Omaha Pathways Community HUB

Omaha Community Foundation Affiliate

August 3rd, 2023

Request for Applications:

Community Care Agencies (CCAs)

Webinar Overview

- This webinar is being recorded and will be posted at https://omahafoundation.org/HUB-RFA
- The PCHI® model provides licensed content which cannot be used, copied, or modified without a license agreement or sub-license agreement.
- We will have open Q&A discussion following the presentation.
    - Feel free to put questions in the chat and / or wait for the discussion.

Webinar Agenda

- Summary: Pathways Community HUB Institute® Model
- Building a HUB in Omaha
- Role of the Community Care Agency
- Request for Applications Overview
- Questions & Answers

Pathways HUB Purpose and Vision

- By implementing the PCHI® evidence-based model of care coordination we aim to:
  - Improve health outcomes and reduce disparities by addressing the social risk factors driving poor health outcomes
  - Effectively leverage a CHW workforce and create a model of financial sustainability
  - Access and align resources across sectors for greater impact

Acknowledgements

- Funding to launch the Omaha HUB was provided by CHI Health, Healthy Blue Nebraska, Nebraska Total Care and United Healthcare as part of their missions to help improve the health of Nebraskans.

- A Core Team of leaders and organizations collaborated to bring this work to fruition:

- I Be Black Girl is providing expertise in the strategy and implementation to ensure we center and honor the lived experience and individual perspective of those we are serving.

Pathways Community HUB

PCHI® Model Overview

Omaha Pathways Community HUB

Omaha Community Foundation Affiliate

Key Terms

- **PCHI®:** The Pathways Community HUB Institute (PCHI)® is a nonprofit organization that supports the Pathways Community HUB model through national certification and technical assistance to communities.
- **PCH / HUB:** The Pathways Community HUB is the local, neutral entity that provides the infrastructure (training, technology, contracting, quality assurance, etc.) for the PCH model to be implemented. The Omaha PCH is being housed within Omaha Community Foundation.
- **Pathway:** Set of specific care coordination steps to help address an identified, modifiable risk factor. In the PCH Model there are 21 Standardized pathways that cover a variety of social, health, and medical needs.
- **CHW:** Community Health Workers lead the care coordination and follow-up as trusted individuals with a deep understanding of the community they serve. CHWs are employed by the Care Coordination Agency (CCA) and may be called other titles such as care coordinators, peer specialists, promotoras, or resource specialists, as examples.
- **CCA:** Care Coordination Agencies are local organizations that are part of the PCH (HUB) and are implementing the PCH model. The CCA employs the community health workers (or similar role) and their supervisors, who assist and connect community members to social service, healthcare, and behavioral health providers.
- **Outcome:** In the PCH model the "outcome" refers to the standardized definition for when a risk has been addressed and a Pathway can be closed. For example, in the Employment Pathway the outcome is someone is working 30 days from date of hire.
- **Risk / Risk Factor:** This model is focused on identifying and mitigating factors that influence health at an individual level (medical, social, and behavioral), and that can be modified through improved access to resources and health behaviors (i.e., individually modifiable risk factors [IMRF]).

A more comprehensive list of terminology and definitions can be found as part of the RFA Supplemental Materials.

PCHI® Model

The PCHI® Model provides a value-based, quality improvement framework requiring national certification and a standardized data model to implement a **community-based** care coordination network, called a Pathways Community HUB (PCH).

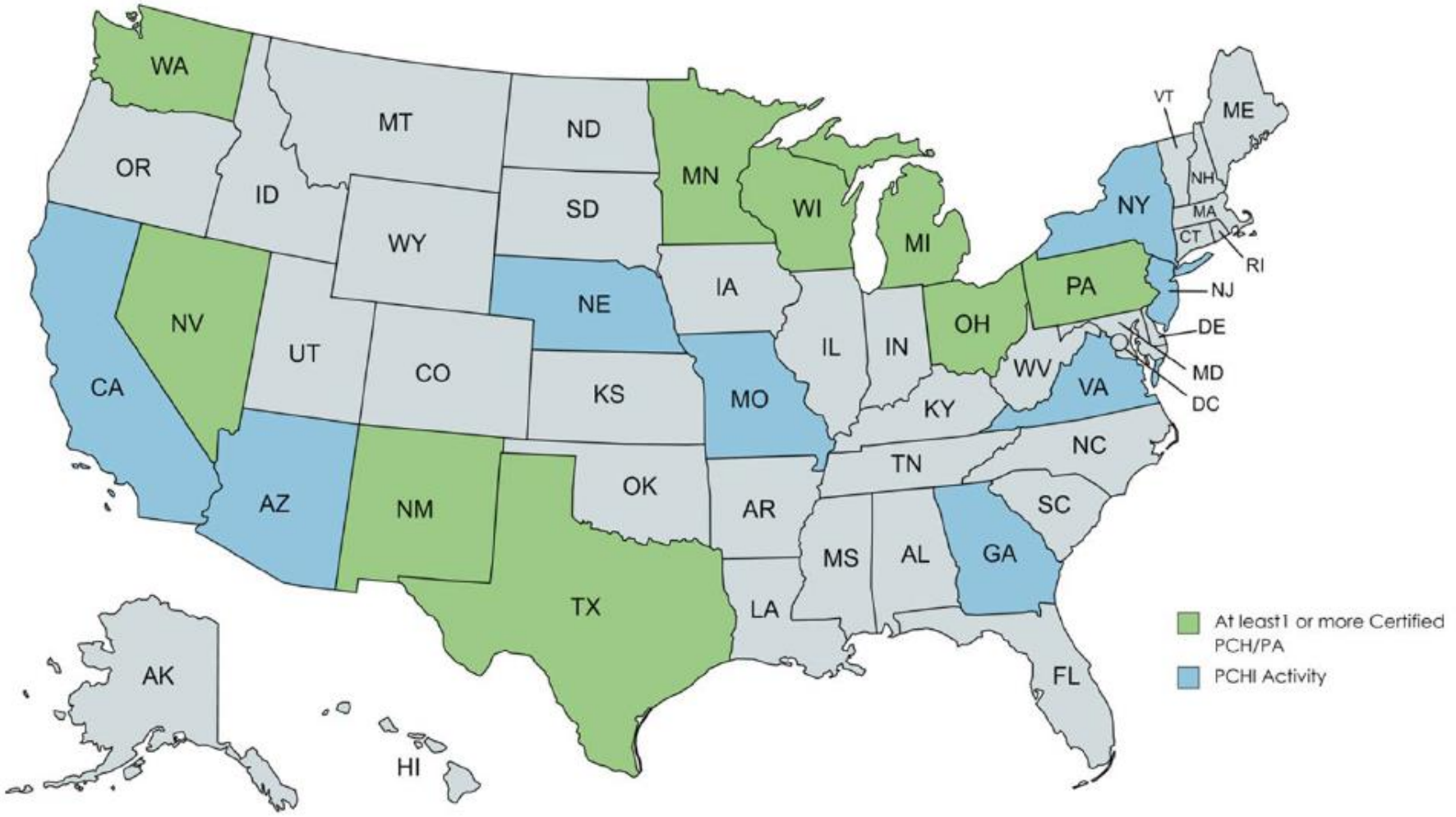
Leverages the skills of community health workers to find and engage residents experiencing challenges accessing resources and are at the greatest risk for poor health outcomes.

