October 21, 2019

Dear Colleagues:

The 2020/2021 State of Ohio Biennial Budget provided increased funding to the Ohio Commission on Minority Health (Commission). This funding will allow for the further scaling of the Certified Pathways Community HUB Model. To this end, the Ohio Commission on Minority Health announces the third release of the availability of funds for calendar years 2020/2021 to support model expansion and replication grants. The new funding level for this grant funding period will be as follows: three new HUBs at $175,000 – for the first year. Grant applications selected for funding during the first release will make budget adjustments to reflect the new funding levels. This is a competitive-bid process and second year funding is impinging upon first year performance.

The third release will provide support for the replication and implementation of three new Pathways Community HUBs. New HUBs may be in the planning phase or may be in the beginning stages of operation. Please note, new HUBs will have an assigned existing HUB as a mentor. To this end, existing HUBs must not have any conflicting agreements that would prevent a mentoring relationship with an assigned new HUB that will be located in the new HUB locations as listed herein.

The three new HUBs must be located in and target services within one of the following areas: Clark County, Dayton (Montgomery), Fairfield County, Lorain (Lorain), Warren (Trumbull). The selection of these area was based on the Ohio Department of Health's 2014 Infant Mortality county - level data. Please note the Commission will only award funding for the development of one New Pathways Community HUBs within each of the identified five areas of the state which are listed in this paragraph as areas in previous IM HUB CY20 grant releases have already received funding. Furthermore, each new HUB must be a stand-alone HUB, located in the area which it will serve, and it must be fully responsible for implementing each component of the HUB model. No nested, lookalike or hybrid HUBs are permitted as this grant type funds a replication model.

Please note, this grant mandates: 1) the adoption and implementation of the "Pathways Community HUB Model", 2) the achievement of Pathways Community HUB model certification as a condition of funding, 3) implementation of all 20 pathways to demonstrate projected outcomes and 4) weekly data entry into the mandatory data system. Applicants must demonstrate the ability to implement quarterly clinical and pathway measures as well as the ability to evaluate program effectiveness. 5) No regional, hybrid, nested (services or billing through another HUB) nor look alike HUBs will be permitted. 6) Prior to submitting this proposal, please be aware that the service areas must be one of the aforementioned counties (or specific targeted areas within an aforementioned county). The service area may also include very specific targeted smaller geographic areas, such as a census tract or zip code area, in a contiguous county. THIS CAN ONLY OCCUR ONCE the need in the county of origin is met. Regional service areas are not permitted. 7) Additional funding can be used to help provide one-year survival data.

NEW APPLICATION PROCESS

Minority Health Grant Management (MHGM) System
In an effort to ensure grant application submission and grant reporting processes are more efficient, and to support the state of Ohio’s paper reduction initiative, the Commission has launched its electronic grants management system.

The Ohio Commission on Minority Health launched our automated grant application and reporting system. The notice of this system launch was sent out on our listserv and placed on our agency website and social media platforms. Pre Recorded technical Assistance Sessions on how to access, register and complete a grant application are located on the Commission website www.mih.ohio.gov, in the grant HUB Funding area on the Grant Opportunities page.
All grant applications must be submitted in the MHGM system to be considered for funding. In addition, if selected for funding, approved applicants will also submit all quarterly, annual, fiscal and evaluation reports in the MHGM system.

Enclosed, please find the application guidance for the Replication and Expansion of the Certified Pathways Community HUB Model for SFY 2020, which must be used along with the MHGM user guide when submitting the application for funding.

Please note all required documents and forms with required signatures must be uploaded in the MHGM to be considered for funding.

We strongly encourage you to: 1) Read the application guidance; 2) Read the MHGM Applicant User Guide; 3) Listen to the pre-recorded MHGM system Technical Assistance session or 4) View the Commission’s MIH Grant Application Overview webinars on the Commission’s website at www.mih.ohio.gov.

Given that this is a new system, we strongly advise that you allow sufficient time to allow any questions you may have to be submitted via email and responded to prior to the application deadline. Typically, responses are posted within 1-2 business days of receipt. Please send questions to minhealth@mih.ohio.gov.

The deadline for submission for this funding opportunity in the MHGM system is by 11:59 pm, Friday, December 6, 2019.

Sincerely,

Angela C. Dawson

Angela C. Dawson
Executive Director
BACKGROUND
In February 1986, the Governor’s Task Force on Black and Minority Health was appointed to determine the reasons why a disparity existed between the health status of minority and non-minority Ohioans and to recommend methods to remediate the disparity. In April 1987, the Task Force issued a final report including 12 recommendations. The twelfth recommendation called for the establishment of a Commission on Minority Health to implement the Task Force recommendations.

The Commission was established by Amended Substitute House Bill 171 and commenced operation on July 1, 1987. The Commission is interested in funding projects which are innovative, culturally sensitive and specific in their approach toward reduction of the incidence and severity of those diseases or conditions which are responsible for excess morbidity and mortality in minority populations. In 2000, the Commission provided seed funding to support the Community Health Access Project who helped to develop the Community Pathways HUB Model. Since then the Commission has funded the implementation of this model through our demonstration grant funding program.

The 2020/2021 State of Ohio Biennial Budget provided funding to the Ohio Commission on Minority Health. This funding was allocated to initiate the Certified Pathways Community HUB Model Expansion and Replication – Infant Mortality funding opportunity. This funding will provide support to expand five existing Pathways Community HUBs, one existing pending Pathways Community HUB and the replication and implementation of six new Pathways Community HUBs. Existing HUBs must have been in operation, at full capacity, for no less than three years. The three new HUBs must be located in and target services within one of the following areas: Clark County, Dayton (Montgomery), Fairfield County, Lorain (Lorain), and Warren (Trumbull) areas, based on the Ohio Department of Health’s 2014 Infant Mortality county-level data. Please note the Commission will only award funding for the development of three New Pathways Community HUBs within each of the identified five areas of the state which are listed above.

The HUB Model is an evidence-based community care coordination approach that has also demonstrated effectiveness within racial and ethnic populations. The Pathways Community HUB Model has been endorsed by several federal agencies such as: Agency for Healthcare Research and Quality, Center for Medicaid and Medicare Services, Center for Disease Control and Prevention, Health Resources and Services Administration, National Institute of Medicine and others. Applicants for funding are encouraged to visit the Agency for Healthcare Research and Quality to view the resource tool:


In addition, the Kresge Foundation has funded the creation of the Pathways HUB Certification Process. All grantees must agree to be certified and/or maintain certification to retain funding. The HUB Certification Prerequisites and HUB Certification Standards are located at the following link: pchi-hub.com. This Certification Process will be overseen by the Pathways Community HUB Institute. For additional information on the certification process which will occur in Year 2 of this funding cycle for new grantees, contact Ms. Brenda Leath at Pathways Community HUB Institute (pchi-hub.com). The costs for certification are an allowable cost. Information about certification costs can be found at pchi-hub.com.

This grant initiative is designed to assist the Commission in achieving the Healthy People 2020 goals of reducing the rate of all infant deaths, and to improve on each service area’s preterm birth rate. All grantees must work to achieve these established goals, along with efforts to address increased early and adequate access to prenatal healthcare, timely post-partum visits, increasing safe sleep practices, access to behavioral health services and the provision of other services that decrease social determinants of health risk factors that negatively impact birth outcomes.
INTRODUCTION
The Ohio Commission on Minority Health announces the availability of funds for FY20/21 for Infant Mortality grants. Grant funds in will not exceed:

- Year 1 - $288,800, for Existing Pathways Community HUB applicants in FY2020
- Year 2 - $175,000 for Existing Pathways Community HUB applicants in FY2021
- Year 1 - $191,000 for Existing pending HUB applicants in FY2020
- Year 2 - $191,000 for Existing pending HUB applicants in FY2021
- Year 1 - $175,000 for New HUB applicants in FY2020
- Year 2 - $288,800 for New HUB applicants in FY2021

As previously mentioned, the Commission will fund up to three new Pathways Community HUBs that must be located in the five aforementioned target areas. Other areas included in the first two rounds have already been funded.

Please note that existing HUB funding includes funds for the purpose of mentoring an assigned new HUB. To this end, existing HUBs must not have any conflicting agreements that would prevent a mentoring relationship with an assigned new HUB that will be located in the new HUB locations as listed herein. Should an existing HUB not have an assigned mentee, the number of expected enrollments will increase, proportionate to the additional level of funding. Furthermore, each new HUB must be a stand-alone HUB, located in the area which it will serve and it must be fully responsible for implementing each component of the HUB service model to include billing as per HUB Prerequisite #1 which states that, “The HUB is an independent legal entity or an affiliated component of a legal entity.” To this end, New HUBs may not nest their services or billing with an existing or pending HUB.

Amended Substitute House Bill 171 established Commission grants for the purpose of health promotion and prevention of disease among minority Ohioans who are economically disadvantaged. Minority groups are defined as African Americans, Hispanics, Native American Indians and Asians. Given that this grant is a model replication effort, all grantees will be required to primarily target minority at-risk pregnant women. However, Southeast Ohio applicants will be required to target minority at-risk pregnant women along with the majority population in their area.

This is a competitive-bid process and funding will be awarded to 501 (c) (3) community-based agencies or organizations with valid and active 501(c) (3) designation and status, as per the Internal Revenue Service (IRS) website. Furthermore, a copy of the agency’s IRS tax exempt certificate must be submitted at the time of application. Agencies using the tax exemption of a national parent organization must also submit a letter of authority to use the certificate of the national parent organization. The letter must be on original letterhead of the parent organization and it must bear the original signature of the CEO of the parent organization.

