CONFIDENTIAL INFORMATION” or another appropriate proprietary legend. If disclosed orally, the disclosing party shall be responsible for clearly informing the receiving party, in writing within thirty (30) days, of the confidential nature of the information disclosed, except for PHI which confidentiality is governed by HIPAA. The obligation of non-disclosure and non-use shall not apply to the following:

(1) Confidential Information at or after such time that it is or becomes publicly available through no fault of the receiving party;
(2) Confidential Information that is already independently known to the receiving party;
(3) Confidential Information at or after such time that is disclosed on a nonconfidential basis by a third party with the legal right to do so; or
(4) Confidential Information required to be released by any governmental entity with jurisdiction provided that the receiving party notifies the disclosing party prior to making such release of information.
The obligations under this Confidentiality Section shall survive and continue for five (5) years after termination of this Agreement. The parties understand that certain Confidential Information may be reported to the Sponsor or Prime Recipient and such information may become publicly available. It is the obligation of the disclosing party to safeguard any Confidential Information. Contractor acknowledges that this Confidentiality Section shall not limit KP’s obligation to report activities performed under this Agreement to the Sponsor or Prime Recipient. Confidential Information shall not be used for any purpose other than this Study without the prior written consent of the disclosing party and a written amendment to this Agreement.

Upon termination or expiration of this Agreement, the Receiving Party shall return to the disclosing Party or, if permitted by the disclosing Party, destroy Confidential Information of the disclosing party. The receiving party may retain one archival copy for verification of the work performed.

Each disclosing party is and shall remain the sole owner of the Confidential Information provided to the receiving party. No license or other right or property interest under trademark, patent, copyright or other legal theory is granted, transferred to or implied with respect to the Confidential Information furnished by the disclosing party or its affiliate to the receiving party or to any systems, equipment or software of the disclosing party or to its affiliate or their contractors and consultants which may be accessed by the receiving party pursuant to this Agreement, except as otherwise provided in the Statement of Work or as required by the terms of this Agreement.

1.4 PUBLICATIONS

Review and Comment. All proposed publications and presentations concerning the Study or the Work will be subject to any requirements and review processes and procedures specified in this Agreement or by the Sponsor. Subject to the provisions of this Agreement, each Party may publish and publicly present the results of the Work. No less than thirty (30) days prior to submission to a publisher or any external forum, each Party shall provide the other Party with a copy of any proposed publication or presentation for review and comment, which review shall be limited to determining whether the publication or presentation includes the disclosure of Confidential Information or patentable subject matter. Publications or presentations shall not include Protected Health Information as defined in 45 C.F.R Section 164.501 or the Confidential Information of the other Party (other than the final aggregated research results of the Work) without the written permission of such Party. If the reviewing Party believes that patentable subject matter is disclosed in the manuscript or presentation and so notifies the publishing Party in writing within the thirty (30) day review period, said publication will be withheld for a reasonable period of time (but not to exceed sixty (60) days) until all applicable patent filings are completed. With respect to public presentations, each Party shall use reasonable efforts to provide review and comments more promptly than the full period of review specified in this Section, if requested by the submitting Party.

Authorship. Qualification for authorship and contributorship shall be determined in accordance with the “Uniform Requirements for Manuscripts Submitted to Biomedical Journals,” published
by the International Committee of Medical Journal Editors (ICMJE). Publications shall carry appropriate acknowledgment of funding support from Sponsor and Kaiser Permanente, in the form required by the Sponsor and Kaiser Permanente, respectively, and a disclaimer that the contents are the responsibility of the authors and do not necessarily represent the official views of Sponsor or Kaiser Permanente.

License; Dissemination. Except as otherwise provided in the conditions of the Award, when publications or similar materials are developed from work supported in whole or in part by information derived from the performance of the Work, a copy of such materials and a perpetual, royalty-free license to use them for educational and research purposes shall be provided to Kaiser Permanente and such materials shall be subject to a royalty-free, nonexclusive, and irrevocable license to the Government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. In addition, upon acceptance of a manuscript for publication, Kaiser Permanente or Contractor will submit to “PubMed Central” an electronic version of each final, peer-reviewed manuscript prepared by such Party, respectively, to be made publicly available no later than twelve months after the official date of publication, including all modifications from the publishing peer review process, and all graphics and supplemental material associated with the article.

2.0 TERM AND TERMINATION OF THIS AGREEMENT (DURATION):

This Agreement shall commence on the Agreement Start Date set forth above and shall continue through the Agreement End Date unless terminated earlier pursuant to the Kaiser Permanente Terms and Conditions.

3.0 DESCRIPTION OF SERVICES

Scope of Work to be provided. Contractor shall, at its own risk and expense, perform the Services identified in Attachment A, Scope of Work and Budget, and, except as otherwise specified, furnish all labor, equipment and materials required.

Resources to be provided. Contractor shall ensure that its personnel and any approved contractors assigned to perform Services under this Agreement (“Personnel”) have the necessary qualifications, competence, and experience required to fulfill their respective responsibilities in providing the Services and Deliverables detailed in this Agreement. As applicable, specific skills and experience are further described in Attachment A, Scope of Work and Budget. Kaiser Permanente agrees to provide the specified number of patient referrals as outlined in the Scope of Work.

Location. Unless otherwise specified in Attachment A, Services shall be performed primarily at KP Customer’s designated facility, with occasional travel to other Kaiser Permanente facilities as required by the project and at the request of Kaiser Permanente. Contractor represents and warrants that Services will not be provided from locations outside the United States.
4.0 PRICING AND PAYMENT

Invoicing and Budget. Except as expressly provided in this Agreement, Contractor’s compensation shall not exceed the amount specified for each period of performance in the Budget (Attachment A) and Kaiser Permanente shall not under any circumstances be obligated to pay Contractor any amount in excess of this limit without a written amendment to this Agreement signed by authorized representatives of both Parties. All invoices must reference the Agreement number and at a minimum include current and cumulative costs, the Agreement Reference number, and certification in compliance with the Uniform Guidance, including (without limitation) 2 CFR 200.415. Invoices that do not contain this information may be rejected. Contractor agrees to provide sufficient documentation for all reimbursable costs and expenses and any other information Kaiser Permanente may reasonably require. Contractor shall email a copy of each invoice to the Kaiser Permanente Administrative Contact as outlined at the top of this Agreement. Kaiser Permanente will pay Contractor for accepted services performed in accordance with the terms of this Agreement and the Scope of Work within twenty one (21) days of receipt of a complete and accurate invoice.

