2026 Community-Based Care Coordination

Partner Request for Proposals

PROJECT TITLE:	Community Care Hub; Community-Based Care Coordination
PROPOSAL DUE DATE:	November 7, 2025 5:00 pm PST
ESTIMATED TIME PERIOD FOR CONTRACT:	January 1st, 2026- December 31st, 2026

Purpose and Background

Greater Health Now (GHN), serving as a regional Accountable Community of Health (ACH) under the direction of the Washington State Health Care Authority (HCA), is committed to advancing health equity and improving population health through collaborative, community-driven approaches. In alignment with HCA directives, GHN is actively building the capacity to establish, maintain, and support a Community Care HUB within its broader Social Care Network.

The Community Care HUB serves as a centralized infrastructure designed to coordinate and connect individuals to essential health and social services. GHN facilitates and supports Community-based Care Coordination as a vital component of the HUB, ensuring that care coordinators are empowered to engage with community members, identify needs, and navigate available resources effectively.

Through this model, GHN promotes closed-loop referrals, strengthening community collaboration between providers and community organizations to ensure individuals receive timely and appropriate services. By fostering strong partnerships and leveraging data-informed strategies, GHN enhances the region's ability to deliver integrated, person-centered care and build a more connected and resilient community.

In support of this work, GHN aims to partner with and support Community-Based Organizations (CBOs) and their Community-Based Workforce (CBWs) by providing funding for CBW positions, offering workforce development opportunities, and delivering technical assistance. These efforts are designed to build sustainable capacity within the community, enhance service delivery, and ensure that trusted local organizations and workers are equipped to play a central role in the Community Care HUB.

Funding

GHN intends to fund the Community-based care coordination work of **20-30 Community-Based Organizations employing 45-55 Community-Based Workers between January 1, 2026, and December 31, 2026**. Proposals should be for Community-based care coordination services provided by a minimum of 1 to a maximum of 5 (1-

5 FTE) Community-Based Workers (CBW) and a recommended 0.2 Supervisor FTE per CBW.

The application includes a budget template for submission and review. The submitted budget should include the proposed CBW staff salary and benefits, 0.2FTE supervisor's salary and benefits per CBW FTE. These FTE costs may include a 15% administration rate. A separate Infrastructure Application is available for Health-Related Social Needs (HRSN) Infrastructure Funds that can provide funding for Technology, Development of Business or Operational Practices, Workforce Development, Outreach, Education, and Stakeholder Convening.

Any contract awarded as a result of this procurement is contingent upon funding availability. GHN will negotiate contracts with payers (state, federal, local, managed care, etc.) for sustainable and ongoing funding to meet community needs and community health outcomes, creating a braided funding model. GHN will determine the best funding streams to meet partner and community needs, and the partner will bill GHN directly.

GHN will guarantee reimbursement of monthly expenses up to 75% of the proposed and approved budget upon execution of the contract and then will pay the remaining 25% of the approved budget based upon the contractor's completion of Key Performance Indicators and contract expectations. GHN will provide additional opportunities for incentive payments based on target goals that exceed contracted Key performance indicators.

Prioritized Populations

To expand services to community members who are underserved and significantly impacted by health disparities, organizations who serve and have community-based worker representation of priority populations as identified by their organization within their service area will be prioritized.

Examples of Priority Populations for Engagement May Include but not limited to:

- Communities and individuals at risk of not receiving care
- Populations living in rural areas
- Uninsured or underinsured individuals
- Maternal health, pregnant people and families
- Black, Indigenous, People of Color
- Individuals lacking access to primary care and preventative care
- Justice-involved individuals
- Older populations
- Individuals in Transitions of Care

Prioritized Services

- Case management, outreach, and education
- Housing transition navigation services
- Rent/temporary housing
- Medical respite
- Nutrition support
- Caregiver respite
- Medically necessary environmental adaptations
- Community transition services
- Personal care and homemaker services; and/or
- Transportation for non-emergency, non-medical needs

To promote whole-person health and strengthen care coordination across systems, priority will be given to organizations who:

1. Have established partnerships with community-based organizations and agencies that address health related social needs, such as housing, food security, behavioral health, transportation, and other supportive services.
2. Demonstrate a committed and actionable plan to build such partnerships.
3. Prioritization will be given to organizations who have existing collaborations or a clear strategy to develop partnerships with healthcare systems, including but not limited to hospitals, clinics, primary and specialty care providers, and emergency medical services (EMS). These partnerships should reflect a shared commitment to coordinated, person-centered care and improved health outcomes.
4. If the organization is a healthcare system, prioritization will be given to organizations who have existing collaborations or a clear strategy to develop partnerships with community organizations that provide health related social services.
5. Provide client centered care coordination services across external settings or in the community.
6. Are currently involved in Community Case Conferencing or are willing to initiate and support Community Case Conferencing.

