2B: Community-Based Care Coordination Supplemental Workbook

Project Stage Milestones	Completion Deadline (Demonstration Year, Quarter)	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 Q2 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 caseloads 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 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.
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

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