Request for Applications (RFA)

Subject Matter Expertise:

Practice Transformation Coaches for Community Health Centers

1. Patient Centered Medical Home (PCMH)
2. Social Determinants of Health (SDOH)

RFA Released: March 12, 2018

Applications Due: Rolling

Point of Contact:

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California Primary Care ASSOCIATION

Request for Applications Overview

The California Primary Care Association (CPCA) is soliciting interested individuals to serve as contract Practice Transformation Coaches for our Patient-Centered Health Home (PCHH) and Social Determinants of Health (SDOH) Initiatives. Ideal candidates will have specific content and training experience with California's network of community clinics and health centers (CCHCs). The role of the Practice Transformation Coach is to provide support and guidance to community health centers working to become a recognized PCMH (Patient-Centered Medical Home) or supporting the integration of a standardized SDOH screening tool called PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences). The role of the coach is one of facilitation, motivation, communication and education. The coach will utilize these skills to engage and assist the practice in redesigning care processes to provide evidence based, patient-centric care that maximizes resources and facilitates an efficient work environment.

Transformation of a practice is an evolutionary process which takes significant time and support for success. The responsibilities of a coach is to assist in setting the vision and the broad approach, as well as assist in very concrete tasks that will move the practice forward in making change. At a high level the coach will:

- Help to prepare the organizational infrastructure for quality improvement implementation through such activities as advising on team-building, improving communication, facilitating meetings, and helping to develop leadership skills.

- Communicate the vision for change through activities such as presenting best practices and sharing what other organizations have done, both as it relates to NCQA recognition and Patient Centered Health Home operations.

- Help people to better understand how their practice compares to the ideal and where there is room for improvement by observing and delineating practice operations, assessing needs, and assessing baseline data, as well as guiding discussions of the current practice and opportunities for change.

- Assist with the preparation, implementation and reporting for the PRAPARE tool to help community health centers identify and act on social determinants of health through various activities such as evaluating data, responding to social determinants of health data with interventions and partnering with key community organizations.

Organization Information – California Primary Care Association (CPCA)

For over 20 years, CPCA has provided leadership and education to California's community clinics and health centers. We serve our members and their networks so that they can best serve their communities and improve the health status of over six million Californians. CPCA represents more than 1,300 not-for-profit Community Health Centers and Regional Clinic Associations who provide comprehensive, quality health care services, particularly for low-income, uninsured and underserved Californians. CPCA's mission is to lead and position community clinics, health centers, and networks through advocacy, education, and serve as key players in the health care delivery system to improve the health status of their communities.

Purpose – Patient Centered Health Home (PCHH) Initiative Overview

A Patient Centered Health Home is an approach that uses a 'whole person' orientation to provide comprehensive health care by facilitating an active partnership between patients, their family, and their primary care provider team to provide high quality, timely care in a coordinated and consistent way. Since 2014, CPCA created the PCHH initiative to support our members achieve PCMH recognition. PCMH accreditation goes through the National Committee for Quality Assurance (NCQA), the Accreditation Association of Ambulatory Health Care (AAAHC) or The Joint Commission (TJC). CPCA members have historically sought PCMH recognition from NCQA. This approach provides patients with what they need, when they need it, in a manner where patients and providers work as partners in managing their care that is coordinated with the right people talking to each other. The basic tenet of the Patient Centered Medical Home is to reduce episodic sick care and move toward management of the patient and community to maintain their collective health. Find more information in **Appendix A.**

Purpose – Social Determinants of Health (SDOH) Initiative Overview

Social Determinants of Health are the external conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. In order to position health centers to perform well in a value-driven, accountable health system, as well as contribute to the community-level transformation changes necessary to improve population health and achieve health equity, they must more systematically understand and plan for the social risk factors that put their patients at risk for poor outcomes and higher cost. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) assessment tool is now the dominant standardized social risk screening protocol used by health centers nationally, and it has become an increasingly utilized tool across California. CPCA is committed to support PRAPARE as part of a national effort to

help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. Find more information in **Appendix B.**

Information Requested

Applications may be e-mailed to Peter Dy at pdy@cpca.org. Applicants should expect to receive a self-assessment link following an application submission. Applicants must submit the following attachments in their e-mail:

