



Accountable Health Communities Model



Learning System and Implementation Plan Guide: An Overview

Presenters

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Agenda

Objectives:

- Review the learning system purpose and goals
- Describe learning system activities and requirements
- Discuss requirements for the implementation plan section of the application, as outlined in the AHC Funding Opportunity Announcement (FOA) and Implementation Plan Guide

Guide Sections:

- General Guidance
- Drivers of Model Success
- Organizational Structure and Model Participant Relationships
- Intervention Framework
- Start-Up Period Work Plan
- Implementation Period Work Plan
- Risk Mitigation Strategy

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Learning System

Overview

- Learning system background
- Learning system requirements
- Developing aims
- Identifying appropriate drivers
- Developing a driver diagram
- Summary

Learning System Background (1 of 2)

- CMS will create a learning system to support shared learning and continuous quality improvement by bridge organizations, other model participants, and CMS.
- The goal of the learning system will be to facilitate the sharing of information and promising practices among bridge organizations and other model participants.

Learning System Background (2 of 2)

- This all-teach, all-learn paradigm will encourage and support award recipients to improve upon their interventions throughout the duration of the model.
- The learning system will be designed to assure that data-driven decisions are being made that can accelerate and optimize the desired outcomes of the model.

Learning System Requirements (1 of 3)

- Award recipients will be required to participate in learning system activities.
- CMS will use various approaches to group learning and information exchange to assist award recipients with:
 - Sharing their experiences
 - Tracking their progress
 - Rapidly adopting new ways of achieving improvement in the AHC model

Learning System Requirements (2 of 3)

- CMS will require, as a condition of award, bridge organizations and other model participants to work with the learning system program to:
 - Engage in results-driven learning
 - Create a driver diagram as a framework to guide and align intervention design and implementation activities
 - Provide data and feedback to CMS to:
 - 1) Assure that their learning and improvement needs are being met
 - 2) Contribute to the creation of a collection of promising practices

Learning System Requirements (3 of 3)

- Provide understanding of state and federal programs that complement AHC-like interventions in the communities they serve
- Develop, track and report on quality improvement efforts, activities, and measures at regular intervals
- Align data-driven decisions with the successful outcomes sought by the AHC model
- Participate in learning system events in-person (lasting approximately two days) and virtually (i.e., web series, online seminars, and teleconferences)

Defining Aims

- Establish a clear goal
- Describe how much improvement will occur
- Include a timeframe for achieving this improvement
- A good aim is:
 - Specific
 - Measurable

Developing Aims: Example

- Aim: By year 3 of the intervention, there will be a 50% reduction in wait times to first contact with the community service provider for high-risk patients
- Specific: Aim is focused on high-risk patients
- Time frame: Time frame for achieving the improvement is by year 3
- Quantifiable: Measure the change from baseline to the goal of 50%

Defining Drivers

- Drivers are levers or powerful actions that will propel the interventions towards the aim.
- There is a cause and effect relationship between the aim and the drivers.
- Primary drivers are considered the strongest and most direct of these levers.
- Primary drivers can be supported by multiple secondary levers or secondary drivers.

Identifying Primary Drivers

- Keep your eye on the aim
- Consider what you are trying to accomplish
- Determine the high-level priorities or steps
- Consider the impact of these high-level priorities or steps
- Determine the significance of the impact on your aim
- Select the high-level priorities or steps with the most significant impact to be the Primary Drivers

Primary Drivers: Example

- Review Aim from the example: By year 3 of the intervention, there will be a 50% reduction in wait times to first contact with the community service provider for high-risk patients
- Potential Primary Drivers
 - Program alignment to improve efficiencies and integration, and decrease duplication
 - Data systems for outcome evaluation and continuous quality improvement
 - Target high-risk populations

Identifying Secondary Drivers

- Drill down from the Primary Drivers to identify what is needed or important for the success of the Primary Driver
- Select the steps, requirements, or activities to support a specific Primary Driver
 - These items become the Secondary Drivers
- Primary Drivers typically have one or more Secondary Drivers to support them.