Studies by Medicaid Managed Care plans have demonstrated a return on investment and measured health improvement for members who received PCHI Model care coordination.

A certified PCH improves health, reduces costs, and promotes equity.

PCHI® Implementation – 17 States and Counting!

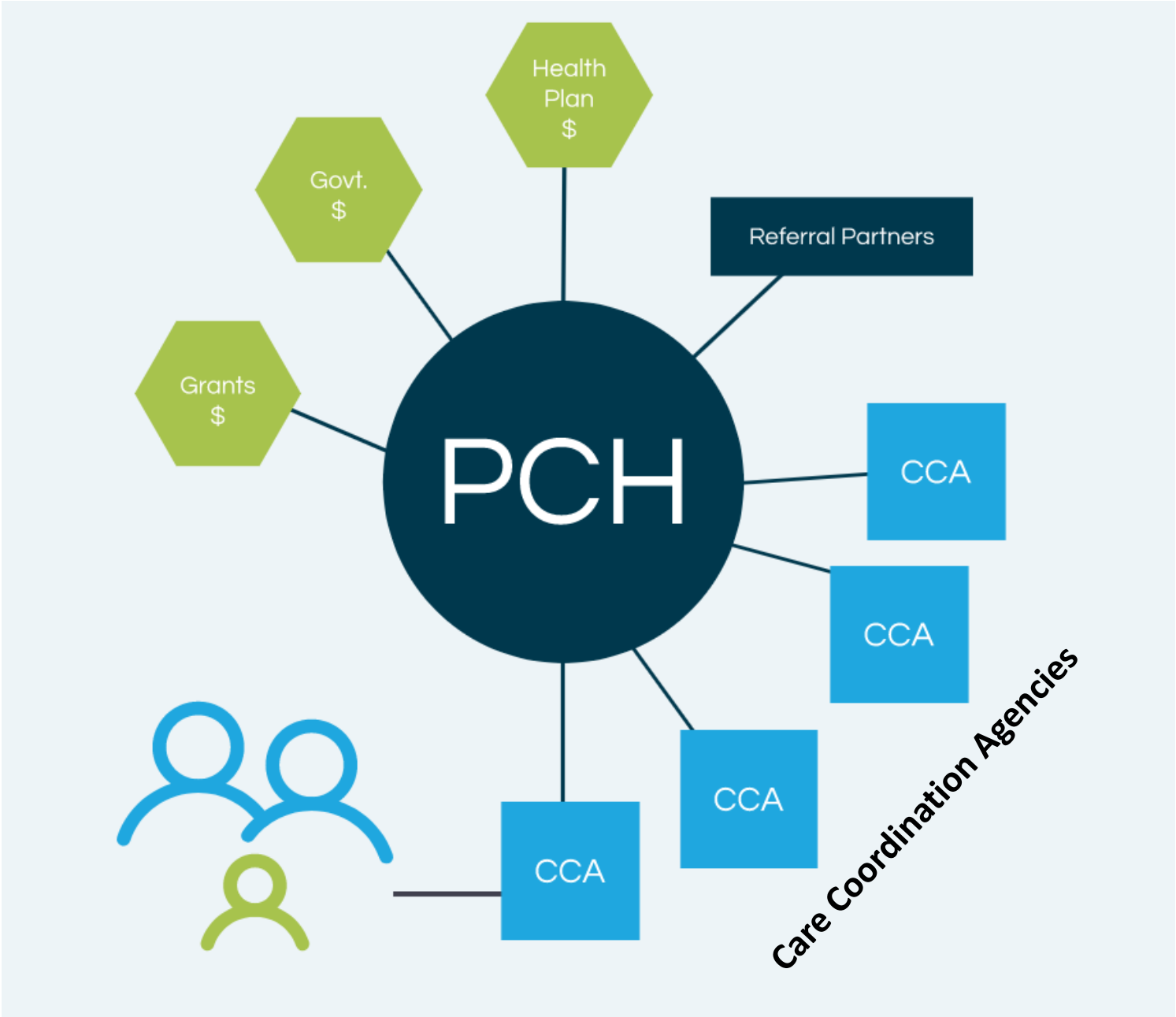
As of 1/31/23 there are 21 certified organizations in 9 states and 23 in development



PCHI® Model Framework

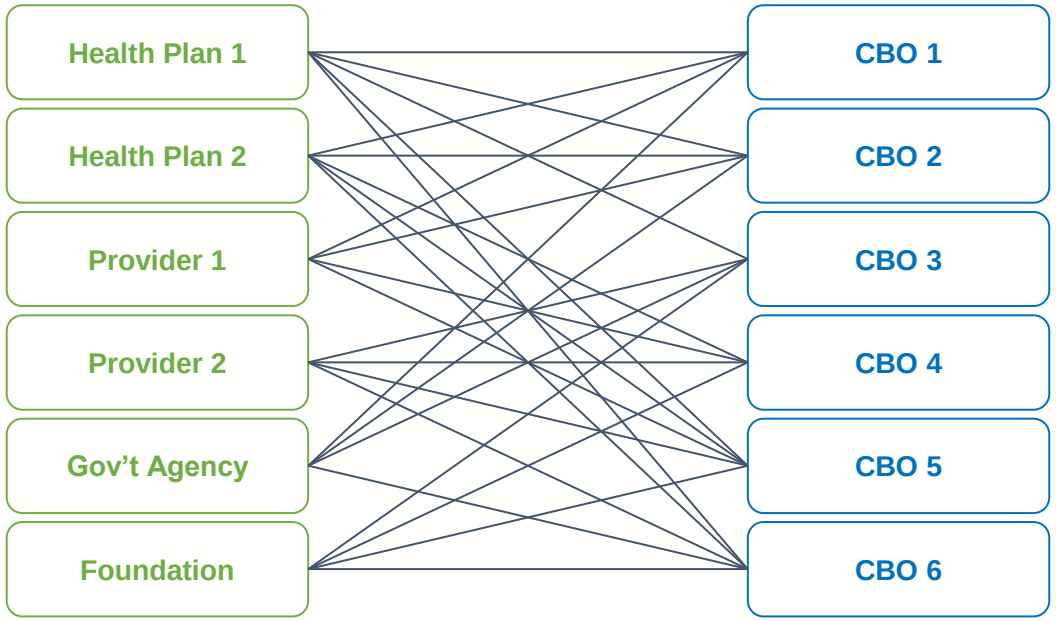
- Community Health Worker driven model
- Pathways Community HUB (PCH or HUB) is a neutral, trusted, and collaborative convenor—not a healthcare provider and is based in community being served
- PCH builds a network of CBOs to serve as Care Coordination Agencies that employ CHWs and supervisors
- PCH builds a referral / resource network
- PCH provides governance, training, quality assurance, and reporting
- PCH responsible for resource development--securing **outcome-based** contracts and other funding
- PCH works across sectors to address the complex social needs of participants at the individual and policy level