Budget Revisions. The Budget as specified in Attachment A may not be amended except by a written amendment to this agreement signed by authorized representatives of both Kaiser Permanente and Contractor. Contractor may re-budget funds without obtaining approval by Kaiser Permanente. In the absence of a written amendment to this Agreement, Kaiser Permanente shall not be obligated to reimburse the Contractor for any costs other than the costs and amounts specified in the Budget that are properly incurred and allocated to this project.

Final Invoice. No later than forty-five (45) days after Contractor’s completion of the services specified in the SOW or expiration or termination of this Agreement, whichever occurs first, Contractor shall submit a final invoice clearly marked “FINAL,” showing the cumulative total costs incurred by Contractor and allocable to this Agreement. If Kaiser Permanente does not receive a final invoice from Contractor by the end of this time period (or an extension mutually agreed upon by the Parties in writing), the cumulative undisputed amount invoiced by Contractor as of the expiration of such time period shall be deemed a full and final settlement of all payments due under this Agreement. Kaiser Permanente will use good faith and reasonable efforts to obtain payment for a final invoice submitted by the Contractor between the 45th and 60th days after completion of the services or expiration or termination of this agreement. The final invoice must include the following certification signed by an official who is authorized to legally bind the entity: “By signing this report, I certify to the best of my knowledge and belief that the report is true, complete, and accurate, and the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the Federal award. I am aware that any false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims or otherwise. (U.S. Code Title 18, Section 1001 and Title 31, Sections 3729-3730 and 3801-3812).”

Taxes. Kaiser Permanente will have no obligation to Contractor, Contractor’s employees or any taxing authority to pay, or withhold from payment hereunder, any federal, State, or local income tax, or any portion of FICA or any other payroll, compensatory or other taxes relating
to Contractor or any individual assigned by Contractor to provide service.

IN WITNESS WHEREOF, KP Customer and Contractor have executed this Agreement as written below.

[The remainder of this page is intentionally left blank]

<table>
<thead>
<tr>
<th><strong>CONTRACTOR:</strong></th>
<th><strong>KP CUSTOMER:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>By: _____________________________</td>
<td>By: _____________________________</td>
</tr>
<tr>
<td>(Signature)</td>
<td>(Signature)</td>
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<tr>
<td>Title:</td>
<td>Title:</td>
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<tr>
<td>Print Name:</td>
<td>Print Name:</td>
</tr>
<tr>
<td>Date:</td>
<td>Date:</td>
</tr>
<tr>
<td>Address and Contact Person for Notices:</td>
<td>Address and Contact Person for Notices:</td>
</tr>
</tbody>
</table>

Email: _____________________________
Fax: _____________________________

**ATTACHMENT A**
**SCOPE OF WORK AND BUDGET**

Scope of Work

Insert Scope of Work and provide any specific skills and experience required by personnel to complete the work.

BUDGET

Insert budget and specify any invoicing terms such as cost-reimbursable or fixed fee and schedule for fixed fee reimbursement.
COMMUNITY PATHWAYS NETWORK - PATHWAYS SUMMARY

Academic Support:
• Complete and submit application or referral
• 3-month check-in confirming participant has accessed the resource

Pathway Complete: Participant is receiving and engaged in academic support resource (tutoring, etc.) for a minimum of 3 consecutive months.

Addictions Services:
• Complete and submit application or assessment to provider (for one on one or group services)
• Connect to service
• 3-month check-in

Pathway Complete: Confirm participant has connection with provider, understands the treatment plan, and has attended 75% of group classes and/or one on one sessions for a minimum of 3 consecutive months.

Adolescent Well-Child:
• Schedule appointment with primary care provider
• Confirm participant has attended appointment with provider

Pathway Complete: Youth has had a visit with primary care provider and scheduled any necessary follow-up appointments and has an understanding of treatment plan (if applicable).

Child Care:
• Identify affordable childcare provider
• Completed and submit childcare application to facility/provider

Pathway Complete: Participant has child(ren) ages 0-Pre-K enrolled in a licensed or registered, safe, and affordable childcare setting for a minimum of 3 consecutive months.

Chronic Disease Self-Management:
• Identify chronic disease self-management course, complete and submit application
• Enroll in course

Pathway Complete: Confirm participant has attended 75% of courses (if applicable) for 3 consecutive months.

Clothing:
• Identify clothing resource
• Connect to participant to clothing resource

Pathway Complete: Confirm clothing is no longer a barrier as defined by participant.
Dental Care - Dental Home:
• Dental provider identified and appointment made

Pathway Complete: Confirm participant has an established dental home, has attended a minimum of one appointment with dental provider, scheduled necessary follow-up appointments, and has an understanding of treatment plan.

Dental Care- Urgent/Emergent
• Emergent dental resource identified and plan for connection established

Pathway Complete: Urgent or emergent dental need resolved and participant has an understanding of treatment plan.

Developmental Disability Services: (Adult/Youth)
• Complete and submit application brokerage

Pathway Complete: Confirm participant is connected to brokerage, has a plan, and is compliant as defined at 3-month (adult) 6-month (youth) check-in.

Driver’s License/Identification: (one-step – same as completion step)
• Complete and submit application

Pathway Complete: Confirm participant has received and in their possession appropriate identification card (this includes driver’s license, passport, state identification card, etc.).

Education:
• Complete and submit application (if necessary)
• Connect to service

Pathway Complete:
1. Adult Enrollment – Navigator has confirmed the participant has completed the course or term and has established a plan to fulfill their educational goals. (*This includes skill development and technical training)
   For ongoing courses – client has attended a minimum of 75% of classes within 3 consecutive months.
2. K-12 Attendance – participant has maintained a minimum of 90% attendance for 6 consecutive months.
3. Preschool – (this includes Early Head Start, Head Start, Preschool) child(ren) age 5 and under enrolled and attending program with a minimum of 80% attendance for 3 consecutive months.
Employment:
• Connect participant with necessary resources to update/create resume and cover letter (if necessary)
• Employment application and cover letter (if applicable) completed and submitted to potential employer

Pathway Complete: Confirm participant has consistent source(s) of steady income with a legal organization and is gainfully employed for a period of 3 consecutive months.

