	Caregiver Project	Refugee Project	Medical-Health Neighborhood Infrastructure
Description	Education and training of PCMH staff (front office staff, MA's, RN's, care managers) to: 1) Improve awareness of caregiver role 2) Improve knowledge of and link to caregiver resources 3) Increase number of caregivers completing the *Powerful Tools for Caregivers* (PTC) course.	Identify, education, and train refugee leaders in their respective community regarding navigating the healthcare system: 1) enrollment in insurance 2) enrollment in PCMH 3) access to transportation to/from appointments 4) resources in the community	Implementation and evaluation of care coordination compacts (CCC) between primary care and specialty clinics to: 1) Improve effective two-way communication between primary and secondary providers 2) Increase appropriate and timely referrals and consultations with prompt feedback of findings/recommendations. 3) Effectively co-management of patients when necessary.
Target Population	Caregivers of individuals who have a family member seeking care at a participating PCMH	Refugee's nearing the end of their 8 months of support	2-3 Primary Care and 2-3 Specialty clinics (for each PC clinic)
Timeline	March '17-Jan '18 Education event, caregiver assessment/ identification, resource distribution, linkages to PTC course and community resources, caregiver navigator identification, contract with caregiver navigators, program evaluation	March '17-Jan '18 Recruitment, gathering partner agencies, assessment of resources, education and training, stipends for refugee leaders, evaluation	Feb '17-Jan '18 Recruitment of clinics, education/outreach to specialty clinics, CCC templates, education and training on CCC's, CCC implementation, development of CCC scorecard, CCC evaluation
Measurements (examples)	-Number of identified caregivers -number of resources distributed -number of caregivers linked to caregiver navigator -number of care navigator contacts with caregivers -number of caregivers enrolled in PTC course	-Number of refugee leaders who receive training and education -Number of contacts within their community to offer support -Number of successes (enrollment in insurance, enrollment in PCMH, etc.)	-Number of CCC's implemented (# of primary care; # of specialty care) -CCC Scorecard Results (examples could include): % of CCC elements capture in referral notes from Primary to Specialty Care providers % of CCC elements capture in notes from Specialty Care to Primary Care providers % of documentation sent from specialist to primary care within X time frame % of patient scheduled within X time frame % or urgent patients seen within 1 week
Potential Partner Agencies	Area Agency on Aging, Living Independence Network Corporation, Idaho Parents Unlimited, Idaho Caregiver Alliance	Agency for New Americans, World Relief, Idaho Office of Refugees, Catholic Charities, Your Health Idaho, Idaho Department of Health and Welfare	PCMH's, Specialty Practices, Payers
Impact	Improve caregivers confidence and ability to care for their loved ones. Improve caregiver linkages to resources. Reduce cost associated with institutionalized care.	Short Term: Health care access, including insurance coverage, PCMH enrollment, appropriate use of health care services. Long Term: Embedded refugee leaders who can be used to deploy education/information throughout their communities	Improved referrals (relationships and processes); minimization of duplication of testing, schedule new patient appointments more efficiently, reductions in avoidable utilization, decrease costs, improved care coordination, enhanced access to care, integrated care planning
Sustainability (as it related to the CHC)	Scalable project that can be replicated to focus on other components and/or social determinants of health, such as education, housing, etc.	Was not discussed	Small pilot of voluntary PCMH clinics and subsequent specialty practices to develop infrastructure for using CCC's within these clinics – CCC forms, process, workflows, evaluation of

