

Project Charter

The Project Charter allows for project focused documentation and level setting of key decisions and inputs that come from other tools such as driver diagrams and aim statements. The project charter documents the project plan in a comprehensive way.

Name of Project:	Providing Access and Transforming Health (PATH) Collaborative Planning and Implementation (CPI) Initiative: Northwest Region
Project Time Period:	January 1, 2023 – December 31, 2023
Brief Description of Project/Scope:	<p><i>What will the Collaborative or focus on?</i></p> <p>The CPI initiative provides funding for county and regional collaborative planning efforts to support the implementation of Enhanced Care Management (ECM) and community supports in the Northwest region of Northern California. The Northwest region counties are Del Norte and Humboldt. The Population Health Innovation Lab (PHIL) will support the Northwest region.</p> <p>This CPI collaborative consists of partners across different jurisdictions in California to identify, discuss, and resolve implementation issues and determine how PATH and other CalAIM initiatives (e.g., Incentive Payment Program) may be used to address program implementation gaps and improve health outcomes for varying populations of focus.</p>
Background/ Problem Statement:	<p><i>How did you get here? What is the problem? This may be your aim statement (see separate tool), it may be a more focused problem that drives the aim statement.</i></p> <p>How can the Northwest region collaborative work cross-collaboratively to develop the “on-the-ground” needed capacity among partners to scale up services provided to Medi-Cal beneficiaries through ECM and Community Supports?</p>
Goals:	The Northwest region collaborative will strengthen capacity of “on-the-ground” partners to successfully participate in the Medi-Cal delivery system and scale up services provided to Medi-Cal beneficiaries through ECM and Community Supports.
Deliverables/ Objective (1): (Please use SMART¹ objectives)	<p><i>What are the outcomes you are looking to accomplish?</i></p> <p>Build community-based organization (CBO) partner capacity to bill for Community Supports by providing trainings and 1:1 technical assistance through December 31, 2023.</p>
Expected Impact:	<p><i>How will the changes result in an improvement? Who is better off?</i></p> <p>This will increase institutional knowledge around billing and enable CBO partners to accept more patient referrals and reduce the frequency of CBO partners turning down clients. As a result, CBOs will be able to sustain provision of Community Supports.</p>
Milestones (with estimated time frames):	<p><i>What are the key milestones the group wants to meet? By what time?</i></p> <p>Technical Assistance (TA) and Q&A sessions led by billing specialists at Partnership HealthPlan of California, California Department of Health Care Services (DHCS), and/or TA providers hired by PHIL.</p>

¹ SMART: Specific, Measurable, Achievable, Relevant, and Time-Bound

Constraints, Assumptions, Dependencies, and Risks	<ul style="list-style-type: none"> • Sufficient TA and trainings available to meet CBO needs • TA and trainings are relevant and effective • CBO capacity to engage in TA and trainings
Measures of Success:	<p><i>Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.</i></p> <ul style="list-style-type: none"> • Increase institutional knowledge on different billing practices. • Increase number of billing specialists hired. • Change in volume of client referrals that are accepted/denied due to billing issues.
Deliverables/ Objective (2): (Please use SMART ¹ objectives)	<p><i>What are the outcomes you are looking to accomplish?</i></p> <p>Strengthen provider and CBO relationships with Partnership Health Plan and DHCS by December 31, 2023.</p>
Expected Impact:	<p><i>How will the changes result in an improvement? Who is better off?</i></p> <ul style="list-style-type: none"> • Communicating directly with Partnership HealthPlan and DHCS will enable collaborative participants to share feedback and streamline information gathering for providing ECM and Community Supports in the region. • Reduce impact of disconnect between MCP and on the ground partners by ensuring that on-the-ground partners to provide direct feedback on ECM and Community Supports implementation challenges. • Increased DHCS and Partnership Health Plan collaborating with partners to streamline communications to address barriers for increasing capacity.
Milestones (with estimated time frames):	<p><i>What are the key milestones the group wants to meet? By what time?</i></p> <ul style="list-style-type: none"> • Identify key points of contacts with Partnership HealthPlan and DHCS to have two-way direct lines of communication with on-the-ground partners. • Partnership HealthPlan and DHCS representatives routinely attend discussion forums and meetings hosted by CPI.
Constraints, Assumptions, Dependencies, and Risks	<ul style="list-style-type: none"> • Assuming Partnership HealthPlan and DHCS have capacity for direct line of communication with partners. • Assuming that direct line of communication will result in action/changes in response to partner feedback.
Measures of Success:	<p><i>Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.</i></p> <ul style="list-style-type: none"> • One or more Partnership HealthPlan personnel attends all monthly convenings. • One or more DHCS personnel attends all monthly convenings.
Deliverables/ Objective (3): (Please use SMART ¹ objectives)	<p><i>What are the outcomes you are looking to accomplish?</i></p> <p>CPI collaborative participants will establish cross-sector care coordination infrastructure to improve and coordinate patient care by December 31, 2023.</p>