Food Access:
• Provide participant with information on food resources
• Complete and submit application

Pathway Complete: Confirm participant/family has had a minimum of 3 consecutive months access to a minimum of two meals per individual per day (*two meals as defined by client/family).

Food Access - Urgent:
• Connect participant with immediate food resources

Pathway Complete: Confirm participant has received the necessary emergent food resources.

Health Insurance Coverage:
• Connect to assister
• Confirm coverage

Pathway Complete: Participant has enrolled with a health insurance provider, understands how to use health insurance to access healthcare, and maintains coverage for a minimum of 6 consecutive months.

Health Literacy:
• Provide support for participant to demonstrate their ability to engage with their health insurance provider

Pathway Complete: Confirm participant has recorded their health information and has demonstrated knowledge of how to communicate with Health System.

Housing:
• Complete and submit application
• Confirm participant has accessed housing resource

Pathway Complete:
1. New Housing – Confirm participant has moved into affordable and stable housing and maintains that housing for 6 months consecutively.
2. Eviction Prevention – Confirm participant has a plan to maintain current housing, has received necessary support, including rent assistance, and is housed in current housing for a minimum of 6 consecutive months.
Income: (TANF, Child Support, Unemployment)
• Complete and submit application
• Confirm participant has accessed necessary income resource.

Pathway Complete: Confirm participant has applied for and receiving said income for 3 consecutive months.

Legal Services:
• Identification of legal counsel and first appointment scheduled
• Check-in to confirm participant met with legal counsel, created plan, and understands plan

Pathway Complete: Participant reports an understanding of legal plan for specific need and reports legal issue has been resolved or has significantly improved.

Life Care Planning:
• Life care planning resources provided

Pathway Complete: Confirm participant has met with a provider and completed an Advanced Care Directive.

Medical Appointment Pathway
• Identify and provide potential providers necessary for medical need and schedule appointment

Pathway Complete: Confirm participant has seen medical provider a minimum of one time, has scheduled any necessary follow-up appointments, and understands treatment plan (if applicable).

Medical Home:
• Identify and provide medical home provider options and schedule appointment

Pathway Complete: Confirm participant has seen a provider a minimum of one time, scheduled any necessary follow-up appointments, and understands treatment plan (if applicable).

Medication Reconciliation - Level 1 (0-7 prescriptions) & Level 2 (8+ prescriptions):
• In person meeting to complete Medication Reconciliation Form (includes all prescribed and over-the-counter medications)
• Confirm participant has met with medical provider and reviewed Medication Reconciliation Form and medication education has been completed

Pathway Complete: Confirm participant has reconciled their medications.
Mental Health:
- Complete and submit application or assessment to provider (for one on one or group services)
- Check-in to confirm participant has accessed resource

Pathway Complete: Participant has connection with provider, understands the treatment plan, and has attended 75% of group classes and/or one on one sessions for a minimum of 3 consecutive months.

Parenting Support:
- Identify parenting resource, complete and submit application for home visiting or parenting class
- Check-in to confirm connection to resource

Pathway Complete: Confirm participant has completed components of their program and has established a plan to fulfill their parenting goals.

Pro-Social Engagement:
- Pro-social activity identified (this may include religious, volunteering, arts and craft, affinity group, sports, or other personally enriching activity), application completed and submitted
- Check-in to confirm connection to resource

Pathway Complete: Confirm participant is enrolled in activity (if applicable) and actively engaged for a minimum of 3 consecutive months.

SSI, SSD, Workers’ Compensation
- Complete and submit application
- 2-month check-in to confirm connection to resource

Pathway Complete: Confirm participant has applied for and receiving said income for 3 consecutive months.

Transportation:
- Identify necessary transportation resource, complete and submit application
- Check-in to confirm connection to transportation resource

Pathway Complete: Participant reports transportation is no longer a barrier to receiving services for at least 3 consecutive months.

Transportation TriMet PANOW: (Pathway reimbursement differs from general Transportation)

Pathway Complete: Participant receives TriMet transportation resource from navigator.
Utilities:
• Complete and submit application with all necessary documentation
• Check-in to confirm connection to utilities resource

Pathway Complete: Confirm participant is receiving necessary assistance to keep all appropriate utilities turned on and functioning for a minimum of 6 consecutive months.

Youth Development:
• Resource identified, complete and submit application
• Check-in to confirm connection to resource

Pathway Complete:

Mentorship
1. 12 and Younger – enrollment/connection with a mentor and a minimum of 75% of meetings with mentor attended.
2. 13 and Older – established relationship with mentor and has met a minimum of 3 times for a minimum of 3 months.
PATHWAYS MODELS

KAISER PERMANENTE:
Medication Reconciliation Pathway

Initiation: CHW will Initiate Medication Reconciliation Pathway for all Participants.

If Participant is discharged from hospital with changes, CHW will complete Pathway in collaboration with Pharmacy.

CHW will repeat the Medication Reconciliation Pathway with Participants as needed.

<table>
<thead>
<tr>
<th>Step One:</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW and Participant meet in-person and complete the Medication Assessment Form (include all prescriptions and over the counter medications).</td>
<td></td>
</tr>
<tr>
<td>• How was the form sent? (Mail/Secure Email, Secure Fax, Delivered in-person)?</td>
<td></td>
</tr>
<tr>
<td>• Who received the form?</td>
<td></td>
</tr>
<tr>
<td>• On which date was the form sent?</td>
<td></td>
</tr>
<tr>
<td>• Did the provider receive the form?</td>
<td></td>
</tr>
</tbody>
</table>

Move to Step Two and follow the questions

<table>
<thead>
<tr>
<th>Step Two:</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant brings their “brown bag” (all items from form) and their Medication Assessment Form to be reviewed and reconciled by either the PCP, Pharmacists, or NP, who can be scheduled for a same-day or next day appointment. Medication education is given at this time. CHW will assist Participant to complete Pill Card and receive Med Box.</td>
<td></td>
</tr>
<tr>
<td>• Who provided the education (pharmacist, case manager, physician)?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant have an updated list of all the medications s/he takes?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant understand how to take her/his medications and know what they are for?</td>
<td></td>
</tr>
<tr>
<td>• Was the Participant referred to KP Financial Assistance?</td>
<td></td>
</tr>
</tbody>
</table>

www.familiasenaccion.org
### Step Three: Check-in within 30 Days of Appointment Date