This Request for Proposal solicits grant applications meeting the requirements set forth in Chapter 3704 of the State of Ohio Administrative Code. Applications will be accepted exclusively from agencies or institutions meeting the eligibility criteria established by the Commission on Minority Health.

ELIGIBILITY
Priority shall be given to grant applicants who develop services in accordance with the mission of the Commission. To receive consideration for funding, applicants must:

- Demonstrate that at least 20% of project funds are received from sources other than grants awarded by the Commission on Minority Health;
- Be a public or private organization which has a valid and active 501 (c)(3) designation and status at the time of application;
- Develop and establish a management board for the administration of the grant, composed of proportionate representation of the population to be served and submit the Board Composition form with the grant application;
- Provide services in close proximity to minority communities or include minority communities in their stated service area; and
- Meet all licensure and certification requirements of the State of Ohio;
• Answer all questions listed on the Administrative Compliance form, and
• Comply with all current and applicable laws, regulations, rules, and administrative guidelines of the Ohio Commission on Minority Health.

The following are ineligible for funding consideration:

• Individuals
• Organizations that do not have a valid and active 501(c)(3) designation and status at the time of application
• National organizations: local chapters or affiliates of national organizations may be eligible if they meet the definition of a "community-based health group"
• Organizations applying for the sole purpose of acquiring funds to supplement existing programs without any plan for enlarging their scope of work
• Organizations in the process of creating or starting a "community-based health group" for the sole purpose of applying for grants from the Commission.
• Regional, hybrid, nested or look alike HUBs

Ohio Revised Code (O.R.C.) Section 9.24 prohibits the State from awarding a contract to any offeror(s) against whom the Auditor of the State has issued a finding for recovery if the finding for recovery is “unresolved” at the time of the award. By submitting a proposal, offeror warrants that it is not now, and will not become a subject of an “unresolved” finding for recovery under O.R.C. 9.24, prior to the award of any contract arising out of this RFP, without notifying the Commission of such finding.

PUBLIC RECORD NOTICE
It is expressly understood by the parties that the Ohio Commission on Minority Health (OCMH) is a public office and is subject to the Ohio Public Records Act, O.R.C. 149.43, et. seq. Upon receipt of a public records request, OCMH is required to provide prompt inspection or copies within a reasonable period of time of responsive records that OCMH determines, in its sole discretion, are public records subject to release.

If your organization chooses to have what is considered a proprietary trade secret, they must complete the following statement and submit to the Ohio Commission on Minority Health on your agency letterhead:

OCMH agrees not to disclose, without giving prior notice, any specific information that (organization) has previously identified as a proprietary trade secret. In the event that a person seeks that information through a public records request, OCMH will notify (organization) in the course of OCMH’s legal review to give (organization) an opportunity to establish to the satisfaction of OCMH that the information constitutes a proprietary trade secret that is exempt from disclosure under the Public Records Act. If OCMH does not find that the information constitutes a proprietary trade secret, OCMH will notify (organization) of its intention to disclose the information in accordance with law. (Organization) may choose to seek appropriate legal action, including injunctive relief, to prevent disclosure of the information at issue.

CRITICAL ELEMENTS OF ACTIVITIES
(Grant Participation Requirements)

The Ohio Commission on Minority Health expects successful applicants will be able to meet the following grant requirements.

1. All grant recipients must have a fully executed Acknowledgement of Terms (AOT), to include original signatures on the AOT as well as compliance with all identified program and all identified fiscal special conditions within 60 days of grant notice. The AOT will be provided to grant recipients after the awarding of the grant. Failure to meet this requirement will result in forfeiture of the grant.
2. All grantees must attend a mandatory grant start up orientation and Certified Pathways Community HUB training in Columbus, Ohio on or around December 2019. Therefore, applicants must account for travel, meal and lodging within their
program budget. The State will reimburse based on rates for lodging within the Continental United States (CONUS) set by the federal General Administration (GSA). Mileage reimbursement may not exceed the State of Ohio rate of $.52 per mile.

3. All funded agencies must agree to enter their data into the Care Coordination System which was developed for the Pathways Community HUB Model. http://carecoordinationsystems.com/. (The costs related to Care Coordination Systems are estimated to be up to $25,000 per year; pro-rated as needed. This is an allowable cost.)

4. All funded agencies must provide the Commission’s Program Manager, and the Research Evaluation Enhancement Program (REEP) access to their data within the Care Coordination System to allow for review, analysis, and monitoring of aggregate and disaggregated data and related information.

5. All funded HUBs must track, monitor and report on client services and pathways and provide updates in real time to the CCS data system. The data must be reviewed weekly to ensure accuracy. This data report must include total births by race, ethnicity and trimester, total births by birthweight (normal, low, very low), and preterm births by race, ethnicity and trimester.

6. All grantees must provide quarterly program, fiscal and evaluation reports to update the Commission on program progress and outcomes of each required goal and objective to date to include a discussion of the relationship between qualitative and quantitative outcomes.

7. All grantees must participate on monthly statewide HUB calls on a standing date to be shared in the AOT.

8. Existing Certified Pathways Community HUB applicants must: DOES NOT APPLY TO NEW HUBS FOR THIS RFP
   a. Have been in operation, at full capacity, for no less than three years and must reside in one of the following areas: Akron (Summit), Cincinnati (Hamilton), Mansfield (Richland), Youngstown (Mahoning), and Toledo (Lucas) prior to receipt of funding.
   b. Coordinate with the OCMH to provide and attend HUB orientation training.
   c. Agree to mentor an assigned agency implementing a new HUB replication.
   d. Establish required on-going regular communication with the assigned “New HUB”.
   e. Expand HUB service delivery within one month of funding to include immediate participant and staff recruitment (if needed) once the Notice of Award has been received.
   f. Provide Pathways care coordination services within the first month of funding to the targeted at-risk population.
   g. Expand staff as needed within the first month of funding.
   h. Utilize Community Health Workers (CHWs) to help achieve improved birth outcomes for those at-risk. CHWs may be certified or uncertified upon hire, through the Community Care Agency. However, the HUB must ensure (through sharing of CHW education opportunities) that each CHW meets the minimum training requirements as outlined in Appendix C. Certification must be obtained in approximately 6 months. Minimum training requirements are subject to change. Please visit pchi-hub.com to request additional information.
   i. Provide a one year follow up on each baby born into the HUB program

9. Existing pending Certified Pathways Community HUB applicants must: DOES NOT APPLY TO NEW HUBS FOR THIS RFP
   a. Have been in operation, at full capacity, for no less than one year and must reside in one of the following areas: Akron (Summit), Cincinnati (Hamilton), Mansfield (Richland), Youngstown (Mahoning), and Toledo (Lucas) prior to receipt of funding.
   b. Coordinate with the OCMH to provide and attend HUB orientation training.
   c. Agree to be a mentee to an assigned agency implementing an existing HUB for replication.
   d. Establish required on-going regular communication with the assigned “Existing HUB”.
   e. Expand HUB service delivery within one month of funding to include immediate participant and staff recruitment (if needed) once the Notice of Award has been received.
   f. Provide Pathways care coordination services within the first month of funding to the targeted at-risk population.
   g. Expand staff as needed within the first month of funding.
h. Utilize Community Health Workers (CHWs) to help achieve improved birth outcomes for those at-risk. CHWs may be certified or uncertified upon hire, through the Community Care Agency. However, the HUB must ensure (through sharing of CHW education opportunities) that each CHW meets the minimum training requirements as outlined in Appendix C. Certification must be obtained in approximately 6 months. Minimum training requirements are subject to change. Please visit pchi-hub.com to request additional information.
  
i. Provide a one year follow up on each baby born into the HUB program

10. New HUB Grantees must agree to:

a. Participate in HUB model orientation training.

b. Implement recruiting and hiring of staff and recruitment of participants within the first month of funding.

c. Utilize Community Health Workers (CHWs) to help achieve improved birth outcomes for those at-risk. CHWs may be certified or uncertified upon hire, through the Community Care Agency. However, the HUB must ensure (through sharing of CHW education opportunities) that each CHW meets the minimum training requirements as outlined in Appendix C. Certification must be obtained in approximately 6 months. Minimum training requirements are subject to change. Please visit pchi-hub.com to request additional information.

d. Adopt and implement the Pathways Community HUB model within 90 days of funding.

e. Begin the certification process within 6 months of Pathways HUB model service implementation. (Related costs to the certification process are allowable costs up to $15,000 in Year two – Visit pchi-hub.com for cost information.)


g. New Pathways Community HUB applicants and identified HUB care coordination agencies must agree to replicate the Model and participate in HUB Model training and mentoring process.

h. Participate in on-going communication with assigned “Existing HUB”.

i. Provide a one year follow up on each baby born into the HUB program

11. All funded grantees must comprehensively address reduction/elimination of known risk factors among high risk pregnant women through the implementation of all 20 Pathways and monitor these risk factors through a quality improvement program and data submission in the required data system. Please note, the number of pathways initiated should be correlate with the need demonstrated among the grantee’s target population. Furthermore, grantees must use Auto Trigger to initiate pathways.

12. All funded grantees must participate in the OCMH Minority Health Month Expo activity for 2020/2021. This statewide visibility campaign is held each year in Columbus Ohio on or around the last Thursday in March. In an effort to raise awareness about health disparities, OCMH funded agencies are required to set up a display table at the annual event. The 2020 MHM Expo will be held on March 24, 2020.

13. All grantees must create or maintain a Community Pathways HUB Advisory Board. This Community Advisory Board shall include no less than one member who has received services from the community HUB.