1. Capability Statement Word Document
2. Resume or Curriculum Vitae (CV)
3. Letter of Support

- **Capability Statement Word Document**
  - **Capability Statement (page limit: 2 page) that demonstrates ability to deliver services in the content areas chosen, specifically:**
    - Evidence of successful and effective training and support with PCHH or SDoH
    - Demonstrated current, content knowledge of the federal Health Center Program authorized under Section 330 of the Public Health Service Act
    - Any Practice Transformation or Leadership experience
    - Availability to take on practice transformation coaching duties
  - Include one sample presentation/publication
  - Include one past training evaluation demonstrating feedback
- **Resume or Curriculum Vitae (CV)**
- **Letter of Support**
    - From someone who was coached or mentored in the past on each content area
    - One letter of support required per topic area.

Evaluation Criteria (Domain/ Criteria / Points)

Proposals submitted will be evaluated by CPCA staff leadership using the table below. Incomplete applications will not be considered.

Selection Domain	Application Selection Criteria To earn full points in each domain, the applicant must demonstrate:	Points
Capability Statement	Expertise in the selected content area as well as training delivery as evidenced by clear description and demonstration of understanding and experience within the FQHC environment, if applicable.	**15**
Experience and Education	Resumes/CVs clearly show tenure, professional experience and/or education that reflects knowledge and ability in content expertise and training.	**15**
Work Samples	Demonstrate strong subject matter expertise as well as training and communication skills and content knowledge, as evidenced by: • Sample presentation(s) • Training evaluation data • Qualitative data/and or testimonials from community health centers or related audiences (if applicable and available)	**15**
Completeness of Application	Application materials submitted are responsive to RFA guidance, clear and complete.	**5**
Total Points		**50**

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Appendix A: CPCA PCHH Practice Transformation Coach

The role of the PCHH Practice Transformation Coach is to provide support and guidance to community health centers working to become a recognized Patient Centered Health Home. The role of the coach is one of facilitator, motivator, communicator and educator. The coach will utilize these skills to engage and assist the practice in redesigning care processes to provide evidence based, patient-centric care that maximizes resources and facilitates an efficient work environment.

Transformation of a practice is an evolutionary process which takes significant time and support for success. The responsibilities of a coach is to assist in setting the vision and the broad approach, as well as assist in very concrete tasks that will move the practice forward in making change. At a high level the coach will:

- Help to prepare the organizational infrastructure for quality improvement implementation through such activities as advising on team-building, improving communication, facilitating meetings, and helping to develop leadership skills.
- Communicate the vision for change through activities such as presenting best practices and sharing what other organizations have done, both as it relates to NCQA recognition and PCMH operations.
- Help health center staff to better understand how their practice compares to the ideal and where there is room for improvement by observing and delineating practice operations, assessing needs, and assessing baseline data, as well as guiding discussions of the current practice and opportunities for change.

Core competencies of the coaching role include:

- Some clinical understanding and credibility.
- Experience with and understanding of the outpatient clinical setting.
- General knowledge and experience with quality improvement methods.
- Knowledge of, and experience with, the Model for Improvement and the Building Blocks of High Performing Primary Care.
- Knowledge of, and experience with, the NCQA PCMH recognition process.
- Familiarity with data systems, including registries.
- Understanding of performance reporting and measurement.
- Group facilitation skills.
- Project management skills.
- Knowledge of practice management and/or financial aspects of the practice.

Scope of Work

- Through the CPCA PCHH Initiative, the coach will work with the health center. The goal of this coaching project is to facilitate the practice changes necessary to achieve PCMH recognition through a national recognition body (e.g. NCQA, AAAHC, TJC).
- Help community health centers prepare the organizational infrastructure for quality improvement implementation through various activities, such as advising on team-building, improving communication, facilitating meetings, and helping to develop leadership skills.
- Communicate the vision for change throughout community health center leadership and staff through activities such as presenting best practices and sharing what organizations have done, both as it relates to NCQA recognition and practice transformation.