<table>
<thead>
<tr>
<th>CHW will confirm that Participant is using their Pill Card and Med Box.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is the Participant carrying her/his list of medications?</td>
</tr>
<tr>
<td>• Is the Participant sharing her/his list of medications with all of the service providers s/he interacts with?</td>
</tr>
<tr>
<td>• Is the Participant taking her/his medications as directed and knows what to do in case of forgetting one dose?</td>
</tr>
</tbody>
</table>

### COMPLETION:
At the time of Step Three, the Patient Navigator will determine if the Participant has reconciled their medications. A response of “Yes” to all of the questions indicates that this Pathway is Complete. A response of “No” to one or more questions indicates that an additional intervention is needed and the Pathway resumes at Step Two.
**KAISER PERMANENTE:**  
**Chronic Disease Management Pathway**

**Initiation:** If the Participant has a chronic disease that s/he would like help managing, then s/he is a good candidate for this Pathway. CHW will check-in with Participant by phone or in person every week.

<table>
<thead>
<tr>
<th>Step One: Chronic Disease Education</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the Participant with information and resources about their chronic disease(s) and explain options for classes.</td>
<td></td>
</tr>
</tbody>
</table>

**Move to Step Two and follow the questions**

<table>
<thead>
<tr>
<th>Step Two: Chronic Disease Program Enrollment/Connection</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose Chronic Disease Management type, refer to class, and record the location of the program.</td>
<td></td>
</tr>
</tbody>
</table>

**Move to Step Three and follow the questions**

<table>
<thead>
<tr>
<th>Step Three: Chronic Disease Self-Management Program</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| Was this a helpful program?  
• Strongly disagree 1 2 3 4 5 Strongly Agree | |

**COMPLETION:** If the Participant attends at least half of their classes and rates the statement at “4-5”, then this Pathway is complete. If not, then an additional application/referral is needed and the Pathway resumes at Step One.

**Chronic Disease Management Types:**

<table>
<thead>
<tr>
<th>Exercise: Walk with Ease</th>
<th>Stress Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP Class (Internal)</td>
<td>Support Group</td>
</tr>
<tr>
<td>Living Well/Tomando Control de Su Salud</td>
<td>Other: Seed to Supper, Empodérate</td>
</tr>
<tr>
<td>Living Well/Diabetes</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>Zumba</td>
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</tbody>
</table>
**KAISER PERMANENTE:**

**Health Literacy Pathway**

**Initiation:** If the Participant answers “No” to one or both questions, then s/he is a Good candidate for this Pathway: “Do you know where to go for healthcare services?” and “Do you know how to get the care you need?”

### Step One: Remove Barriers to Care and Provide Resources for Support

<table>
<thead>
<tr>
<th>Action</th>
<th>Date Completed</th>
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</thead>
<tbody>
<tr>
<td>• If the Participant is followed by Team Base Care, we will include the contact information for the main point of contact.</td>
<td></td>
</tr>
<tr>
<td>• Did the Participant contact Rockwood Member services representative and receive information regarding their co-pays and benefits?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant have their Health Insurance Identification card?</td>
<td></td>
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<tr>
<td>• Does the Participant understand the information that is printed on their ID card?</td>
<td></td>
</tr>
<tr>
<td>• Do they know how to use the 1-800 number/website/mobile application?</td>
<td></td>
</tr>
<tr>
<td>• Did the Participant receive information about a relevant health care benefit?</td>
<td></td>
</tr>
</tbody>
</table>

**Ask the Participant:**

Call and ask a question, including asking for an interpreter if necessary.

### Step Two: Higher Level of Care Conversation

<table>
<thead>
<tr>
<th>Action</th>
<th>Date Completed</th>
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</thead>
<tbody>
<tr>
<td>• Did the Participant develop a list of involved service providers (Primary Care Provider and Specialists)?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant know which provider to contact for which health issues or conditions?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant understand the importance of making her/his own appointments, letting the provider know the reason(s) for the visit, and cancelling and re-scheduling them?</td>
<td></td>
</tr>
<tr>
<td>• Is the Participant preparing and bringing a list of questions to her/his appointments?</td>
<td></td>
</tr>
<tr>
<td>• Does the Participant know how to reorder medication and schedule appointments on KP.org?</td>
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</tr>
<tr>
<td>• Does the Participant know the difference between Urgent Care and the ED?</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION:** If the Participant has recorded their health information in the Familias en Acción Senderos Booklet, has completed all activities, and has demonstrated that they know how to communicate with the Health System, then this Pathway is complete.
KAISER PERMANENTE:
Social Service Referral Pathway

**Initiation:** If the Participant has any unmet social, financial, or basic needs, then s/he is a good candidate for this Pathway.

<table>
<thead>
<tr>
<th>Step One: Complete &amp; Submit Social Service Application/Referral</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose Social Service Referral Type (listed below)</td>
<td></td>
</tr>
<tr>
<td>• Child Care/School Enrollment</td>
<td></td>
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<tr>
<td>• Clothing Assistance</td>
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<tr>
<td>• Domestic/Partner Violence</td>
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<tr>
<td>• Education/Job Training</td>
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<td>• Food Security</td>
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<td>• Housing</td>
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<tr>
<td>• Income/Financial Assistance</td>
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<tr>
<td>• Kaiser Permanente Financial Assistance</td>
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<tr>
<td>• Legal Assistance</td>
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<tr>
<td>• Medical Debt Assistance</td>
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<td>• Medication Assistance</td>
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<tr>
<td>• Parent Education Assistance</td>
<td></td>
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<tr>
<td>• Personal Documentation (State Identification)</td>
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<td>• Translation/Interpretation Assistance</td>
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<tr>
<td>• Transportation</td>
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<tr>
<td>• Unemployment Assistance</td>
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<tr>
<td>• Utilities Assistance</td>
<td></td>
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</tbody>
</table>