Secondary Drivers: Example 1

- **Potential Primary Driver:**
Program alignment to improve efficiencies and integration, and decrease duplication
- **Potential Secondary Drivers:**
 - Establish baseline of community's readiness through formal assessment
 - Identify shared services opportunities to address service gaps

Secondary Drivers: Example 2

- **Potential Primary Driver:**

Data systems for outcome evaluation and continuous quality improvement

- **Potential Secondary Drivers:**

- Monitor community progress on established outcome measures (e.g., employment, education, service wait times, and housing)
- Monitor cost savings attributable to program and reinvestments of such savings for long-term program stability

Secondary Drivers: Example 3

- **Potential Primary Driver:**
Target high-risk populations
- **Potential Secondary Drivers:**
 - Establish processes for assessment and referral including identifying high-need persons
 - Establish mechanisms for multi-county access where appropriate

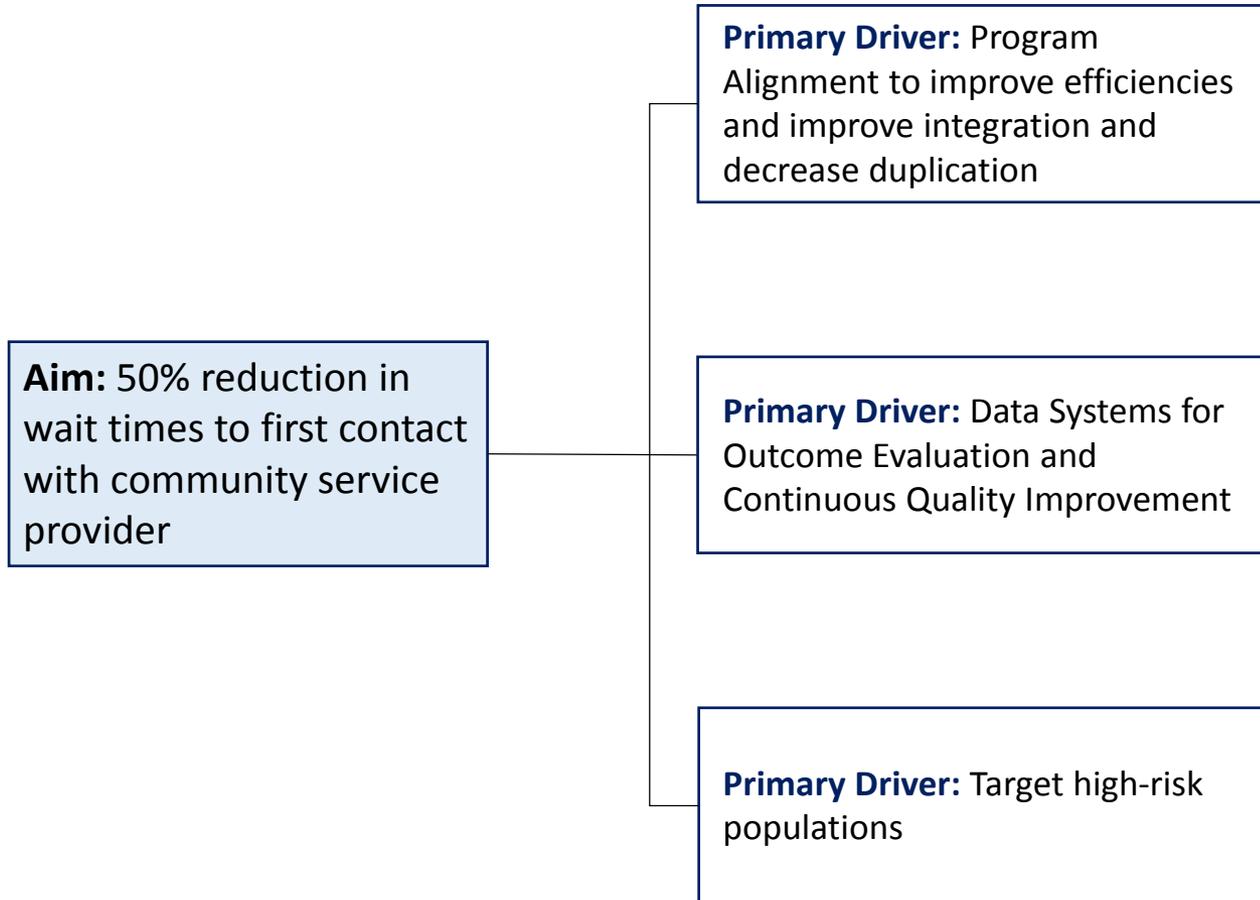
Developing the Driver Diagram

- Refer to the Aim from the example:

Aim: 50% reduction in wait times to first contact with community service provider

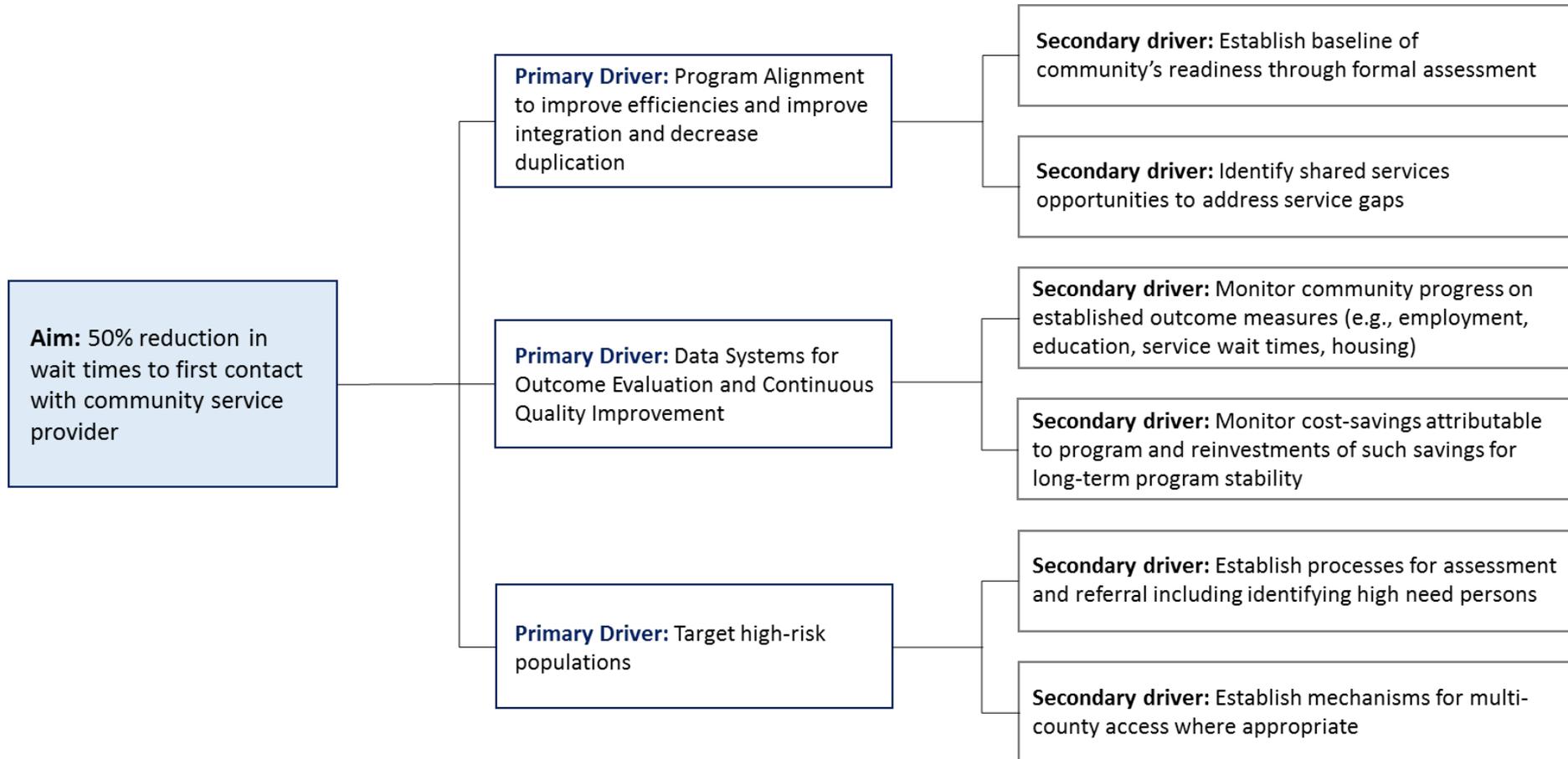
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Developing the Driver Diagram: Adding the Primary Drivers



