Institute on Aging

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Acute Care Transitions (ACT) Model
Resource and Replication Checklist

A practical guide for adapting, implementing, evaluating, and spreading the ACT model

The IOA Enhanced Care Management (ECM) Acute Care Transitions Model is designed to strengthen post-discharge support for people with complex medical, behavioral health, and social needs by improving coordination between hospitals, care teams, and community-based services. This checklist is intended to help other organizations replicate, adapt, and spread the ACT model by outlining the key planning, readiness, implementation, and evaluation steps needed to launch a similar transitional care approach.

Foundational ECM Resources

For communities outside California that do not have CalAIM, California Department of Health Care Services (DHCS) materials can still serve as a helpful foundation for designing an Enhanced Care Management (ECM) approach. DHCS describes ECM and Community Supports as core components of CalAIM that coordinate care for Medi-Cal members with high needs across health care and community settings, and its ECM resources include policy guidance, referral standards, data-sharing guidance, toolkits, and implementation materials.

This checklist is specifically focused on the innovative acute care transitions component of an ECM-style model. It is not intended to comprehensively detail how to establish a full ECM program; organizations seeking broader ECM implementation guidance should consult the DHCS Enhanced Care Management and Community Supports website and ECM Policy Guide as foundational resources.

Additional Information

DHCS Enhanced Care Management and Community Supports Website
This webpage provides an overview of ECM and Community Supports, including how these services coordinate care for Medi-Cal members with high needs across health care and community settings.

https://www.dhcs.ca.gov/calaim-transforming-medi-cal/enhanced-care-management-and-community-supports/

CalAIM Enhanced Care Management Policy Guide

This policy guide offers detailed guidance on ECM design and operations, including populations of focus, core service components, provider networks, engagement, data sharing, and oversight.

https://www.dhcs.ca.gov/wp-content/uploads/2026/05/CalAIM-ECM-Policy-Guide.pdf

1. Developing Your Program and Scope

This section helps define the foundation of the transitional care program before launch. Use it to clarify who the program will serve, which partners are needed, and how success will be measured.

☐ Define the focus population(s), including people with chronic conditions, serious mental health needs, and/or substance use disorders.

☐ Identify key partners, which will include community-based organizations that provide community-based care management services, health insurance plans/providers and hospitals/health systems. Additional partners may include primary care, pharmacy, and other community-based organizations to address social needs.

☐ Establish program goals and key outcomes of interest, such as reducing avoidable readmissions, improving post-discharge engagement, and strengthening medication safety.

☐ Select key performance indicators and create an evaluation plan.

☐ Confirm the program time frame, reporting cadence, and decision points for scaling, redesigning, or ending the pilot.

☐ Assess regional systems and services to identify gaps, root causes, and improvement opportunities.

☐ Engage local stakeholders, including people with lived experience, to co-design equitable, high-quality services.

2. Pre-Launch Readiness

This section focuses on the operational preparation needed before serving clients. Use it to confirm workflows, staffing, tools, training, documentation, funding, and partnership agreements are ready.

☐ Map the end-to-end workflow from admission alert through 30-day post-discharge follow-up.

☐ Define the team model for alerts, discharge information, outreach, medication reconciliation, and community referrals.

☐ Build a shared tracking tool for eligible discharges, outreach attempts, interventions, barriers, and outcomes.

☐ Develop standard scripts for patient outreach, caregiver engagement, medication review, and social needs screening.

☐ Train staff on documentation, escalation pathways, privacy expectations, and closed-loop referrals.

☐ Complete hospital-specific onboarding requirements before go-live, including EHR access, security clearances, credentialing, training, badge access, and site-specific approvals.

☐ Verify all required systems access has been granted and tested before launch or expansion, as access delays may become a critical path dependency and affect pilot timelines.

☐ Define billing, documentation, and reporting requirements.

☐ Identify and confirm funding sources.

☐ Establish roles, responsibilities, and escalation pathways across participating teams.

☐ Finalize contracts, memoranda of understanding, and partner agreements.

3. Implementation

This section supports consistent execution once the program is live. Use it to monitor workflows, maintain communication, track outcomes, and make timely improvements based on data and stakeholder feedback.

☐ Once leadership agreements and workflows are finalized, orient inpatient teams to the ACT model, including CBO roles, eligibility, referral workflows, and handoff expectations.

☐ When possible, have managers and outreach staff present to the full care management team so all staff know when and how to refer.

☐ Confirm communication pathways between inpatient and CBO teams, including points of contact, preferred methods, escalation steps, and response expectations.

☐ Monitor workflows and identify process issues, delays, or variation.

☐ Use culturally responsive tools and materials to support equitable engagement.

☐ Track monthly outcomes and maintain a dashboard to monitor progress.

☐ Meet regularly with stakeholders to review progress, barriers, and improvement opportunities.

☐ Maintain open communication with staff, clients, caregivers, and partners.

☐ Provide accessible, understandable, and population-appropriate patient education tools.

☐ Monitor billing, documentation quality, and service utilization.

☐ Evaluate operations systematically and use findings to refine the model.

4. Evaluation

This section helps organizations evaluate whether the model is reaching the intended population, improving outcomes that matter to clients and caregivers, and strengthening system-level performance. Use it to identify practical data sources, select a pragmatic evaluation framework, and build an approach that supports learning, adaptation, sustainability, and spread.

☐ Define person-level outcomes that matter to clients and caregivers, such as post-discharge connection, medication understanding, follow-up care, reduced unmet social needs, quality of life, and care experience.
☐ Define system-level outcomes that matter to the organization and partners, such as avoidable readmissions, emergency department use, timely outreach, completed transitions, closed-loop referrals, team efficiency, and partner communication.
☐ Identify data sources needed to assess outcomes, including admission and discharge feeds, claims or utilization data, electronic health records, care management documentation, referral systems, client surveys, caregiver feedback, and staff feedback.
☐ Confirm data-sharing agreements, privacy requirements, and workflows for timely person-level and system-level data.
☐ Create a practical data plan that defines each measure, source, owner, collection frequency, reporting cadence, and review process.
☐ Use both quantitative and qualitative data to understand what changed, for whom, under what conditions, and why.
☐ Select an implementation or evaluation framework that fits practical, real-world settings and supports learning, adaptation, and spread.
☐ Review findings with teams, partners, clients, and caregivers to identify improvement opportunities and guide adaptations.
☐ Use results to decide whether to sustain, scale, adapt, or spread the model.

Conclusion

The ACT Model Resource and Replication Checklist is intended to support organizations in adapting a practical, person-centered acute care transitions approach that strengthens coordination, improves post-discharge support, and advances learning across care teams and community partners. By pairing clear implementation steps with pragmatic evaluation, organizations can use this tool to guide local adaptation, sustain improvements, and spread the model over time.

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