The Pathways Community HUB (PCH)



Community-Based Care Coordination

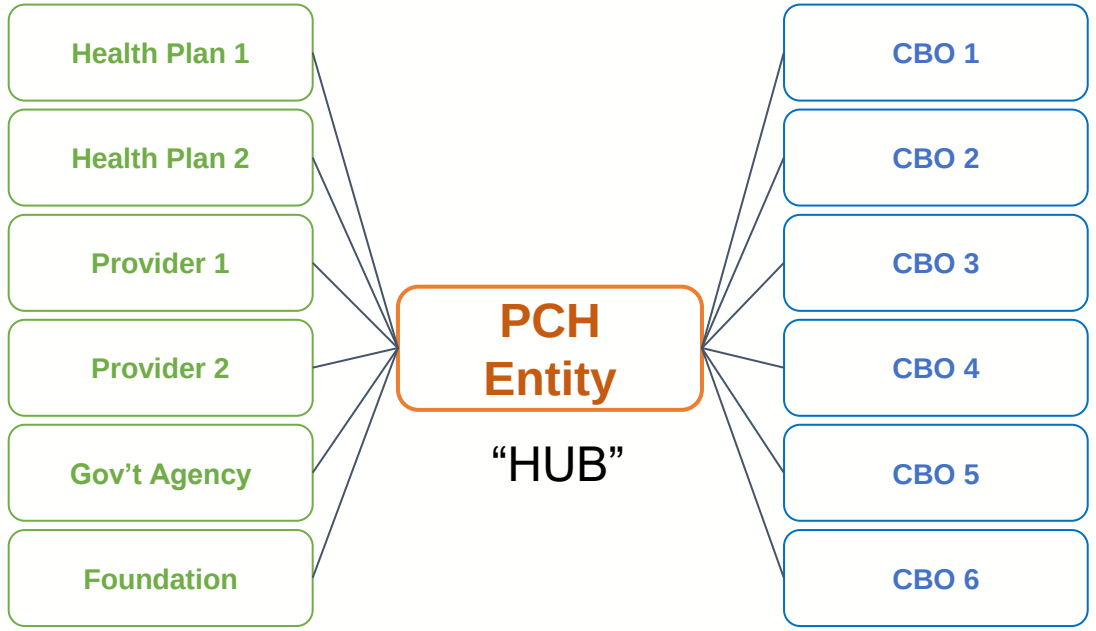
Current State



Challenges

- Different contracts with multiple organizations
- Duplicated efforts
- Siloed CHW outreach process
- Inability for CBOs to contract with different health entities

PCHI® Model



Benefits of the Model

- Pay for outcomes & braided funding creates sustainability
- PCH Entity creates structure, governance oversight, standardized data and reporting, quality assurance, and contracting as a trusted neutral convener.

PCHI® Model Components

- Standardized process to engage and support community members to get access to the health and community resources needed to improve health, quality of life, and overall wellness
- Standard documentation through Demographic, Visit, Pathways and Progress tool
- 21 standard Pathways
- Structured health and social care data model
- 60+ Evidence based Learning Modules
- Standard Outcome and engagement-based billing (50% linked to confirmed outcomes/Pathways)
- Quality Benchmark Report
- National Certification to License PCHI® Content to assure fidelity to the Model

Standard Evidence-Based Pathways

Adult Education
Developmental Referral
Employment
Family Planning
Food Security
Healthcare Coverage
Housing
Immunization Referral
Learning — 60+ Learning Modules
Medical Home
Medical Referral — 24 types of referrals
Medication Adherence
Medication Reconciliation
Medication Screening
Mental Health
Oral Health
Postpartum
Pregnancy
Social Service Referral — 31 types of referrals
Substance Use
Transportation

PCHI® Model Payment Strategy

Braided Funding

- Grants
- Philanthropy
- Value Based Payer Contracts

Outcomes (Value) -Based Contracting

- At least 50% of payment is tied to outcomes or completed Pathways each assigned Outcome Based Units.
- The other 50% is tied to confirmed engagement, measured by completed Visit Forms documenting home visits.
- If a participant is not engaged and Pathways are not completed, there is no payment.

PCHI® Model Payment Example (1 month)

Pathway/ Engagement	Completion	Outcome Based Units	X OBU Value	= $
Housing	Maintained safe and stable housing for 30 days from move-in date.	15	$35*	$525
Social Service	Confirm appointment was kept.	3	$35*	$105
Learning	Demonstrates understanding of Learning Materials.	.5	$35*	$17.50
Engagement	At least 1 monthly documented visit with client.			$175
**For illustration purposes only--Each PCH negotiates the Outcome Based Unit (OBU) rate.*				**Total = $822.50**

Pathways HUB Demonstrated Outcomes

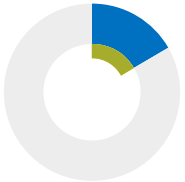
Community Health Access Project

115 CHAP participants matched with 110 births with similar demographics

CHAP participants common non-medical Pathways initiated included:

- Employment (52%)
- Adult Education (50%)
- Smoking Cessation (39%)
- Food Security (30%)
- Housing (27%)

No difference in utilization of prenatal care.



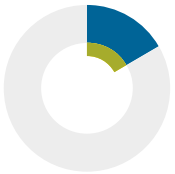
60% decrease in low birth rate

ROI: $3.36 short term & $5.59 long term.

Northwest Ohio Pathways Community HUB

Project with Centene Ohio Plan focused on high-risk mothers.

Found that high-risk mothers without PCH intervention were *1.6x* more likely to deliver a baby needing special care.



For every $1 spent on PCH for Centene members there was a savings of $2.36.

*Newborns born to mothers at high risk enrolled in the PCH have a **PMPM cost savings of $403** during the first year of life compared to those born to mothers not enrolled in the PCH at delivery.*

“I’d still be homeless. I don’t have a doubt. It was just a blessing. She didn’t just help me and then leave me alone.”

"I didn't know these services existed. The help really goes deep. It's wonderful.”

