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 final analysis of current capacity will be a continuation of data collection & analysis CPAA has engaged in throughout project selection and development. Providence CORE will continue to provide support. The ACEs Workgroup will review data and provide input into the final report. *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**: PRAMS, Birth Certificates, Pathways software 2) **Workforce:** practice transformation coaching r.e. reproductive health, training in home visiting models, care coordination training 3) **Value-based purchasing**: financial incentives for prevention and high quality care can overcome political barriers to change
Finalize evidence-based approach(es) and specific target population(s) informed by regional health needs	DY 2, Q2	The ACEs Workgroup will make final decisions about the initial target population(s) based on the assessment of current capacity 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	1) **Engaging providers**: CPAA has established a workgroup to address those projects meeting the needs of people with chronic conditions, including the Bidirectional Integration and has included providers who play a major role in serving Medicaid clients likely to benefit from the project. In addition, CPAA has conducted two efforts to identify partnering providers: 1) an RFQ to identify and engage partnering providers; and 2) an analysis conducted by CORE of the key providers serving 90% of Medicaid clients in the region. Since a successful Bidirectional Integration approach must include other provider types, such as housing, long-term care and children's services, during the planning year, CPAA will expand its identification of partnering providers to include these and other service categories. Continued engagement in the project will be tied to written, formal commitment to the project that specifies participant roles. 2) **Training:** During the planning year, CPAA will design a training program to assure that participating providers are well-versed on HUB standards. Ongoing training will serve to support and reinforce providers' efforts to adopt these practices. To the extent possible, CPAA will leverage statewide training resources, including those offered by HCA and DOH.
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	DY 2, Q3	CPAA will implement a rigorous project planning and monitoring approach to implementation of each project. The ACH will employ project planning software and tools to lay out required deadlines, key tasks, subordinate tasks, and milestones. The project plan will define the parties responsible for executing each task, critical paths and key dependencies. Failure to meet a critical milestone will prompt a timely management response at regular meetings that CPAA will convene with the staff and providers responsible for implementation of each project.

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.		
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. For the 10 recommendations to improve women's health, the Clinical Director will work with project partners and the Clinical Advisory group to develop and approve guidelines for this element of the project.
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 issue regular reports to participating providers designed to: 1) inform providers on where to target their efforts; and 2) advise providers on progress toward meeting required objectives. For example, if a provider is working to reduce readmissions, CPAA or a designated partner will help practices identify clients with high hospital admission rates or at high risk for readmission. Second, CPAA or designated partner will need to report to provider practices their overall progress on meeting the required metrics for each project. When a provider or a group of practices is not making adequate progress on meeting key metrics, CPAA will conduct outreach to and develop a plan of action, which would likely entail a face-to-face meeting to review the reports and an action plan to remedy identified gaps or barriers.
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 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.	DY 3, Q4	The Clinical Director will work with the partners in the Bi-directional Integration project to implement the 10 recommendations and the Bright Futures model in clinical settings with appropriate patient populations. Partners will identify which elements they will pursue and the Clinical Director will ensure needed training and TA are available. Partners working on evidence based home visiting will hire and ensure staff are appropriately trained in the model. If the Care Coordination project targets the high risk OB population, they will coordinate closely with partners working on home visiting strategies to ensure project alignment and avoid duplication of efforts.
Stage 3: Scale & Sustain		

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Increase scope and scale, expand to serve additional high-risk populations, and add partners to spread approach to additional communities.	DY 4, Q4	Clinical partners will continue to expand their implementation of the 10 Recommendations and the Bright Futures model throughout the demonstration, increasing the scope of their improved services for their full patient population. Metrics regarding the penetration of home visiting services for pregnant women across the CPAA region will be reviewed throughout the demonstration 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	Project partners will report regularly on implementation progress and metrics. Reports will be used to identify quality improvement goals.
Provide ongoing supports (e.g., training, technical assistance, learning collaboratives) to support continuation and expansion.	DY 4, Q4	The CPAA will lead a learning collaborative for MCH project partners. Training and TA will be identified through the quality improvement process and made available to partners as appropriate.
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 workgroup to help assure the discussion is relevant to the prevailing method of provider reimbursement.