14. Each existing HUBs must deliver services to a minimum of 190 at-risk pregnant women prioritizing minority women within FY20, to reflect that a minimum of 50% of the women enrolled will be in their first trimester, 30% of the women enrolled will be in their second trimester, and no more than 20% of the women enrolled will be in their third trimester. Doesn’t apply to new HUBs.

15. Each existing pending HUB must deliver services to a minimum of 125 at-risk pregnant women prioritizing minority women within FY20, to reflect that a minimum of 50% of the women enrolled will be in their first trimester, 30% of the women enrolled will be in their second trimester, and no more than 20% of the women enrolled will be in their third trimester. Doesn’t apply to new HUBs.

16. Each new HUB must deliver services to a minimum of 115 at-risk pregnant women prioritizing minority women within FY20 to reflect that a minimum of 50% of the women enrolled will be in their first trimester, 30% of the women enrolled will be in their second trimester, and no more than 20% of the women enrolled will be in their third trimester.

17. Each existing HUB must deliver services to a minimum of 115 at-risk pregnant women prioritizing minority women within FY21 to reflect that a minimum of 50% of the women enrolled will be in their first trimester, 30% of the women enrolled will
be in their second trimester, and no more than 20% of the women enrolled will be in their third trimester. Doesn’t apply to new HUBs.

18. Each existing pending HUB must deliver services to a minimum of 125 at-risk pregnant women prioritizing minority women within FY21 to reflect that a minimum of 50% of the women enrolled will be in their first trimester, 30% of the women enrolled will be in their second trimester, and no more than 20% of the women enrolled will be in their third trimester. Doesn’t apply to new HUBs.

19. Each new HUBs must deliver services to a minimum of 190 at-risk pregnant women prioritizing minority women within FY19 to reflect that a minimum of 50% of the women enrolled will be in their first trimester, 30% of the women enrolled will be in their second trimester, and no more than 20% of the women enrolled will be in their third trimester.

20. Prior to submitting this proposal, please be aware that there are grant reporting mechanisms and evaluation reports that are required to be submitted to the Commission, in the MHGM System, on a quarterly basis if funded.

21. All grantees are required to submit: Annual Program Evaluation Reports, a 2020 Annual Program Reports and a 2021 Biennial Program Report by the required deadline as outlined in the AOT once awarded.

22. Prior to submitting this proposal, please be aware that the service areas must be one of the aforementioned counties (or specific targeted areas within an aforementioned county). The service area may also include very specific targeted smaller geographic areas, such as a census tract or zip code area, in a contiguous county. THIS CAN ONLY OCCUR ONCE the need in the county of origin is met. Regional service areas are not permitted.

23. Grantees are allowed to directly charge the grant to pay for CHW certification training from a community-based organization that is an approved/certified training entity by the Ohio Board of Nursing. Colleges and university based CHW certification programs are discouraged due to the infrequency and length of time between CHW classes.

24. Grantees are expected to ensure CHWs follow up with mothers to determine the infant’s one-year survival outcome.

25. The grantee is expected to recruit a minimum of 80% minority at risk pregnant women to effectively work to reduce infant mortality in their target area and within Ohio. This is particularly important give that certain areas of the state do not have a large percentage of minority at risk women. However, it is expected that recruitment of minority women would be prioritized.

26. It is the responsibility of each HUB to ensure that there are no duplicative payments for client services. Meaning, the HUB may not use grant funds to cover current Medicaid clients who may have other services paid for by Medicaid. However, each HUB is still expected to maximize any services that Medicaid eligible clients can receive.

**FUNDING**

For calendar year (SFY) 20-21, this Request for Proposal (RFP) has maximum funding ceilings as follows: Year 1 - $175,000 for New HUB applicants in FY2020 per applicant agency. ONLY ONE APPLICATION WILL BE ACCEPTED PER AGENCY in the MHGM System. The time period of January 1, 2020 through December 1, 2020 constitutes the first funding period covered by this RFP. Notification of funding will be in January 2020. As with all grants, funding is contingent on the availability of funds. Grants will be effective January 2020 with an immediate startup required: this must be reflected in the recruiting, hiring of staff, in the first month and the immediate implementation of program activities no later than the 2nd month of the 1st Quarter of funding.

**IMPORTANT:** This is a performance-based grant. The 2021 year of funding is non-competitive but is contingent upon a grantee achieving a proportionate level of projected outcomes during the first year of funding and the availability of funds. The Commission reserves the right to terminate a grant prior to the second funding cycle if the project does not perform in accordance with stated measurable outcomes. For the second year, program activities must continue, without gaps in services, by providing program activities beginning January 2021 through December 2021.
The Commission will not consider funding for proposals:
- Which seek funding to support residential services;
- When treatment constitutes the primary service;
- Which request funds for the purpose of construction or renovation;
- To conduct research and/or studies independent of service delivery;
- Which are legislatively mandated and funded by other public dollars;
- Exclusively designed to conduct conferences or workshops;
- Regional, hybrid, nested or look alike HUBs

APPLICATION DEADLINE and PROPOSAL PREPARATION
Applicants must submit their application in the electronic MHGM System. All applications must be submitted in the MHGM system by 11:59 p.m., December 6, 2019. All applications submitted after the time of 11:59 PM, will be considered late and will not be reviewed. All grant applications must be a complete (no missing requirements or signatures) and submitted in the MHGM system to be considered for funding. PLEASE BE AWARE: The submission of a technical assistance request regarding the application guidelines or the MHGM system during the application period will not change the application due date.

PLEASE NOTE: HAND DELIVERED, FAXED, EMAILED OR US MAILED APPLICATIONS WILL NOT BE ACCEPTED.

Pre-Recorded MHGM System - Technical Assistance Session
The Technical Assistance sessions to orient grantees to the new MHGM system located on the Commission website at www.mih.ohio.gov, on the Grant Opportunities page. Applicants can access the pre-recorded session that provides an overview of how to access, register and apply in the MHGM system on the Commission website at www.mih.ohio.gov at their convenience.

Grant Application Details – Technical Assistance Sessions
The Commission will provide one HUB grant RFP overview webinar which will provide an overview of the RFP for the application process and provide information to assist you in the development of your proposal. The pre-recorded TA sessions is available on our website as well. You are strongly encouraged to view the HUB RFP application webinar.

Application Question? – Submit Questions to OCMH
Please submit system related questions and RFP related questions to minhealth@mih.ohio.gov. All questions will be provided a response. Responses will then be placed in a frequently asked questions (FAQs), which will be posted the Commission website at www.mih.ohio.gov, on the Grant Opportunities page.

PROPOSAL PREPARATION
Proposals that do not provide all of the requested information, or do not meet all the requirements specified in the RFP, will be determined incomplete and will be disqualified. The Applicant User guide can be accessed on the Commission website at www.mih.ohio.gov.

Please refer to pages 1-10 of the Applicant User Guide general MHGM information to include account creation, passwords, login and quick tips. Each user must have only ONE user profile. Each user (program, fiscal, evaluator, etc.) must create their own user profile.

Responses to this RFP application should be prepared following the guidance described below.
IMPORTANT: The application sections do not have a save button. Grantees will have a maximum of 30 minutes to enter information. At 30 minutes the application will time out (due to network security concerns) and your work will not be saved. Please plan accordingly. OCMH suggests that you prepare your application in a separate word document to then copy and paste each section into the system. Once you click “Next” to advance to the next section the information will then be saved.

1. Face Sheet: To complete this section access the application in the MHGM system and refer to page 21 in the Applicant User Guide. Please use FY2020 as the state fiscal year. This will allow the proper application content to populate.

2. Organization Information: To complete this section access the application in the MHGM system and refer to page 23 in the Applicant User Guide.

3. Project Abstract: To complete this section access the application in the MHGM system and refer to page 24 in the Applicant User Guide.

4. Proposal Narrative: To complete this section access the application in the MHGM system and refer to page 25 in the Applicant User Guide. Be sure to answer each question in the proposal narrative section.
   a. Health Areas to be Addressed
   b. Demographics (Race, Ethnicity, Gender, Age Groups)
   c. Description of the Applicant Agency
   d. Problem Need Statement - In your response to these questions, be sure to provide a comprehensive narrative to describe the target area, target population, target area’s problems, needs, supporting data and research as well as the agency’s capacity to serve the target population.
   e. Comparative Advantage Return on Investment
   f. Elements of Sustainability

5. Staff Description: To complete this section access the application in the MHGM system and refer to page 28 in the Applicant User Guide.
   a. Staff Demographics.
   b. Board/Advisory Group Demographics.

6. Method of Implementation: To complete this section access the application in the MHGM system and refer to page 31 in the Applicant User Guide. In your response to these questions, be sure to provide a comprehensive narrative describing the proposed activities that will be provided under this grant.

7. Project Action Plan: To complete this section access the application in the MHGM system and refer to page 32 in the Applicant User Guide. Applicants will complete this required section in the MHGM system under Project Action Plan (formerly five standardized goals and objectives; now three standardized goals and objectives) FY20. As a reminder all required objectives must be responded to. For instructions on how to complete this section please refer to your MHGM Applicant User Guide.