Photos courtesy of Northwest Ohio Pathways Community HUB

Building a HUB in Omaha

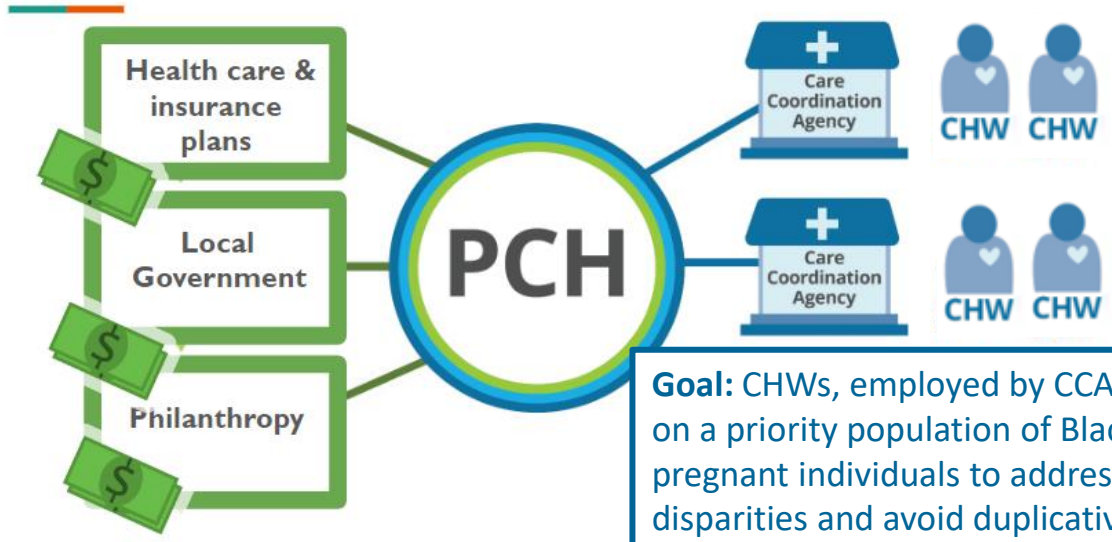
Overview

Omaha Pathways Community HUB

Omaha Community Foundation Affiliate

Omaha PCH Demonstration Project

- **Timeline**: May 2023 – December 2024
- **Focus Population**: Pregnant women / individuals living east of 72nd Street in Douglas and Sarpy Counties with high risk for poor birth outcomes
  - Priority is to serve Black pregnant people due to persistent disparities in birth outcomes
  - Impacting healthy birth outcomes
- **Objectives:**
  - Contract with 2 Community Care Agencies
  - Hire / Train 4 CHWs implementing the model
  - Serve approx. 100 pregnant individuals
  - Measure pathways and birth outcomes
  - Begin payer contracting
  - Begin evaluation plan



Goal: CHWs, employed by CCAs, focus on a priority population of Black pregnant individuals to address gaps / disparities and avoid duplicative efforts

Focus Population Determination:

Community Health Needs Assessment – Omaha, NE

Addressing health-related social needs is a critical component of achieving health equity

Indicator	Omaha Metro	White	Black	Hispanic	Mid/ High Income	Low Income	Very Low Income
Infant Mortality Rate (per 1,000 live births)	5.8	4.9	12.1	5.5	-	-	-
Lack of Health Insurance Coverage	9.0%	6.4%	9.8%	24.5%	4.5%	16.4%	21.8%
Difficulties / Delays in receiving Health Care	36%	33.1%	47.1%	46.2%	31%	46.3%	59.8%
ED utilization	6.9%	5.7%	12.4%	7.6%	3.9%	12.7%	18.1%
Symptoms of Chronic Depression	32.8%	29.,8%	38.3%	49.9%	27.8%	44.8%	52.7%
Moderate to Severe Anxiety/ Depression	15.6%	13.8%	18.7%	21.8%	10.8%	23.1%	36..0%
Perceive most days as "extremely/very" stressful	12.8%	11.5%	17.3%	17.1%	10.0%	13.7%	28.8%
Difficulty accessing mental health services	6.1%	5.6%	4.2%	10.1%	4.2%	11.2%	14.2%
Do not have $400 Cash to cover emergency expenses	18.%	13.8%	45.9%	29.4%	9.0%	32.9%	63.3%
"Always/Usually/Sometimes" worried about paying rent/mortgage	23.9%	18.6%	47.7%	46%	15.9%	37.4%	56.2%
"Often/Sometimes" worry about food running out	19.7%	14.0%	48.5%	41.7%	9.9%	38.7%	57.8%
Low Health Literacy	16.7%	12.7%	24.8%	28.7%	13.9%	23.1%	27.3%

Recent Health Care Experiences Were Worse Due to Race

White 1.8%
Black 15.2%
Hispanic 8.5%
Other 15.1%

Source: Professional Research Consultants. 2021. Community Health Needs Assessment: Douglas, Cass, and Sarpy Counties, NE and Pottawattamie County, IA.

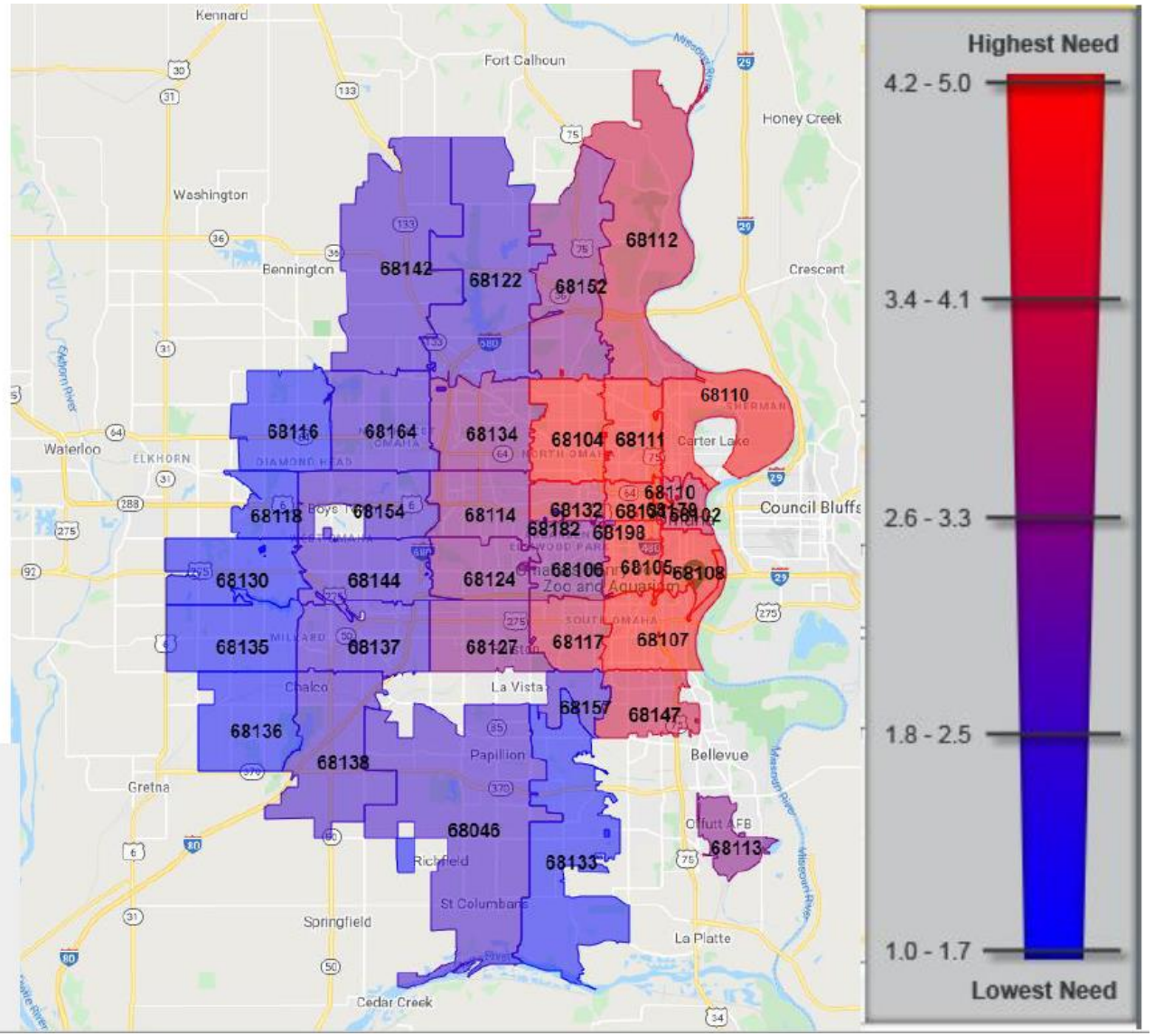
Focus Population Determination:

Community Need Index

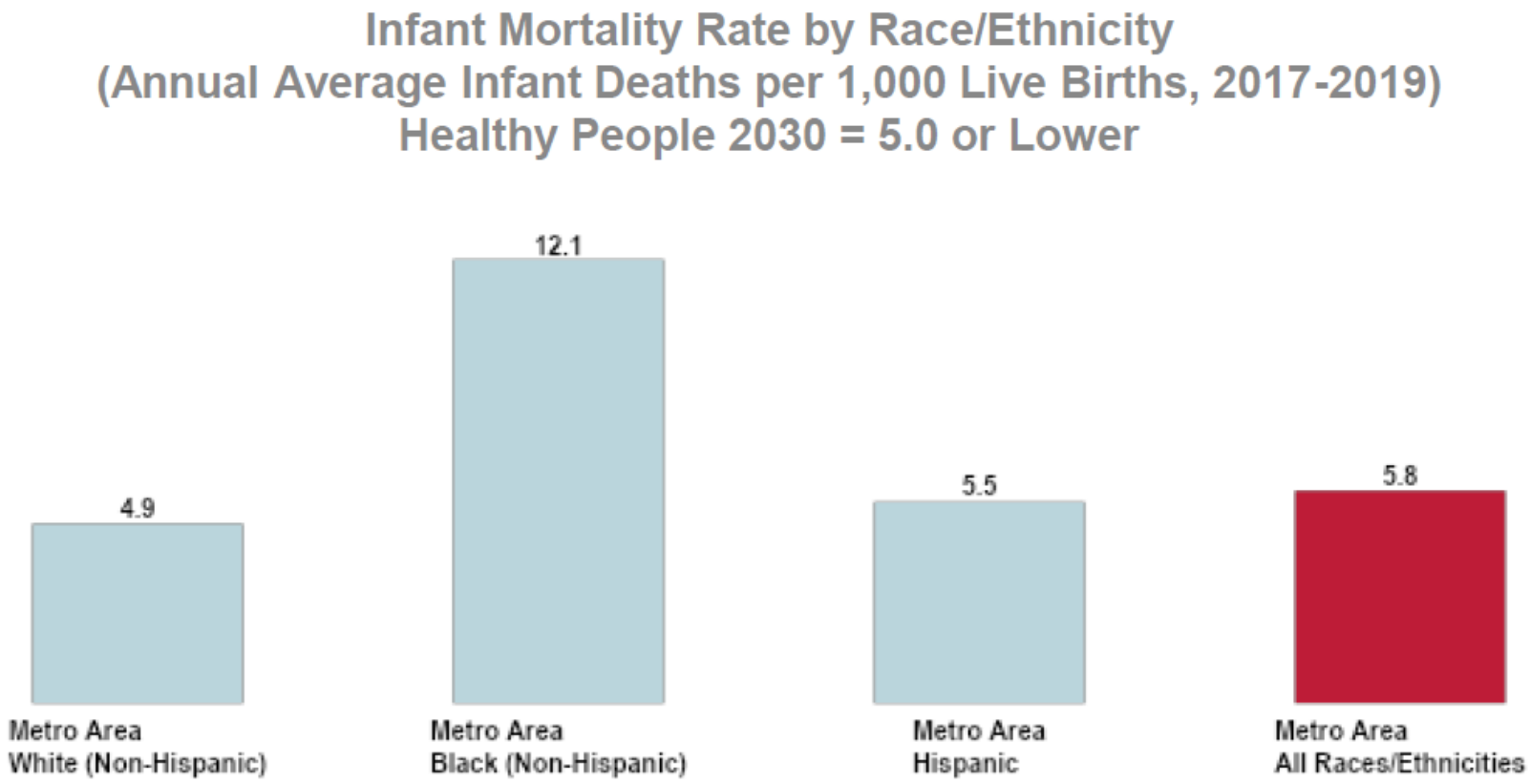
Zip Codes with greatest CNI scores		
Zip Code	CNI	Population
68108	4.8	15,716
68110	4.8	9,326
68111	4.8	23,986
68131	4.8	13,091
68105	4.6	25,092
68107	4.6	30,960

Measures (barriers) used in CNI:

- Income (poverty)
- Cultural (minority/ LES)
- Education (high school diploma)
- Insurance (unemployed/ uninsured)
- Housing (renters)



Focus Population Determination:

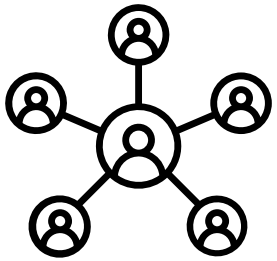


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted February 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

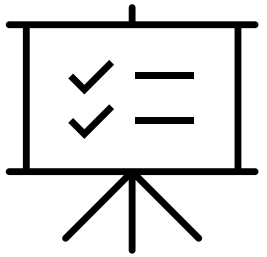
Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Building a HUB in Omaha

