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: Southwest Region
Project Time Period:	**January 1, 2023 – December 31, 2023**
Brief Description of Project/Scope:	*What will the Collaborative focus on?* 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 Southwest region of Northern California. The Southwest region counties are Lake, Marin, Mendocino, Napa, and Sonoma. The Population Health Innovation Lab (PHIL) will support the Southwest region. 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.
Background/ Problem Statement:	*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*. The CPI participant organizations are positioned across the Readiness Roadmap, still working towards successful implementation of Enhanced Care Management (ECM) and Community Supports services. Areas to support advancing along the Roadmap include: technical (contracting, capacity and infrastructure), relationship (historic experiences with public support and MCP relationships), billing issues (financial and reimbursement challenges) and systematic challenges (siloed processes, change management, and the lack of coordinated care and information sharing). How can the Southwest 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?
Goals:	The PATH Collaborative Planning and Implementation (CPI) initiative will support the advancement of CPI participants at least one step along the Readiness Roadmap towards successfully implementing Enhanced Care Management (ECM) and Community Supports services within the Medi-Cal delivery system through collaborative solutions that expand CPI participants' capacity and infrastructure needed to move towards an equitable, coordinated, and accessible Medi-Cal system by Dec 31, 2023.

Deliverables/ Objective (1): **(Please use SMART[1] objectives)**	*What are the outcomes you are looking to accomplish?* Increase capacity for CBOs to deliver ECM and CS services under CalAim.
Expected Impact:	*How will the changes result in an improvement? Who is better off?* 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.
Milestones (with estimated time frames):	*What are the key milestones the group wants to meet? By what time?* 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. Assess community-based organization (CBO) gaps in supporting ECM and Community Support services Offer CBO learning opportunities to address identified gaps in understanding ECM and Community Supports services (e.g., EHR, Delivery and Payment System processes). Facilitate technical assistance (e.g., how to leverage other financial support, billing Partnership HealthPlan) to strengthen organizational capacity of CBOs, particularly those that have historically been under-resourced.
Constraints, Assumptions, Dependencies, and Risks	• 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:	*Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.* • Identify gaps in CBOs delivering ECM and Community Support services • Track number and satisfaction of Learning Opportunities offered by PHIL • Increase knowledge during Learning Opportunity sessions • Facilitate TA for CBOs historically under-resourced and track satisfaction with TA
Deliverables/ Objective (2): **(Please use SMART[1] objectives)**	*What are the outcomes you are looking to accomplish?* Improve standardization of communication pathways between Partnership Healthplan and ECM / Community Support Implementers to enable optimal care delivery collaboration.

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

Expected Impact:	*How will the changes result in an improvement? Who is better off?* • 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 space for on-the-ground partners to provide direct feedback on ECM and Community Supports implementation challenges. • Increased DHCS and Partnership HealthPlan collaborating with partners to streamline communications to address barriers for increasing capacity.
Milestones (with estimated time frames):	*What are the key milestones the group wants to meet? By what time?* • Facilitate a "Solutions Network" subgroup comprised of representatives from each type of CPI organization and Partnership HealthPlan (PHC) to understand opportunities for process improvements in ECM / Community Supports contracting and delivery and to implement solutions. • Identify key points of contacts with Partnership HealthPlan to have two-way direct lines of communication with on-the-ground partners. • Partnership HealthPlan representatives routinely attend discussion forums and meetings hosted by CPI.
Constraints, Assumptions, Dependencies, and Risks	• Assuming Partnership HealthPlan 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:	*Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.* • Encourage participation and track representation from each county and type of organization participating in the Solutions Network • One or more Partnership HealthPlan personnel attends all monthly convenings.
Deliverables/ Objective (3): **(Please use SMART[1] objectives)**	*What are the outcomes you are looking to accomplish?* Care Delivery Improvements: Establish a system of coordinated care across stakeholders in the region.
Expected Impact:	*How will the changes result in an improvement? Who is better off?* Establishing cross-sector care coordination understanding and 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, referrals, and data exchange across partners.