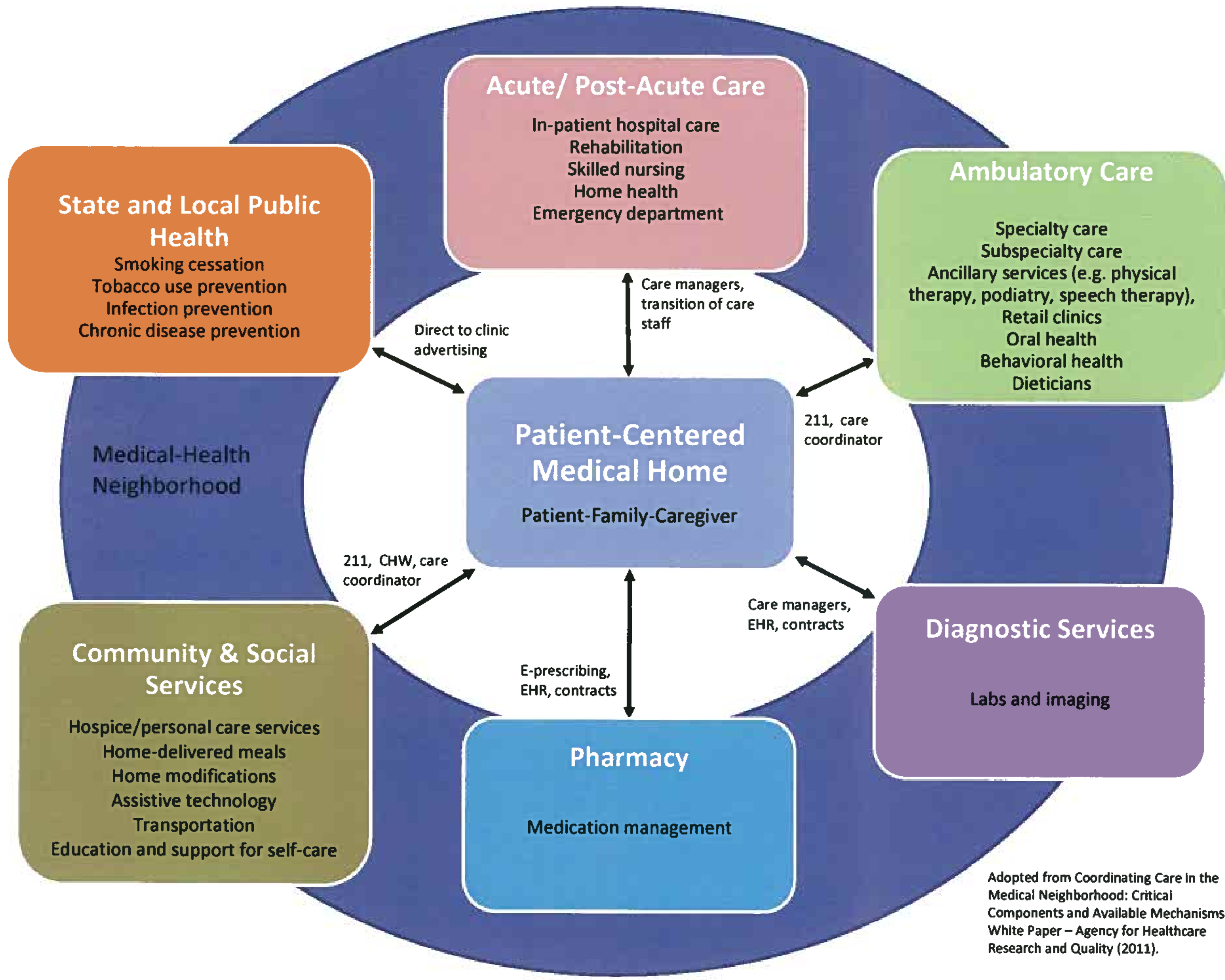
			effort, etc. will be formalized for replication to additional specialty practices working with the participating clinics. This proof of concept could lead to scalability of the model to additional PCMH's and medical neighbors. ROI's can be calculated using cost indexing, claims data, and Scorecard reports to show improved efficiency. Although the focus is on medical neighbors this model of formal communication pathways could be adjusted for community and social services providers as well. This model supports also supports value based care.
Oversight	Sub-committee of CHC?	Sub-committee of CHC?	PHD SHIP team
Solution Impact (1-10 scale below)			
Implementation Effort (1-10 scale below)			

Effort / Impact Analysis

Solution Impact	Implementation Effort 1–5 (LOW)	Implementation Effort 5–10 (HIGH)
5–10 (HIGH)	**Potential Home Runs** Solution ideas placed in this quadrant (low effort, high impact) should be the focus of a team's energy since they are suspected to result in the best return on investment	**Worth the Effort?** Solutions ideas placed in this quadrant (high effort, high impact) often require significant additional analysis to determine whether or not they should be implemented
1–5 (LOW)	**Potential Quick Hits** Solutions ideas placed in this quadrant (low effort, low impact) may require additional analysis to determine whether or not they should be implemented, but teams should not fall into the trap of analysis paralysis	**NOT Worth the Effort** Solution ideas placed in this quadrant (high effort, low impact) should be set aside, and only reassessed if solutions in the other three quadrants prove to be unviable

Solution Impact: (LOW) 1 2 3 4 5 6 7 8 9 10 (HIGH)

Implementation Effort: (LOW) 1 2 3 4 5 6 7 8 9 10 (HIGH)



Adopted from Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms. White Paper – Agency for Healthcare Research and Quality (2011).