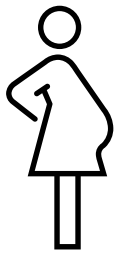
Omaha Community Foundation hosting the HUB:



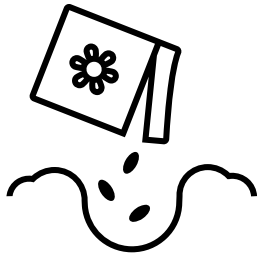
Neutral Convener



Administrative Infrastructure



Responding to a community health need



Experience in incubation

Role of the Community Care Agency

Omaha Pathways Community HUB

Omaha Community Foundation Affiliate

Care Coordination Agencies (CCA)

Contract with HUB to:

- Sublicense access to the PCHI® Model
- Employ CHWs and ensure core competencies are met*
- Provide care coordination to community members at greatest risk in the focus population:
  - Identify individually modifiable risk factors
  - Use standardized Pathways to track risk mitigation
  - Provide “whole-person” care and “whole-family” care
- Participate in quality improvement processes, program evaluation, and the broader community strategy to address social determinants of health

*the HUB will pay for and facilitate any needed training to meet core competencies

Community Health Workers (CHWs)

Standard Documentation and Reporting

- **Release of Information** – participant permission to share information with the CCA and HUB for purposes of ensure quality services, billing, and evaluation. Outlines information security practices.
- **Demographics form (intake)** – participant background info (age, race, ethnicity, primary language, current diagnoses, family, etc.) and reason / referral source
- **Visit form** – completed at each visit, supports CHW and participant conversations to identify gaps / opportunities / risks, "open notes" format, defines participant action step and next visit
- **Progress Form** – "bird's eye view" of episode of care, tracks visits and pathways, supports CHW and supervisor work, primary source of information for funding and billing
- **Pathways Reporting** – tool for CHW to track workflow and progress on addressing an identified risk. While steps are different each Pathway has the same format and includes the defined outcome.
- **Other TBD (screening, assessment, etc.)** – the HUB may determine that in some or all cases additional standard forms are required (i.e., depression screening, ACEs assessment, etc.)

Standard Evidence-Based Pathways

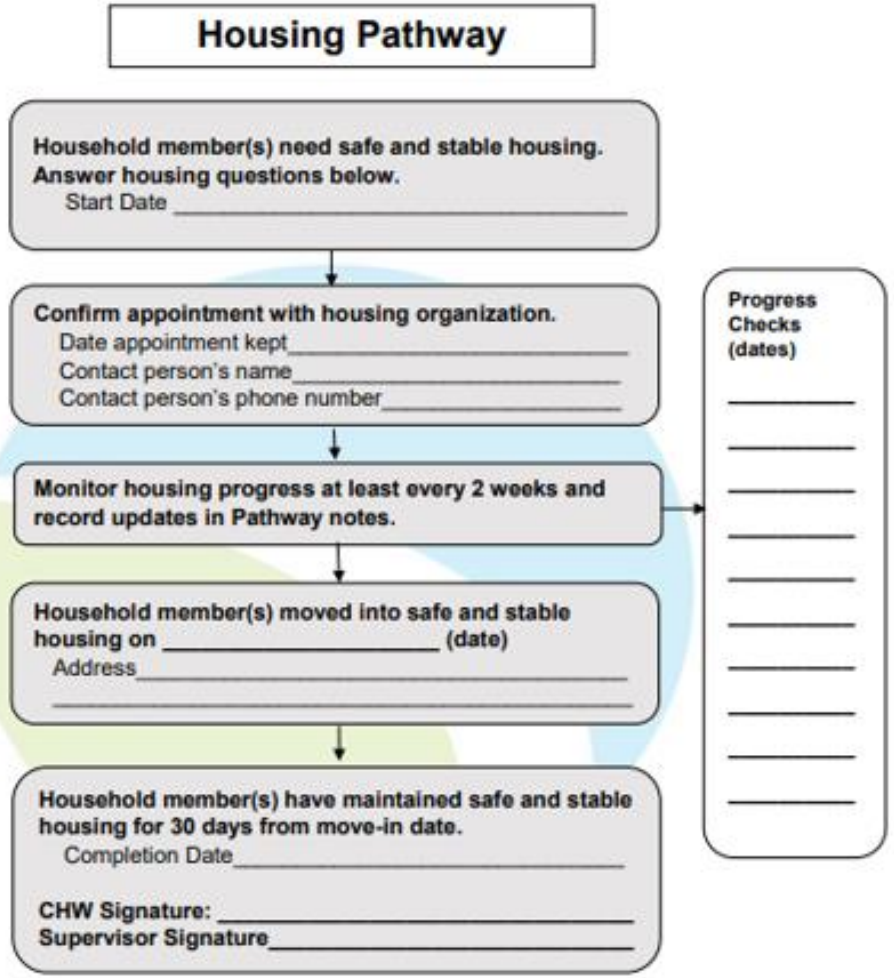
Adult Education
Developmental Referral
Employment
Family Planning
Food Security
Healthcare Coverage
Housing
Immunization Referral
Learning
Medical Home
Medical Referral
Medication Adherence
Medication Reconciliation
Medication Screening
Mental Health
Oral Health
Postpartum
Pregnancy
Social Service Referral
Substance Use
Transportation

60+ Learning Modules

24 types of referrals

31 types of referrals

Example Pathways: Housing



Housing questions:

Homeless

__ Living outside
__ Living in shelter
__ Living with family or friends
__ Other_____

Eviction

__ Too many people
__ Drug-related
__ Legal issue
__ Criminal history
__ Untidy home
__ Unpaid rent
__ Other_____

Has housing, but needs new housing:

__Safety issues
- Environmental issues (infestation, mold, lead, temperature, noise)
- Crime
- Interpersonal Violence
- Fire or other natural disaster
- Other_____

__Too many for living space
__Financial/Poor rental history
__Legal or criminal issue
__Discrimination
__Disability
__Self-imposed (pets)
__Poor location to access services
__Other _____

