

Accountable Care Partnership Plans External Quality Review Technical Report Calendar Year 2019



This program is supported in full by the
Commonwealth of Massachusetts Executive Office of Health and Human Services, Office of Medicaid.

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SECTION 1. EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to children with special needs) through managed care entities. Regulations were promulgated, including those related to the quality of care and service provided by managed care entities to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that a managed care entity or its contractors furnish to Medicaid recipients. In Massachusetts, the Commonwealth has entered into an agreement with KEPRO to perform EQR services for its contracted managed care entities.

The EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services. It is also posted to the Medicaid agency website.

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a restructuring of MassHealth. The waiver included the introduction of Accountable Care Organizations (ACOs). In this model, providers have a financial interest in delivering quality, coordinated, member-centric care. Three ACO models were implemented in Massachusetts:

Exhibit 1: Massachusetts Accountable Care Organization Models

| ACO Model | Description |
|--|---|
| Accountable Care Partnership Plans (ACPPs), also referred to as “Model A ACOs” (N=13) | Groups of primary care providers (PCPs) who work with just one managed care organization to create a full network that includes PCPs, specialists, behavioral health providers, and hospitals. |
| Primary Care Accountable Care Organizations (PCACOs), also referred to as “Model B ACOs” (N=3) | Groups of primary PCPs who form an ACO that is responsible for treating the member and coordinating their care. Primary Care ACO Plans work with the MassHealth network of specialists and hospitals and may have certain providers in their “referral circle.” The “referral circle” provides direct access to certain other providers or specialists without the need for a referral. |
| Lahey-MassHealth Primary Care Organization, also referred to as the “Model C ACO” (N=1) | The Lahey MassHealth ACO is comprised of 16 primary care practice sites. The ACO has contracted with MassHealth managed care organizations to administer claims and manage membership. |

CMS has determined that ACPPs are considered managed care organizations and, as such, are required to participate in all mandatory External Quality Review activities (see below). Primary Care Accountable Care Organizations are considered primary care case management plans and are required to participate in performance measure and compliance validation. 2019 PCACO external quality review activities are described in a separate technical report.

SCOPE OF THE EXTERNAL QUALITY REVIEW PROCESS

KEPRO conducted the following external quality review activities for MassHealth Accountable Care Partnership Plans in the CY 2019 review cycle:

- Validation of three performance measures, including an Information Systems Capability Assessment; and
- Validation of two Performance Improvement Projects (PIPs).

Compliance validation must be conducted by the EQRO on a triennial basis. ACPP compliance validation will be conducted in 2021.

To clarify reporting periods, EQR technical reports that have been produced in calendar year 2019 reflect 2018 quality measurement performance. References to 2019 performance reflect data collected in 2018. Performance Improvement Project reporting is inclusive of activities conducted in CY 2019.

The Massachusetts Accountable Care Partnership Plans are listed in the table that follows.

Exhibit 2: MassHealth Accountable Care Partnership Plans

| Accountable Care Partnership Plans | Abbreviation Used in this Report | Membership as of December 31, 2018 | Percent of Total ACPP Population |
|--|---|---|---|
| Be Healthy Partnership | HNE-Be Healthy | 38,364 | 7.5% |
| Berkshire Fallon Health Collaborative | Fallon-BFHC | 15,617 | 2.5% |
| BMC HealthNet Plan Community Alliance | BMCHP-BACO | 109,325 | 21% |
| BMC HealthNet Plan Mercy Alliance | BMCHP Mercy | 28,274 | 5.5% |
| BMC HealthNet Plan Signature Alliance | BMCHP-Signature | 18, 107 | 4% |
| BMC HealthNet Plan Southcoast Alliance | BMCHP-Southcoast | 16,236 | 3% |
| Fallon 365 Care | Fallon 365 | 30,371 | 6% |
| My Care Family | AllWays-My Care | 33,896 | 6.5% |
| Tufts Health Together with Atrius Health | Tufts-Atrius | 31,319 | 6% |
| Tufts Health Together with BIDCO | Tufts-BIDCO | 36,601 | 7% |
| Tufts Health Together with Boston Children's ACO | Tufts-BCH | 85,291 | 16% |
| Tufts Health Together with Cambridge Health Alliance | Tufts-CHA | 28,204 | 5% |
| Wellforce Care Plan | Fallon-Wellforce | 51,780 | 10% |
| Total | | 523,385 | 100% |

PERFORMANCE MEASURE VALIDATION & INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements.

In 2019, KEPRO conducted Performance Measure Validation in accordance with CMS EQR Protocol #2 on three measures that were selected by MassHealth:

- Asthma Medication Ratio Less than or Equal to .50;
- Seven-Day Follow Up After Hospitalization for Mental Illness; and
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.

The focus of the Information Systems Capability Assessment is on components of information systems that contribute to performance measure production. This is to ensure that the system can collect data on enrollee and provider characteristics and on services furnished to enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete and verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect service information in standardized formats to the extent feasible and appropriate.

KEPRO determined that all MassHealth ACPPs followed specifications and reporting requirements and produced valid measures.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION

MassHealth ACPPs conduct two contractually required Performance Improvement Projects (PIPs) annually. In accordance with Appendix E of their contract with EOHHS, must conduct one PIP from each of the two domains:

- Domain 1: Behavioral Health – Promoting well-being through prevention, assessment, and treatment of mental illness including substance use and other dependencies.
- Domaine 2: Population and Community Needs Assessment and Risk Stratification – Identifying and assuming priority populations for health conditions and social determinant factors with the most significant size and impact and developing interventions to address the appropriate and timely care of these priority populations.

In late-2018, the ACPPs submitted proposed topics for two-year projects to MassHealth for its review and approval. In Calendar Year 2019, Accountable Care Organizations implemented the following Performance Improvement Projects:

Domain 1: Behavioral Health

Five ACPPs focused on increasing the rate of follow up visits within seven days of discharge for members hospitalized for a mental illness (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and Be Healthy Partnership).

Seven ACPPs focused on improving the rate of depression screenings and follow-up plans (Berkshire Fallon Health Collaborative, Fallon 365 Care, Wellforce Care Plan, Tufts Health Together with Atrius Health, Tufts Health Together with BIDCO, Tufts Health Together with Boston Children's ACO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP focused on Initiation and Engagement in Treatment (My Care Family).

Domain 2: Population and Community Needs Assessment

Five ACPPs focused on improving Asthma Control and Medication Adherence (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and My Care Family).

Four ACPPs focused on utilizing Health-Related Social Needs Screening to identify both pediatric and adult members in need of additional services to improve health outcomes (Tufts Health Together with Atrius Health, Tufts Health Together with Boston Children's ACO, Tufts Health Together with BIDCO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP each focused on the following areas:

- Improving Rates of Controlling High Blood Pressure (Berkshire Fallon Health Collaborative).
- Improving Rates of Immunizations for Adolescents - Combo 2 (Fallon 365 Care).
- Improving Rates of CDC - HbA1c testing for the diabetic population (Wellforce Care Plan).
- Improving outcomes in diabetic patients through integrated care management (Be Healthy Partnership).

KEPRO evaluates each PIP to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocols. The KEPRO technical reviewer assesses project methodology. The Medical Director evaluates the clinical soundness of the interventions. The review considers the ACPP's performance in the areas of problem definition, data analysis, measurement, improvement strategies, and outcome. Recommendations are offered to the ACPP.