Milestones (with estimated time frames):	*What are the key milestones the group wants to meet? By what time?* • Comprehensive list of care coordination tools and platforms across partners • Establish standardized workflows which facilitate integrated care coordination among cross-sector partners with built in flexibilities for local best practices as well as customizations for specific populations of focus. • Create an aligned process map of the referral and transfer steps between ECM organizations in the region and the necessary PHC touchpoints. • Engage the Solutions Network and key stakeholders in shared strategic planning and advocacy towards sustainable technology solutions to enable and sustain care coordination workflows and referral processes.
Constraints, Assumptions, Dependencies, and Risks	• 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:	*Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.* • Track number of integrated care coordination workflows established because of CPI collaborative participation • Percent of CPI participating organizations aligned with the referral process map • Percent of providers reporting satisfaction with their organization's written hand-off and follow up plan • Identify care coordination strategies • Percent of organizations that electronically share referral and care coordination information •
Deliverables/ Objective (4): **(Please use SMART[1] objectives)**	*What are the outcomes you are looking to accomplish?* Build a relationship among community-level service delivery networks to increase ECM and Community Supports system
Expected Impact:	*How will the changes result in an improvement? Who is better off?* • Improved relationships across the care delivery ecosystem leading to more equitable, accessible, and coordinated care • 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):	*What are the key milestones the group wants to meet? By what time?* • Host regular CPI convenings and trainings with representation from all types of CPI organizations, especially those historically under-resourced.

Constraints, Assumptions, Dependencies, and Risks	• Some providers may not participate if CPI duplicates collaboration elsewhere or if they cannot financially sustainably provide ECM or Community Supports services • Difficulty developing protocols and finding personnel for implementation
Measures of Success:	*Please indicate measure in terms of quantity, quality, and impact. Use the measurement strategy template to further detail your measurement plan.* • Facilitate and track number of CPI collaborative convenings as well as participants representing historically under-resourced organizations • Number of CPI convening sessions with an activity session that includes participant interaction or networking
Key Partners	Partnership HealthPlan of California Department of Healthcare Services (DHCS) Sterling Hospitalist Medical Group, Inc. dba Titanium Healthcare SHARE Sonoma County Redwood Community Health Coalition - Petaluma, CA 24 Hour Home Care Adventist Health Mendocino Coast Hospitality Center Redwood Community Health Coalition Moms Meals Emcara Health Sonoma County Human Services Department Marin County CalAIM Collaborative Partnership HealthPlan of CA Partnership HealthPlan Master Care, Inc. County of Sonoma MidPen Housing Serene Health National Healthcare and Housing Advisors Serene Health

	Food For Thought Napa County Sutter Health HEALTH ADVOCATES Home and Health Care Management EA Family Services California WIC Association Kerry Landry Health Care Consulting, LLC E Center WIC Homeward Bound of Marin County of Sonoma- Dept of Health Services Marin Health and Human Services California Association of Licensed Midwives California Collaborative for Long-Term Services and Supports (CCLTSS) County of Mendocino HiPaaS Inc. Sonoma Connect | Sonoma Unidos EA Family Services North Coast Opportunities Inc Community Connect of California Redwood Community Services Committee on the Shelterless North Coast Clinics Network Community Support Network Napa County St. Vincent Preventative Family Care Redwood Quality Management Company North Coast Opportunities Aging Action Initiative

	Community Action Marin Marin Community Clinic NHHA ORCA Behavioral Health Manifest Medex BluePath Health Community Action Partnership Sonoma County Hickman Strategies LLC Hospital Council - Northern & Central California Hospital Council Northern & Central California Kaiser Permanente Kaiser Permanente kstambaugh@lifelongmedical.org LifeSTEPS Mom's Meals PHC Serene Health Unite Us Home Safety Services Seneca Family of Agencies
Project Sponsor	Is there a leader of the group?
Anticipated FTE dedicated to this project	How much FTE and resources are you (as the facilitator) dedicating to supporting this effort? 1 Program Manager (100%) 1 Project Coordinator (100%) Research staff support (100%) Communications (20%) Program Administration (10%)
Anticipated funds needed to support this project	How are organizations leveraging funds from other CalAIM initiatives (CITED) to support this improvement effort? Participants are encouraged to seek support from the TA Marketplace and to apply for CITED funds.

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