8. Line Item Budget: To complete this section access the application in the MHGM system and refer to page 37 in the Applicant User Guide.
   A. General Information:
      i. Enter the required budget information in the MHGM system. Be sure to include costs associated with developing and implementing your proposed demonstration grant. Instructions are included for each form as appropriate.
      ii. Enter the budget narrative describing unit cost and itemization of each line item in the MHGM system.
      iii. Enter the 20% required matching funds. Administrative Code 3704-2-02 states: “That at least twenty percent of applicant funds and/or resources are received from sources other than grants awarded by the Commission on Minority Health”. In other words, the Commission cannot be the sole funding source of an agency. Please note,
this 20% match is not required to be a cash match but can be in-kind resources.

iv. Specified line item costs are appropriate and reasonable/justifiable.

v. Costs support direct client activities.

vi. All line items must be itemized and list unit cost for each requested expenditure.

vii. The Narrative should provide a detailed overview of the specific budget line item.

viii. Budget Appropriateness and Reasonableness: All line items need to be itemized and list unit costs. This should be detailed and reflect a per-hour or unit cost

B. Personnel and Fringe Benefits – Instructions

i. Only those employees in positions which provide direct client services are to be listed in the personnel section. (Given the increase there should be enough funding to keep this is administrative costs)

ii. Do not list contractual personnel or consultants in this section. They should be entered in the Contractual section.

iii. Provide the yearly salary budgeted for each position listed. The amount should be consistent with similar positions in the agency based on Full-Time Equivalency (FTE).

iv. The total number of months of employment projected per position for this grant.

v. Calculate the percent of time the employee will devote exclusively to the project under this grant; for example, a 40-hour per week agency employee who provides 20 hours of service on this project would be listed as 50%.

vi. Provide a narrative on the employee's salary that will be funded by the Commission based on annual salary number of months on the project and the percentage of time on the project.

Example: 1) An employee with an annual salary of $15,000 who works 12 months at 50% of his/her time would earn $7,500 from Commission funds; 2) an employee with an annual salary of $20,000 who works nine months at 25% of his/her time on the project would earn $3,750 from the Commission.

vii. If the agency pays one rate during a probationary period with an increase after probation, state budget assumptions on separate lines for each category and provide a narrative explanation.

viii. Provide the detailed narrative for the fringe benefits to be charged to the grant for all positions listed in the budget.

ix. Provide the percentage of employee fringe benefits.

x. Where appropriate, match must be identified for each line item.

C. Travel

i. Only employees who implement and provide direct services detailed in the project proposal and included in the approved budget may be reimbursed for actual travel expenses.

ii. Consultants may not charge travel to the grant under the travel category. Their travel must be included in the contract for reimbursement.

iii. State estimated number of miles that will be traveled and the rate at which payment would be made, not to exceed the State of Ohio of $.52 cents per mile. Example: 2,000 miles at $.52 cents = $1,040.00

iv. Projected number of overnight lodgings, number of people involved and the rate per day/per person should be stated. Lodging rate per day/per person may not exceed the state rate of $80.00 plus room tax (if applicable).

v. Meal expenses are allowable for dinner and breakfast when on an approved overnight stay, not to exceed $27.00 per day with receipts for full days of travel preceded and followed by overnight stays.

vi. Out-of-state travel is a non-allowable cost under this grant.

vii. Fees for conferences/training sessions, when determined to be related to specific job-duties and/or responsibilities are reimbursable or allowable. Projected number of such sessions and costs should be stated.

viii. Travel cost (mileage, meals, and hotel accommodations) to attend the Awards Ceremony and Health Expo scheduled for March 2020.
D. Equipment

Equipment is any tangible item having a useful life of one year or more which is purchased in whole or in part with Commission funds. Non-allowable costs include, but are not limited to, the following under this grant:

- DVD players/accessories
- Portable cameras
- Television
- Computers (laptops, tablets, notebooks, etc.)
- Ink Cartridges
- Typewriters
- Furniture (will provide state/federal salvage applications to successful grantees)
- Surcharge of Cell phones
- Vehicle purchases
- Reflotron machines
- Copiers
- Refrigerators
- Baby/infant seats, cribs, clothing, shoes
- Wii and other high-priced computer games or Fitbits.

Leasing/rental of any of this equipment may be considered. The rate per month and the number of months for leasing/rental should be stated.

E. Supplies (Each item must have a cost per unit stated)

For purposes of Commission funds, supplies consist of expendable property items which have a useful product life of one year or less. Supplies include all tangible, expendable property other than equipment purchased with Commission funds. Equipment priced less than $100 (e.g., staples, scissors, wastebaskets, paper, and pens) is considered office supplies.

Consistent with the Governor’s Executive Order 2007-09S, “refreshments” are not reimbursable under this grant. (See Commission website at www.mih.ohio.gov to review this EO.)

Printing: Costs may include typesetting, actual printing or photocopying of the material which is completed by a commercial printing company. Included also are costs for pamphlets, brochures and flyers. Provide the unit cost.

Contracts: Agreements for all sub-contracts must be submitted with the following being addressed: scope of service, beginning/ending date, hourly rate and total number of contract hours. Please note: Training for CHW certification is an allowable expense.

Advertising: Specify the media and cost of advertisement (e.g. 3 ads at $50.00 per ad).

Evaluator: As indicated in the Proposal Preparation section, a HUB evaluator must be selected.

Program Audit: If funded for Year II, agencies must include the cost for a program audit. Administrative/Indirect Costs: Total cost must not exceed 15% of the amount requested. Administrative costs can be direct and/or indirect and must be itemized. Below are types of administrative examples:

1) Administrative charges: salaries of support staff (administrators, secretaries, accountants). Provide the percentage of time on the project per line item;
2) Rental/space leasing: space rental is an allowable cost. Space for which rental fees will be paid must meet the following requirements:
   a. The number of months and the rate at which payment will be made should be stated;
b. When rent is shared among several programs, the amount charged to the Commission must not exceed the Commission's fair share. The agency must submit documentation of how the Commission's fair share was determined (e.g., if Commission-funded project uses 20% of the space, the Commission may be charged no more than 20% of the total rent);
c. submit a copy of the lease which includes the building owner's name, location of the building, square footage, total amount of rent paid, terms of agreement, termination clause, signatures of lessee and lessor;
d. approved rent is non-transferable from the original site to a new or relocated site.
e. Rent will not be approved for:
   • Space which is paid for by another state/federal program or private grant;
   • Space in buildings purchased with federal funds;
   • Space donated to the applicant agency.
   • Utilities: heat, water, electricity, etc.

9. Project Documentation - To complete this section in the MHGM system, refer to page 45 in the Applicant User Guide.

The project documentation area consists of a list of documents that must be downloaded and uploaded into the MHGM system for submission with your application. For a list of mandatory downloads and a list of uploads, please consult the applicant user guide as instructed above.

Please note, items that have an asterisk (*) beside them are mandatory upon submission of the grant.

Evaluation Plan

Evaluation procedures are both quantitative and qualitative, document intervention, and assess the degree to which intended objectives are achieved by clients or the agency. Therefore, it is expected that all funded HUBs have access to an evaluator from the beginning of the project through the end of the life of the project. An evaluator should be included in the project to assist the program director in designing client assessment forms in order to retrieve demographics and baseline information and to measure behavioral changes. Applicants are strongly encouraged to contact an evaluator when developing the proposal.

As an evidenced-based model, the HUB must have the infrastructure and capacity to fully implement the Certified Pathways Community HUB Model. Therefore, the HUB must have adequate infrastructure to track and document, and monitor the delivery of services to those at-risk and must have the capability to document the pathways process and outcomes.

All Commission funded grantees must agree to enter their data in a common Care Coordination System (CCS) data system developed for the HUB Pathways model and provide the Commission and Research and Evaluation Enhancement Program (REEP) panel of Wright State University access to review, monitor, and analyze information and aggregate data.

This grant requires implementation of clinical and non-clinical measures for the 20 Pathways. These measures must be included in the evaluation section. Organizations must demonstrate the ability to implement quarterly clinical and non-clinical measures to evaluate program effectiveness. Please ensure that you build into your plan the collection of required participant data (clinical measures, feedback) on a quarterly basis to allow for the reporting of behavioral outcomes. Please remember, the number of pathways initiated correlate to the needs of the high risk population served. Furthermore, each pathway that is deemed necessary must be opened as the need is determined, and reported on in each quarter. There is not to be a delay in documenting pathways opened, in the data collection system.

a. Describe the agency’s capacity to:

   Provide reports to the Ohio Commission on Minority Health that must include, at a minimum:
   • Number and demographics of clients served
   • Number of births, weights of infants (health weight, normal weight, low birth weight, very low birth weight, term of
birth (i.e.: preterm)) to include data by race, ethnicity and trimester of the at-risk mother’s enrollment.

- Number and demographics of infants served
- Risk (Social Determinant) tracking over time
- Information by client, care coordinator, agency, and HUB
- List of standardized Pathways
- Initiated Pathways (Number of women in this status)
- Pathways in Process (Number of women in this status)
- Incomplete Pathways and
- Completed Pathways
- Follow up on the one-year status of babies born into the HUB
- The number of mothers lost to contact in a given funding year by quarter and year to date

b. Provide a description of the role of the evaluator in the program’s design, implementation, the process and outcomes through the Care Coordination Systems which is designed to track, monitor, and report on client services.

c. The projected numbers for evaluation purposes must be based on those who both participate in educational programing as well as non-clinical and clinical measures.

d. Describe, in detail, the method(s) that will be used to determine whether the established standardized Pathways goals and objectives are being met by the HUB and whether the expected outcomes are being achieved. **Do not state in percentages.** Limiting your responses to statements such as, “we will hire a data analyst”, will be considered non-responsive.

e. Provide an overview of the valid time-lined outcomes and effectiveness of the project.

f. Provide an overview of how the current or proposed continual quality improvement plan will impact service delivery changes.