Based on its review of the MassHealth ACPP PIPs, KEPRO did not discern any issues related to any plan's quality of care or the timeliness of or access to care. Recommendations made were ACPP-specific, the only theme emerging being the importance of defining measurable, achievable goals to the success of the project.

SECTION 2. THE MASSHEALTH COMPREHENSIVE QUALITY STRATEGY

Introduction

Under the Balanced Budget Act managed care rule 42 CFR 438 subpart E, Medicaid programs are required to develop a managed care quality strategy. The first MassHealth Quality Strategy was published in 2006. An updated version, the MassHealth Comprehensive Quality Strategy which focused not only to fulfill managed care quality requirements but to improve the quality of managed care services in Massachusetts, was submitted to CMS in November 2018. The updated version broadens the scope of the initial strategy, which focused on regulatory managed care requirements. The quality strategy is now more comprehensive and serves as a framework for EOHHS-wide quality activities. A living and breathing approach to quality, the strategy will evolve to reflect the balance of agency-wide and program-specific activities; increase the alignment of priorities and goals where appropriate; and facilitate strategic focus across the organization.

MassHealth Goals

The mission of MassHealth is to improve *the health outcomes of its diverse members by providing access to integrated health care services that sustainably promote health, well-being, independence, and quality of life.*

MassHealth defined its goals as part of the MassHealth Comprehensive Quality Strategy Development process. MassHealth goals aim to:

1. *Deliver a seamless, streamlined, and accessible patient-centered member experience, with focus on preventative, patient-centered primary care, and community-based services and supports;*
2. *Enact payment and delivery system reforms that promote member-driven, integrated, coordinated care; and hold providers accountable for the quality and total cost of care;*
3. *Improve integrated care systems among physical health, behavioral health, long-term services and supports and health-related social services;*
4. *Sustainably support safety net providers to ensure continued access to care for Medicaid and low-income, uninsured individuals;*
5. *Maintain our commitment to careful stewardship of public resources through innovative program integrity initiatives; and*
6. *Create an internal culture and infrastructure to support our ability to meet the evolving needs of our members and partners.*

Stakeholder Involvement

MassHealth actively seeks input from a variety of stakeholders to identify quality improvement priorities in pursuit of its goals related to Comprehensive Quality Strategy Development. These stakeholders include, but are not limited to, members, providers, managed care entities, advocacy groups, and sister EOHHS agencies, e.g., the Departments of Children and Families and Mental Health. Toward that end, KEPRO expects ACPPs to include members and providers as stakeholders in the design and implementation of its Performance Improvement Projects.

MassHealth Delivery System Restructuring

In November 2016, MassHealth received approval from the Centers for Medicare and Medicaid Services to implement a five-year waiver authorizing a \$52.4 billion restructuring of MassHealth. The waiver included the introduction of Accountable Care Organizations (ACOs). In this model, providers have a financial interest in delivering quality, coordinated, member-centric care. Organizations applying for ACO status were required to be certified by the Massachusetts Health Policy Commissions set of standards for ACPPs. Certification required that the organization met criteria in the domains of governance, member representation, performance improvement activities, experience with quality-based risk contracts, population health, and cross-continuum care. In this way, quality was a foundational component of the ACO program. ACOs were approved to enroll members effective March 1, 2018.

Another important development during this period was the re-procurement of MassHealth managed care organizations. It was MassHealth's objective to select MCOs with a clear track record of delivering high-quality member experience and strong financial performance. The Request for Response and model contract were released in December 2016; selections were announced in October 2017. Tufts Health Public Plans and Boston Medical Center HealthNet Plan were awarded contracts to continue operating as MCOs. Contracts with the remaining MCOs (CeltiCare, Fallon Health, Health New England, and Neighborhood Health Plan) ended in February 2018.

Quality Evaluation

MassHealth evaluates the quality of its managed care program using at least three mechanisms:

- Contract management – MassHealth contracts with plans include requirements for quality measurement, quality improvement, and reporting. MassHealth staff review submissions and evaluate contract compliance.
- Quality improvement performance programs – Each managed care entity is required to complete two Performance Improvement Projects (PIPs) annually, in accordance with 42 CFR 438.330(d).
- State-level data collection and monitoring – MassHealth routinely collects performance measure data from its managed care plans.

How KEPRO Supports the MassHealth Managed Care Quality Strategy

As MassHealth's External Quality Review Organization, KEPRO performs the three mandatory activities required by 42 CFR 438.330:

- 1) Performance Measure Validation – MassHealth Managed Care Quality Strategy. MassHealth has traditionally asked that three measures be validated.
- 2) Performance Improvement Project Validation – KEPRO validates two projects per year.
- 3) Compliance Validation – Performed on a triennial basis, KEPRO assesses plan compliance with contractual and regulatory requirements.

The matrix below depicts ways in which KEPRO, through the External Quality Review (EQR) process, supports the MassHealth Managed Care Quality Strategy:

| EQR Activity | Support to MassHealth Quality Strategy |
|--|---|
| Performance Measure Validation | <ul style="list-style-type: none">• Assure that performance measures are calculated accurately.• Offer a comparative analysis of plan performance to identify outliers and trends.• Provide technical assistance.• Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services. |
| Performance Improvement Project Validation | <ul style="list-style-type: none">• Ensure the inclusion of an assessment of cultural competency within interventions.• Ensure the alignment of MassHealth priority areas and quality goals with MassHealth goals.• Ensure that Performance Improvement Projects are appropriately structured and that meaningful performance measures are used to assess improvement.• Ensure that Performance Improvement Projects incorporate stakeholder feedback.• Share best practices, both clinical and operational.• Provide technical assistance.• Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services. |

| | |
|-----------------------|---|
| Compliance Validation | <ul style="list-style-type: none"> • Assess plan compliance with contractual requirements. • Assess plan compliance with regulatory requirements. • Recommend mechanisms through which plans can achieve compliance. • Facilitate the Corrective Action Plan process. • Recommend ways in which MassHealth can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and access to health care services. |
|-----------------------|---|

SECTION 3. PERFORMANCE MEASURE VALIDATION

PERFORMANCE MEASURE VALIDATION METHODOLOGY

The Performance Measure Validation process assesses the accuracy of performance measures reported by the managed care entity. It determines the extent to which the managed care entity follows state specifications and reporting requirements. KEPRO validates three ACP performance measures.

KEPRO's ACP performance measure validation audit methodology assesses both the quality of the source data that fed into the measures under review and the accuracy of their calculation. As part of source data review, five numerator-compliant cases per measure were verified. Enrollment data were reviewed for accuracy. Measure calculation review included reviewing the logic and analytic framework for determining the measure numerator, denominator, and exclusion cases, when applicable.

MassHealth contracted with CareSeed for the calculation of ACP performance measures. Performance measure validation, therefore, focused on these organizations' data and processes. Individual ACPs did not participate in or contribute to the PMV process. The following documents and files were provided by MassHealth and CareSeed in support of the performance measure validation process:

- A completed Information Systems Capability Assessment Tool (ISCAT) from CareSeed for performance measure creation and measure data validation protocols;
- A completed Information Systems Capability Assessment Tool (ISCAT) from MassHealth for performance measure data collection information (claims, encounter, and enrollment data) and data transfer to CareSeed;
- Performance measure data reports from CareSeed for each of the three measures selected for validation that include the numerator, denominator, and exclusion counts as well as the final PMV measure rate calculation;
- An Excel spreadsheet containing numerator-compliant data from CareSeed for each of the three selected measures for primary source verification purposes;
- Primary source verification information from MassHealth for the three selected measures;
- A copy of all enrollment data provided to CareSeed by MassHealth;
- Enrollment data for 30 members selected at random by the auditor; and
- Enrollment data for the same 30 members from CareSeed to ensure the enrollment data matches the MassHealth primary source enrollment data after CareSeed enrollment data processing.

