Supplemental Workbook - 2B Implementation Approach

Project Stage Milestones	Deadline (DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity to effectively focus on the need for regional community-based care coordination	DY 2, Q2	Building on past regional capacity assessments, CPAA will conduct an online survey of key clinical and social service providers in the region to gauge the current state of capacity for effective community based care coordination services delivery. Particular emphasis will be placed on potential partnering providers, i.e., key partners identified during the project design phase to date. We will augment this survey through a discussion of survey results with key clinical and social service partners as well as technical assistance partners (e.g., Pathways Community HUB Institute). We also plan to utilize the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub. Providence CORE will continue to provide support. The Care Coordination Work Group will review data and provide input into the final report. *We will complete final analysis by end of Q~~1~~2 in DY2.*
Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	DY 2, Q2	**1) Systems for Population Health Management:** Population health data analysis will continue to be used to refine target populations, including identifying sub-groups and sub-regions. Additionally, we will develop an inventory of our partnering providers' electronic health record (EHR) systems to develop strategies for information sharing. This will include push and pull notifications based on the level of system interoperability. CPAA will also explore opportunities for expanding the use of EPIC among partnering providers, given that approximately 40% of our region is already using this technology platform. A recent plan developed by our region over the last few years includes specific strategies to leverage EPIC, including with providers who do not have routine access to EPIC. More specifically, the Pathways model will implement and maintain a data system that documents a standardized approach to care coordination as it is implemented across the region. This unique data set creates the capacity to analyze patient experience and outcomes in a way that is not currently possible. Data generated through the Pathways project will be monitored, analyzed, and shared at a variety of operational levels to continuously improve patient experience. Individual Care Coordinating Agencies will review data about their own performance and the progress of their patients. The HUB Manager will provide the care coordination workgroup and other partners with regular reports that observe impact and opportunities for improvement across the entire region. The new Population Health Management system for Pathways will help partners across the region to understand what prevents people from accessing services and improving their health. 2**) Workforce:** The Pathways HUB project will grow the regional workforce of community health workers and similarly skilled care coordinators through Domain I workforce strategies. CPAA will hire staff who represent the diversity of the populations served. The CPAA will develop capacity to provide training for care coordinators and their supervisors that is accessible to partners across the region. Additionally, CPAA has solicited feedback from the Domain 2 Work Group to identify training needs to support the broader development of provider workforce capacity. CPAA will continue this assessment of provider workforce needs during implementation planning through an online survey of providers. Survey results will be discussed by the Care Coordination Work Group to interpret the results and ensure completeness. This includes providing targeted training of our partnering providers' personnel on evidence-based Pathways strategies and models with the help of technical assistance partners, including, but not limited to, HCA, DOH, Qualis Health, Foundations for Healthy Generations, Pathways Community HBU Institute, and Care Coordination Systems. In addition, CPAA will continue to explore provider workforce recruitment and retention support strategies that benefit all project areas, such as offering loan forgiveness and conditional scholarships. Additional workforce mitigation strategies CPAA will explore include shared workforce strategies, such as

		expanding access to telehealth, changing overly burdensome licensing requirements for certain practitioners, developing internships for college students, and establishing a learning collaborative of partnering providers. As with investments in Systems of Population Health Management, our investments in Workforce training, recruitment, and retention will be coordinated across all project areas in order to develop synergies. **3) Value-based Purchasing:** Given the importance of MCOs in funding clinical care for Medicaid beneficiaries, CPAA has included MCO representatives in all stages of project selection and planning, including project work groups. This ensures that our project design and implementation aligns well with current and emerging VBP approaches. Since HCA contracts with MCOs, working closely with HCA will be crucial. The Pathways model is specifically designed around value-based purchasing concepts of paying for outcomes rather than volume or frequency of patient encounters. The Pathways model will engage MCOs as payers for care coordination outcomes. As Care Coordinating Agencies design their operations around this value-based purchasing model, the CPAA will document and share lessons learned that advance broader value-based purchasing goals for the region. CPAA will work with the statewide VBP Task Force to assess how VBP contracts can support successful community based care coordination and share insights gained on evolving VBP opportunities with partnering providers. This will allow partnering providers to assess VBP options and prepare their organizations for value-based care delivery. Again, CPAA's efforts to support provider movement to value-based care will not be specific to Pathways, but support all project areas, including Pathways.