**Institutional Review Board (IRB)**

- For Grantees pursuing IRB approval, if you are working with an academic institution, your evaluator may be involved in a review process with the college or university’s Institutional Review Board (IRB). It is important to keep in mind that the IRB process generally takes several weeks to complete and may add time to the start-up of the project. **However, submission of the IRB does NOT stop the program activities startup date of January 2020. Program activities must begin on January 2020.**

- The OCMH expects grantees to perform direct service within the first quarter of project funding. Therefore, it is recommended that you simultaneously apply for an IRB, when you apply for OCMH funding. If it is later determined that you will not use the IRB there will be no detriment to the OCMH funded project.

- Signatures: To complete this section access the application in the MHGM system and refer to page 49 in the Applicant User Guide.

- Submit: To complete this section access the application in the MHGM system and refer to page 50 in the Applicant User Guide.

G. **Year Two Project Summary**

Provide a brief narrative that describes the major tasks and activities planned for year 2 (should the continuation grant be funded) and how they will be accomplished. Make sure program activities will start in January 2021 and are ongoing without gaps in services.
PROPOSAL REVIEW / SELECTION

Responses to this RFP, which are determined to be complete and in compliance with the requirements of the Commission will be reviewed by teams following the general criteria listed below.

A weighted system will be applied to the proposal criteria. The weighed system will not be shared with applicants. The final selection process will involve a ranking system based on the weighted score, reflecting compliance with the proposal criteria. Grants will be awarded to the highest-ranking applicants who represent a combination of geographic, demographic, service delivery/program activity mix, targeted to ethnic/racial groups, and diseases and conditions identified by the Commission as identified in this RFP.

Proposal Scoring
(Listing of some of the items which are considered during the review of grant applications):

I. Service Area Design
   ▪ There is clear documentation of an access problem for health care or identification of a disproportionately at-risk population.
   ▪ Programs are directed at a clearly defined target population consistent with the Commission’s definition of economically disadvantaged minority(ies).
   ▪ The need for the program is well documented.
   ▪ The comprehensive plan to meet population needs.

II. Innovation and Impact
   ▪ The project is designed specifically for the proposed target population and includes measures to determine the acceptability of services to the community.
   ▪ The project will result in some measurable impact on the identified population.
   ▪ The applicant states expected health behavior outcome changes as a result of proposed interventions.
   ▪ The number of individuals to be impacted by the proposed program.

III. Program Design
   ▪ The applicant has demonstrated that cultural beliefs, attitudes and practices have been considered and included in designing the program.
   ▪ Barriers to service; i.e., availability, acceptability, language and cost have been considered, and appropriate recourse is included in the approach to the project.
   ▪ The problems to be addressed are clearly stated in specific rather than general terms, can be reasonably addressed during the grant period, and can be accomplished with the dollars available for the project.
   ▪ Program design should describe the clinical and non-clinical measure procedures that ensure data collection and reporting procedures.
   ▪ Program participants are involved in the Community Advisory Board.

IV. Evaluation
   ▪ The applicant has a plan to measure required areas per the RFP evaluation guidance.
   ▪ The applicant has plans to establish baseline data, collect, enter data weekly and report participant data on a quarterly basis to determine behavior outcomes.
   ▪ The applicant has a plan to provide continuous quality improvement.
   ▪ The applicant has a plan to ensure the timely provision of information to the data system.
   ▪ The applicant has a mechanism to allow the data analysis to inform the program implementation.

V. Budget Appropriateness and Reasonableness
   ▪ Administrative Code 3704-2-02 states: “That at least twenty percent of applicant funds and/or resources are received from sources other than grants awarded by the Commission on Minority Health”. In other words, the
Commission cannot be the sole funding source of an agency.
- Specified line item costs are appropriate and reasonable/justifiable.
- Costs support direct client activities.
- All line items must be itemized and list unit cost for each requested expenditure.

**Grant Reporting/Participation Requirements**

Prior to submitting this proposal, please be aware that there are grant reporting mechanisms and evaluation reports that are required to be submitted to the Commission on a quarterly basis if funded. Grants management is required by your agency to be responsible for submission of or participating in the following:

- The Acknowledgement of Terms (AOT) will be provided to grant recipients, in MHGM, after the awarding of the grant. Failure to respond to special conditions upload both the special condition responses and the signed AOT into MHGM system by the deadline provided will result in forfeiture of the grant.

- All grant recipients must have a fully executed Acknowledgement of Terms (AOT), to include original signatures on the AOT as well as compliance with all identified program and all identified fiscal special conditions within 30 days of grant notice.

- Submission of Program and Fiscal quarterly reports (in MHGM) along with the Program Evaluation Report.

- Ensure Program Evaluator Reports are reviewed by the program’s evaluator prior to submission (via upload) to the Commission.

- Participation in the MHM Kickoff Expo sponsored by the Commission, usually conducted on the last Thursday in March each funding year. In an effort to raise awareness, OCMH funded program grantees are required to set up a display table at the annual health expo.

- The Program Director and their evaluator will participate face to face, webinar, and/or conference call meetings with their assigned REEP Panel member.

- Participation in monthly HUB phone calls

- Year-end Program Evaluation Report submission in MHGM by the required deadline.

- A Biennial Program Report submission in MHGM by the required deadline.

**NOTE:** Please double-check your grant proposal for:
- Accuracy
- Signatures on all signature forms.
- Missing pages, omitted sections, forms, signatures, and mathematical errors. As all of the above items WILL impact your overall score and may disqualify your application.
The following appendices are subject to revision and or update as per the Pathways Community HUB Institute. Please check [www.pchi-hub.com](http://www.pchi-hub.com) for the most recent revisions or updates.

# APPENDIX A

## COMMUNITY HUB PATHWAYS (20)

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Community Care Coordinator __________________________  Agency __________________

**Adult Education Pathway**

**Initiation**

Client identifies educational need(s).

**Partner with client to establish/review educational goals.  Document goal and desired outcomes.**

**Assist client in registering for training or educational course:**
- Gather necessary documentation for registration
- Determine if client needs to take an assessment/placement exam & schedule exam date.

**Confirm that client is registered in class or training program and attends first class.**

**Monitor client’s progress with educational program.**
- Confirm at least bi-weekly that client is attending classes and document progress

**Completion**

Confirm that client successfully completes stated educational goal:
- Course / class completed
- Training program completed
- Quarter / semester completed

**Start Date**

**Educational Goals**

**Date of first class**

**Check-in dates**

Record reason if Finished Incomplete:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

1
Client’s Name _____________________________ Date of Birth ____________

Community Care Coordinator __________________________ Agency ____________

Behavioral Health Pathway

**Initiation**

Client with behavioral health issue(s).

1. Identify referral source.

2. Document behavioral health issue(s).
   (Describe below)

Schedule appointment for appropriate level of service based on client’s need.

**Completion**

Client has kept **three scheduled appointments**. Monitor follow up appointments with Medical Referral Pathway.

Describe behavioral health issue(s):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Care Coordination Plans:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Record reason if Finished Incomplete:

________________________________________________________________________
Client’s Name ___________________________ Date of Birth ________________

Community Care Coordinator ___________________________ Agency _____________

Developmental Referral Pathway

Initiation

Child < 3 years with suspected developmental delays -- record reason for developmental referral.

Explain Part C services and review family’s rights.

Explain agency options to obtain developmental evaluation. Refer child to Central Intake.

1. Obtain parental/guardian consent for evaluation

2. Assist family with scheduling developmental evaluation and obtaining a prescription from primary care provider.

Provide education to caregivers regarding importance of keeping appointment.

Completion

Document the date and results of completed developmental evaluation.

Results and recommendations:

____________________________________________

____________________________________________

Record reason if Finished Incomplete: _______________________________________

Start Date

__________________________________

__________________________________

__________________________________

Reason for referral

Refused to Central Intake

□ Yes □ No

__________________________________

Reason given if “no”

Scheduled date of evaluation

__________________________________

Education provided

□ □ Yes □ No

__________________________________

Date of completed evaluation
Developmental Screening Pathway

**Initiation**
Child < 3 years of age at-risk for a developmental delay.

Child should be screened at least every 6 months using the age appropriate ASQ or ASQ-SE.

Educate family about the importance of developmental milestones.

Obtain consent from parent/guardian to do developmental screening.

**COMPLETION**
Child successfully screened using the age appropriate ASQ or ASQ-SE.

**Education provided**
- Yes
- No

**Start Date**

**Date of screen**

Circle ASQ Screen Used
- 2
- 4
- 6
- 8
- 9
- 10
- 12
- 14
- 16
- 18
- 20
- 22
- 24
- 27
- 30
- 33
- 36

Communication
Gross Motor
Fine Motor
Problem Solving
Personal-Social

Circle ASQ-SE Screen Used
- 6
- 12
- 18
- 24
- 30
- 36

Total Score

Month/year for next screen

Record reason if Finished Incomplete: ________________________________
Education Pathway

**Initiation**
Education Pathway started by (check only one):

- □ Program based curriculum
- □ Client requests assistance
- □ Referral from health care provider
- □ Referral from another provider
- □ Community care coordinator initiated

**Start Date**

**Document education provided**
(Example: educational content – module, section, etc.)

**Education**
Format:
- □ Handout
- □ Talking points
- □ Video
- □ Other: _________

**Document educational format used (check only one).**

**Completion**
Client reports that he/she understands educational information

Record reason if Finished Incomplete: ____________________________________________
Employment Pathway

Initiation
Client is requesting assistance in obtaining a job.

Partner with client to identify:
1. Education and work history
   - Previous work experience
   - Educational level completed
   - Employment goals (special training needed for desired job)
2. Identify barriers to employment (felony record, financial constraints, etc.)

Care coordinator will work with client to confirm that résumé is completed.