The table below presents the three measures selected for performance measure validation (PMV) for Measurement Year 2018 as well as each measure's description as provided by NCQA:

Exhibit 3: Measures Selected for Performance Measure Validation

| Measure Name and Abbreviation | Measure Description |
|---|---|
| AMR – Asthma Medication Ratio | The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. |
| FUH - Follow-Up After Hospitalization for Mental Illness (7 days) | The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner within 7 days after discharge. |
| IET - Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment | <p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:</p> <ul style="list-style-type: none">• <i>Initiation of AOD Treatment.</i> The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.• <i>Engagement of AOD Treatment.</i> The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. |

COMPARATIVE ANALYSIS

The tables that follow contain the criteria through which performance measures were validated as well as KEPRO's determination as to whether or not the plans met these criteria. Each ACP satisfied the requirements of each criterion.

Performance Measure Validation: Asthma Medication Ratio (AMR)

| | | | |
|--------------------------------------|----------------|-----------------------|--------|
| Methodology for Calculating Measure: | Administrative | Medical Record Review | Hybrid |
|--------------------------------------|----------------|-----------------------|--------|

| Review Element | ACPPs' Rating |
|--|---------------|
| DENOMINATOR | |
| <u>Population</u> | |
| ACPP population was appropriately segregated from other product lines. | Met |
| Members identified as having persistent asthma who were enrolled during the measurement year and the year prior to the measurement year with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. | Met |
| <u>Geographic Area</u> | |
| Includes only those Medicaid enrollees served in the ACPP's reporting area. | Met |
| <u>Age & Sex: Enrollment Calculation</u> | |
| Ages 5–64 as of December 31 of the measurement year. | Met |
| <u>Data Quality</u> | |
| Based on the IS assessment findings, the data sources for this denominator were accurate. | Met |
| Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code. | Met |
| <u>Proper Exclusion Methodology in Administrative</u> | |
| Exclude members who had any diagnosis below any time during the member's history through December 31 of the measurement year: <ul style="list-style-type: none"> — Emphysema — COPD — Obstructive Chronic Bronchitis — Chronic Respiratory Conditions Due to Fumes or Vapors — Cystic Fibrosis — Acute Respiratory Failure | Met |
| Members who had no asthma controller or reliever medications dispensed during the measurement year. | Met |
| NUMERATOR | |
| <u>Administrative Data: Counting Clinical Events</u> | |
| Standard codes listed in NCQA specifications or properly mapped internally developed codes were used. | Met |
| All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant. | Met |
| Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate. | Met |

Performance Measure Validation: Follow-Up After Hospitalization for Mental Illness (FUH)
– Seven-Day Rate

| | | | |
|---|-----------------------|------------------------------|---------------|
| Methodology for Calculating Measure: | Administrative | Medical Record Review | Hybrid |
|---|-----------------------|------------------------------|---------------|

| Review Element | ACPPs' Rating |
|---|----------------------|
| DENOMINATOR | |
| <u>Population</u> | |
| ACPP population was appropriately segregated from other product lines. | Met |
| Enrolled on the date of discharge through 30 days after discharge. | Met |
| An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm on the discharge claim on or between January 1 and December 1 of the measurement year. | Met |
| <u>Geographic Area</u> | |
| Includes only those Medicaid enrollees served in the ACPP's reporting area. | Met |
| <u>Age & Sex: Enrollment Calculation</u> | |
| Members 6 years and older as of the date of discharge. | Met |
| <u>Data Quality</u> | |
| Based on the IS assessment findings, the data sources for this denominator were accurate. | Met |
| Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code. | Met |
| <u>Proper Exclusion Methodology in Administrative</u> | |
| Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. | Met |
| NUMERATOR – 7 DAY FOLLOW-UP RATE | |
| <u>Administrative Data: Counting Clinical Events</u> | |
| Standard codes listed in NCQA specifications or properly mapped internally developed codes were used. | Met |
| All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant. | Met |
| Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate. | Met |

Performance Measure Validation: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

| | | | |
|---|-----------------------|------------------------------|---------------|
| Methodology for Calculating Measure: | Administrative | Medical Record Review | Hybrid |
|---|-----------------------|------------------------------|---------------|

| Review Element | ACPPs' Rating |
|--|----------------------|
| DENOMINATOR | |
| <u>Population</u> | |
| ACPP population was appropriately segregated from other product lines. | Met |
| Members enrolled 60 days (2 months) prior to the new episode of Alcohol or Other Drug (AOD) abuse or dependence through 48 days after the episode. | Met |
| <u>Geographic Area</u> | |
| Includes only those Medicaid enrollees served in the ACPP's reporting area. | Met |
| <u>Age & Sex: Enrollment Calculation</u> | |
| Members 13 years and older as of December 31 of the measurement year. | Met |
| <u>Data Quality</u> | |
| Based on the IS assessment findings, the data sources for this denominator were accurate. | Met |
| Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code. | Met |
| <u>Proper Exclusion Methodology in Administrative</u> | |
| Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence, AOD medication treatment or an alcohol or opioid dependency treatment medication dispensing event during the 60 days (2 months) before the new episode of AOD abuse or dependence. | Met |
| NUMERATORS | |
| <u>Administrative Data: Counting Clinical Events</u> | |
| Standard codes listed in NCQA specifications or properly mapped internally developed codes were used. | Met |
| All code types were included in analysis, including CPT, ICD10, and HCPCS procedures, and UB revenue codes, as relevant. | Met |
| Data sources used to calculate the numerator (e.g., claims files, provider files, and pharmacy records, including those for members who received the services outside the plan's network, as well as any supplemental data sources) were complete and accurate. | Met |

COMPARATIVE PERFORMANCE MEASURE RESULTS

The tables below depicts the validation designation for each of the measures validated by KEPRO in Calendar Year 2018. Because NCQA has not developed benchmarks specific to accountable care organizations, one is not provided for comparison purposes.

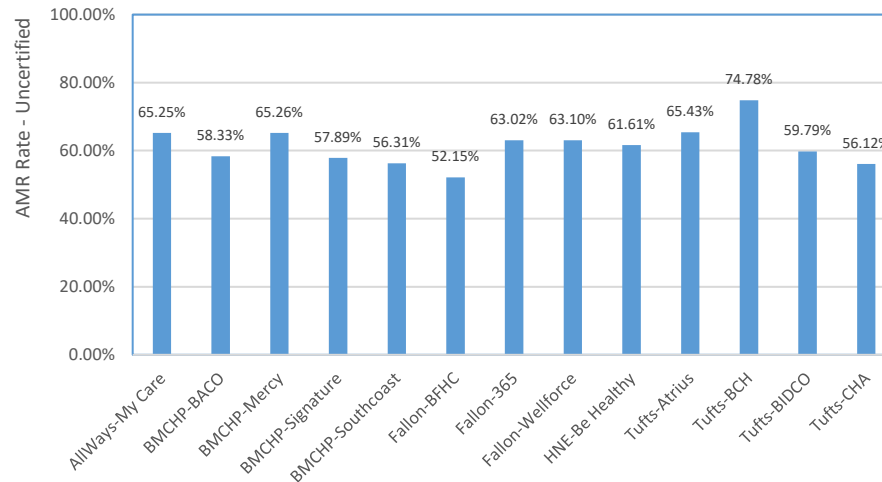
Measure 1. 2018 Asthma Medication Ratio \geq 0.5 (AMR)

The range of 2018 AMR performance rates was 22.63 percentage points. The lowest performing ACPP was Fallon-BFHC at 52.15%. The highest performing plan was Tufts-BCH at 74.78%. The weight-adjusted average was 63.23%. Please note that these rates are reported as adjusted, unaudited, and uncertifiable HEDIS rates. Five ACPPs conducted performance improvement projects in 2019 focused on improving AMR performance, i.e., BMCHP-BACO, BMCHP-Mercy, BMCHP-Signature, BMCHP-Southcoast, and AllWays My Care.