Minimum Qualifications

GHN aligns with Washington State standards and collaborates with cross-ACH partners statewide to deliver effective, community-based care coordination. The initiative aims to elevate community-based care as a statewide priority by demonstrating that investment in a community-based workforce is a proven and impactful strategy for improving population health—both regionally and across Washington.

Achieving this requires accurate tracking of services based on established standards, transparent reporting, and ensuring that partner organizations and their community-based workforce are appropriately compensated for the services they provide. GHN provides infrastructure and tailored technical assistance—guided by a Partner Readiness Assessment—to reduce administrative burden for Social Care Network (SCN) partners and support improved performance outcomes.

GHN has worked collaboratively across the state, including with cross-ACH partners, to develop a set of performance indicators that enhance the Network's reach, engagement, and coordination of resources and services for individuals. These indicators are tracked through GHN's electronic client management record system, ensuring consistency, accountability, and data-driven decision-making across the Network.

The following are the minimum qualifications for Organizations:

- Licensed to do business in the State of Washington / Holds a WA business license
- At least three (3) years of experience providing community-based care coordination in alignment with GHN standards within GHN's region (Kittitas, Yakima, Benton, Franklin, Walla Walla, Whitman, Asotin, Garfield, Columbia Counties and The Yakama Nation)

- Physical presence in GHN service area (Kittitas, Yakima, Benton, Franklin, Walla Walla, Whitman, Asotin, Garfield, Columbia Counties and The Yakama Nation)
- Tier 1 Community-Based Care Coordination contracts must use GHN's Client Management System (CMS)
- No exclusions from sub-awards on Sam.gov
- Proof of Liability Insurance
- Capacity and willingness to explore providing Health Benefit Exchange insurance navigation services with trained staff.
- Evidence of community partnerships to support whole person health and efficient care coordination services.
- Established partnership with local health systems/community HRSN providers or plans to partner.
- If a previous contractual relationship is relevant, contract performance will be considered in the review process/decision criteria for selection.

The following are the key performance indicators for Community-based care coordination network partners once selected:

KPI 1: Conversion from Referral to Enrollment
KPI 2: Completion of Health-Related Social Needs (HRSN) Assessment and Signed Consent and Release of Information obtained within 2 weeks of initiation of services
KPI 3: Timely Community Resource Linkage Success Rate
KPI 4: Percentage of Enrolled client needs successfully met
KPI 5: Caseload Balance per Care Coordinator

Contracted Organizations are also expected to adhere to the following standards:

- At least a quarterly average enrollment of at least 35 clients per community-based worker (CBW) covered by this agreement OR 60% of referred clients within reporting period are enrolled in the program using the Client Management System (CMS)
- At least three outreach attempts were made to refer clients prior to discharge and documented appropriately in CMS. Must attempt over 5 business days.
- Documentation of consent to services and client authorization for data sharing documented appropriately in the Client Management System.
- Documentation standards consist of Intake Assessment, Care Plan based on client goals, Visit/Progress notes, Documented referrals to other services, Discharge Plan, Discharge Plan, Discharge summary.
- At least 80% of enrolled clients have completed an HRSN Assessment and completed profile in Client Management System.
- Clients are discharged appropriately at the end of services with a discharge form completed in Client Management System.

Contracted Organizations are also expected to adhere to ACHs Community—Based Care Coordination standards:

Community-based care coordination Standards				
	Engage	**Assess**	**Support**	**Connect**
Purpose	Reach and build relationships with people in communities who have complex needs and want support to improve their health	Identify the social conditions that significantly compromise a client's health and identify services a client might be eligible for	Co-develop a care plan that addresses the client's goals and nurtures their belief and ability to meet these goals	Assist the client to access community resources and clinical services
Steps	1. Establish Trust with community 2. Outreach & Engage 3. Offer Services 4. Obtain Consent 5. Document	6. Complete Intake 7. Complete HRSN Assessment 8. Check for Eligibility 9. Make it a conversation to Maintain trust 10. Document	11. Develop Client-Centered Care Plan 12. Encourage Client Progress 13. Educate 14. Advocate 15. Engage Care Team 16. Document	17. Locate Social & Health Services 18. Offer Services 19. Support Client & Provider Readiness 20. Complete Closed Loop Referrals 21. Close Client Case 22. Document

Supports Offered to Community-Based Organizations to meet standards

The Greater Health Now Community Care Hub ("Hub") supports contracted partners in building sustainable pathways through funding and capacity-building resources. This enables community-based organizations (CBOs) and community-based workers (CBWs) to strengthen their infrastructure and pursue long-term funding opportunities.

Partnership with GHN also provides guidance on federal funding requirements and equips partners with the tools needed to access additional funding streams.

