



Accountable Health Communities Implementation Plan: A Guide for Applicants

Overview and Purpose

This guide is for informational purposes only and is provided to assist applicants in understanding the Accountable Health Communities (AHC) Funding Opportunity Announcement (FOA) implementation plan requirements. Applicants cannot rely on examples as being accurate or applicable to the model specifications in the FOA. Applicants that use the information in this Guide will not receive any more consideration during the objective review than applicants that do not use this information.

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

- (1) Implement the AHC intervention as intended;
- (2) Achieve Track-specific milestones; and
- (3) Engage in quality improvement.

CMS will monitor the performance of each award recipient based on milestones established by this funding opportunity, the Terms and Conditions of Award, and the implementation plan approved by CMS. 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 (e.g., Health Resource Equity Statement, assessments of program duplication) to facilitate the concatenation of program operations with CMS contractor functions. The CMS project officer will use the implementation plan to discuss and document the progress each award recipient is making throughout the performance period.

This guide is divided into seven sections:

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Section A: General Guidance

Per the AHC FOA, each applicant must submit an implementation plan as part of their application. Each implementation plan should detail the applicant’s proposed approach to achieving program goals, milestones, and benchmarks. The objective review panel will note evidence of how effectively the applicant addresses implementation plan requirements found in *Section 5.2 Application Structure and Content, Subsection on Implementation Plan* in the AHC FOA.

Applicants may use this guide in developing their implementation plans. The implementation plan should include the following elements (noted on page 68 of the AHC FOA), as reordered here to align with the organization of this guide:

- The driver diagram, which serves as a framework for intervention design and implementation and establishes self-directed performance indicators for quality improvement.
- A narrative and diagram of the organizational structure detailing the applicant’s existing and/or proposed relationships with other model participants (i.e., state Medicaid agency, clinical delivery sites, and community service providers) and the flow of cooperative agreement funds, data, and communications among the parties.
- Policies and procedures for screening and referral, community service navigation services, and integrator role functions (for detailed descriptions of each intervention, see sections 2.4.1.2 Track 1 – Awareness Intervention Proposal Requirements, 2.4.1.3 Track 2 – Assistance Intervention Proposal Requirements, and 2.4.1.4 Track 3 – Alignment Intervention Proposal Requirements in the AHC FOA).
- Process descriptions for staff training and intervention rollout, which the applicant must further develop into standard operating procedures (SOPs) if awarded a cooperative agreement.
- A detailed work plan that includes milestones, dates, and task owners for the start-up period (see Tables 3, 4, and 5 in the FOA for track-specific milestones).
- A high-level work plan outlining milestones, dates, and task owners for the duration of the period of performance (see Tables 3, 4, and 5 in the FOA for track-specific milestones).
- An assessment of risks to implementation and assumptions that may impact projected timelines, and mitigation strategies for reducing the probability of the risk occurring.

Additionally, all applicants should include, as appendices to the implementation plan, the following documents, *which do not count toward the implementation plan page limit*:

- Health Resource Equity Statement (HRES), which serves as a Disparities Impact Statement – up to 3 pages (see Appendix 8 in the FOA for more information and guidance).
- Assessment of Program Duplication for each program identified as potentially duplicative – 2 pages per checklist/no limit on number of checklists (see Appendix 7 in the FOA for more information and guidance).

Section B: Drivers of Model Success

The driver diagram provides a framework for understanding the goals of the program and the specific actions that are needed for the program to be successful. The driver diagram will also be important for identifying milestones and determining what areas to consider for monitoring and performance measurement over the course of the program.