Care coordinator will work with client to monitor applications submitted for employment.

Completion
Client has found consistent source[s] of steady income and is employed over a period of 3 months.

Record reason if Finished Incomplete:

Check-in dates
Family Planning Pathway

**Initiation**
Client has requested information on family planning methods.

Provide family planning education.

Schedule appointment with primary care provider or clinic

**Follow-up with client:**
Confirm that client kept appointment and document family planning method in chart. **Pathway is complete if tubal ligation, vasectomy, IUD, implant or shot given.**

**Completion**
If client has chosen a method other than tubal ligation, vasectomy, IUD, implant or shot, then Pathway is complete if client is still successfully using that method after 30 days.

**Start Date**

**Education given**
☐ Yes  ☐ No

**Date of appointment**

**Provider or Clinic**

**Date appointment kept**

**Family Planning Method**
- Tubal Ligation (4)
- Vasectomy – partner (4)
- IUD (4)
- Implant (4)
- Shot (4)
- Abstinence (5)
- Natural family planning (5)
- Pills (5)
- Patch (5)
- Ring (5)
- Diaphragm (5)
- Condom (5)
- Cervical cap (5)
- Spermicide (5)
- Other (5)

Record reason if Finished Incomplete: ________________________________
Health Insurance Pathway

Initiation
Client needs health insurance.

Assist client and/or family in completing forms as directed and submit to appropriate agency.

Confirm with agency that all forms have been received and have been completed properly.

Completion
Arrange follow-up within 2-6 weeks of application submission to confirm acceptance or denial of insurance.

- If denied, record reasons in client’s record and refer client to other community resources.
- If accepted, document status – including insurance number – in client’s record.

Record reason if Finished Incomplete (Reason denied and referral made):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
**Initiation**

Client and/or family is identified to be in need of affordable and suitable housing.

**Identify reason(s) why housing is required:**
- □ Eviction
- □ Safety Issue(s)
- □ Homeless
- □ Too many for living space
- □ Domestic Violence
- □ Financial
- □ Lead
- □ Poor rental history
- □ Fire/Natural Disaster
- □ Poor location for access to services
- □ Self-imposed (pets)
- □ Disability
- □ Discrimination
- □ Other: ____________________

**Partner with client to contact appropriate housing organization and schedule an appointment to meet and discuss housing options.**

Help client prepare for meeting with required documentation, childcare, transportation, etc.

**Care coordinator confirms that client kept appointment with housing organization.**

If client is placed on a waiting list for housing, obtain name & phone number of contact person to follow up with regarding status.

**Follow up with housing contact person at least bi-weekly to monitor housing progress.**

**Completion**

Confirmation that client and/or family has moved into an affordable suitable housing unit for a minimum of 2 months.

Record reason if Finished Incomplete: ____________________________

---

**Start Date**

**Appointment Scheduled**

**Appointment Kept**

**Contact Person**

**Contact number**

**Check-in Dates**

**Completion Date**
Client’s Name ___________________________ Date of Birth __________________

Community Care Coordinator ___________________________ Agency ____________

Immunization Referral Pathway

Initiation

Client less than 18 years of age is confirmed to be behind on immunizations.

Educate family about the importance of immunizations.

Appointment(s) scheduled with provider or clinic for missed immunizations.

Completion

Client’s immunization record reviewed and verified to be up to date.

Start Date

Missing Immunizations:

Education given

□ Yes □ No

Appointment Dates

Completion Date

Reviewer

Record reason if Finished Incomplete:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Immunization Screening Pathway

**Initiation**

Any client less than 18 years of age

- Determine immunization status by using the family’s immunization record.
- If family is unable to provide records, obtain written consent from client’s parents/guardians to request immunization record from provider(s).

**Education**

Educate family about the importance of immunizations and maintaining up-to-date record.

**Identification**

Identify person trained in the current immunization protocols to review immunization status.

**Completion**

Client’s immunization record reviewed and verified.

1. Client is up to date on all age appropriate immunizations. Monitor immunization status during routine visits. Record Pathway as complete.

2. Client is not up to date on all age appropriate immunizations. Record Pathway as Finished Incomplete. Document reasons why immunizations are behind & start the Immunization Referral Pathway.

**Immunization History from:**

- Family’s record
- Electronic registry
- Health care provider
- Health department
- Other

**Education Provided**

- Yes
- No

**Immunization Records Reviewer**

**Completion Date**

- Up to date
- Not up to date

**Record Reason if Finished Incomplete:**
**Initiation**
Any child greater than 12 months of age, and any child with identified risk factors (see step #4).

Provide **lead education** to all families with young children and/or expectant mothers.

Find out if child has ever had a blood lead test and document

**Determine if child needs a blood lead test:**
1. Medicaid
2. High risk zip code
3. “yes” to any of the following questions:
   - Live in or regularly visit a house, day-care center, preschool, or the home of a babysitter/relative built before 1950?
   - Live in or visit a house that has peeling, chipping, dusting, or chalking paint?
   - Live in or visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling?
   - Have a sibling or playmate that has or did have lead poisoning?
   - Frequently come in contact with an adult who has a hobby or works with lead? (examples: construction, welding, pottery, painting, etc.)

**Appointment** scheduled with provider to do blood lead test.

**Completion**
**Confirm** that appointment was kept and **document results** of lead blood test in client’s record as:

- Elevated: ≥ 10 μg/dl
- Non-elevated: < 10 μg/dl

**Refer to Health Department**
Medical Home Pathway

Initiation
Client needs a medical home (an ongoing source of primary medical care).

Determine payment source for health care.

Find appropriate primary medical provider options for payment source.

1. Obtain release of information from client.
2. Assist family in scheduling appointment.
3. Provide education about the importance of keeping the appointment.

Completion
Confirm that appointment was kept.

Payment Source:
- Medicaid
- Medicare
- Private Insurance
- Self Pay
- Other: __________

Medical Provider

Date of initial appointment

Education provided
- Yes
- No

Date of kept appointment

Record reason if Finished Incomplete:

_______________________________________
Client’s Name ____________________________ Date of Birth ________________

Community Care Coordinator ____________________________ Agency ____________

Medical Referral Pathway

**Initiation**
Client needs a **health care appointment.**
Document type of appointment needed – use codes.
*(Only ONE code per Pathway!)*

**Educate** client / family about the importance of regular health care visits and keeping appointments.

Appointment scheduled with health care provider / clinic.

**Completion**
Verify with health care provider that **appointment was kept.**

---

**Start date**

**Referral - Code**

**Education provided**

☐ Yes ☐ No

**Appointment date**

**Date appt. kept**

Document how appointment was verified

---

**Code Numbers for Medical Referral Pathway**

1. Primary Care
2. Specialty Medical Care ________________________________
3. Dental
4. Vision
5. Hearing
6. Family Planning
7. Mental Health
8. Substance abuse
9. Speech and Language
10. Pharmacy
11. Other, please specify in record ________________________________

**Record reason if Finished Incomplete:** ________________________________
Medication Assessment Chart

STEP 1:

- List all the medications **currently used** by your client on the chart below. Include all medications – prescription, over the counter, herbal, alternative, topical, eye drops, etc.
- Have your client and/or client’s caregiver **open each** of the bottles or medication containers and note any difficulties in performing this task.
- Have your client and/or client’s caregiver **identify** each medication. Ask them to describe what the medicine is for? How many doses of the medicine are to be taken each day?
- Discuss the **shape and color** of the medicine with your client or client’s caregiver. Explain that they should notify the health provider if the shape and color of the pill changes to make sure they are using the correct medicine and/or dose.
- Have the patient and/or client’s caregiver read the medication name on the label. Assess reading, memory problems. Review all parts of the label including how to order refills.

**Prescription Medications (need a doctor’s prescription to get)**

<table>
<thead>
<tr>
<th>Name of Medicine &amp; Dose</th>
<th>Can open? yes / no</th>
<th>What is this medicine for? (client’s description)</th>
<th>How many doses each day? (client’s response)</th>
<th>Can read the label and knows how to get refills? yes / no</th>
<th>Comments</th>
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</table>

Client’s Name ___________________________ Community Care Coordinator ___________________________

Date of Birth ________________ Today’s Date ________________ Agency ___________________________
Client’s Name __________________________  Community Care Coordinator __________________________

Date of Birth ________________  Today’s Date ________________  Agency __________________________

<table>
<thead>
<tr>
<th>Name of Medicine &amp; Dose</th>
<th>Can open? yes / no</th>
<th>What is this medicine for? (client’s description)</th>
<th>How many doses each day? (client’s response)</th>
<th>Can read the label and knows how to get refills? yes / no</th>
<th>Comments</th>
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</tbody>
</table>

**Over the counter medicines (no prescription needed), herbal or alternative treatments**

<table>
<thead>
<tr>
<th>Name of Medicine or treatment?</th>
<th>Can open? yes / no</th>
<th>What is this medicine or treatment for? (client’s description)</th>
<th>How many doses each day? (client’s response)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
STEP 2 - Ask the following questions:

1. Are you having problems getting your medications? □ Yes □ No
   If yes – why?
   __________________________________________________________
   __________________________________________________________

2. Do you have problems paying for your medications? □ Yes □ No
   If yes – what can you afford?
   __________________________________________________________
   __________________________________________________________

3. Are you having any side effects from your medications? □ Yes □ No
   If yes – describe:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

4. Do you use more than one pharmacy to get your medications? □ Yes □ No
   If yes – please list all pharmacies:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Notes:
____________________________________________________________
____________________________________________________________
____________________________________________________________

____________________________________________________________  _________________
Provider Signature                                          Date
Medication Assessment Pathway

Initiation
Client is taking prescribed medication(s).