Finalize target population and evidence-based approach informed by regional health needs	DY 2, Q2	**1)Target Population(s):** CPAA has conducted significant analysis of available data and engaged partners through the Council and the Care Coordination Workgroup to develop a preliminary list of target populations: • Individuals with comorbid behavioral health issues and chronic diseases • Homeless populations • High-risk OB patients • Frequent utilizers of Emergency Medical Services linked with inadequate management of disease The Care Coordination Workgroup will use further information generated by the final assessment work to determine which of these populations will be targeted for initial start-up implementation of the pathways model and which populations will be added as the number of Care Coordination Agencies and case-loads for each agency are scaled up during the Demonstration period. In support of this analysis, during Q2 we will continue to work with CORE to refine our data tools. As we progressively narrow down our target population(s) through these efforts, our Care Coordination Work Group and partnering providers, with technical assistance from Pathways HUB experts, will be able to make a final determination about the project's target population(s). **2) Evidence-based Approach:** The Pathways model is the only evidence-based approach listed for project 2B in the toolkit, and will be utilized for the CPAA Care Coordination project. We will work with national experts in the Pathways model to support the Care Coordination Workgroup in understanding best practices for how to implement this evidence-based model and ensuring it addresses local needs. CPAA will employ all of the evidence-based approaches included in the Medicaid Transformation Toolkit in this project area; no one strategy will be sufficient to achieve the level of impact required. CPAA will work with the Care Coordination Work Group to identify additional strategies that may need to be included ~~in order~~ to reach the desired outcomes. With the support of CORE, during Q2 the work group will vet these strategies as to likely impact and feasibility (cost, provider readiness, etc.) before a final determination about chosen evidence-based approaches will be made.

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Identify project lead entity, including: -Establish HUB planning group, including payers. -Designate an entity to serve as the HUB lead.	DY 2, Q2	CPAA and CHOICE already serve as the lead entity for similar activities and there is considerable support for it to continue serving as the "neutral" HUB role under this project. CHOICE has already hired a Pathways HUB Program Manager who is responsible for design and implementation of the HUB. The CPAA will continue to use the Care Coordination Workgroup as the HUB planning group until a final HUB governance is created and put into place. *This decision will be finalized by DY2, Q1.*
Identify and engage project implementation partnering provider organizations, including: -Review national HUB standards and provide training on the HUB model to stakeholders -Identify, recruit, and secure formal commitments for participation from all implementation partners, including patient-centered medical homes, health homes, care coordination service providers, and other community-based service organizations, with a written agreement specific to the role each will perform in the HUB -Determine how to fill gaps in resources, including augmenting resources within existing organizations and/or hiring at the HUB lead entity	DY 2, Q2	CPAA has already identified the HUB lead (Michael O'Neill), the HUB planning group (Care Coordination Work Group), and key clinical partnering providers for this project using (1) the well-established network of partnerships with a broad range of clinical providers through CHOICE Regional Health Network's health improvement projects; (2) responses to a Request for Qualifications (RFQ) that was issued this summer; and (3) an analysis of the main Medicaid providers in the CPAA region by our strategic data analytics partner, CORE. In the coming weeks, we will be systematically reaching out to those main Medicaid providers that have not yet engaged in project planning to introduce the project and encourage participation in project design and implementation planning. Concurrently, we will reach out to social service providers in our region whose participation is vital for successful care coordination. We are using our extensive stakeholder list from work that CHOICE has led to improve care coordination in the region over the last several years as a starting point. We will augment this list of potential partnering providers with information gleaned from our regional asset mapping (see above) to ensure a comprehensive approach. The recruitment of specific partnering providers ~~—~~ both clinical and community-based ~~—~~ will be guided by our final decision about the target population(s) and sub-regions for this project. CPAA will seek a mix of Care Coordinating Agencies that include clinical and other community-based services. Partnering organizations that will provide care coordination and organizations that will make referrals to the Pathways program will receive detailed technical support to ensure participants are well-versed on HUB model standards. In order to secure formal commitments for participation from implementation partners, during Q2 CPAA will define the specific scope of work for each partnering provider (what and where will investments be made); reporting requirements of partnering providers (what measures and how frequently will reports be made); payment of partnering providers (how much and when payment occurs). Partnering providers will only commit to participating in the Transformation if they are clear on expectations and can assess the risks and rewards of their participation. CPAA will work with its Finance Committee and TA partners (e.g., Health Management Associates, Manatt, etc.) to establish the necessary payment framework. CPAA will work with its Pathways HUB Manager and the Care Coordination Work Group to clarify the scope of work of prospective partnering providers. CPAA will utilize its Support Team to assess partnering providers' scope of work across project areas. CPAA looks at the Transformation projects as an integrated project portfolio; hence, our partnering providers will be asked to engage in integrated project initiatives, rather than discreet, stand-alone projects. We anticipate that partnering providers will be able to make a firm commitment to participating in the Transformation once they have a full understanding of their implementation role across the entire project portfolio. These commitments will be memorialized in written agreements/contracts.