Standard Outcomes

Pathway	Outcome
Adult Education	**Confirm that participant completes educational goal.** ___ Course/class successfully completed ___ Training program completed ___ Quarter/semester completed ___ Other: _____
Developmental Referral	**Developmental evaluation completed.**
Employment	**Participant is still working 30 days from date of hire.**
Family Planning	**Family Planning Completed (check one):** ____ Permanent Sterilization ____ Long-Acting Reversible Contraceptive ____ 30-Day confirmation for other methods
Food Security	**No problems, or anxiety about, consistently accessing adequate food for the past 30 days.**
Healthcare Coverage	**Confirm that participant has healthcare coverage.**
Housing	**Household member(s) have maintained safe and stable housing for 30 days from move-in date.**
Immunization Referral	**Provider, pharmacist, or clinic confirms that participant's immunizations received and are up to date.**
Learning	**Participant demonstrates understanding of learning materials.**
Medical Home	**Confirm that participant kept the appointment.**
Medical Referral	**Confirm that appointment was kept.**
Medication Adherence	**One month from reconciliation visit, participant reports that there are no barriers and he/she is taking medication(s) as prescribed.**
Medication Reconciliation	**Primary care provider and/or pharmacist and participant agree on prescribed medications.**
Medication Screening	**Verify with primary care provider or pharmacist that Medication Screening Tool was received.**
Mental Health	**Confirm participant has kept 3 scheduled mental health appointments.**
Oral Health	**Confirm that appointment was kept.**
Postpartum	**Confirm postpartum appointment kept and answer postpartum information questions.**
Pregnancy	**Normal birth weight baby (> 5# 8 oz/2500 grams)**
Social Service Referral	**Confirm that appointment was kept.**
Substance Use	**Participant kept appointments and treatment related to substance use for 30 days.**
Transportation	**Household member(s) had no problems, or anxiety about, consistently using transportation for the past 30 days.**

Learning Modules

- 60+ evidence-based learning modules across 4 domains:*
  - Medical
  - Social
  - Behavioral Health
  - Safety
- A tool for CHWs to review with participants related to specific individually-modifiable risk factors that may be improved through education and behavior change
- Designed to be delivered in person for about 10 minutes
- “Ask – Tell – Ask” collaborative communication method
- CHWs should deliver at least one module per visit depending on active Pathways and goals

*Some modules are currently translated into Spanish and work continues to translate all modules in 2023

Learning Modules - Example

Primary Care & Preventive Screenings

Check In:

- How often do you see your regular doctor (primary care provider)?
- What health screenings have you had in the last year?

Your primary care doctor and their team of healthcare providers get to know you and your family and make a record of your symptoms, signs, and medication needs.

Preventive Care for You and Your Family

Regular visits to your primary care provider for illnesses and preventive screenings can have a beneficial impact on your and your family's future health.

Your primary care provider can:

- Check to see that your blood pressure and other vital signs are normal.
- Make sure that you are up to date on cancer, infection, and cholesterol screenings. Identifying abnormal screenings early is critical to successfully treating illnesses.
- Refill your medications on a regular basis and make sure that you are taking them in the safest and most effective manner.
- If you haven't already, find an office to receive your primary care: use this location for health issues that are not an emergency.

For your infants and children, their primary care provider or pediatrician can:

- Make sure your child receives the appropriate immunizations and health screenings.
- Provide your child with developmental screenings and referrals for interventions for speech, muscular problems or other developmental issues, if needed.
- Assure your child's weight, height and head growth is progressing normally.
- Provide you with information regarding parenting strategies, nutrition, ways to improve school performance, and other childhood concerns.

Using the Emergency Room

- When you have an emergency, go to the emergency room.
- Going to the emergency room for any illness that you could see your regular family doctor or pediatrician for is not recommended. Primary and preventative care is more beneficial.
- Excessive use of the emergency room and frequent hospitalizations are significant risk factors for you and your children's health.
- Unnecessarily using the ER can result in:
  - Long waiting times
  - Tests and procedures that you may not need
  - Significantly greater expenses

Having a long-term relationship with your primary care physician can set an example for your family and make a big difference in all of your health.

Check Back:

- **Talk about how do you can prioritize preventive health for you and your family.**

References

Emergency Room, Urgent Care or Primary Care Physician? | Patient Advice | US News. (n.d.). Retrieved 11/25/22 from https://health.usnews.com/health-care/patient-advice/articles/2018-02-07/emergency-room-urgent-care-or-primary-care-physician

Community Advisory Council (CAC)

- The CAC provides guidance on implementation of the HUB and oversight of the quality improvement processes.
- CAC helps ensure standardized processes and ensures all community stakeholders are involved to help address whole-person care.
- Representatives from each CCA and CHWs will be expected to participate.
- Additional members will include HUB leadership, partner representatives (i.e., payers, healthcare providers, referral partners), and community members
- Subgroup will serve as Steering Committee

Request for Applications Details

Omaha Pathways Community HUB

Omaha Community Foundation Affiliate

RFA Overview

- Seeking applications for two (2) agencies to be a Community Care Agency (CCA) in the Omaha HUB
- Applications must be submitted by 5:00 p.m. CT on August 25th via OCF grant portal
- Questions may be submitted via email, and answers will be posted on our webpage
- Technical Assistance sessions will be held on:
    - Thurs, Aug 10th 12:00 – 1:00 CT
      https://us02web.zoom.us/j/83757196173?pwd=YW9wc3ltdTZoS1pxaVNvajJhc1Fjdz09
    - Fri, Aug 18th 10:00 - 11:00 CT
      https://us02web.zoom.us/j/82468701651?pwd=UitHbHd4YTFFa2RZcWlJeDlNWkhZZz09
- Applications will be reviewed and assessed using a scoring rubric by a selection committee including members of the PCH Core Team and other Community representatives
- Depending on results of the applications and Committee discussions, applicants may be asked for a follow up “interview” with the Committee.
- We anticipate final decisions to be communicated by early October

Funding for Outcomes-Based Payments

- Application is seeking potential budget to support 2* CHWs per organization
    - Salary (range is ok) + benefits
    - Supervision costs
    - Other operational expenses (cell phone, mileage, supplies, etc.)
- Range of funding available per CHW (inclusive of all costs above) for one year is *approximately* $65,000 - $80,000
- Funding to each CCA will be a combination of “engagement fees”/ up-front payments and the remainder will be tied to outcomes. The final funding model will be developed with the HUB and selected CCAs.
- The HUB will work with selected agencies to finalize budgets to ensure costs are covered for each agency, equity in pay / funding, etc.

*this assumes 2 full-time CHWs. The HUB and CCAs can discuss the potential of part time positions. CHWs must be at least 0.5 FTE working in this model.

RFA Materials

The following materials are available at https://omahafoundation.org/HUB-RFA :

- Notice of Request for Applications
- RFA Application
- Review and Selection Process Overview
- Summary of HUB / CCA Standards
- Terminology Sheet
- Sample Job Descriptions – CHW and Supervisor
- Kick-Off Webinar & TA Sessions (slides and recordings to be added)
- Answers to submitted questions (to be added)

Application Submission

- Applications will be submitted online through OCF's online grant portal
    - https://omahafoundation.submittable.com/submit/268500/omaha-pathways-hub-community-care-agency-request-for-applications-2023
- New users will first need to create an account
- Applications can be saved and re-visited during the application window
- Ongoing communications will come via the grant portal platform

RFA Overview

Section 1. Applicant Information

Section 2. Requirements

Section 3. Applicant knowledge, capacity and relevant experience (Core application questions)

Section 4. Organizational Policies and Assurances

Applicant Requirements

Section 2. To be considered as a CCA, you must meet all the following requirements. Please check the box if your organization meets each requirement.

