Supplemental Workbook – 3B/Reproductive and Maternal/Child Health 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 high-quality reproductive and maternal and child health care	DY 2, Q2	The assessment of current state capacity will be a continuation of data collection and analysis CPAA has engaged in throughout project selection and development. CORE will continue to provide analytical data support. The Reproductive and Maternal & Child Health Work Group will review current state data and provide input into the final report. An assessment of current state capacities will be completed to avoid duplicating efforts and instead build upon existing assets and resources to the greatest extent possible. This includes an assessment of existing home visiting programs 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. *We will complete final analysis by end of Q1 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**: We will need to explore if and how we can connect birth certificate filings with the Pathways software to facilitate outreach to eligible mothers and families. Additionally, we will need to work with providers and EHR systems to ensure they can track pregnancy intention counseling for both women and men. Furthermore, we need to assess which technology platforms in the region produce the most referrals to home visiting programs. Lastly, if we're expanding service sites for certain interventions (i.e., increasing access to well child visits), then we need to develop a plan for ensuring those service sites have access to billing and population health management software. 2) **Workforce:** Initially, the project will be supported through investments in the training of partnering providers in evidence-based methods/approaches practice, including training on MCH home visiting models, trauma informed practices, one key question, LARC training, Stony Brook Children's Hospital Enriched Medical Home Intervention (EMHI), Bright Futures and gender neutral pregnancy intention counseling. Given the lack of provider capacity in many parts of our region, we will also need to make broader investments in regional workforce development, including exploring shared workforce models and telehealth. Other investments benefitting the program include: transformation coaching r.e. reproductive health, training in-home visiting models, care coordination training. These investments will support the providers to be more successful for implementation and help men, women, and children be healthier. 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, which is crucial for the project's long-term sustainability. Since HCA contracts with MCOs, working

		closely with HCA will be essential. CPAA will work with the statewide VBP Task Force to assess how VBP contracts can support reproductive, maternal and child health 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. CPAA's efforts to support provider movement to value-based care will not be specific to this project, but support all project areas, including maternal and child health. Financial incentives for prevention and high quality care can potentially overcome political barriers to change.
Finalize evidence-based approach(es) and specific target population(s) informed by regional health needs	DY 2, Q2	The Project Work group has completed its selection of evidence-based approaches. All approaches listed in the Transformation Project toolkit will be pursued. We will make a final decision about the initial target population(s) based on the current capacity assessment and environmental scan. *We anticipate completing this step in Q1 of DY2.*
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.	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 maternal and child health care. We will use information gathered from our regional asset mapping (see above) to identify potential partnering providers. 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. 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 are confident that partnering providers will be able to make a firm commitment to participate 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.
For each selected approach, develop a project implementation plan that includes at minimum: -Implementation timeline. -The selected evidence-based approach (es) and description of the target population, including justification for how the approach is responsive to the specific needs in the region. -Explanation of how the project aligns with or enhances related initiatives, and avoids duplication of efforts and/or duplication of federal funds. Project plans must consider current implementation of all Home Visiting Models and how they might be strengthened or expanded. -Description of the mode of service delivery, which may include home-based and/or telehealth options. -Roles and responsibilities of partners. -Describe strategies for ensuring long-term project sustainability.	DY 2, Q3	By the end of DY 2 Q3., CPAA staff will develop 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 2A and 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 reproductive, maternal and child health improvements through the Pathways model and through Project 2A through integrated care in pediatric settings. 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 that 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 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 completed to avoid duplicating efforts and instead build upon existing assets and resources to the greatest extent possible. This includes an assessment of existing home visiting programs 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	DY 3, Q1	Evidence based home visiting programs and the Bright Futures model already have established operating guidelines and procedures. The Clinical Director will ensure project partners implementing these elements of the project have access and are utilizing these tools. CPAA will work closely our American Academy of Pediatric Practice members in the region to support Bright Futures implementation. Furthermore, CPAA will work with existing Home Visiting Programs in the region to support expansion and coordination of home visiting programs to develop guidelines, policies, procedures, and protocols. For the 10 Recommendations to Improve Women's Health and other interventions, the Clinical Director will work with project partners (project work group) and the Clinical Provider Advisory Committee to develop and approve guidelines that ensure consistent implementation of the evidence-based approaches. 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. Implementation will be completed by DY 3 Q1.
Develop Quality Improvement Plan (QIP), which must include ACH-defined strategies, measures, and targets to support the selected evidence-based approach(es)	DY 3, Q2	CPAA will establish a progressive implementation and performance monitoring system by DY 3 Q2. 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 -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	DY 3, Q4	CPAA will implement the project by 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 and assist with rapid cycle quality improvement. The project manager is responsible for ascertaining partnering providers' training and technical assistance needs, which are expected to surface through provider

such as those provided through supported housing programs. -Establish a rapid-cycle quality improvement process that includes monitoring performance, providing performance feedback, implementing changes and tracking outcomes. -Establish a performance-based payment model to incentivize progress and improvement.		reports and regular meetings with providers, and to arrange for necessary trainings and technical assistance. The manager will then track outcomes through our partnering provider monitoring system. 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 reproductive, maternal and child health.
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. 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 by DY 4 Q4. 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. In general, emphasis will be placed first on expanding reproductive, maternal and child health 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. However, clinical partners are expected to expand their implementation of the 10 Recommendations and the Bright Futures model throughout the Transformation Project, thus gradually increasing the scope of their improved services to their full patient population. Metrics regarding the penetration of home visiting services for pregnant women across the CPAA region will be reviewed throughout the Transformation Project and will be used to identify populations in need of additional home visiting capacity.
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 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 that the selected implementation 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 maternal and child health 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 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. Training and TA will be identified through the quality improvement process and made available to partners as appropriate. 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 maternal and child health 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 reproductive, maternal and child health 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 selected strategies and the transition to value based payment for services.	DY 4, Q4	During DY4, and as part of its continuous quality improvement efforts, CPAA will incorporate discussion of how existing payment approaches may be modified or enhanced to transition to value-based payment. CPAA has included MCO representation on the work group to help assure the discussion is relevant to the prevailing method of provider reimbursement. In partnership with MCOs, HCA, and our partnering providers, CPAA will conduct a survey of its partnering providers and MCOs to measure VBP penetration for reproductive, maternal and child health. 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 maternal and child health 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.