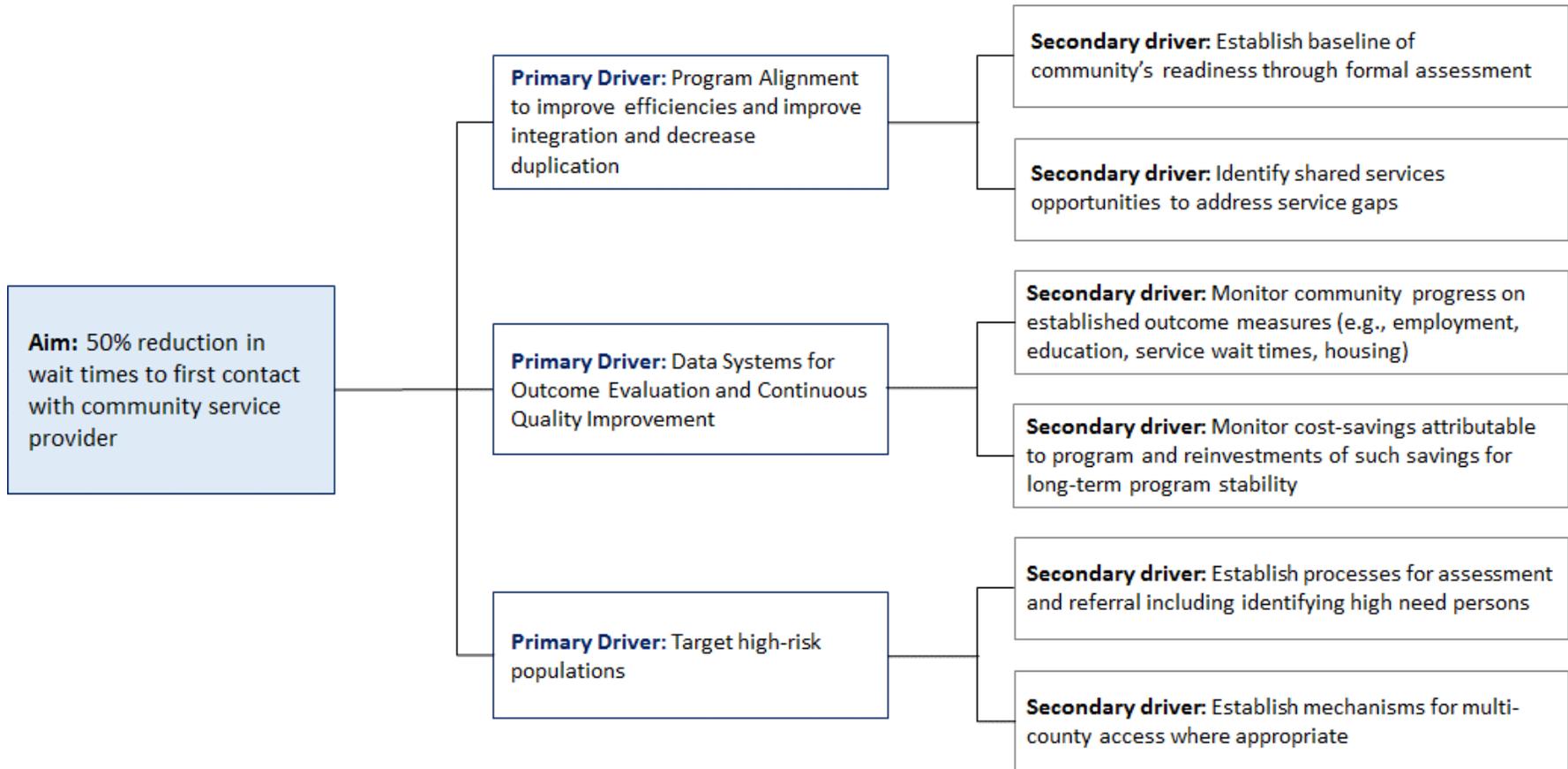
The components of the driver diagram include: (1) the aim/goal; (2) primary drivers; and (3) secondary drivers. When developing the driver diagram, the first focus should be on defining very clear aims/goals for the project. The aims should be measurable within specified time frames.

The drivers are activities/ policies/ practices that if put into place will move the program along to achieve the aim. The primary drivers, sometimes referred to as “key drivers”, are system components or factors that contribute directly to achieving the aim. Secondary drivers are actions, interventions, or lower-level components necessary to achieve the primary drivers. Secondary drivers should be used to identify changes that can be tested in order to affect the primary drivers.

Each driver should be able to be measured, and most drivers should align with specific process measures. In addition to a driver diagram, propose process measures you will use to assess the activities you plan to carry out to achieve the aim, as well as outcome measures you will use to assess the impact of those activities. There should also be a logical relationship between the process and outcome measures selected for performance measurement and the primary and secondary drivers that link directly to the aim. Process and outcome measures proposed in the implementation plan will be reviewed and approved by CMS after awards are made and will become part of the metrics used to evaluate your continued performance.