**Move to Step Two and follow the questions**

<table>
<thead>
<tr>
<th>Step Two: 1st Check-in within Two Weeks of Application/Referral Date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does Participant need help accessing more benefits or services?</td>
<td></td>
</tr>
<tr>
<td>Yes or No?</td>
<td></td>
</tr>
</tbody>
</table>

**Move to Step Three and follow the questions**

<table>
<thead>
<tr>
<th>Step Three: 2nd Check-in within 30 Days of Application/Referral Date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the Participant need help accessing more benefits or services?</td>
<td></td>
</tr>
<tr>
<td>Yes or No</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION:** At the time of Step Three, the Patient Navigator will determine if the Participant needs further access to benefits or services. A response of “No” indicates that this Pathway is Complete. A response of “Yes” indicates that an additional application/referral is needed and the Pathway resumes at Step One.
KAISER PERMANENTE:  
Medical Continued Care & Higher Level of Care Pathway

**Initiation:** CHW will initiate Medical Continued Care Pathway if the Participant needs ongoing support after completing the Medical or Chronic Disease Pathway or there is an identified need for a higher level of care.

CHW will check-in with Participant by phone or in person every week.

<table>
<thead>
<tr>
<th>Step One: Remove Barriers to Care and Provide Resources for Support</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| • The CHW will check-in by phone or in person about the Participants chronic disease or medical condition.  
• The CHW will make appointments, ensure the Participant attends appointments, remove barriers to receiving care (i.e. transportation, social services), and accompany Participant to appointments as needed.  
**Ask the Participant:** Do you have any additional barriers that need to be addressed?  
• At this time, the CHW will also connect the Participant and family to support groups and resources internal and external to Kaiser Permanente, as needed.  
**Ask the Participant:** Was the Participant connected to resources?  
Do you need additional support and would you like to hear about other care options? |

**Move to Step Two and follow the questions**

<table>
<thead>
<tr>
<th>Step Two: Higher Level of Care Conversation</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| Determined upon the participant’s situation and course of illness, the CHW will discuss additional care options such as residential, supportive living, etc.  
Did you discuss additional care options with the Participant? (Responses: Yes, No, not applicable)  
Ask the Participant: Do you feel that you have a good understanding of the various care options? (Responses: Yes, No, not applicable)  
Level 2 Discussion: Initiate at referral  
CHW will connect with appropriate KP provider for referral and support decision making. |

Ask Participant:
Would you like continued support from the CHW at this time? If yes, this Pathway would be re-activated. If no, complete Pathway.

**COMPLETION:** This pathway will continue for 90 days or until the participant indicates they no longer need the support.

This Pathway can be reopened by request from the care team and the patient.
KAISER PERMANENTE:
Medical Referral Pathway

Initiation: If the Participant has care gaps identified in Health Connect, then the Community Health Worker (CHW) will help the patient make a PCP appointment to address these gaps.

If an approved specialty referral is in place, then this Pathway is activated.

<table>
<thead>
<tr>
<th>Step One:</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedule an appointment with Primary Care/Specialty Care and attend the appointment with the patient if needed/requested.</td>
<td></td>
</tr>
<tr>
<td>Check with Rockwood member services about Specialty coverage</td>
<td></td>
</tr>
<tr>
<td>Choose Medical Referral type (see list below)</td>
<td></td>
</tr>
</tbody>
</table>

Move to Step Two and follow the questions

<table>
<thead>
<tr>
<th>Step Two:</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check-in with Patient after Initial Visit</td>
<td></td>
</tr>
<tr>
<td>Do you feel like your needs were met? Yes/No</td>
<td></td>
</tr>
</tbody>
</table>

COMPLETION: At the time of Step Two, the Community Health Worker will determine if their needs were met. If the answer is “Yes” then Pathway is complete. If the answer is “No” then a new Pathway is initiated. If this is a continued process in specialty (e.g. long-term chronic disease), this will activate the “Long Term Care Coordination Pathway”. If additional medications are prescribed to Participant, this will activate the “Medication Reconciliation Pathway”.

Medical Type:

- Dental
- Family Planning
- Hearing
- Palliative Care
- Pharmacy
- Primary Care
- Specialty Care
- Speech and Language
- Vision
**KAISER PERMANENTE:**
Life Care Planning Pathway

**Initiation:** CHW will initiate Life Care Planning Pathway for all Participants. This Pathway will be initiated within 3045 days, after the relationship has been established with the Participant.

<table>
<thead>
<tr>
<th>Step One:</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the Participant:</td>
<td></td>
</tr>
<tr>
<td>• Have you ever thought who would speak for you if you couldn’t speak to the health care team?</td>
<td></td>
</tr>
<tr>
<td>If the Participant does not have an Advanced Directive, or if the Advanced Directive is five years or older, reapproach what is in the Advanced Directive and make sure the information is still current.</td>
<td></td>
</tr>
</tbody>
</table>

*Move to Step Two and follow the questions*

<table>
<thead>
<tr>
<th>Step Two: Check-in 45 days after Initial Conversation</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CHW will contact the Participant and see if an Advanced Directive has been submitted or if a Health Care Agent has been identified.</td>
<td></td>
</tr>
<tr>
<td>If not, the CHW will readdress the conversation and ask if there are any questions.</td>
<td></td>
</tr>
<tr>
<td>• Was a Health Care Agent identified?</td>
<td></td>
</tr>
<tr>
<td>• Did the Participant submit an Advanced Care Directive?</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION:** If the Participant has completed the Advanced Care Planning conversation with the CHW, then this Pathway is complete.
**KAISER PERMANENTE:**

**Insurance Pathway**

**Initiation:** If the Participant is uninsured or needs to renew his current Insurance, then s/he is a good candidate for this Pathway.