Exhibits 4 and 5. 2018 ACPP Asthma Medication Ratio Rates

| 2018 Adjusted, Unaudited, Uncertifiable HEDIS Rate | AllWays My Care | BMCHP-BACO | BMCHP-Mercy | BMCHP-Signature | BMCHP-Southcoast | Fallon-BFHC | Fallon-365 | Fallon-Wellforce | HNE Be Healthy | Tufts-Atrius | Tufts-BCH | Tufts-BIDCO | Tufts-CHA |
|--|-----------------|------------|-------------|-----------------|------------------|-------------|------------|------------------|----------------|--------------|-----------|-------------|-----------|
| Ratio of Controller Medications to Total Asthma Medications of 0.50 or Greater | 65.25% | 58.33% | 65.26% | 57.89% | 56.31% | 52.15% | 63.02% | 63.10% | 61.61% | 65.43% | 74.78% | 59.79% | 56.12% |

ACPP 2018 Asthma Medication Ratio ≥ 0.5



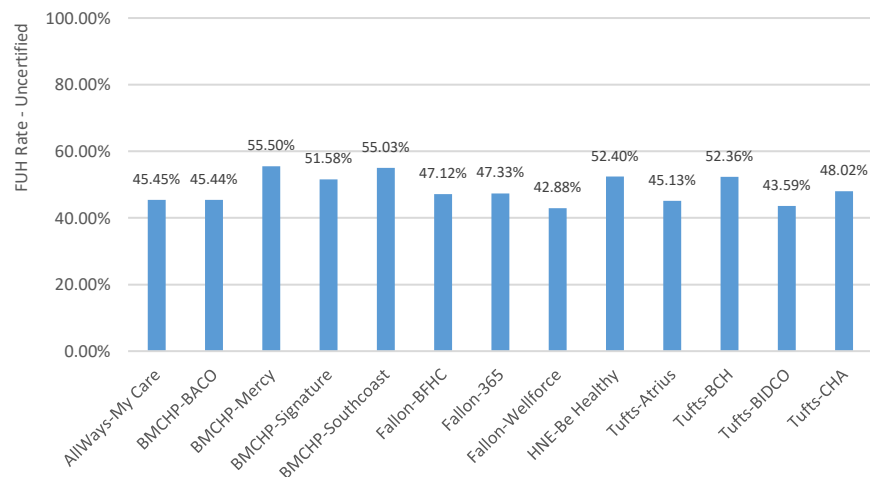
Measure 2. FUH – Seven-Day Follow-Up After Hospitalization for Mental Illness (FUH)

The range of 2018 Seven-Day FUH performance rates was 11.91 percentage points. The lowest performing ACPP was Fallon-Wellforce at 42.88%. The highest performing plan was BMCHP-Mercy at 55.50%. The weight-adjusted average was 48.03%. Please note that these rates are reported as adjusted, unaudited, and uncertifiable. Five ACPPs conducted performance improvement projects in 2019 focusing on increasing this rate, i.e., BMCHP-BACO, BMCHP-Mercy, BMCHP-Signature, BMCHP-Southcoast, and HNE Be Healthy.

Exhibits 5 and 6. 2019 ACPP Seven-Day Follow Up After Hospitalization for Mental Illness

| 2018 Adjusted, Unaudited, Uncertifiable HEDIS Rate | AllWays My Care | BMCHP-BACO | BMCHP-Mercy | BMCHP-Signature | BMCHP-Southcoast | Fallon-BFHC | Fallon-365 | Fallon-Wellforce | HNE Be Healthy | Tufts-Atrius | Tufts-BCH | Tufts-BIDCO | Tufts-CHA |
|--|-----------------|------------|-------------|-----------------|------------------|-------------|------------|------------------|----------------|--------------|-----------|-------------|-----------|
| Seven-Day Follow-Up After Hospitalization for Mental Illness | 45.45% | 45.44% | 55.50% | 51.58% | 55.03% | 47.12% | 47.33% | 42.88% | 52.40% | 45.13% | 52.36% | 43.59% | 48.02% |

ACPP 2018 7-Day Follow-Up After Hospitalization



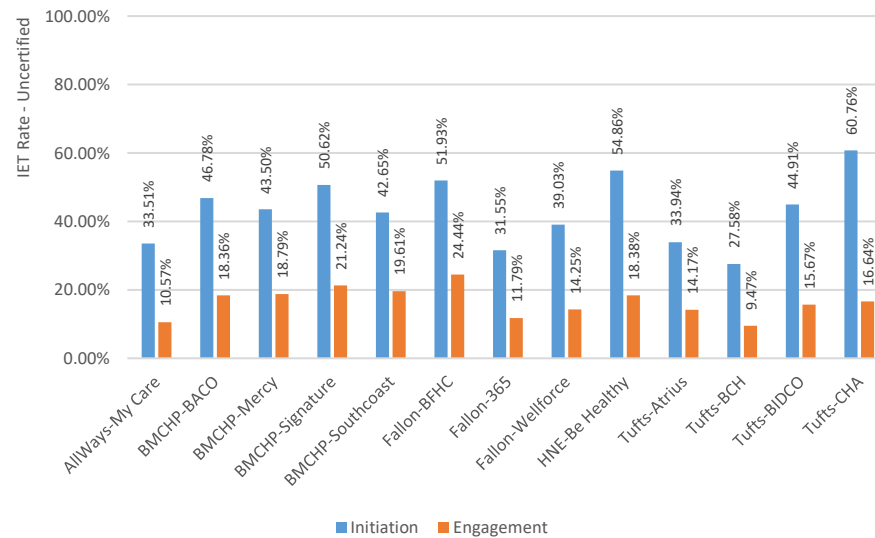
Measure 3. IET - Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment

The range of 2018 IET Initiation performance rates was 27.92 percentage points. The lowest-performing ACPP was Tufts-BCH at 27.58%. The highest performing plan was Tufts-CHA, 60.76%. The range of the Engagement rate was 14.97 percentage points. The lowest-performing ACPP on the Engagement rate was Tufts-BCH at 9.47. The highest-performing ACPP was Fallon BFHC at 24.44%. The weighted average Initiation rate was 41.57% and the weighted average Engagement rate was 15.43%. Please note that these rates are reported as adjusted, unaudited, uncertifiable HEDIS rates. AllWays My Care conducted a performance improvement project in 2019 focusing on increasing this rate.