Example 1: At-Risk Youth Intervention Driver Diagram on page 4 depicts a potential driver diagram using the first example aim from above (i.e., to reduce expenditures and improve outcomes for high risk youth and young adults by June 2020 as evidenced by 50% reduction in wait times to first contact with community service provider). **It cannot be relied on as being accurate or applicable to the model specifications in the FOA.**

Example 1: At-Risk Youth Intervention Driver Diagram

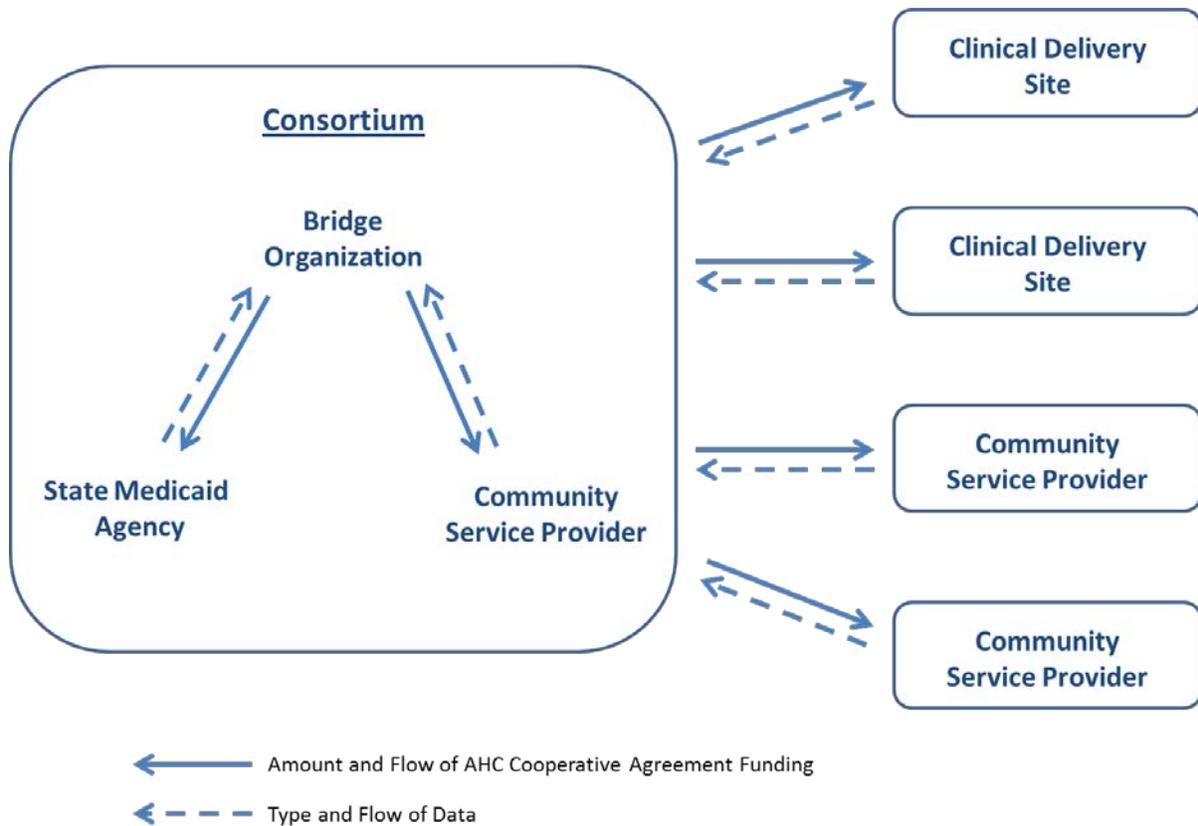


Section C: Organizational Structure and Model Participant Relationships

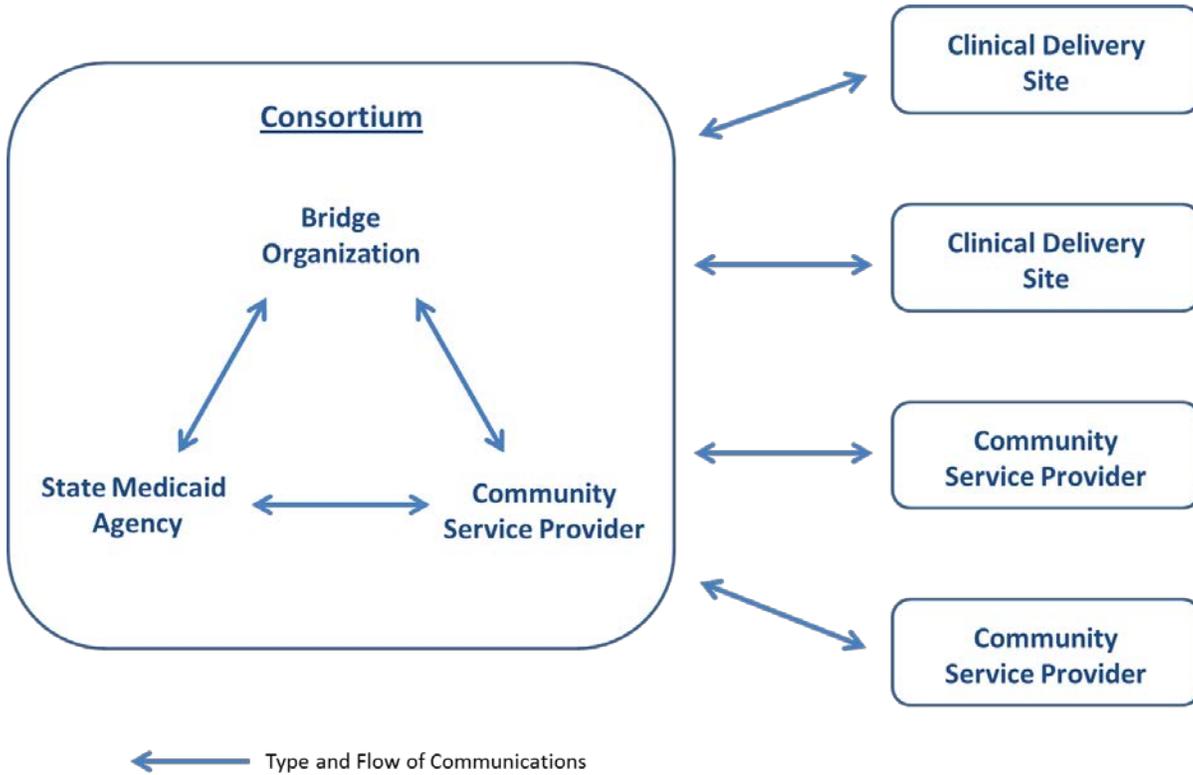
Provide one or more diagrams and corresponding narratives detailing the organizational structure of your intervention, including relationships with model participants (state Medicaid agency, clinical delivery sites, and community service providers, among others). Include information about the flow of AHC cooperative agreement funds, data, and communications among model participants to implement the intervention.

Example 2: Diagram of the Model Participant Organization and Flow of Funds and Data, and Example 3: Diagram of Communications among Model Participants are **provided for informational purposes only. They cannot be relied on as being accurate or applicable to the model specifications in the FOA.**

Example 2: Diagram of the Model Participant Organization and Flow of Funds and Data



Example 3: Diagram of Communications among Model Participants



Section D: Intervention Framework