☐ We are a nonprofit organization serving Omaha, NE

☐ We are willing to employ and supervise Community Health Workers that are trained to implement the PCHI® Model of care coordination through the Omaha Pathways Community HUB (HUB).

☐ We have experience in/interest in providing home-based and community-based services to help residents experiencing significant challenges accessing social and medical services get connected to available resources.

☐ We have experience in/interest in providing services focused on pregnant individuals and their families in order to improve birth outcomes.

☐ We have read the Summary Standards document and understand that the PCHI® Model requires certain standards to be met and that CCAs will partner with the HUB on ongoing development and quality improvement processes to meet the needs of those we serve and meet the PCHI® certification requirements.

☐ We confirm that we have professional liability insurance coverage of not less than $1,000,000 per occurrence.

Core Application Questions

Section 3. Please answer the following questions to help us better understand your organization and its interest and capacity to partner with the HUB as a Care Coordination Agency (CCA). [8 questions total]

1. Share your **understanding of the Pathways Community HUB Institute® Model** and the primary reason(s) your organization is **interested in being a Care Coordinating Agency (CCA)** for the Omaha Pathways Community HUB.

2. Share your organization's history and **experience as it relates to navigation or care coordination services** for social and medical needs for individuals and families in Omaha, NE. Include details on the following:

- Experience specifically serving individuals east of 72nd st. or from communities that are historically under-resourced.
- Examples of your success, outcomes achieved, and how your organization addressed any barriers.
- Examples of how you've established trust with those you serve.
- If you have specific populations you serve and / or limitations on who you are able to serve through your organization.

3. Explain your **experience in working to improve birth outcomes**, and/or address maternal and child health needs, including how this work fits within your Mission. Or, how you plan to grow your work and Mission related to this work.

4. Explain your **experience serving the Black community** including the nature of services, outcomes, and how you integrate the experiences and perspectives of members of the Black community in your ongoing work (i.e., planning, implementation, and evaluation). Or, how you plan to grow your work in this focus areas.

Core Application Questions Continued

5. Community Health Workers (CHWs) are key to the success of the HUB model. In this model we define CHWs as trusted individuals with deep knowledge of the community, expertise in navigating resources, and strength in building relationships. CHWs should share identities with those they serve which may include race, ethnicity, language, lived experience or others. CHWs are often called by different titles such as Promotoras, peer navigators, outreach specialists, etc. There is an example job description in the RFA materials that can be modified with the HUB and selected agencies as needed.

Share your **experience employing and supervising CHWs** (or a similar role). Include:

- How many CHWs you currently employ
- A high-level description of where and how your CHWs practice and who they are serving
- Your supervision model (including details on personnel providing supervision and how supervision is provided)
- Training requirements for your CHWs and any ongoing training / development provided to CHWs

If you do not currently employ CHWs, describe your interest in employing CHWs and your plan for supervision, support and training of CHWs.

Core Application Questions Continued

6. Describe how **diversity, equity, inclusion and belonging are addressed** within your organization. Share how this is addressed from a program/client experience perspective, as well as with leadership, board involvement, employees and overall operations.

7. This funding will support two (2) CHWs at an organization (or FTE equivalent). Indicate how many CHWs you plan to dedicate to providing community-based care coordination through the HUB, or if you anticipate hiring new positions (and if so, estimated length of time to hire).

8. The HUB and selected agencies will work together to finalize budgets and payment models. To help inform that work please indicate **your resource / funding needs** to support employment of two (2) CHWs (or FTE equivalent) to work through the HUB. Please estimate costs including CHW salary, benefits, supervision costs, and associated operating expenses (i.e., mileage, supplies, mobile phone, etc.). Please share if you have existing funding to support CHWs in this work including any details you can share about funding level and period of funding available.

Section 3 will be answered on a separate document and uploaded into the grant application online. Answers should be provided to all questions within 4 pages, single space, 11 pt font.

Organizational Policies and Assurances

Section 4.

- Provide a copy of your non-discrimination policy
    - Please do not provide entire operating manual but only select relevant page(s)
- Leadership attestation for support of this work
    - Include appropriate leader contact information
    - Leader = someone with organization decision-making authority (e.g., CEO or like position)

Review and Selection Process

Application Review Rubric (stronger responses will earn higher number of points)

Core Application Questions	Scoring	Core Application Questions	Scoring
1. Understanding of PCHI® Model and interest in serving as CCA.	0 – 5pts	7. Plan for hiring CHWs	0 – 2pts
2. Experience with navigation / care coordination services (serving communities historically under-resourced) [or plan to build this work]	0 – 5pts	8. Funding needs / availability of existing funds	0 – 3pts
3. Experience working to improve birth outcomes / address maternal and child health needs [or plan to build this work]	0 – 3pts	**Additional Review Questions**	**Scoring**
4. Experience serving Black community and centering lived experience in the work [or plan to build this work]	0 – 3pts	Non-Discrimination Policy	0 – 2pts
5. Experience employing CHWs and planned supervision model [or plan to build this work]	0 – 5pts	Organization acknowledgement of requirements / leadership assurance	0 – 2pts
6. Approach to Diversity, Equity, Inclusion, and Belonging	0 – 2pts	Overall impression of application and applicant's ability to effectively implement the project	0 – 5pts

Key Considerations:

- Funding is to support agencies to partner with the HUB to build and implement the PCHI® model in Omaha
    - Setting the foundation for growth and expansion
    - Innovating to address social needs and equity
    - Not to fund existing work or expand existing capacity
- The CCAs have critical responsibilities to effectively lead this work with fidelity
    - Strong supervision, partnership development, quality improvement, data collection and documentation are needed
    - Understanding of the standards and requirements is important (see RFA materials for summary of standards)
- The partner and resource network is wide reaching and there is a need and opportunity for all to engage

Next Steps

- Materials available at https://omahafoundation.org/HUB-RFA
- Applications will be submitted via OCF grant portal
    - https://omahafoundation.submittable.com/submit/268500/omaha-pathways-hub-community-care-agency-request-for-applications-2023
- Questions can be submitted via email to Kelly@omahafoundation.org
    - Updated answers will be shared online within 3 days of receipt
- Technical Assistance Sessions
    - Thurs, Aug 10th 12:00 – 1:00 CT
      https://us02web.zoom.us/j/83757196173?pwd=YW9wc3ltdTZoS1pxaVNvajJhc1Fjdz09
    - Fri, Aug 18th 10:00 - 11:00 CT
      https://us02web.zoom.us/j/82468701651?pwd=UitHbHd4YTFFa2RZcWlJeDlNWkhZZz09

Questions?

Omaha Pathways Community HUB

Omaha Community Foundation Affiliate

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