Exhibits 6 and 7. 2019 ACPP Rates of Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment

| 2018 Adjusted, Unaudited HEDIS Rate | AllWays My Care | BMCHP-BACO | BMCHP-Mercy | BMCHP-Signature | BMCHP-Southcoast | Fallon-BFHC | Fallon-365 | Fallon-Wellforce | HNE Be Healthy | Tufts-Atrius | Tufts-BCH | Tufts-BIDCO | Tufts-CHA |
|-------------------------------------|-----------------|------------|-------------|-----------------|------------------|-------------|------------|------------------|----------------|--------------|-----------|-------------|-----------|
| Initiation of AOD Treatment | 33.51% | 46.78% | 43.50% | 50.62% | 42.65% | 51.93% | 31.55% | 39.03% | 54.86% | 33.94% | 27.58% | 44.91% | 60.76% |
| Engagement of AOD treatment | 10.57% | 18.36% | 18.79% | 21.24% | 19.61% | 24.44% | 11.79% | 14.25% | 18.38% | 14.17% | 9.47% | 15.67% | 16.64% |

ACPP 2018 Initiation and Engagement in AOD Treatment



INFORMATION SYSTEMS CAPABILITY ASSESSMENT

The focus of the Information Systems Capability Assessment is on the components of MassHealth and CareSeed information systems that contribute to performance measure production. This is to ensure that the system can collect data on the enrollee, on provider characteristics, and on services furnished to enrollees through an encounter data system or other methods. The system must be able to:

- Ensure that data received from providers are accurate and complete;
- Verify the accuracy and timeliness of reported data;
- Screen the data for completeness, logic, and consistency; and
- Collect service information in standardized formats to the extent feasible and appropriate.

Claims and Encounter Data. The reviewer reviewed five numerator-compliant cases per measure under audit per ACPP to ensure that the ACPPs' claims numerator data met numerator requirements. The following claims numerator data were requested:

Exhibit 8. Numerator Documentation

| Measure | Numerator Documentation Requested |
|---------|--|
| AMR | <ul style="list-style-type: none">• Inbound member prescription claims showing asthma controller medications, asthma reliever medications, and the dispensing date (include injections); or• Pharmacy Benefit Manager (PBM) records showing asthma controller medications, asthma reliever medications, and the dispensing date (including injections). |
| FUH | <ul style="list-style-type: none">• Evidence that the follow-up visit occurred with a behavioral health provider and that the visit medical billing code met the measure requirements. |
| IET | Copies of treatment records corresponding to the initial and follow-up visits; or Inbound claims from the treating provider(s). |

The primary source documentation submitted established that claims numerator data met the numerator requirements for all ACPPs. There were no issues identified with claims or encounter data processing.

Enrollment Data. Enrollment data for 30 ACPP members were selected at random by the reviewer. Enrollment data for the same 30 members were provided by CareSeed to ensure the enrollment data matched the MassHealth primary source enrollment data after CareSeed enrollment data processing. The reviewer determined that the enrollment data for the sample of 30 members successfully matched. There were no issues identified with enrollment data or processes.

Data Integration. ACPD performance measure rates were produced using CareSeed software. MassHealth provided ACPD data to CareSeed in CareSeed-compliant extract format. The data were then loaded into the CareSeed measure production software. MassHealth had adequate processes to track the completeness and accuracy of data at each transfer point.

Source Code. NCQA-certified CareSeed software was used to produce the performance measures. There were no source code issues identified. The validated measures are not eligible for certification under NCQA’s Measure Certification Program. The ACPD measure rates are referred to as, “Adjusted, Unaudited, Uncertifiable HEDIS Rates” because enrollment was assigned to MassHealth members who were enrolled in the ACPD prior to the ACO program start date.

MEASURE-SPECIFIC VALIDATION DESIGNATION

Exhibit 9. Measure-Specification Validation Designation

| Measure-Specific Validation Designation | | |
|---|-------------------------|---|
| Performance Measure | Validation Designation | Definition |
| AMR – Asthma Medication Ratio | Valid measure (no bias) | Measure data were compliant with NCQA specifications and the data, as reported, were valid. The measure is not eligible for certification under NCQA’s Measure Certification Program. The rate is designated or referred to as an “Adjusted, Unaudited, Uncertifiable HEDIS Rate” because enrollment was assigned to MassHealth members who were enrolled in an ACPD prior to the ACO program start date, and who were also members of the same ACPD in 2018. |
| FUH - Follow-Up After Hospitalization for Mental Illness (7 days) | | |
| IET - Initiation and Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment | | |

STRENGTHS

- MassHealth used an NCQA-certified vendor, CareSeed, for the production of ACPD performance measures.
- In its first external quality review, the PCACO program successfully completed performance measure validation.

OPPORTUNITIES & RECOMMENDATIONS

None identified.

CONCLUSION

In summary, KEPRO's validation review of the selected performance measures indicates that the MassHealth's Accountable Care Organization Partnership Plans' measurement and reporting processes were fully compliant with specifications and were methodologically sound.

SECTION 6. PERFORMANCE IMPROVEMENT PROJECT VALIDATION



INTRODUCTION

THE PERFORMANCE IMPROVEMENT PROJECT LIFE CYCLE

To permit more real-time review of Performance Improvement Projects (PIPs), MassHealth has adopted a two-stage approach.

Baseline/Initial Implementation Period: Calendar Year 2019

Planning Phase: January 2019 - March 2019

During this period, the ACPs developed detailed plans for interventions. ACPs conducted a population analysis, a literature review, and root cause and barrier analyses, all of which contributed to the design of appropriate interventions. ACPs reported on this activity in March 2019. These reports described planned activities, performance measures, and data collection plans for initial implementation. Plans were subject to review and approval by MassHealth.

Initial Implementation: March 2019 - December 2019

Incorporating feedback received from MassHealth and KEPRO, the ACPs undertook the implementation of their proposed interventions. The ACPs submitted a progress report in September. In this report, the ACPs provided baseline data for the performance measures that had been previously approved by MassHealth.

Final Implementation Period: Calendar Year 2020

Final Implementation Progress Reports: March 2020

ACPs will submit another progress report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including successes and challenges.

Final Implementation Annual Report: September 2020

ACPs will submit a second annual report that describes current interventions, short-term indicators and small tests of change, and performance data as applicable. They will also assess the results of the project, including success and challenges, and describe plans for the final quarter of the initiative.

The cycle will begin anew in 2021.

All reports are reviewed by KEPRO and the 2019 reports are discussed herein. Each project is evaluated to determine whether the organization selected, designed, and executed the projects in a manner consistent with CMS EQR Protocol 3. KEPRO also determines whether the projects have achieved or are likely to achieve favorable results. KEPRO distributes detailed evaluation criteria and instructions to the ACPs to support their efforts.

The review of each report is a four-step process:

- 1) *PIP Questionnaire*. The ACPP submits a completed questionnaire for each PIP. This questionnaire is stage-specific. The Planning Report asks the ACPP to provide a project rationale; member-focused and provider-focused goals; a barrier analysis; a description of stakeholder involvement; a description of the intervention and implementation plans; plans for small tests of change and effectiveness analysis; anticipated barriers to implementation and plans to address those barriers; and proposed performance indicators. The Implementation Update Report asks the ACPP to provide a population analysis of the project-eligible members; a strategy for member and/or provider engagement; updates to project goals; an update on intervention implementation progress; the use of small tests of change; plans to improve the intervention(s); plans for data analysis; a description of performance indicators; and baseline performance rates.
- 2) *Desktop Review*. A desktop review is conducted for each PIP. KEPRO's Technical Reviewer and Medical Director review the PIP questionnaire and any supporting documentation submitted by the plan. Working collaboratively, they identify issues requiring clarification as well as opportunities for improvement. The focus of the Technical Reviewer's work is the structural quality of the project. The Medical Director's focus is on clinical interventions.
- 3) *Conference with the Plan*. The Technical Reviewer and Medical Director meet telephonically with representatives selected by the plan to obtain clarification on identified issues as well as to offer recommendations for improvement. The plan is offered the opportunity to resubmit the PIP questionnaire within ten calendar days, although it is not required to do so.
- 4) *Final Report*. A PIP Validation Worksheet based on CMS EQR Protocol Number 3 is completed by the Technical Reviewer. Individual standards are rated either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points achieved by the sum of all available points. The Medical Director documents his or her findings, and in collaboration with the Technical Reviewer, develops recommendations. The findings of the Technical Reviewer and Medical Director are synthesized into a final report.