Coach Responsibilities

The Practice Transformation Coach will provide tailored assistance to facilitate practice transformation and guide the health center through the recognition process. Specific activities will include:

- Evaluate practice pre-assessment surveys to determine an appropriate health home recognition implementation plan.
- Create and share a health home recognition implementation plan (road map) to be reviewed and approved by sites.
- Provide survey review support as sites are ready to complete recognition application materials to NCQA.
- Provide project management support and track milestones and activities in project management tools.
- Regularly interact with sites to provide feedback, answer questions and monitor implementation plan progress.
- Review PCMH recognition documentation made available by sites.
- Develop PCHH analysis report to include identified implementation and transformational goals.
- Participate in (and occasionally lead) PCHH implementation site meetings when appropriate.
- Conduct site visits as appropriate as a means of check-in, participating in meetings, or providing overall health home recognition implementation support as needed.
- Regularly interact with sites to provide ad-hoc support to PCHH implementation team members through emails/phone calls to provide feedback, answer questions and monitor implementation plan progress.
- Assist practices in locating needed resources for Patient Centered Health Home transformation.

- Review PCHH recognition documentation made available by sites.
- Participate in live, virtual NCQA evaluations for new and renewing practices.
- Participate in NCQA virtual check-in with PCHH implementation team as needed.
- Provide quality improvement and sustainability planning support post-recognition application success, when engaged in transformational coaching.
- Conduct gap analysis that identifies and maximizes workflows to align with evidence-based decision-making techniques.
- Provide support and training for the annual recognition process, including to educate health centers about sustainability measures that will facilitate annual reporting recognition. This can include those activities already addressed above.

Additional responsibilities include:

- Attend regular professional development opportunities to maintain qualifications.
- Participate on coach peer networking calls and events as able.
- Availability to respond to staff in a timely manner.

Qualifications

Required Qualities:

- Experience in a clinical or healthcare setting.
- At least two years of clinical quality improvement, process improvement, and/or population management experience.
- Knowledge of the Patient-Centered Medical Home and/or Chronic Care models.
- Experience working with community health centers and/or safety net practices.
- Familiarity with health information technology, including practice management systems, electronic health records, and/or registries.

Desired Qualities:

- A degree in health administration, health information, nursing, or public health.
- Ability to establish and maintain effective working relationships.
- Certification in healthcare quality or healthcare information.

Time Expectations

Based upon agreed consultant time capacity, coaches can expect to dedicate approximately 4-5 hours per week per practice. Actual time spent per practice will vary based on site's needs and goals. Communication between a coach and their assigned practices will be mostly electronic (conference calls, webinars, etc.), with occasional on-site meetings as needed. Periodic travel for site visits and meetings, including driving an automobile and flying in an airplane may be needed.

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Appendix B: CPCA SDOH Practice Transformation Coach

The role of the Practice Transformation Coach is to provide support and guidance to community health centers on collecting data needed to better understand and act on their patients' social determinants of health with the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool. The role of the coach is one of facilitator, motivator, communicator and educator.

Transformation of a practice is an evolutionary process which takes significant time and support for success. The responsibilities of a coach is to assist in setting the vision and the broad approach as well as assist in very concrete tasks that will move the practice forward in making change. At a high level the coach will:

- Help to prepare the organizational infrastructure for implementing PRAPARE, a SDOH data collection tool, through such activities as advising on team-building, improving communication, facilitating meetings, and helping to develop leadership skills.
- Help health center staff to better understand SDOH, how their practice compares to the ideal, where there is room for improvement by observing and delineating practice operations, assessing needs, and assessing baseline data, as well as guiding discussions of the current practice and opportunities for change.

Core competencies of the coaching role include:

- Knowledge and understanding of data, measurement and social determinants of health.
- Experience and understanding of the outpatient clinical settings and community resources.
- General knowledge and experience with quality improvement methods.
- Familiarity with data systems, including registries and electronic health systems.
- Ability to understand and explain data reports in different ways to different stakeholders.
- Group facilitation and project management skills.
- Knowledge of practice management and/or financial aspects of the practice.
- Experience in researching models, tracking workflows, and sharing written information.
- Knowledge of clinical settings and culture, including an understanding of managing change.
- Ability to think strategically and deliver technically.
- Excellent interpersonal, oral and written communication and organizational skills.
- High level of comfort with ambiguity and ability to create direction from it.
- Knowledge of existing community partnerships to address social risk factors.