<table>
<thead>
<tr>
<th>Step One: Remove Barriers to Care and Provide Resources for Support</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive a notice/call regarding the status of your application?</td>
<td></td>
</tr>
<tr>
<td><strong>Yes/No</strong></td>
<td></td>
</tr>
<tr>
<td>If the Participant response is “Yes” then the CHW may advance to the next step, if the response is “No” then the CHW will continue to address any barriers.</td>
<td></td>
</tr>
</tbody>
</table>

**Move to Step Two and follow the questions**

<table>
<thead>
<tr>
<th>Step Two: 1st Checkin within two weeks of application/referral date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive a notice/call regarding the status of your application?</td>
<td></td>
</tr>
<tr>
<td><strong>Yes/No</strong></td>
<td></td>
</tr>
<tr>
<td>If the Participant response is “Yes” then the CHW may advance to the next step, if the response is “No” then the CHW will continue to address any barriers.</td>
<td></td>
</tr>
</tbody>
</table>

**Move to Step Three and follow the questions**

<table>
<thead>
<tr>
<th>Step Three: 2nd Check-in within 45 days of application/referral date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you receive a final determination notice regarding your application?</td>
<td></td>
</tr>
<tr>
<td><strong>Yes/No</strong></td>
<td></td>
</tr>
<tr>
<td>If the Participant response is “Yes” then the CHW may advance to the next step, if the response is “No” then the CHW will continue to address any barriers.</td>
<td></td>
</tr>
</tbody>
</table>

**COMPLETION:** At the time of Step Three, the Community Health Worker will determine if the Participant needs additional support in obtaining coverage. If additional support is needed the Pathway will start at Step Two.
KAISER PERMANENTE:
Mental Health Referral Pathway

Initiation: All Participants will receive the PHQ2. CHW will disseminate the PHQ1, which may trigger PHQ9. CHW will send the PHQ9 information to PCP for results via staff message in Health Connect. The PCP can refer to SW if needed.

If question 9 is positive for suicidal risk, then CHW will connect with EPS (Emergency Psychiatric Services).

<table>
<thead>
<tr>
<th>Step One:</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| • Provide the Participant with information and resources about Mental Health Services in the community and virtual.  
• Address any barriers that may exist to accessing community resources or appointments.  
• Choose Mental Health Referral type (below) | |

MENTAL HEALTH REFERRAL TYPES:
• Counseling  
• Kaiser Permanente Primary Care Social Worker  
• Recovery Support  
• Big White Wall (website)

Move to Step Two and follow the questions

<table>
<thead>
<tr>
<th>Step Two: 1st check-in within one week of Community Resources given and referral date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Move to Step Three and follow the questions

<table>
<thead>
<tr>
<th>Step Three: 2nd check-in after services were accessed.</th>
<th>Date Completed</th>
</tr>
</thead>
</table>
| Do you feel that your needs were met?  
Strongly Disagree: 1  2  3  4  5  Strongly Agree | |

COMPLETION: At the time of Step Three, the CHW will determine if the Participant’s needs were met. If the Participant rates the statement at 4-5, then this Pathway is complete. If not, then an additional application/referral is needed and the Pathway resumes at Step One. If longer term services are needed, this will activate the “Long Term Care Coordination Pathway.” If additional medications are prescribed to Participant, this will activate the “Medication Reconciliation Pathway.”
**KAISER PERMANENTE:**
Alcohol & Drug/Substance Abuse Referral Pathway

**Initiation:** CHW will disseminate AUDIT 3, which may trigger AUDIT 10. The AUDIT 10 will be interpreted by the PCP, and the PCP will make appropriate referral from there.

**Step One:**
<table>
<thead>
<tr>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PCP will send the CHW results. The CHW connects the Participant with the referral provider and appropriate support groups. CHW can connect with RKW Member Services to assess benefits.</td>
</tr>
</tbody>
</table>

**Alcohol & Drug/Substance Abuse Referral Types:**
- Counseling
- Kaiser Permanente Primary Care Social Worker
- Recovery Support
- Residential Treatment

**Move to Step Two and follow the questions**

**Step Two:**
<table>
<thead>
<tr>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW will advocate as needed for process to expedite/be completed</td>
</tr>
</tbody>
</table>

**Move to Step Three and follow the questions**

**Step Three:**
<table>
<thead>
<tr>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this program meeting your needs?</td>
</tr>
<tr>
<td>Strongly Disagree 1  2  3  4  5  Strongly Agree</td>
</tr>
</tbody>
</table>

**COMPLETION:** At the time of Step Three, the Community Health Worker will determine if the program or provider is meeting the Participant’s needs. A response of “4-5” indicates that this Pathway is Complete. A response of “1-3” indicates that an additional referral is needed and the Pathway resumes at Step One”. If additional medications are prescribed to Participant, this will activate the “Medication Reconciliation Pathway.” If longer term services are needed, this will activate the “Long Term Care Coordination Pathway.”
## PATHWAYS ASSESSMENT

<table>
<thead>
<tr>
<th>Patient Navigator</th>
<th>Referral Source</th>
<th>Today’s Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MM DD YYYY</td>
</tr>
</tbody>
</table>

### Participant Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name and Middle Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Gender</th>
<th>Marital Status</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Email</th>
<th>Address</th>
</tr>
</thead>
</table>

Does Familias en Acción have permission to leave messages that identify us as a provider? [ ] Yes [ ] No

### Emergency Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
</table>

### Legal Guardian?

Power of Attorney, Guardianship, Conservatorship, etc. [ ] Yes [ ] No

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Address</th>
</tr>
</thead>
</table>

### 1. Health Literacy Pathway Assessment:

Do you have health insurance? [ ] Yes [ ] No

What is your current insurance plan?

<table>
<thead>
<tr>
<th>What is your health insurance/ID number?</th>
<th>Do you have your insurance card with you?</th>
</tr>
</thead>
</table>

How and when did you first enroll in your health insurance plan?

Notes:
### What do you know about your benefits? Are doctor’s visits covered? Medications?

<table>
<thead>
<tr>
<th>Notes</th>
<th>Premium:</th>
<th>Co-Pays &amp; Rx:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much do you pay for your health care each month?</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Does someone assist you with these payments?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>In the past year, were you unable to obtain medical services due to cost?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Initiation:** If the Participant answers “No” to one or both questions, then s/he is a good candidate for this Pathway: “Do you know where to go for healthcare services?” and “Do you know how to get the care you need?”