GHN will provide the following supports for CBOs contracted through the Community Care Hub

- Contract Clarification of Expectations and Funding Inquiries
- Orientation & Onboarding of CMS and the GHN Hub
- 1:1 Technical Assistance & Monitoring
- Open Office Hours

- Timely responses to all inquiries
- Workforce Training & Shared Learning
- Technology & Reporting Infrastructure
- Incentives to Reward Higher Performance
- Networking and collaboration with fellow community-based entities
- Leadership training and development
- Opportunities and platforms to showcase work at regional level
- Access to and support from a local GHN representative

Timeline

- October 2025 – RFP information posted to GHN website
- October 14-31 – Open office hours for CBO RFP support:
  - Every Tuesday at 11am – 1pm
  - https://teams.microsoft.com/l/meetup-join/19%3ameeting_MmFlZTQ5ZDUtNWRhMi00YzRkLTgxZDMtZjZmMzY3Y2U5MTE2%40thread.v2/0?context=%7b%22Tid%22%3a%225cfb43b6-1410-46d6-aed1-8ef20b3b9553%22%2c%22Oid%22%3a%2225795af7-d75c-472a-b0e4-f35a6e2909e6%22%7d
- November 7, 2025 - Proposals Due
- October/November 2025 - Proposals Reviewed as received
- December 2025 – Announcements of successful applications
- January 1, 2026 – Contract start date

Please send any questions about this process and/or eligibility to Social Care Network team: socialcarenetwork@greaterhealthnow.org

Application Contents

- Narrative Proposal may be completed on Organization's letterhead
- Completed Request for Proposal Application Questionnaire (provided)
- Completed Community-Based Care Coordination Budget (template provided)
- Funding Guidelines Document (provided)
- Completed 2026 Infrastructure application (if applying for additional funding)
- GHN 2026 Infrastructure Fund Application Guide (provided)
- Infrastructure Budget Template (template provided)

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Narrative Response

Narrative should include the following:

- Describe how your organization will support requested Community-based Workers to provide community-based care coordination, according to the standards listed in RFP; please include a narrative of how you would spend contract funds. For example (staffing, technology, travel, administrative costs)
- Describe how your organization will implement Community-Based Care Coordination Standards as outlined in the table on the RFP. (Engage, Assess, Support and Connect)
- Describe your organization's experience employing community-based care coordinators with lived experience, and how you support CBW's in their professional development.
- Please describe how community-based care coordination fits into your strategic plan.
- Summarize your organization's experience in community-based care coordination, including the skills, network requirements, and activities needed to meet Key Performance Indicators.
- Describe your organization's experience serving prioritized population as outlined by Greater Health Now.
- Describe your organization's experience providing services for one or more priority health and/or social needs listed in the RFP. This can include internal services or existing relationships with community referral partners.
- Describe your organization's key partnerships with community organizations, including coalitions, networks, stakeholders, and referral partners. Highlight the role and impact of each collaboration.
- Describe how your organization is currently partnering—or planning to partner—with health systems to advance your strategic goals, improve patient outcomes, or expand service delivery?
- If currently contracted with Greater Health Now, what adjustments would you make to maximize impact and enhance care coordination services?
- Provide a brief narrative describing your organization's current sustainability plan or your approach to developing one during the contract year, specifically as it supports care coordination. Include key goals, anticipated outcomes, and how progress will be tracked.

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GHN provides three contract opportunities for Community Partners:

	Tier 1: Community-Based Care Coordination Services	**Tier 2: Training and Resiliency Support**	**Tier 3: Access to workforce development training**
Data Reporting	Required to use Connect2Coordinator Client Management System (C2C CMS	Quarterly Reports due with organization-wide data minimums C2C CMS Limited access to track referrals or option to adopt	No data reporting Care Hub Referrals encouraged
Does GHN assign incoming referrals to them?	Yes	No	No
Training	Full training suite required	Min. Training Required • Intro to CBCC • Complex Care • HIPAA or Informed Consent (if accessing C2C CMS)	CBW-focused offerings added to our Leadership Training suite – Complex Care, Mental Health First Aid, QPR, and Trauma-Informed Care
Resiliency Support	Min. Resiliency Support Required Twice monthly sessions and evaluation surveys	Min. Resiliency and Support Required Twice monthly sessions and evaluation surveys	Offered Independently as requested by organization
Funding	75% guaranteed FTE and IR reimbursement, the remaining 25% based on defined performance, additional incentives applied for exceeding baseline KPI's.	Training and Resiliency support: $10,000/CBW/Yr for completion of training and resiliency support. Quarterly Reporting. Hub referrals, $15,000/Qtr. $60,000 total annual per organization. Patient Activation Measure Utilization, $5,000 annual	None
Monitoring	Monthly audit reports/ Convenings/bi-annual surveys and no less than one site visit evaluation.	Quarterly reports delivered to GHN, attendance and participation in TRSP and one time site evaluation of implementation of Care Coordination, 2-4 surveys as requested.	None