Scope of Work

- Assist community health centers in the preparation and technical implementation of the PRAPARE tool. The goal is to prepare health centers to use the standardized patient risk assessment tool as a process and collection of resources to identify and act on social determinants of health in an effort to promote community transformation and achieve health equity.
- Communicate the importance for the new data collection initiative and educating key staff on the importance of collecting social determinants of health and how it aligns with activities the organization is already doing.
- Help community health centers prepare the foundation for identifying and acting on social determinants of health through various activities, such as developing workflow models, motivational interviewing, developing data strategies, building capacity to respond to SDOH data, reporting on SDOH measures, identifying social risks impacting patient populations, analyzing data to determine core needs of patients and collaborating with community resources.

Coach Responsibilities

The Practice Transformation Coach will provide tailored assistance to facilitate successful technical implementation and ongoing use of the PRAPARE tool. Specific activities will include:

- Develop workflow models for a new data collection initiative.
- Assist with the technical implementation of the PRAPARE with EHRs.
- Assist with identifying social risks that are impacting patient population.
- Develop a data strategy for assessing SDOH (data documentation, reporting templates, data integration and population-level planning).
- Develop a system for reporting data so it can be effectively communicated to providers, community partners, payers, policymakers and other stakeholders to promote community transformation.
- Help with evaluation of SDOH data (data gathering/validation process).
- Build capacity to respond to social determinants of health data.
- Monitor and advance community partnerships around SDOH activities.
- Identify gaps in information to further SDOH initiative and develop data strategy plans.
- Function as a key contributor to the development of a more impactful patient care team that attends t
- o the determinants of poor health using respectful, sensitive and motivational interviewing strategies, and creating actionable responses to patient priorities.

- Address enabling services interventions that create barriers for patients.
- Support community health centers in developing partnerships with community based, non-medical organizations to support addressing identified SDOH needs.
- Help health centers form cross-sectional partnerships with non-clinical community-based organizations.
- Function as a key contributor to the development of a more impactful patient care team that attends to the determinants of poor health using respectful, sensitive and motivational interviewing strategies, and creating actionable responses to patient priorities.
- Engage policy and practice conversations relating to equity, tracking health disparities, and providing technical assistance to community health centers members that are investing in SDOH work.
- Augment ways to share SDOH data across sites to foster ongoing quality improvement.
- Conduct site visits as appropriate as a means of check-in, participating in meetings, or providing overall PRAPARE implementation support as needed.
- Regularly interact with sites to provide ad-hoc support for PRAPARE implementation team members through emails/phone calls to provide feedback, answer questions and monitor implementation plan progress, and communicate to CPCA liaison when issue arises.
- Work to develop and offer onsite training for staff around workflows for tracking and improvement of social determinants.
- Augment ways to share data across sites to foster ongoing improvement.
- Engage conversations relating to equity, tracking health disparities, and providing technical assistance to health centers that are investing in social determinants of health work.

Additional responsibilities include:

- Attend regular SDOH Peer Network, Learning Cohorts or in-person trainings.
- Participate on coach peer networking calls and events as able.
- Availability to respond to staff in a timely manner.

Qualifications

Required Qualities:

- Knowledge of Social Determinants of Health and data collection tools such as PRAPARE.
- Experience in a clinical or healthcare setting.
- At least two years of process improvement, and/or population management experience.
- Knowledge of patient engagement, developing workflows electronic health records, data analytics and motivational interviewing.
- Experience working with community health centers and/or safety net practices.
- Familiarity with health information technology, electronic health records, and/or registries.

Desired Qualities:

- A degree in health administration, health information, nursing, or public health.
- Ability to work well in a professional environment, including respect for different styles and personalities; enthusiasm for collaboration, communication and celebration.
- Certification in healthcare quality or healthcare information.

Time Expectations

Based upon agreed consultant time capacity, coaches can expect to dedicate approximately 4-5 hours per week per practice. Actual time spent per practice will vary based on site's needs and goals. Communication between a coach and their assigned practices will be mostly electronic (conference calls, webinars, etc.), with occasional on-site meetings as needed. Periodic travel for site visits and meetings, including driving an automobile and flying in an airplane may be needed.