---

2. Social Service Referral Pathway & Financial Literacy Pathway Assessments:

<table>
<thead>
<tr>
<th>Number of adults in household</th>
<th>Number of children under 18</th>
</tr>
</thead>
</table>

**Do you live:**
- [ ] Alone
- [ ] With partner/spouse
- [ ] With other persons

**Are you:**
- [ ] Employed
- [ ] Unemployed
- [ ] Seeking Employment
- [ ] Disabled
- [ ] Retired

**Where do you currently work? (or last place of employment):**

<table>
<thead>
<tr>
<th>What is your monthly gross income?</th>
<th>What is the source of your income?</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

**Are you a Veteran of the Armed Forces?**
- [ ] Yes
- [ ] No

**Do you need assistance with childcare and/or school enrollment?**
- [ ] Yes
- [ ] No

**Are you interested in obtaining more education or job training?**
- [ ] Yes
- [ ] No

**Do you need assistance with transportation?**
- [ ] Yes
- [ ] No

**What type of transportation do you use?**
- [ ] My own vehicle
- [ ] Someone else’s vehicle
- [ ] Rides from friends/family
- [ ] Public Transportation
- [ ] Taxicabs

**Do you need assistance with housing?**
- [ ] Yes
- [ ] No

**Do you need any additional financial assistance?**
- [ ] Yes
- [ ] No

**Would you benefit from a class about how to manage your money?**
- [ ] Yes
- [ ] No

**Notes:**

**Initiation:** If the Participant has any unmet social, financial, or basic needs, then s/he is a good candidate for the Social Services Referral Pathway. If the Participant answers “Yes” to the question: “Would you benefit from a class about how to manage your money?” then s/he is a good candidate for the Financial Literacy Pathway.
3. Medical Referral Pathway Assessment:

**Where do you get your care? How often?**

<table>
<thead>
<tr>
<th>List of Physicians:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Physician</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Name of Physician</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**How do you usually communicate with your providers?**

- [] Phone
- [] E-mail
- [] Website
- [] Patient Visit
- [] All of the above
- [] Other
- [] Don’t Know

Have you been to the ER in the last 6 months?  
[ ] Yes  [ ] No  How many times?

**What was the reason for the visit(s)?**

**Notes:**

**Do you have any current illnesses?**

<table>
<thead>
<tr>
<th>How long?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

**Do you have any current health conditions that are not being treated or addressed?**  
[ ] Yes  [ ] No

**What illnesses have you experienced in the past?**

<table>
<thead>
<tr>
<th>How long ago?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

**List Past Surgeries/Hospitalizations:**

<table>
<thead>
<tr>
<th>When?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

*Initiation: If the Participant has indicated that s/he has any unaddressed health conditions, then s/he is a good candidate for this Pathway.*
4. Chronic Disease Management Pathway Assessment:

<table>
<thead>
<tr>
<th>How do you rate your health?</th>
<th>☐ Excellent</th>
<th>☐ Good</th>
<th>☐ Fair</th>
<th>☐ Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you know about your chronic health conditions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever participated in a Chronic Disease Self-Management Program?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you like to?</td>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Initiation: If the Participant has a chronic disease that s/he would like help managing, then s/he is a good candidate for this Pathway.

5. Medication Reconciliation Pathway Assessment:

| Do you currently take prescription medications? | ☐ Yes | ☐ No |
| Do you currently take over-the-counter medications? | ☐ Yes | ☐ No |
| Do you currently use home remedies? | ☐ Yes | ☐ No |
| If yes, describe: |
| Do you have any allergies? | ☐ Yes | ☐ No |
| List allergies: |
| Are you having problems getting or paying for your medications? | ☐ Yes | ☐ No |
| If yes, why? |
| Are you having any side effects from your medications? | ☐ Yes | ☐ No |
| If yes, describe: |
| Do you understand what all of your medications are for? | ☐ Yes | ☐ No |
| If no, describe: |
| Do you know how often to take them? | ☐ Yes | ☐ No |
| If no, describe: |
| Do you know what to do if you forget a dose? | ☐ Yes | ☐ No |
| If no, describe: |
| Notes: |

Initiation: If the participant answers positively to more than one question from the Medication Reconciliation questions in the Pathways Assessment, then s/he is a good candidate for this Pathway.

6. Alcohol & Drug/Substance Abuse Referral Pathway Assessment:

| Do you use tobacco products? | ☐ Yes | ☐ No |
| Are you interested in quitting? | ☐ Yes | ☐ No |
7. Mental Health Referral Pathway Assessment:

<table>
<thead>
<tr>
<th>Over the last two weeks, how often have you been bothered by any of the following problems?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things:</td>
</tr>
<tr>
<td>□ Not at all □ Several days □ More than ½ the days □ Nearly every day</td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless:</td>
</tr>
<tr>
<td>□ Not at all □ Several days □ More than ½ the days □ Nearly every day</td>
</tr>
<tr>
<td>Have you ever had an experience that caused you physical, emotional or psychological distress?</td>
</tr>
<tr>
<td>Are you interested in going to a counselor, psychologist or therapist?</td>
</tr>
</tbody>
</table>

Notes: If the Participant answers “Yes” to any of the questions, “Are you interested in quitting?” then s/he may be a good candidate for this Pathway.

Pathways Assigned:

<table>
<thead>
<tr>
<th>Pathways Assigned:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health Literacy</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>2. Social Services Referral</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>3. Financial Literacy</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>4. Medical Referral</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>5. Chronic Disease Management</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>6. Medication Reconciliation</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>7. Alcohol and Drug/Substance Abuse Referral</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8. Mental Health Referral</td>
</tr>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

Is there anything we did not cover today that you would like assistance with or that you have questions about?

Assessment Summary:
**MEDICATION CHART**

The following chart could help patients work more closely with caregivers and health care providers. It could be downloaded at: http://careoregon.org/meds

There are also instructions you can print, and a video to help you get started, also alternate language options.