PERFORMANCE IMPROVEMENT PROJECT TOPICS

MassHealth ACPPs conduct two contractually required PIPs annually. In accordance with Appendix B of the Model A ACPP's contract, ACPPs proposed to MassHealth one PIP from each of the two domains:

Domain 1: Behavioral Health – Promoting well-being through prevention, assessment, and treatment of mental illness including substance use and other dependencies.

Domaine 2: Population and Community Needs Assessment and Risk Stratification – Identifying and assuming priority populations for health conditions and social determinant factors with the most significant size and impact and developing interventions to address the appropriate and timely care of these priority populations.

In Calendar Year 2019, ACPPs conducted the following Performance Improvement Projects (PIPs).

Domain 1: Behavioral Health

Five ACPPs focused on increasing the rate of follow up visits within seven days of discharge for members hospitalized for a mental illness (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and Be Healthy Partnership).

Seven ACPPs focused on improving the rate of depression screenings and follow-up plans (Berkshire Fallon Health Collaborative, Fallon 365 Care, Wellforce Care Plan, Tufts Health Together with Atrius Health, Tufts Health Together with BIDCO, Tufts Health Together with Boston Children’s ACO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP focused on Initiation and Engagement in Treatment (My Care Family).

Domain 2: Population and Community Needs Assessment

Five ACPPs focused on improving Asthma Control and Medication Adherence (BMC HealthNet Plan Community Alliance, BMC HealthNet Plan Mercy Alliance, BMC HealthNet Plan Signature Alliance, BMC HealthNet Plan Southcoast Alliance, and My Care Family).

Four ACPPs focused on utilizing Health-Related Social Needs Screening to identify both pediatric and adult members in need of additional services to improve health outcomes (Tufts Health Together with Atrius Health, Tufts Health Together with Boston Children’s ACO, Tufts Health Together with BIDCO, and Tufts Health Together with Cambridge Health Alliance).

One ACPP each focused on the following areas:

- Improving Rates of Controlling High Blood Pressure (Berkshire Fallon Health Collaborative).
- Improving Rates of Immunizations for Adolescents - Combo 2 (Fallon 365 Care).
- Improving Rates of CDC - HbA1c testing for the diabetic population (Wellforce Care Plan).
- Improving outcomes in diabetic patients through integrated care management (Be Healthy Partnership).

Based on its review of the MassHealth Accountable Care Organizations' performance improvement projects, KEPRO did not discern any issues related to any plan's quality of care or the timeliness of or access to care.

ANALYSIS

ACPPs participated in the Performance Improvement Project process for the first time beginning in November 2018. The lifecycle of a Performance Improvement Project is that ACPPs submit a project topic for review and approval to MassHealth. In cooperation with MassHealth, KEPRO offers suggestions to the ACPPs related to the parameters of the project and advises MassHealth on project viability.

Upon approval on their project topics, in March 2019, the Accountable Care Partnership Plans developed and submitted plans for Performance Improvement Projects for review by KEPRO. In March 2019, the ACPPs submitted project plans that included the rationale for the project and evidence of stakeholder involvement in a barrier analysis relative to the project's goals. Having identified barriers to goal attainment, ACPPs presented detailed interventions designed to resolve the barriers to goal attainment. In their project proposals, ACPPs also detailed the performance indicators, whereby they would measure goal attainment, and the parameters by which the indicators would be measured. In September 2019, ACPPs presented a population analysis, documented a process of continuous quality improvement of their interventions, and presented the baseline rates of their performance indicators.

Looking back on the first year of the performance improvement process, the ACPPs submitted viable project plans and in 2020, they are now working on the evaluation of their first full year of project performance. From the perspective of MassHealth, KEPRO, and the ACPPs, many lessons were learned.

With regard to topic selection and the scope of their goals to improve members' services:

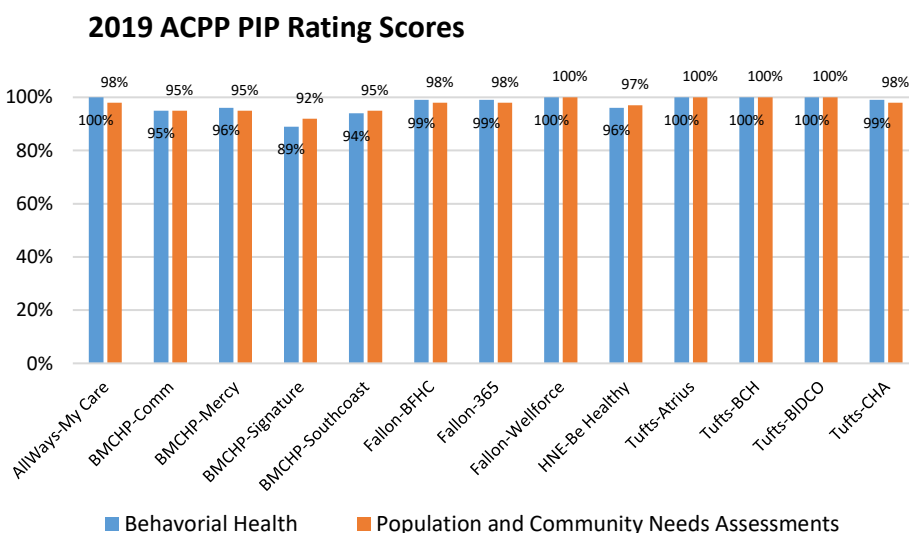
- In some cases, managed care plans chose to address topics in which they were already experiencing positive performance. In other instances, significant opportunities for improvement as evidenced in performance rates were not addressed by a performance improvement project.
- In other cases, ACPPs with multiple provider partners submitted project proposals addressing a single topic but did not offer provider partner-specific rationales for their selection. For example, each partner in an ACPP might have the goal of developing depression screening protocols without documenting that early detection of depression is a documented priority for the partner's members. In order to ensure that each ACPP partner document the needs of its members relative to the chosen topic (which should be based on member-needs), KEPRO recommends that MassHealth provide clear guidance to the managed care plans in November 2020, when topics are proposed for the next quality cycle. It suggests that a standardized format be developed for the submission of project proposals to encourage the submission of expected information.

- KEPROs recommend that processes be put in place to direct the managed care plan's limited resources on the latter. Specifically, 2019 managed care plan performance rates should be reviewed for outlier performance. Negative outlier performance could be correlated to the topics' priority within the MassHealth Comprehensive Quality Strategy. The outcomes of this analysis could be communicated to the managed care plan for its consideration. Managed care plans could be required to obtain baseline performance rates, which when compared to established benchmarks, could be used to justify project selection.

