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Project Stage Milestones	Deadline DY, Qtr)	ACH Approach for Accomplishing Milestones
Stage 1: Planning		
Assess current state capacity to effectively deliver care transition services	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 care transitions services delivery. Particular emphasis will be placed on potential partnering providers, i.e., key partners, including major Medicaid providers, 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 providers as well as technical assistance partners (e.g., Qualis Health) in order to gain a shared understanding of the survey results, assess the implications of the survey, and backfill missing information. We also plan to use the results of surveys conducted by other partners, such as the DOH Practice Transformation Hub to round this current state capacity analysis. These efforts will result in an updated, comprehensive assessment of our region's current state capacity to effectively deliver care transition services.
Identify how strategies for Domain I focus areas – Systems for Population Health Management, Workforce, Value-based Payment – will support project	DY 2, Q2	By the end of DY2, Q2, CPAA will have finalized the specific Domain 1 strategies that will support the project. **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. The action plan developed by our region over the last few years within the regional care transitions improvement project led by CHOICE Regional Health Network includes specific strategies to leverage EPIC, including for providers who do not have routine access to EPIC. Connection of health information technology systems is integral to the implementation of evidence-based approaches and emphasizing the importance of producing and sharing information on patient discharge plans will assist clinicians to better address the transitional coordination aspects of a patient's care. Additionally, CPAA will facilitate continued shared learning about risk screening tools used by our region's hospitals to identify patients with an elevated risk of re-hospitalization to ensure systematic risk screening occurs. Importantly, our investments in Systems of Population Health Management will be coordinated across all project areas so that they become mutually reinforcing. **2) Workforce:** CPAA has solicited feedback from the Domain 2 Work Group to identify training needs to support the 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 work group to interpret the results and ensure completeness. This includes providing targeted training of our partnering providers' personnel on evidence-based transitional care strategies and models with the help of technical assistance partners, including, but not limited to, HCA, DOH, and Qualis Health. 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 workgroups. We will continue to do so. 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. CPAA will work with the statewide VBP Task Force to assess how VBP contracts can support successful transitions of care 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 transitional care, but support all project areas, including transitional care.

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Finalize target population and evidence-based approach informed by regional health needs	DY 2, Q2	**1) Target Population(s):** CPAA determined it would target efforts in areas where the region underperformed compared to the state average and focus on areas where there was the greatest need for improvement. As a result of the analysis, we identified target populations and project areas that would address gaps and have the deepest impact for populations that most needed an intervention. As a proxy to identify areas where there are significant health disparities, CPAA looked at Medicaid claims data and mortality rates in counties by census tracts to identify specific target populations and sub-regions for our projects. We believe by addressing health disparities, health equity will improve in our community. Going forward, we will review the target population(s) prioritized by other project areas to determine whether there are shared population(s) across project areas. CPAA will perform a similar cross-analysis of sub-populations and sub-regions. Aligning our target populations and sub-regions across project areas to the greatest extent possible will generate maximum synergies and impact. In support of this analysis, 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 work group and partnering providers will be able to make a final determination about the project's target population(s). **2) Evidence-based Approach:** CPAA will employ all of the evidence-based approaches included in the Medicaid Transformation Toolkit to include INTERACT™4.0, The Care Transitions Intervention (CTI), Transitional Care Model (TCM), and Care Transitions Interventions in Mental Health; no one strategy will be sufficient to achieve the level of impact required. CPAA will work with the Transitional Care Work Group and Clinical Provider Advisory Committee to identify additional strategies that may need to be included in order to reach the desired outcomes. With the support of CORE, 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.
Identify, recruit, and secure formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach -For projects targeting people transitioning from incarceration: identify and secure formal partnerships with relevant criminal justice agencies (including but not limited to correctional health, local releasing and community supervision authorities), health care and behavioral health care service providers, and reentry-involved community-based organizations, including state and local reentry councils.	DY 2, Q2	CPAA has already identified 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 transitional care. We are using our extensive stakeholder list from work that CHOICE has led to improve post-acute transitions of care 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. If transitions from incarcerations are chosen as a project focus, we will prioritize outreach to relevant criminal justice agencies. In order to secure formal commitments for participation from implementation partners, 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); and 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 project 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. These commitments will be memorialized in written agreements/contracts by the end of DY2, Q2.
Develop project implementation plan, which must include: -Implementation timeline-Description of selected evidence-based approach, target population, justification for how approach is responsive to specific needs in the region-If applicable, explanation of how the standard pathways selected in Project 2B align with the target population and evidence-based approach selected in this project;-Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts, consider Health Home and other care management or case management services, including those provided through the Department of Corrections-Roles and responsibilities of implementation partners-Description of service delivery mode, which may include home-based and/or telehealth options-Describe strategies for ensuring long-term project sustainability	DY 2, Q3	The project implementation plan will be developed by CPAA staff in close collaboration with the project 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 with Project 2B through the comprehensive review and coordination of target populations across different project areas detailed above (see Finalization of target population and evidence-based approaches). If feasible, CPAA will use Project 2B to help support care transitions improvements through the Pathways model. Additionally, our two advisory committees - the Clinical Provider and Consumer Advisory 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 the implementation plan employs evidence-based approaches, is responsive to the needs of the region, and impacts high-need target populations. 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 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. This includes an assessment of existing care management and case management services and the reach of the Health Home program in our region. Again, this current state assessment will be reviewed across different project areas to develop maximum leverage and avoid duplication. In the implementation plan, the service delivery mode will be clearly articulated based on the selected target population/s. The program 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 program 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 as necessary to support consistent implementation of the model / approach	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, there are readily available sets of guidelines and procedures available for the INTERACT program, the Transitional Care Model, and the Coleman Model. 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, or fill in any missing guidance documents. The project 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 project 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.