<table>
<thead>
<tr>
<th>Drug Name &amp; Strength</th>
<th>When &amp; How Many</th>
<th>How Is It Working?</th>
<th>YOU</th>
<th>PROVIDER RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>WHY TAKING?</td>
<td>DAILY</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>WEEKLY</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>AS NEEDED</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
</tbody>
</table>

**OTHER NOTES:**

If this chart does NOT match your medication instructions given to you by your doctor or pharmacist, please let your doctor know. Use this QR code to watch a quick video www.careoregon.org/MEDS-quickstart
SAMPLE COMMUNITY HEALTH WORKER / HEALTH NAVIGATOR JOB DESCRIPTION

Mission Statement of Agency or Program:

Position Summary:

The Community Health Worker / Health Navigator (CHW) works directly with clients, families, and health care personnel to support Latino clients with understanding their health benefits, removing social determinant barriers, or working with specific health conditions. The Community Health Worker will work as a member of a care coordination team and will support clients in implementing their individual care plan. The CHW will be working with client health information and must be able to maintain strict confidentiality using the HIPAA requirements. This position requires a flexible, self-directed person, who is excellent at handling situations where all the details may not yet be available or determined and can search for the information that is needed. This person must be an excellent communicator with Latinos in the community as well as professional health care employees and must be bilingual in English and Spanish. The person must have a strong background in working with the Latino culture and understand the nuances of the values that impact medical care. They must be able to empower the clients to manage their health and to teach clients how to access the health care that they need. Experience and knowledge of the health care system is required. This is a fast-paced, interactive, demanding environment.

Reports to:

Job Responsibilities:

• Process referrals and conduct client intake, OHP and Medicaid application assistance, enrollment and orientation by phone or in person
• Enter client, referral and Pathway data into database
• Communicate with members of care coordination team
• Assist clients in addressing social needs that serve as barriers to health and selecting Pathways
• Provide referrals to complete Pathways
• Conduct and participate in trainings
• Write monthly reports
• Other duties as required

Requirements and Qualifications:

• Bachelor degree or equivalent in health, social work, or related field; or minimum of two years of experience in human services, healthcare, social services or non-profit sector with demonstrated knowledge of working with the Latino community.
• Self-motivation and the ability to work independently with strong analytical and problem solving skills
• Possess excellent attention to detail, good organizational skills and ability to prioritize multiple and varied tasks.
- Good working knowledge of Microsoft Office computer program and data entry skills.
- Valid driver’s license with reliable, insured vehicle
- Bilingual in English and Spanish with the ability to communicate effectively, both orally and in writing.
- Excellent phone communication skills
- Certified CHW is preferred, but training can be obtained
PATIENT CARE NAVIGATOR JOB DESCRIPTION - KAISER PERMANENTE

Job Summary:

The Patient Care Navigator for Primary Care, Complex Care Medical Home will work on an interdisciplinary team to support the non-clinical needs for our most fragile, aging and complex members. The Navigator will assure standardization of processes across facilities, supporting multiple medical office buildings and training across the region. The Navigator will be responsible for sharing important community resources and practices to our members and providers to ensure that the team meets patient care requirements. Specifically, the Navigator coordinates alternative services for patients seeking non-clinical care and where other avenues of care are more appropriate to affect optimal patient outcomes, achieve continuity and quality of care and reduce cost (Triple Aim). Patient/Family education will be a key component of success.

Major Responsibilities:

1. Assist patients in problem solving potential issues related to health care delivery, financial or social barriers (e.g. request interpreters as appropriate, transportation services or prescription assistance). 15%

2. Be the system navigator and point of contact for patients and families who suffer complex medical and social needs. May assume advocate role on the patient’s behalf to ensure approval of the necessary services for the member in a timely fashion. 20%

3. Provides regular outreach to a panel of patients to identify social and medical risks upstream, and communicates these risks in the medical record, and coordinates care with the right team member (or resource) at the right time. 20%

4. Creates collaborative relationships with patients and clinical staff across a variety of areas within Kaiser Permanente and entities external to the organization to ensure patients receive quality healthcare services. 10%

5. Educates and advocates for the function in a variety of venues to increase awareness and understanding of the program and its contribution to the triple aim. 5%

6. Works collaboratively with the complex care multidisciplinary team through active participation in daily huddles and weekly oversight meetings to ensure program is successful in meeting established Triple Aim goals and objectives around patient care/services. 10%

7. Provides consulting and educational services with patients to reach collaborative agreements regarding appropriate venues of care, including continuing care services and provides patients with resources and support in end-of life care planning. Supports the training/onboarding of new Navigator staff. 10%

8. Assists patients in connecting with community resources and health services within Kaiser Permanente as instructed by designated clinical on the team. 10%
Experience:

1. Minimum Education: Associates Degree
2. Preferred Education: Bachelor’s degree.
3. Basic Qualifications:
   Minimum four (4) years of experience in the health related field with at least two (2) of those years having direct patient contact
4. Preferred Work Experience
   Preferred experience in the community health care setting.
   Preferred experience as a health coach and/or community health care worker.

Additional Requirements

- Competent computer skills with proficiency in Microsoft Office products and ability to learn new programs to support the program.
- Ability to work well on a team.
- Excellent written and verbal communication skills.
- Ability to complete Motivation Interviewing Certification.
- Ability to organize and prioritize workload; effective time and project management skills in achieving program initiatives and priorities.
- Ability to successfully complete tasks with little or no supervision.
- Ability to anticipate patient and team member needs.

September 2014
REFERENCES:

- **Health System Organizational Readiness and Internal Planning**

- **Build the Partnership**
  - Oregon Health Authority. January 6, 2012 The Role of Non-Traditional Health Workers in Oregon’s Health Care System Recommendations for Core Competencies and Education and Training Requirements for Community Health Workers, Peer Wellness Specialists and Personal Health Navigators developed by Oregon Health Policy Board Workforce Committee Non-Traditional Health Worker Subcommittee
  - Colorado Patient Navigator Training: http://patientnavigatortraining.org/website/pn_model.htm

- **Define Contractual and Financial Agreements**
  - Community Health Access Project (CHAP)-Connecting those at risk to Care. http://chap-ohio.net/
  - Redding M & Redding S. Program Uses “Pathways” to Confirm Those At-Risk Connect to Community Based Health and Social Services, Leading to Improved Outcomes. ARHQ Innovations Exchange.
• **Build an Integrated Team**

• **Mutual Training and Education**

• **Program Evaluation**
  - Community Health Access Project (CHAP)-Connecting those at risk to Care. http://chap-ohio.net/
  - Redding M & Redding S. Program Uses “Pathways” to Confirm Those At-Risk Connect to Community Based Health and Social Services, Leading to Improved Outcomes. ARHQ Innovations Exchange.