With respect to the ACPs meeting the challenges of designing and implementing a PIP, the ACPs assembled project teams that generally submitted well-developed project plans. Some ACPs struggled with certain requirements, such as designing strategies for evaluating the effectiveness of their intervention activities and documenting their efforts to continuously improve their intervention activities through small tests of change. In this regard, KEPRO not only reviews the project reports to determine whether the project rating criteria were met, but KEPRO also includes into its rating reports many recommendations for improving the effectiveness of their PIP interventions. Even for response items rated "3" (meets rating criteria), KEPRO offers suggestions for further improvement that are aligned with the expectation of "continuous quality improvement."

The chart that follows depicts the Performance Improvement Project evaluation ratings received by each Accountable Care Partnership Plan.

Exhibit 10: PIP Ratings by ACP and Domain



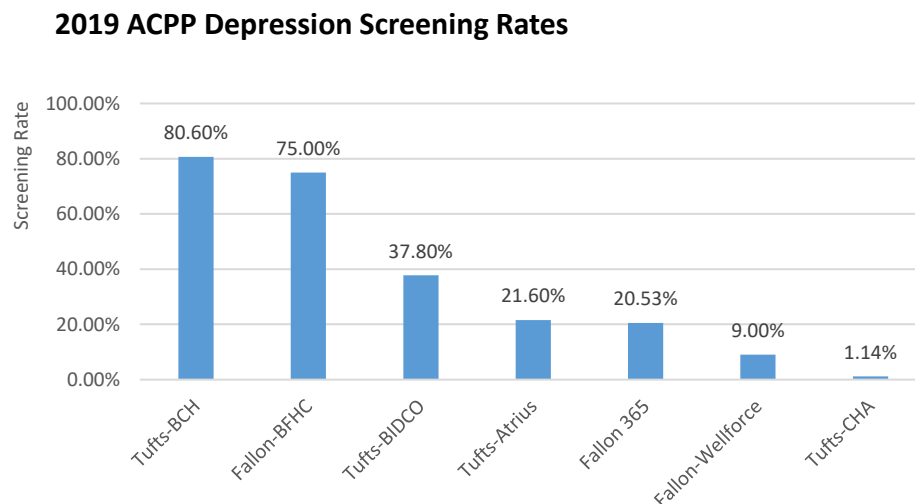
MassHealth Accountable Care Partnership Plans used a wide variety of approaches to address their project goals.

Exhibit 11: Interventions by Domain

| Intervention | Behavioral Health | Population and Community Needs Assessment and Risk Stratification |
|----------------------------|-------------------|---|
| Care Management | 3 | 5 |
| Member Education | 3 | 3 |
| Provider Education | 5 | 4 |
| Technology-Based Solutions | 6 | 3 |
| Staffing | 3 | 0 |
| Workflow Modifications | 7 | 5 |

KEPRO looks forward to the results of the first remeasurement for these interesting projects in March 2020.

Seven ACPPs undertook Performance Improvement Projects related to depression screening. Because of the number of projects addressing this topic, as well as the fact that 2019 represented a true baseline – managed care plans most likely had not put quality initiatives into place previously -- KEPRO conducted an analysis of these ACPPs baseline depression screening rates and found a range of 79.46 percentage points (1.14% to 80.6%).

Exhibit 12: 2019 ACPP Depression Screening Rates

The results of the first remeasurement may provide useful information on whether certain types of interventions are more effective in improving performance.

SUMMARY OF MANAGED CARE PLAN-SPECIFIC PERFORMANCE IMPROVEMENT PROJECTS

Summaries of ACP performance improvement projects follow. The section below is intended to provide the reader with a reference for how the project description content was derived.

| | |
|--|---|
| Project Title | The project title is assigned by the managed care plan. |
| Rationale for Project Selection | In their project proposals, managed care plans are required to provide a rationale for the project's selection. The language in this section is extracted from the project proposal submitted by the plan to MassHealth in November 2018. |
| Project Goals | Managed care plans articulated project goals in the Planning Report and in the Initial Implementation Report. To eliminate the possibility of misinterpretation, KEPRO has provided these goals exactly as stated by the managed care plan. |
| Performance Indicators | This section identifies the performance indicators by which the managed care plan intends to evaluate the success of the performance improvement project. Baseline (2018) performance is provided as is the plan's goal for the 2019 remeasurement period. |
| Interventions | Here, KEPRO summarizes at a high level the interventions the plan has or plans to implement to achieve its goals. Plan interventions are often complex, multi-layered initiatives with many moving parts. Space limitations preclude providing detailed, comprehensive descriptions of each intervention. |
| Performance Improvement Project Evaluation | KEPRO evaluates projects against a set of pre-determined criteria that speak to the strength of the interventions as well as the overall project design. Elements of project design include, but are not limited to, the size of the affected population; analyses of the member population and barriers; barrier mitigation strategies; and intervention effectiveness. These criteria are summarized in the first column of the accompanying table. The managed care plan's success at meeting the criteria are summarized in the final rating score. |
| Plan and Project Strengths | In this section, KEPRO recognizes the managed care plan's efforts as they relate to project design. It also recognizes organizational structures that contribute to the overall quality improvement process. |

Recommendations
and Opportunities
for Improvement

In this section, KEPRO offers suggestions for improving the design of the quality improvement project including both intervention design and the overall construct of the project.

DOMAIN 1: BEHAVIORAL HEALTH

DEPRESSION

BERKSHIRE FALLON HEALTH COLLABORATIVE (FALLON-BFHC) - IMPROVING THE RATE OF DEPRESSION SCREENINGS AND FOLLOW-UP PLANS FOR THE BERKSHIRE FALLON HEALTH COLLABORATIVE POPULATION

Rationale for Project Selection

“The role and impact of depression on an individual and the system can be multifaceted. Adolescents with depression may exhibit problems in school performance, daily living, and functioning such as impaired social and interpersonal relationships. Research demonstrates that rates of major depression increase significantly during adolescent years into adulthood and early onset of major depressive disorder (MDD) in adolescents is associated with higher risks of suicide attempt, death by suicide and MDD recurrence in young adulthood. Lastly, the National Vital Statistics Reports on "Deaths: Leading Causes for 2016," reported the leading cause of death for the population aged 1-44 was unintentional injuries, with suicide being the second leading cause of death for age group 10-24. In adults, other than the usual symptoms of depression that you would expect to observe, it can also affect the entire body, particularly when not treated ... Identifying and treating depression early may proactively prevent a myriad of emotional and medical issues, thus improving the individual's quality of life while, at the same time, having the ability of decreasing the burden on the health care system.”

Project Goals

Member-Focused

- Increase the number of members who are screened for depression using a paper-based PHQ-9 or other approved screening tool, as evidenced by a 2019 calendar year baseline of 6.12%, a 10% improvement above the 2018 baseline rate of 5.56%.

Provider-Focused

- At least 80% of providers will receive education to improve understanding of the resources available for members with an elevated PHQ-9.
- At least 80% of providers will receive education to improve documentation of follow-up interventions provided or offered to members with an elevated PHQ-9 screening or other approved screening tool.

- Increase the number of encounters during the measurement year for which providers who administer a PHQ-9, and have a positive finding, document the appropriate follow up as evidenced by a 10% improvement above the 2018 baseline rate of 75%, leading to an overall rate of 82.5%.

Performance Indicators

- 1) The rate of Fallon-BFHC members aged 12-64 on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year.
 - Fallon-BFHC's 2018 baseline rate is 5.56%.
 - Its goal for the 2019 remeasurement period is 6.12%.
- 2) The rate of Fallon-BFHC members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool and, if screened positive, a follow-up plan is documented on the date of the positive screen.
 - Fallon-BFHC's 2018 baseline rate is 75.0%.
 - Its goal for the 2019 remeasurement period is 82.5%.