Start Date

Complete the Medication Assessment Chart with your client and/or client’s caregiver:
1. Include all medications your client says he/she is taking right now (prescription, over the counter, herbal, alternative, etc.)
2. Record what your client says about the medication in his/her own words – even if it is different from the label.

Send completed Medication Assessment Chart to client’s primary care provider.

Date information sent
☐ Fax
☐ HUB
☐ Mail
☐ Other __________

Completion
Verify with primary care provider that chart was received.
If medication issues are identified by health care provider – initiate Medication Management Pathway.

Verification Date

Medication concerns:
☐ Yes ☐ No

Record reason if Finished Incomplete: ____________________________________________
Medication Management Pathway

Initiation
Client is not taking medications as prescribed.
(Record referral source)

Obtain list of medications client should be taking from:
(check all that apply)
- Primary care provider
- Medication reconciliation form from hospital
- Medication reconciliation form from emergency department
- Pharmacist
- Other:

Visit client in his/her home and complete the Medication Assessment Chart:
1. Send completed Medication Assessment Chart and any reconciliation forms to client’s primary care provider.
2. Schedule appointment with primary care provider – record date.

Primary care provider completes medication reconciliation:
1. Care coordinator receives updated medication list.
2. Home visit scheduled within 3 business days to follow-up.

Visit client in his/her home and complete the Medication Assessment Chart – send completed chart to primary care provider for review.

Completion
Verify with primary care provider that client is taking medications as prescribed.

Record reason if Finished Incomplete: ________________________________
Postpartum Pathway

Initiation
Client has delivered and needs to schedule a postpartum appointment.

Schedule appointment with health care provider.

Follow-up with client:
1. Confirm that client kept appointment.
2. Document family planning method chosen in client’s record.
3. Determine if client has any questions or

Start date

Date of delivery

Date of appointment

Health care provider

Date postpartum appointment completed

Family planning method

Record reason if Finished Incomplete: ________________________________
Pregnancy Pathway

**Initiation**
Any woman confirmed to be pregnant through a pregnancy test.

**Provide pregnancy education.**

**Schedule appointment with prenatal care provider:**
- Date of 1st prenatal appointment
- Estimated Due Date
- Concerns identified

**Check on woman’s prenatal appointments at least monthly.**

**Completion**
Healthy baby > 5 lbs. 8 ounces (2500 grams).
Document baby’s birth weight, estimated age in weeks and any complications

**Start date**

**Education given**
- [ ] Yes
- [x] No

**Date of 1st PN appt. – set up by**
- [ ] Client
- [ ] Care Coordinator

**Prenatal care provider**

**Due date**

**Concerns**

**Date of birth**

**Birth weight**

**Gestational age**

(weeks)

Record reason if Finished Incomplete:

---

Client’s Name ____________________________ Date of Birth ________________

Community Care Coordinator ____________________________ Agency ____________
Smoking Cessation Pathway

Initiation
Client states that he/she is a cigarette smoker/tobacco user.

1. Determine where client is in the Behavior of Change Model.
2. Develop and document care plan in record:
   • Pre-Contemplator: Educate and motivate at each visit.
   • Contemplator: Set a quit date and discuss withdrawal symptoms.
   • Action: Frequent support visits (especially the first 2 weeks after quitting) coping strategies and self-help materials.
   • Maintenance: Continue to ask about client’s smoking status at each visit; continue education and encouragement.
   • Relapse: Reassure client that most smokers take several attempts before finally quitting → set another quit date.

For all clients - stress the need to quit smoking at EACH visit:
   • Short & long-term health, social and economic benefits of quitting.
   • Discuss and document any barriers identified.
   • Discuss and document all options and refer if appropriate:
     - Self-help materials
     - Drug therapy
     - Smoking cessation programs

Completion
Client has stopped smoking / using tobacco products.

Start date
Tobacco product
Amount

Behavior of Change Model – check stage:
- Pre-contemplator
- Contemplator
- Action
- Maintenance
- Relapse

Completion date
- Self report
- Lab test confirmation

Record reason if Finished Incomplete: ____________________________
Social Service Referral Pathway

Initiation
Client needs a social service referral.
Document type of service needed - use codes.
(Only ONE code per Pathway!)

Provide appropriate education and discuss the importance of keeping appointments

Appointment scheduled with social service provider.

Completion
Verify that client kept scheduled appointment.

Start date
Code number

Education provided
☐ ☐ Yes  ☐ No

Date of appointment
Date of kept appointment

Document how appt. was verified

Code Numbers for Type of Service
1. Child Assistance
2. Family Assistance
3. Food Assistance / WIC
4. Housing Assistance
5. Insurance Assistance
6. Financial Assistance
7. Medication Assistance
8. Transportation Assistance
9. Job/Employment Assistance
10. Education Assistance
11. Medical Debt Assistance
12. Legal Assistance
13. Parent Education Assistance
14. Domestic Violence Assistance
15. Clothing Assistance
16. Utilities Assistance
17. Translation Assistance
18. Help Me Grow
19. Other: ________________________________

Give reason if Finished Incomplete: ________________________________________________
Appendix B

Pathways Community HUB Certification Attestation Statement

Pathways Community HUB Name: ______________________________________________________

Address: ___________________________________________________________________________

Attestation Contact Name and Telephone Number: __________________________________________

I certify that before signing this attestation statement, I have carefully read and understand the Pre-Requisites and Standards of the Pathways Community HUB Certification Initiative, and that the HUB and its partner care coordination agencies can document that they comply with the following requirements:

☐ At least one .5 FTE community care coordinator is employed at each care coordination agency in the Pathways Community HUB network.

☐ New employees of the Pathways Community HUB and partner care coordination agencies receive comprehensive training on the HUB Model of care coordination.

☐ The Pathways Community HUB has reviewed, and reviews biennially, the policies and procedures of each of the care coordination agencies to assure that all of the items listed in Certification Standard #7 are met – “The HUB and its care coordination agency members have effective Human Resource Policies and Procedures”.

☐ Each contracted care coordination agency has human resources policies and procedures in place that assures culturally and linguistically competent services.

I certify that the responses in this attestation are accurate, complete, and current as of this date. I acknowledge that the standards must be continually adhered to.

__________________________________________________________________________

Signature

__________________________________________________________________________

Print (name of signature)

__________________________________________________________________________

Title

__________________________________________________________________________

Date
## APPENDIX C

### STANDARDIZED COMMUNITY HEALTH WORKER CORE COMPETENCIES

with Minnesota, Ohio, and Texas Certification Standards

<table>
<thead>
<tr>
<th>Core Competency 1: Health</th>
<th>Specific Skills</th>
<th>Minimum Instruction</th>
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</thead>
<tbody>
<tr>
<td><strong>Content Area</strong></td>
<td><strong>Specific Skills</strong></td>
<td></td>
</tr>
<tr>
<td>Physical, mental, emotional and spiritual impacts on health</td>
<td>Explaining internal and external basic life resources; social determinants of health; stress and health</td>
<td>2 hours</td>
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<tr>
<td>Basic anatomy and physiology of major body systems</td>
<td>Explaining the basic body system functions and major organs:</td>
<td>8 hours</td>
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<tr>
<td></td>
<td>1. Cardiovascular</td>
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<td>2. Pulmonary</td>
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<td>3. Nervous</td>
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<td>4. Endocrine</td>
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<td>5. Gastrointestinal</td>
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<td>6. Urinary</td>
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<td>7. Muscular-Skeletal</td>
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<td>8. Integumentary</td>
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<td>9. Female &amp; Male Reproductive</td>
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<td>10. Immune</td>
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<tr>
<td>Acute and chronic illnesses including but not limited to heart disease, cancer, stroke, diabetes, and lung disease</td>
<td>Explaining signs and symptoms of:</td>
<td>8 hours</td>
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<tr>
<td></td>
<td>1. Coronary Heart Disease</td>
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<td>2. Hypertension (High Blood Pressure)</td>
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<td>3. Heart Failure</td>
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<td>4. Asthma</td>
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<td>5. Emphysema</td>
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<td>6. COPD</td>
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<td>7. Pneumonia</td>
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<td>8. Ear &amp; Sinus Infection</td>
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<td>9. Stroke</td>
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<td>10. Alzheimer's disease</td>
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<td>11. Diabetes</td>
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<td>12. IBS</td>
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<td>13. Kidney disease</td>
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<td>14. Ulcers</td>
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<td>15. Cancer</td>
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<td>16. Arthritis</td>
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<td>17. HIV/AIDS</td>
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<thead>
<tr>
<th>Behavioral health</th>
<th>Recognizing and making appropriate referral for:</th>
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<tbody>
<tr>
<td></td>
<td>1. Depression (including screenings)</td>
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<td>1. Anxiety Disorder</td>
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<td>2. Bipolar Disorder</td>
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<td>3. Schizophrenia</td>
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</table>
|                   | 4. Referral agencies and reporting processes     | 2 hours

| Vital signs | Understanding and explaining blood pressure, pulse, and temperature readings | 1.5 hours

| Basic cardiopulmonary resuscitation skills | Current American Red Cross Basic CPR certification | As required

| Medical terminology | Explaining basic medical terminology in use with healthcare teams and clients | 1.5 hours