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Developing the Driver Diagram: Adding the Secondary Drivers



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Summary

- Applicants must create a driver diagram as a framework to guide and align intervention design and implementation activities
- Award recipients will be required to:
 - Participate in learning system activities
 - Engage in results-driven learning
- CMS will use various approaches to group learning and information exchange to assist award recipients with:
 - Sharing their experiences
 - Tracking their progress
 - Rapidly adopting new ways of achieving improvement in the AHC model



Implementation Plan Guide

Overview

- Applicants must submit a detailed implementation plan, with the application, that describes how the applicant intends to implement the track to which it is applying and:
 - (1) Implement the AHC intervention as intended;
 - (2) Achieve track-specific milestones; and
 - (3) Engage in program quality improvement.

Purpose

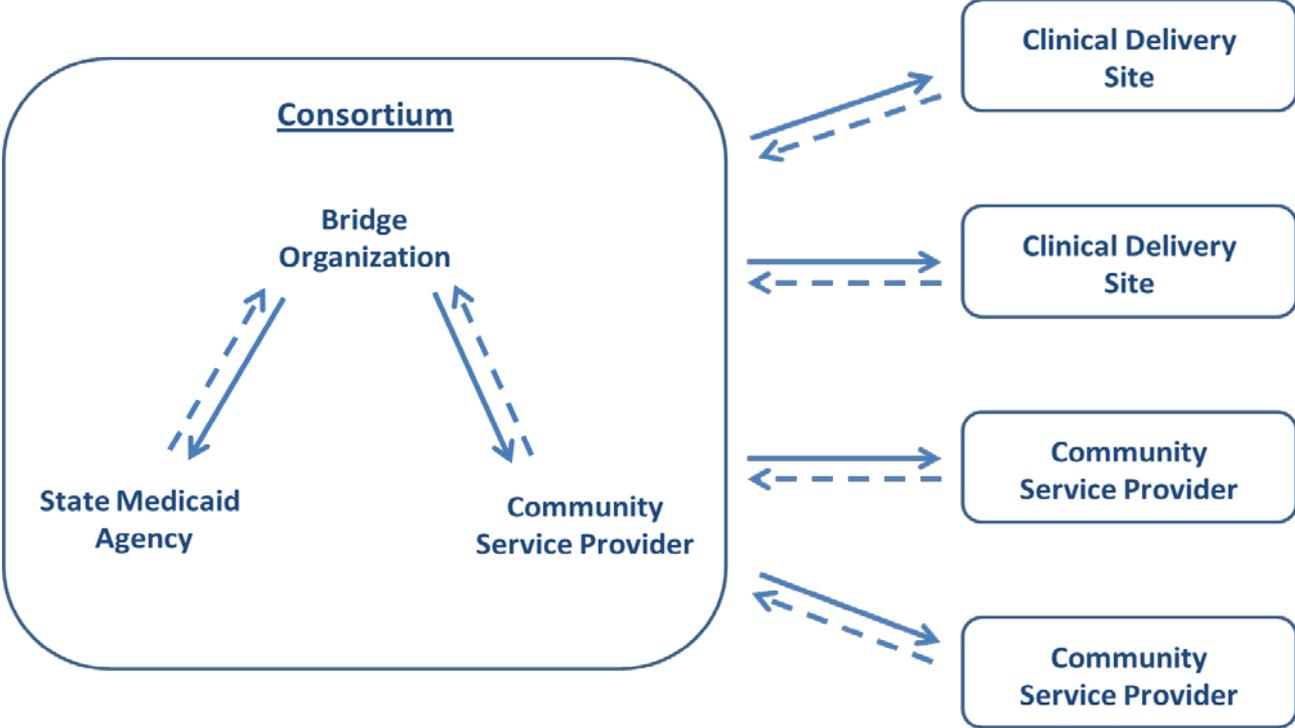
- A CMS-approved implementation plan will:
 - Serve as a roadmap for the AHC model and will focus on the operational realities of model implementation
 - Describe how the applicant intends to effectively launch their program within the defined start-up period and achieve program goals during implementation
 - Function as a stand-alone document that is consistent with, but not duplicative of, the information applicants provide in the Project Narrative