Develop project implementation plan, which must include: -Description of pathways, focus areas, and care coordination service delivery models, -Implementation timeline	DY 2, Q3	By the end of Q3, CPAA staff will develop t~~T~~he project implementation plan ~~will be developed by CPAA staff~~ in close collaboration with the Care Coordination Work Group and in consultation with the Support Team to ensure the project implementation plan integrates well with and supports the other Transformation projects pursued by CPAA. This includes alignment through the comprehensive review and coordination of target populations across different project areas detailed above (see Finalization of target population and evidence-based approaches). Additionally, our two advisory committees - the Clinical Provider and Consumer Advisory

-Roles and responsibilities of implementation partners -Describe strategies for ensuring long-term project sustainability		Committee - will review the project implementation plan to assess feasibility and impact from their respective perspectives and provide guidance on the final implementation plan. This will ensure that the implementation plan employs evidence-based approaches, is responsive to the needs of the region, and impacts high-need target populations. CPAA will make provisions to implement all 20 standardized Pathways and ~~to~~ work towards certification of the HUB during the demonstration period, meeting all requirements of the model. Implementation milestones will be paced to start-up quickly with a limited number of providers who will work out early issues with the program, and then will continue to scale reach and improve impact throughout the length of the demonstration and beyond. CPAA will work with partnering providers to establish timelines that meet the needs of our providers, first by focusing on large Medicaid providers and community-based social service providers, and then gradually building out to include smaller clinical and community-based providers. In finalizing commitment letters from partnering providers, CPAA will include final evidence-based approaches each provider will implement and ensure all implementation requirements are met. CPAA will ensure that alignment across project areas is prioritized to serve specific target populations that cross the entire health care system. An assessment of current state capacities will be conducted to avoid duplicating efforts and instead build upon existing assets and resources to the greatest extent possible. Again, this current state assessment will be reviewed across different project areas to develop maximum leverage and avoid duplication. The HUB Manager will ensure roles and responsibilities of implementing partners are clearly articulated in both the project implementation plan and our contracts with partnering providers. This includes the description of the service delivery mode. The HUB Manager will monitor adherence to the implementation plan by all partners on an ongoing basis. CPAA will work closely with all partnering organizations, including MCOs and BHOs, to ensure that Domain 1 investments are leveraged to support the long-term sustainability of the project (see Domain 1 project support above for details). Additionally, CPAA anticipates working with other ACHs to maximize investments in Domain 1 activities through coordinated investments across the state, or at least those regions that are interested in developing shared capacity, especially around Systems of Population Health Management and workforce development.