Expected Impact:	<i>How will the changes result in an improvement? Who is better off?</i> Establishing cross-sector care coordination infrastructure across partners and counties will allow staff to focus on coordinating patient care through ECM and Community Supports. This will also facilitate case management and data exchange across partners.
Milestones (with estimated time frames):	<i>What are the key milestones the group wants to meet? By what time?</i> <ul style="list-style-type: none"> • Comprehensive list of care coordination tools and platforms across partners • Data sharing procedures • Document standardization procedures
Constraints, Assumptions, Dependencies, and Risks	<ul style="list-style-type: none"> • Funding constraints • Partners' technical expertise of care platforms • Current and potential providers already embedded into their care coordination platform of choice • Different care coordination platforms may not work together
Measures of Success:	<i>Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.</i> <ul style="list-style-type: none"> • Partners can effectively exchange data and facilitate cross-sector case management. • Referral pathways and procedures are identified.
Deliverables/ Objective (4): (Please use SMART ¹ objectives)	<i>What are the outcomes you are looking to accomplish?</i> Build a relationship among community-level service delivery networks to increase provider knowledge of ECM and Community Supports system by December 31, 2023.
Expected Impact:	<i>How will the changes result in an improvement? Who is better off?</i> <ul style="list-style-type: none"> • Increased provider knowledge on how to enroll as ECM provider and/or Community Supports • Increased care for populations of focus
Milestones (with estimated time frames):	<i>What are the key milestones the group wants to meet? By what time?</i> <ul style="list-style-type: none"> • Expand workforce to support ECM & Community Supports • Onboard and train new dedicated staff and providers for ECM & Community Supports
Constraints, Assumptions, Dependencies, and Risks	<ul style="list-style-type: none"> • Some providers do not know how to enroll as an ECM provider • Partners typically only have funds for dedicated staff and providers for short periods of time (i.e., one year) • Difficulty finding personnel for implementation
Measures of Success:	<i>Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.</i> <ul style="list-style-type: none"> • Increased number of enrolled ECM providers and Community Supports • Increase number of dedicated personnel for ECM & Community Supports per provider

Key Partners

Partnership HealthPlan of California
Department of Healthcare Services (DHCS)
Sterling Hospitalist Medical Group, Inc. dba Titanium Healthcare
24 Hour Home Care
Humboldt Senior Resource Center
Moms Meals
Emcara Health
Del Norte Senior Center
Del Norte Mission Possible
Arcata House Partnership
Del Norte County Department of Health & Human Services
Serene Health
North Coast Health Improvement and Information Network
Sutter Health
HEALTH ADVOCATES
Home and Health Care Management
EA Family Services
California WIC Association
CA Commission on Aging
Sutter Health
Arcata House Partnership
California Association of Licensed Midwives
California Collaborative for Long-Term Services and Supports (CCLTSS)
County of Humboldt
HiPaaS Inc.
EA Family Services
North Coast Opportunities Inc
Redwood Community Services



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	<p>North Coast Clinics Network</p> <p>Partnership HealthPlan</p> <p>St. Vincent Preventative Family Care</p> <p>Arcata House Partnership</p> <p>ORCA Behavioral Health</p> <p>Manifest Medex</p> <p>Hospital Council - Northern & Central California</p> <p>Humboldt County WIC</p> <p>Mom's Meals</p> <p>Serene Health</p> <p>Unite Us</p> <p>Roots Food Group</p>
Project Sponsor	Is there a leader of the group?
Anticipated FTE dedicated to this project	<p>How much FTE and resources are you (as the facilitator) dedicating to supporting this effort?</p> <p>1 Program Manager (100%)</p> <p>1 Project Coordinator (100%)</p> <p>Research staff support (100%)</p> <p>Communications (20%)</p> <p>Program Administration (10%)</p>
Anticipated funds needed to support this project	How are organizations leveraging funds from other CalAIM initiatives (CITED) to support this improvement effort?