Organizational Structure and Model Participant Relationships

- One or more diagrams and corresponding narratives detailing:
 - Organizational structure of intervention
 - Relationships with model participants
- Information about the flow of AHC cooperative agreement funds, data, and communications among model participants

Organizational Structure and Model Participant Relationships: Example Diagram 1

Example Diagram of Model Participant Organization and Flow of Funds and Data

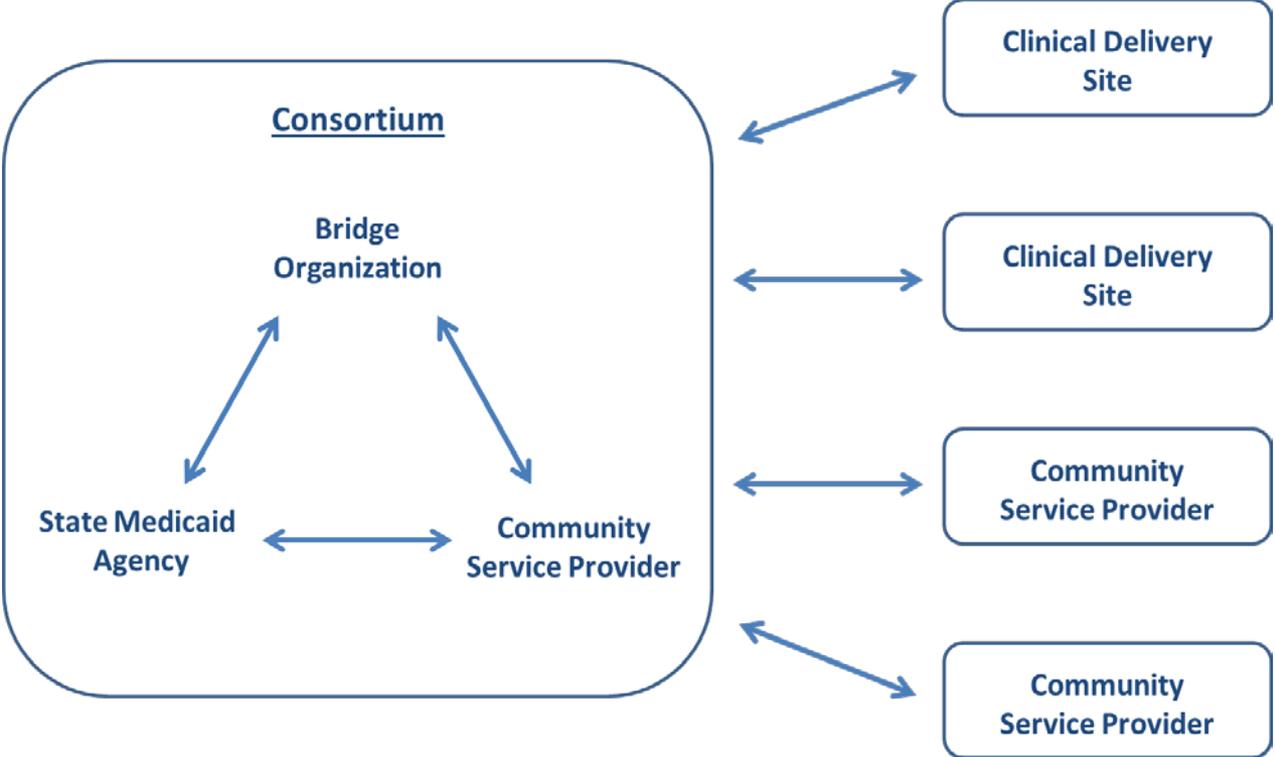


← Amount and Flow of AHC Cooperative Agreement Funding
← - - - Type and Flow of Data