In this section, provide an *outline* of the policies and procedures for implementing the intervention(s) for which you are applying, including:

- Screening;
- Referral Summary activities;
- Community Service Navigation (Tracks 2 & 3 only);
- Advisory Board Development (Track 3 only); and
- Integrator Role and Responsibilities (Track 3 only).

In addition to an outline, provide general process descriptions for the following program activities:

- Staff Training
- Communication with CMS and among model participants
- Data and Information Sharing

The outline of policies and procedures together with the process descriptions of program activities should provide a clear picture of your framework for implementing the intervention. During the start-up period, successful award recipients will be required to fully develop standard operating procedures.

Section E: Start-Up Period Work Plan

Provide a detailed work plan for the project start-up period (Track 1 – Awareness is 6 months; Track 2 – Assistance is 9 months; and Track 3 – Alignment is 12 months), including major milestones described in the AHC FOA, target dates, and task owners. Include timeframes for designing, approving, piloting, and implementing:

- (1) Policies and procedures for staff training, screening and referral, community service navigation services, and integrator role functions;
- (2) Contracts, Memoranda of Understanding (MOUs) and MOU-equivalent documents with model participants; and
- (3) Tools, such as the health-related social need screening, Community Resource Inventory, person-centered action plans, gap analyses, and quality improvement plan.