Stage 2: Implementation		
Develop guidelines, policies, procedures and protocols	DY 3, Q1	By the end of DY3, Q1, CPAA will establish project-specific guidelines, policies, procedures, and protocols necessary to ensure consistent implementation of selected evidence-based strategies and models. In developing these documents, we will build to the greatest extent possible on already existing guidelines, policies, procedures and protocols that the proponents of the selected evidence-based strategies and models have already develop. For instance, we are planning to work with Foundation for Healthy Generations, Pathways Community HUB institute, and Care Coordination Systems to access existing guidelines, policies, and procedures for the main elements of the Pathways model and to gain technical assistance adapting these to our region specific implementation. With guidance from the Clinical Director, the project manager will take the lead on developing any additional guidelines, policies, procedures and protocols necessary to customize the evidence-based strategies and models to our specific regional context, if appropriate. The Care Coordination Work Group will review the proposed project-specific guidelines, policies, procedures, and protocols and make changes as necessary. We will consult with our Clinical Provider Advisory Committee as necessary, as well as with other technical assistance providers that have detailed knowledge of the chosen evidence-based strategies and models. The Program Manager will ensure all partnering organizations have access to and understand the guidelines that will be implemented. The project manager is also

		responsible for monitoring adherence to these guidelines, policies and procedures and protocols through provider spot checks.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / pathways	DY 3, Q2	In working towards certification as a Pathways Community HUB, which the CPAA will achieve during the demonstration period, commitment to continual quality improvement is a required standard. The CPAA will define, document and monitor quality standards in the areas of referral policies and procedures, addressing duplication of services, client interaction, supervision of care coordinators, and HUB oversight. CPAA will establish a progressive implementation and performance monitoring system. This will include regular meetings with partnering providers to assess implementation progress and challenges. These meetings will be augmented by regular provider and regional performance reports that demonstrate movement toward critical milestones and achievement of key outcome goals. If performance problems are identified, the Pathways HUB Manager will take the lead on developing a QIP in consultation with the partnering provider who is underperforming. In developing the QIP, the HUB Manager will be supported by the Clinical Director and senior agency leadership, as well as the Care Coordination Work Group and both the Clinical Provider Advisory Committee and the Consumer Advisory Committee. Whenever possible, the QIP will identify technical assistance resources that help the partnering provider to get back on track. CPAA will establish a common format for QIPs detailing strategies, measures, and targets along with timelines for required improvement to ensure accountability.
Implement project, which includes the Phase 2 (Creating tools and resources) and 3 (Launching the HUB) elements specified by AHRQ: -Create and implement checklists and related documents for care coordinators. -Implement selected pathways from the Pathways Community HUB Certification Program or implement care coordination evidence-based protocols adopted as standard under a similar approach. -Develop systems to track and evaluate performance. -Hire and train staff. -Train care coordinator and other staff at participating partner agencies. -Conduct a community awareness campaign.	DY 3, Q4	In implementing the project, we will follow the project implementation plan (see above), which details timelines, action steps and the specific roles and responsibilities of our partnering providers in their implementation of the selected evidence-based strategies. It will be the responsibility of the project manager to be in regular contact with our partnering providers to monitor adherence to the implementation plan and to ensure project-specific guidelines, policies and procedures and protocols are followed, so that implementation addresses the core components of the Pathways Community HUB model. In the first year of implementation CPAA will contract with up to six care coordinating agencies, provide them with training in implementing the Pathways model, and begin monitoring performance and outcomes. As detailed below, the project manager will utilize regular reports from providers and periodic meetings with partnering providers to monitor partnering provider performance. The project manager is also responsible for ascertaining partnering providers' additional training and technical assistance needs, which are expected to surface through provider reports and regular meetings with providers, and to arrange for necessary trainings and technical assistance. In monitoring the performance of partnering providers, we will use a combination of quantitative information provided by partnering providers through monthly reports (provider specific project metrics and milestones will be negotiated and contractually agreed upon) and qualitative data gathered through regular check-ins with partnering providers by the project manager as well as quarterly provider peer learning meetings. With the help of the CPAA finance committee a performance-based compensation system will be developed and implemented for all projects, including care coordination improvements. Implementation of the Pathways model will be reported on and discussed at Local Forums across the CPAA region to ensure stakeholders and the public in local communities are aware of the program and how to connect people to it.