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Organizational Structure and Model Participant Relationships: Example Diagram 2

Example Diagram of Communications among Model Participants



← Type and Flow of Communications

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Intervention Framework

- Outline of policies and procedures for implementing the intervention(s):
 - Screening
 - Community Referral Summary Activities
 - Community Service Navigation (Tracks 2 & 3 only)
 - Advisory Board Development (Track 3 only)
 - Integrator Role and Responsibilities (Track 3 only)
- General process descriptions for program activities:
 - Staff Training
 - Communication with CMS and among model participants
 - Data and Information Sharing

Start-Up Period Work Plan (1 of 2)

- Detailed work plan for the project start-up period, including major milestones described in the AHC FOA, target dates, and task owners
- Timeframes for designing, approving, piloting, and implementing:
 - Policies and procedures for staff training, screening and referral, community service navigation services, and integrator role functions
 - Contracts, MOUs and MOU-equivalent documents with model participants
 - Tools, such as the health-related social needs screening tool and Community Resource Inventory
- At a minimum, include all track-specific milestones relevant to project start-up from Table 3, 4 and/or 5 in the AHC FOA

Start-Up Period Work Plan (2 of 2)

Start-up period work plans should include the following elements:

- **Key Milestones/Activities:** All major milestones for the project start-up period, including all relevant activities associated with each milestone.
- **Task Owner:** The task owner for each activity in your work plan. The task owner may be an individual, a group of individuals, or an organization.
- **Key Partners/Model Participants:** A list of all partners who are key to achieving the model activity. Partners may include model participants, Advisory Board members, contractors/consultants, and individual or groups within your organization.
- **Months/Timeframe:** Depict the timeframe by including the start and end dates or months, or by shading/highlighting cells in your work plan table, among other methods.

Start-up Period Work Plan: Example

Track 2 (Assistance): Start-up Period Work Plan

Key Milestone / Activities	Task Owner	Key Partners/ Model Participants	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Community Referral Summary (CRS):											
A. Complete Community Resource Inventory											
1 Engage community partners to develop inventory	Project Manager (PM) (Bridge org.)	Community service providers (CSPs), Univ. Social Work Dept.	Start								End
2 Design and draft the inventory	PM (Bridge org.)	Univ. Social Work Dept., IT sub		Start	End						
3 Review with model participants and staff	PM (Bridge org.)	Model participants			Start			End			
4 Finalize inventory	PM (Bridge org.)	Bridge org. management, IT sub						Start	End		
B. Deploy tailored CRS system to participating Clinical Delivery Sites (CDS)											
1 Pilot test and improve SOP for referral summaries	CDS Liaison (Bridge org.)	CDSs, CSPs							Start	End	
2 Provide TA to CDSs	CDS Liaison (Bridge org.)								Start		End

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Implementation Period Work Plan (1 of 2)

- High-level work plan and annotated timeline of major milestones, dates, and task owners for the remaining performance period
- At a minimum, include track-specific milestones from Tables 3, 4 and/or 5 in the AHC FOA

Implementation Period Work Plan (2 of 2)

Implementation period work plans should include the following elements:

- **Key Milestones/Activities:** All major milestones for the remaining performance period, and include all relevant activities associated with each milestones.
- **Task Owner:** The task owner for each activity in your work plan. The task owner may be an individual, a group of individuals, or an organization.
- **Key Partners/Model Participants:** A list all partners who are key to achieving the model activity. Partners may include model participants, Advisory Board members, contractors/consultants, and individual or groups within your organization.
- **Quarterly Timeframe:** Depict the timeframe for each activity by including the start and end dates, or by shading/highlighting cells in your work plan table, among other methods.