At a minimum, include all track-specific milestones relevant to project start-up from Tables 3, 4, or 5 in the FOA, as applicable. Ensure that your work plan covers *all* milestones relevant to project start-up as described in your Project Narrative.

*Example 4: Start-Up Period Work Plan on page 9 is **provided for informational purposes only. It cannot be relied on as being accurate or applicable to the model specifications in the FOA.*** You may adapt this example to suit your proposed intervention and model track as follows:

- **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 (such as clinical delivery sites and community service providers), 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, among other methods.

Example 4: 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
Community Service Navigation:											
A. Train AHC Navigator(s)											
1 Develop Navigator curriculum with multi-stakeholder input	Training subcontractor	Bridge org. staff, CDSs						Start		End	
2 Execute trainings	Training subcontractor	Bridge org. staff, CDSs								Start	End
B. Deploy Community Navigators to participating sites											
1 Develop SOP for navigation services	PM (Bridge org.)	CDSs, CSPs						Start		End	
2 Pilot test, improve and finalize SOP for navigation services	PM (Bridge org.)	CDSs, CSPs								Start	End

Section F: Implementation Period Work Plan

While the work plan in Section E focuses on the start-up period, the work plan in this section is intended to provide a high-level overview and annotated timeline of major milestones, dates, and task owners for the *remaining performance period*. At a minimum, incorporate track-specific milestones from Tables 3, 4, and/or 5 in the AHC FOA as required.

Example 5: Implementation Period Work Plan provided on page 11 is **provided for informational purposes only and cannot be relied on as being accurate or applicable to the model specifications in the FOA**. It may be adapted to suit your proposed intervention and model track, as follows:

- **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 (such as clinical delivery sites and community service providers), 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, among other methods.

Example 5: 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)	Etc.
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			

Section G: Risk Mitigation Strategy

Assess the risks to implementation and assumptions that may impact projected timelines, as well as mitigation strategies for reducing the probability of the risk occurring. You may consider the following questions when assessing potential risk:

- Driver Diagram Strategy
 - Do the assumptions in your driver diagram pose specific risks to achieving the goals of the program?
- Organizational Structure
 - Do you have the internal and external resources and relationships needed to build a strong leadership and organizational structure?
- Consortium/Model Participant Agreements
 - Are there risks to finalizing the consortium relationship in a timely manner?
 - Are there risks to formalizing data sharing agreements between the bridge organization and state Medicaid agency?
- Administrative and Clinical Staffing
 - How will you address recruitment if staffing lags?
 - What strategies will you use to ensure adequate staff training? How will your staff training ensure a baseline level of competence and promote performance consistency?
 - What are your strategies for addressing staff retention and turnover?
- Model Implementation
 - Do the proposed clinical delivery sites have the capacity to screen the minimum target number of beneficiaries, as defined in the FOA?
 - What are barriers to sharing and reviewing data for implementation, monitoring and evaluation purposes? What technology infrastructure will you need to put in place?
 - What steps must be completed to have your intervention ready for deployment within the track-specific start-up period?

Example 6: Risk Mitigation Strategy on page 13 is **provided for informational purposes only and cannot be relied on as being accurate or applicable to the model specifications in the FOA**. It may be adapted, as needed, to suit the risk mitigation strategies for your intervention, as follows:

- Record the relevant year(s) and quarter(s) for each identified risk.
- Align key milestones here with the milestones identified in your work plan.
- In the “Potential Risks and/or Major Assumptions” column, you may record identified risks and/or major assumptions that may impact your ability to achieve milestones.
- Include at least one mitigation strategy for each identified risk and major assumption.

Example 6: 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
3	Y1-Q4	<ul style="list-style-type: none"> Submit progress reports on milestones 	<ul style="list-style-type: none"> Create a tool or spreadsheet to track project activities (internal monitoring metrics) 	<ul style="list-style-type: none"> Current resources are sufficient to allow for creation of a project management tracking tool IT issues with deploying tracking tool to model participants (Navigator, clinical delivery site); ensuring access for everyone who needs to use the tool Data accuracy and quality control 	<ul style="list-style-type: none"> Create a defined process for tracking tool development, including a specific task for defining the data requirements Engage model participants in the development of the tracking tool Develop plan for testing/piloting of the tool Periodic record reviews of navigator tools