Stage 3: Scale & Sustain		

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Increase scope and scale, such as adding partners, focus areas or pathways	DY 4, Q4	In keeping with our overall project approach, we will initially focus our interventions by working with implementation partners that serve large numbers of Medicaid beneficiaries in our region for the specified target population(s) and sub-region. As these core partners experience implementation success, CPAA will be able to build out the project to include progressively more partners, including partners that serve smaller numbers of Medicaid beneficiaries and additional community-based organizations that can augment the reach and scale of the project. In determining these additional implementation partners, CPAA will use its current state analysis with appropriate updates and data reported into the HUB's HIT platform, as well as the data provided by CORE assessing the relative attribution of potential implementation partners. Implementation information from our initial set of partnering providers (documented through performance reports and our peer learning collaborative) will be made available to new implementation partners to leverage existing implementation experience and guide new partners in project planning and implementation. Emphasis will be placed first on expanding Pathways improvements to prioritized target populations from sub-regions to the entire region and then to serving additional high-risk populations. The HUB Manager and Care Coordination Work Group will have a key role in guiding the increase in scope and scale of the project. They will make expansions based on performance targets, the capacity of existing CCAs to serve additional clients, the readiness of additional CCAs to join the HUB, and other factors determined by the HUB governing body.
Employ continuous quality improvement methods to refine the model, updating model and adopted guidelines, policies and procedures as required	DY 4, Q4	Throughout the Transformation Project, CPAA will employ a dynamic quality improvement approach based on the real-life implementation experience of our partners. The HUB Manager will ensure steps are taken towards continuous quality improvement through goal setting and performance review with CCAs. As implementation challenges are encountered, the HUB Manager will involve the HUB governing body, and we will consult with our partnering providers to assess the implementation issues and determine what technical assistance resources might help with resolving the challenges. CPAA will help partnering providers reflect on implementation challenges and develop solutions when partnering providers gather periodically (peer learning collaborative) to share lessons learned and problem-solve together. As a result, we anticipate that Pathways HUB model will experience progressive refinement. Correspondingly, project-specific guidelines, policies, and procedures will need to be updated to capture learning. At this stage of project implementation, we also anticipate partnering with other ACHs that have chosen Pathways as one of their project areas to compare the refinement of the model across ACH regions, further leveraging implementation experience.
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion	DY 4, Q4	Ongoing support will be essential to achieving continuation and expansion of the Pathways HUB model. The HUB will provide access to ongoing training to existing CCAs and to new CCAs joining the HUB. CPAA will use quarterly gatherings of its implementation partners (peer learning collaborative) to determine specific ongoing support needs as well as feedback from individual implementation partners. We anticipate that ongoing support needs will change in later years of the Transformation Project, emphasizing sustainability and shared learning. Thus, working even more closely with our MCO partners to establish new payment mechanisms that will fund Pathways for the long term and providing opportunities for our implementation partners to learn with and from each other, as our region scales up the Transformation Project's scope and reach, will be essential. In providing these supports, CPAA will work with other ACHs that have chosen Pathways as a project area to the greatest extent possible in order to increase the spread of the project and maximize resource efficiencies through economies of scale (e.g., through shared training costs or technical assistance).

Identify and document the adoption by partnering providers of payment models that support the HUB care coordination model and the transition to value based payment for services.	DY 4, Q4	In partnership with MCOs, HCA, and our partnering providers, CPAA will monitor the degree to which value-based purchasing arrangements have been adopted in provider contracts to support transitional care in our region. To this end, CPAA will conduct a survey of its partnering providers and MCOs to determine VBP penetration for Pathways. Given the proprietary nature of provider contracts with health plans, CPAA will limit its inquiry to whether VBP arrangements are in place and, if so, what general type of VBP contract has been agreed upon (upside only, shared upside and downside risk, etc.). CPAA will also work with its partnering providers to scale activities such that all payers, not only MCOs, support Pathways improvements. This is vital for the long-term sustainability of this effort. Lastly, CPAA will work with state policy makers to obtain a long-term commitment that rewards implementation partners, including MCOs, for efficiency gains achieved, rather than punishes MCOs and partnering providers through reduced reimbursements in subsequent years.