Implementation Period Work Plan: Example

Track 1 (Awareness): Implementation Period Work Plan

Key Milestone	Task Owner	Key Partners / Model Participants	Y1-Q3 (Jul-Sep 2017)	Y1-Q4 (Oct-Dec 2017)	Y2-Q1 (Jan-Mar 2018)	Y2-Q2 (Apr-Jun 2018)	Y2-Q3 (Jul-Sep 2018)	Y2-Q4 (Oct-Dec 2018)
Offer to screen 37,500 community-dwelling beneficiaries	Bridge organization	Clinical delivery sites	Start	End				
Provide and review community referral summary with 1,828 community-dwelling beneficiaries	Bridge organization	Clinical delivery sites	Start	End				
Update Community Resource Inventory	Bridge organization	No Wrong Door (NWD) Program; community service providers		Start/End				
Conduct and finalize assessment of program duplication	Bridge organization	State Medicaid Agency; other state agencies		Start	End			
Offer to screen 75,000 community-dwelling beneficiaries	Bridge organization	Clinical delivery sites			Start			End
Update Community Resource Inventory	Bridge organization	NWD Program; community service providers				Start/End		

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Risk Mitigation Strategy (1 of 2)

- Risks to implementation and major assumptions that may impact projected timelines and/or your ability to achieve milestones
- Mitigation strategies for reducing the probability of the risk occurring
 - Include at least one mitigation strategy for each identified risk or major assumption
- The relevant year(s) and quarter(s) for each identified risk

Risk Mitigation Strategy (2 of 2)

- Align key milestones in your risk mitigation strategy with the milestones identified in your work plan.
- Model areas to consider:
 - Driver Diagram Strategy
 - Organizational Structure
 - Consortium/Model Participant Agreements
 - Administrative and Clinical Staffing
 - Model Implementation

Risk Mitigation Strategy: Example

Track 2 (Assistance): Risk Mitigation Strategy

No.	Year-Quarter	Key Milestone(s)	Actions Required for Achievement	Potential Risks and/or Major Assumptions	Proposed Mitigation Strategies for Risks
1	Y1-Q2	<ul style="list-style-type: none"> Deploy tailored community referral summary system to participating sites 	<ul style="list-style-type: none"> Pilot or test the community referral summary system Provide the system to participating sites 	<ul style="list-style-type: none"> Difficulty integrating system into current workflow IT issues may arise at specific sites that did not arise during the pilot of the system 	<ul style="list-style-type: none"> Plan the pilot and system development so that all clinical delivery sites and relevant staff are involved and/or can provide feedback Develop a training session for clinical delivery sites to pre-empt workflow integration issues
2	Y1-Q1 to Y1-Q2	<ul style="list-style-type: none"> Train AHC navigator(s) Deploy AHC navigators to participating sites 	<ul style="list-style-type: none"> Identify and hire a Navigator and ensure adequate training of Navigator 	<ul style="list-style-type: none"> Ability to hire a qualified applicant from within the local community Ensuring adequate resources and time for training 	<ul style="list-style-type: none"> Assess the market; review potential internal candidates and put out an initial “feeler” for additional candidates Early in the start-up period, engage internal training department to develop a timeline and allocate resources for preparation and training activities

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Appendices

- Health Resource Equity Statement, which serves as a Disparities Impact Statement
- Assessment of Program Duplication for each program identified as potentially duplicative

Page Limits

- Track 1: 10 pages
- Track 2: 12 pages
- Track 3: 15 pages

Additional Information

- The implementation plan will be evaluated based on the inclusion of and adequacy in addressing the information listed in Section 5.2 Application Structure and Content, Subsection on Implementation Plan.
- After awards are made, CMS may request modification to the award recipient's implementation plan and associated documents.
- CMS will monitor the performance of each award recipient based on milestones established by the FOA, the Terms and Conditions of Award, and the implementation plan approved by CMS.

Next Steps

- For more information, refer to the Implementation Plan Guide, available at:

<https://innovation.cms.gov/initiatives/ahcm/>

- Questions about the AHC model and applications may be submitted to:

AccountableHealthCommunities@cms.hhs.gov