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Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected model / approach	DY 3, Q2	By the end of DY3, Q2, 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 project manager will take the lead on developing a QIP in consultation with the partnering provider who is underperforming. In developing the QIP, the project manager will be supported by the Clinical Director and senior agency leadership, as well as the project 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, including the following core components across each approach selected: -Ensure implementation addresses the core components of each selected approach -Establish guidelines, policies, protocols and/or procedures as necessary to support consistent implementation of the model -Incorporate activities that increase the availability of POLST forms across communities/agencies (http://polst.org/), where appropriate. -Ensure each participating provider and/or organization is provided with, or has secured, the training and technical assistance resources necessary to follow the guidelines and to perform their role in the approach in a culturally competent manner. -Implement robust bi-directional communication strategies, ensure care team members, including client and family/caregivers, have access to the care plan. -Establish mechanisms for coordinating care management and transitional care plans with related community-based services and supports such as those provided through supported housing programs. -Develop systems to monitor and track performance -Establish a performance-based payment model to incentivize progress and improvement.	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 selected evidence-based strategies and models. 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' 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. Special emphasis will be placed on making sure that care team members have access to shared care plans. We anticipate that establishing effective bi-directional communication strategies and systems will be a major emphasis of this project. This includes establishing functioning care plan exchange capabilities with community-based social service agencies that play a key role in effective transitions of care. Referral processes between clinical organizations will be established or expanded to ensure timeliness of transitional care. 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 transitional care improvements.

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Stage 3: Scale & Sustain		
Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities	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. CPAA will conduct a gap analysis of target providers/organizations that did not implemented any of the evidence-based strategies suggested in the Project Toolkit. This gap analysis will allow us to target outreach efforts and establish partnerships with new providers. CPAA will also focus on core partners who experienced 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 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 transitional care improvements to prioritized target populations from sub-regions to the entire region and then to serving additional high-risk populations. The project work group will have a key role in guiding the increase in scope and scale of the project.
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. As implementation challenges are encountered, 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 the chosen transitional care models 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 transitional care 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	By DY4, CPAA will have identified training and technical assistance needs of major providers in the region and will continue assessing future needs on an ongoing basis. Ongoing support will be essential to achieving continuation and expansion of the transitional care project. 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 transitional care improvements 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 transitional care 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 transitional care 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 transitional care. 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 transitional care 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.