### Core Competency 2: Community Resources

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Specific Skills</th>
<th>Minimum Instructional</th>
</tr>
</thead>
</table>
| Community resources & referral processes to assist various target population groups | Understanding and utilization of:  
  1. Information and referral (I & R) systems  
  2. Community agencies for health, social service, education, and legal aid  
  3. Referral and reporting processes for these agencies  
Collaborating and streamlining services with agencies | 2 hours

| Entitlement programs | Understanding and utilization of local, state and federal public entitlement programs (funding, eligibility and referrals) | 1 hour
### Core Competency 3: Communication Skills

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Specific Skills</th>
<th>Minimum Instruction</th>
</tr>
</thead>
</table>
| Interpersonal communication skills                     | Knowledge and effective usage of:  
1. Verbal and nonverbal communication  
2. Compassionate communication  
3. Language register and discourse patterns  
4. Active Listening and Interpersonal skills           | 5 hours             |
| Interview techniques                                   | Knowledge and effective usage of basic interviewing and verbal response techniques; Motivational Interviewing                                                         | 4 hours             |
| Written communications to health care and service care providers | Knowledge and effective utilization of reports, summaries, memos, and email in professional communication while avoiding common errors | 1 hour              |
| Telecommunication techniques                           | Utilization of effective and appropriate telecommunication techniques, including voicemail and texting                                                              | 1 hour              |

### Core Competency 4: Individual & Community Advocacy

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Specific Skills</th>
<th>Minimum Instruction</th>
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</thead>
<tbody>
<tr>
<td>Diversity &amp; the CHW role in an interdisciplinary team</td>
<td>Recognition of diversity and equality; the CHW role as part of a healthcare team</td>
<td>1 hour</td>
</tr>
<tr>
<td>Self-care skills in various target population groups</td>
<td>Supporting development of client self-care with recognition of inter-cultural, -generational, and socioeconomic differences</td>
<td>3 hours</td>
</tr>
<tr>
<td>Skills to assure that different target population groups receive needed services</td>
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<tr>
<td>Liaison between target population groups and local agencies and providers</td>
<td>Methods of serving as an agency collaborator and advocate for clients</td>
<td>2 hours</td>
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<tr>
<td>Core Competency 5: Health Education</td>
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<tr>
<td><strong>Content Area</strong></td>
<td><strong>Specific Skills</strong></td>
<td><strong>Minimum Instruction</strong></td>
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<tr>
<td>Teaching strategies</td>
<td>Utilization of effective adult learning strategies (for example, Mediated Learning)</td>
<td>2 hours</td>
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<tr>
<td></td>
<td>Consideration of client in Behavior of Change Model</td>
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<tr>
<td>Group education and classes</td>
<td>Plan and lead classes on health issues</td>
<td>1 hour</td>
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<tr>
<td>Client/patient medication and appointment compliance</td>
<td>Reinforce importance of medication and appointment compliance</td>
<td>.5 hour</td>
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<tr>
<td>Healthy lifestyle choices to reduce health risk factors</td>
<td>Educating on nutrition, exercise, and stress management skills</td>
<td>2 hours</td>
</tr>
</tbody>
</table>
| Adverse health consequences of smoking, drinking; and drugs of abuse; Recognizing and making appropriate referral for signs of addiction | Understanding and educating on:  
1. Addiction  
2. Legal Substances: alcohol, tobacco, prescription medications  
3. Illegal Substances – heroin, cocaine, marijuana  
4. Referral agencies and reporting processes | 2 hours                 |
| Oral health care                   | Educating on the importance of oral health care across the lifespan               | .5 hour                 |
| Prevention and wellness            | Explaining basic and age-appropriate prevention and wellness safety               | 1 hour                  |
| Family violence, abuse and neglect | Recognizing and reporting signs of family violence, abuse and neglect; establishing safety plans | 1 hour                  |
| Safety/ and injury prevention techniques | Explaining age-appropriate safety/injury prevention techniques                  | 1 hour                  |
| Causes of morbidity and mortality by age group | Understanding and educating on top causes of morbidity and mortality by age group | .5 hour                 |
### Core Competency 6: Service Skills and Responsibilities

<table>
<thead>
<tr>
<th>Competency Area</th>
<th>Specific Skills</th>
<th>Instruction Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination</td>
<td>Knowledge and ability to help individuals navigate the healthcare system by addressing the physical, social, geographical, and other barriers to personal care</td>
<td>4 hours</td>
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<tr>
<td>Safety of the CHW</td>
<td>Strategies for safe community visitation</td>
<td>1 hour</td>
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<tr>
<td>Gathering and reporting client information</td>
<td>Providing effective screenings, health assessments, documentation</td>
<td>3 hours</td>
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<tr>
<td>Time management</td>
<td>Demonstration of ability to utilize work time effectively</td>
<td>1 hour</td>
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<tr>
<td>Basic clerical, computing, and office skills</td>
<td>Demonstration of basic clerical, computing, and office skills</td>
<td>1 hour</td>
</tr>
<tr>
<td>Professional and personal development</td>
<td>Development of a plan for professional and personal improvement</td>
<td>1 hour</td>
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</tbody>
</table>

### Core Competency 7: Healthcare Needs Across the Life Span

<table>
<thead>
<tr>
<th>Content Areas</th>
<th>Specific Skills</th>
<th>Minimum Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concepts and theories of human development</td>
<td>Understanding basic theories of physical, cognitive, and psychosocial development of humans</td>
<td>2 hours</td>
</tr>
<tr>
<td><strong>Childbearing Years:</strong></td>
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<tr>
<td>(a) Health education</td>
<td>Ability to educate on anatomy, physiology, family planning, and appropriate health care during the childbearing years</td>
<td>3 hours</td>
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<tr>
<td>(b) Related anatomy, physiology, and appropriate health care</td>
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<tr>
<td>(c) Family planning</td>
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<tr>
<td>Pregnancy:</td>
<td>Ability to educate on basic anatomy, physiology, and normal signs related to pregnancy, labor, and postpartum care</td>
<td>5 hours</td>
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<tr>
<td>(a) Basic anatomy, physiology, and normal signs related to pregnancy</td>
<td>Ability to recognize and immediately report warning signs to a registered nurse supervisor or appropriate physician during pregnancy</td>
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<tr>
<td>(b) Recognition of warning signs during pregnancy requiring immediate reporting to the registered nurse supervisor</td>
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<tr>
<td>(c) Health education related to pregnancy, labor, and postpartum care</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Newborn, Infant, Young Child:</th>
<th>Ability to educate on:</th>
<th>5 hours</th>
</tr>
</thead>
</table>
| (a) Routine infant feeding & newborn care | 1. Routine infant feeding  
2. Newborn care  
3. Basic methods to enhance typical child development Immunization schedules and information regarding referral |        |
| (b) Recognizing and reporting problems that can occur in early infancy | Ability to recognize and report problems that can occur in early infancy |        |
| (c) Immunization schedules & information regarding referral to appropriate health care facilities and practitioners | | |
| (d) Basic methods to enhance typical child development | | |

| Children with disabilities | Ability to refer clients for appropriate disability screenings and professional services | 1 hour |

<table>
<thead>
<tr>
<th>Adolescence:</th>
<th>Ability to educate on adolescent health issues, including acute and chronic illnesses, but not limited to asthma, obesity and eating disorders, and high-risk behaviors</th>
<th>4 hours</th>
</tr>
</thead>
</table>
| (a) Age appropriate health education | 1. Ability to educate on adolescent health issues, including acute and chronic illnesses, but not limited to asthma, obesity and eating disorders, and high-risk behaviors  
2. Ability to recognize signs of and make appropriate referrals for adolescent health issues, including acute and chronic illnesses |        |
| (b) Acute and chronic illnesses including, but not limited to asthma, obesity and eating disorders | | |
| (c) High risk behaviors | | |

<table>
<thead>
<tr>
<th>Adults and Seniors:</th>
<th>Ability to educate on and make referrals related to:</th>
<th>4 hours</th>
</tr>
</thead>
</table>
| (a) The aging process    | 1. The aging process  
2. Prevention strategies  
3. Recommended screenings  
4. Adults caring for aging parents  
5. Adults with disabilities |        |
| (b) Prevention strategies | | |
| (c) Recommended screenings | | |
| (d) Adults caring for aging parents | | |
| (e) Adults with disabilities | | |
### Core Competency 8: Community Health Worker Profession

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Specific Skills</th>
<th>Minimum Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare, Public Health</td>
<td>Ability to understand and define public health and resources</td>
<td>1 hour</td>
</tr>
<tr>
<td>History of CHWs</td>
<td>Ability to understand and explain history of CHWs in the United States</td>
<td>1 hour</td>
</tr>
<tr>
<td>CHW Identity</td>
<td>Ability to understand and explain CHW definition, roles, workforce profile, core values</td>
<td>1 hour</td>
</tr>
<tr>
<td>Ethical Code of Principles</td>
<td>Ability to understand and apply confidentiality standards and informed consent</td>
<td>2 hours</td>
</tr>
<tr>
<td>Professional Boundaries</td>
<td>Ability to understand the emotional dynamics of care coordination and establish appropriate boundaries with clients</td>
<td>2 hours</td>
</tr>
</tbody>
</table>

### Core Competency 9: Clinical Practicum

<table>
<thead>
<tr>
<th>Content Area</th>
<th>Specific Skills</th>
<th>Clinical Hours</th>
</tr>
</thead>
</table>
| Agency/Clinical Experience| Ability to work in a clinical practicum setting and meet aforementioned competencies as assessed through:  
  1. Completion of an agency case study (purpose, client eligibility, outcome assessment, funding)  
  2. Development of clinical experience goals  
  3. Interviewing Skills Evaluation  
  4. Home Visitation Evaluation  
  5. Site Supervisor Interview and Report | 72-80  
  130 |

Prepared by Anne Biddle Seifert, MEd
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