Interventions

Fallon-BFHC piloted a paper-based PHQ-9 screening at two practices, one large and one small, to enable the analysis of workflow challenges in differently sized practices. The document was then scanned into the patient's record and made available to the provider in advance of the encounter. Initially, the screen was given to patients attending their first visit at the practice. The ACPP plans to expand the process to apply to screening patients at all visits.

Positive screens were flagged by medical assistants and nurses in preparation for the patient encounter. Guidelines for determining appropriate follow-up protocols were posted on the organization's SharePoint site.

A database was created of members who have not completed a PHQ-9 within the year. This intervention has been rolled out to all practices. Focus groups with practice administrators are being held to see how this intervention may be improved.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon-BFHC received a rating score of 99% on this Performance Improvement Project.

Exhibit 13: Fallon-BFHC PIP Rating Score

| Summary Results of Validation Ratings | Number of Items | Total Available Points | Points Scored | Rating Averages |
|--|------------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 14.0 | 93% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 10.0 | 10.0 | 10.0 | 100% |
| Baseline Indicator Performance Rates | 10.0 | 10.0 | 10.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 39 | 77 | 76 | 99% |

Plan & Project Strengths

- Berkshire Fallon Health Collaborative is commended on the use of free bus passes and taxi vouchers to address possible transportation issues as well as the described use of the Mobile Health Van.
- Additionally, Berkshire Fallon Health Collaborative reported that many practices have an embedded social worker to assist members with follow-up plans, as needed, upon the completion of the PHQ 9.

Recommendations & Opportunities for Improvement

- KEPRO recommends workflows be developed and tested for the referrals and that tracking be developed to monitor appointment attendance.

TUFTS HEALTH TOGETHER WITH BIDCO – IMPROVING DEPRESSION SCREENING AND TREATMENT IN ADOLESCENTS AND ADULTS

Rationale for Project Selection

“Based on data collected by the BIDCO hospital community needs assessment, between 2011-2014, the proportion of Massachusetts residents with any mental health disorder rose from 17.4% to greater than 20% ... Despite the high prevalence of disease, there is evidence of persistent symptoms in more than 50% of patients either due to lack of treatment or inadequate treatment ... Overall in Massachusetts, nearly half of adults with any serious mental illness did not receive care in 2013. Aligning with these findings, the most recent Community Health Needs Assessments performed by the Beth Israel hospitals and Anna Jacques Hospital ... identified depression as a priority focus area.”

Project Goals

Member-Focused

- Improve patient knowledge about depression.
- Improve patient screening for depression.
- Improve patient access to resources to treat depression.
- Improve patient outcomes for patients treated for depression.

Provider-Focused

- Improve provider knowledge about depression.
- Improve provider screening for depression.
- Improve provider knowledge of access to resources to treat depression.

Performance Indicators

- 1) The rate of Tufts-BIDCO-attributed members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year.
 - Tufts Health Together with BIDCO’s 2018 baseline rate is 37.8%.
 - Its goal for the 2019 measurement period is 42.8%.
- 2) The rate of Tufts-BIDCO-attributed members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year and, if screened positive, a follow-up plan is documented on the date of the positive screen.

- Tufts Health Together with BIDCO's 2018 baseline rate is 37.1%.
 - Its goal for the 2019 measurement period is 42.1%.
- 3) The rate of members who have a documented PHQ-9 score in the medical record during the depression follow-up period.
 - Tufts Health Together with BIDCO's 2018 baseline rate is 0.4%.
 - Its goal for the 2019 measurement period is 2.0%
 - 4) The rate of members who achieve remission of depression symptoms as demonstrated a PHQ-9 depression response score of <5 recorded in the medical record during the depression follow-up period.
 - Tufts Health Together with BIDCO's 2018 baseline rate is 0.2%.
 - Its goal for the 2019 measurement period is 2.0%
 - 5) The rate of members who indicate a response to treatment for depression as demonstrated by a PHQ-9 depression response score at least 50 percent lower than the PHQ-9 score associated with the index episode start date recorded in the medical record during the depression follow-up period.
 - Tufts Health Together with BIDCO's 2018 baseline rate is 0.2%.
 - Its goal for 2019 first measurement period is 2.0%.

Interventions

In keeping with its purpose of this PIP is to design and implement a protocol for screening and treating members for the symptoms of depression, Tufts-BIDCO proposed four interventions:

1. Develop and implement provider and staff education and training to implement improved workflows for depression screening and treatment.
2. Develop and improve standardized workflows for depression screening and treatment.
3. Build technology and data analytics capabilities within the EMR to assist providers in identifying patients, screening and treatment for depression.
4. Provide Member education on depression screening and treatment.

Given the scope of this PIP (improving depression screening and treatment in adolescents and adults), KEPRO determined that BIDCO's interventions are well aligned with the project's scope. The four interventions involve a total of 20 activities that include: screening-platform development, deploying screening tools (PHQ-2 and PHQ-9), developing linguistically competent patient education about depression, and tracking treatment outcomes using the PHQ-9.

In its EQR review report, KEPRO commended BIDCO for the wide range of its intervention activities (IT system platforms, provider development, and member engagement) and for the range of its intervention measures (from screening to follow-up for positive screens to response to treatment).

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts-BIDCO received a rating score of 100% on this Performance Improvement Project.

Exhibit 14: Tufts-BIDCO PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 4.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 5.0 | 15.0 | 15.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 27 | 81 | 81 | 100% |

Plan & Project Strengths

- KEPRO commends Tufts-BIDCO on the broad scale of commitment to building its preventive screening capacities.
- Tufts-BIDCO is commended for its promotion of evidence-based guidelines for the treatment of depression for both adolescents and adults.
- Tufts-BIDCO is commended for developing meaningful workflow adaptations that incorporate screening into preventive appointments and for ensuring age-appropriate guidelines are used.

Recommendations & Opportunities for Improvement

- Tufts-BIDCO reports that this project is being implemented according to plan, with its intervention deployments being adapted to the regional characteristics of members and provider practices.
- Tufts-BIDCO notes the challenges of soliciting feedback from providers for the purposes of making its intervention activities relevant to providers and improving future deployments. Toward that end, KEPRO has recommended that Tufts-BIDCO engage providers to identify barriers to provider-adoption of their screening and referral protocols.
- KEPRO commends Tufts-BIDCO for its commitment to the ongoing deployment of depression screening.

TUFTS HEALTH TOGETHER WITH CAMBRIDGE HEALTH ALLIANCE – IMPROVING THE RATE OF DEPRESSION SCREENING AND FOLLOW UP FOR ADOLESCENTS IN PRIMARY CARE

Rationale for Project Selection

“Depression screening is a quick and easy way to identify the first signs of a debilitating disease and enables providers to reach adolescent members who may not otherwise seek professional advice. Furthermore, collaborative care interventions delivered in primary care settings have shown evidence for reducing depression symptoms among adolescents.”

Project Goals

Member-Focused

- Increase the rate of depression screening among adolescent members between the ages 12 years old up to 17 years and 364 days of age.
- Improve follow up and utilization of behavioral health services for adolescent members who yield a positive depression screening result.

Provider-Focused

- Increase provider knowledge of the importance of depression screening and follow-up services.
- Increase the number of referrals to behavioral health services when appropriate.
- Increase the rate of collaborative care interventions including integrated behavioral health services and support for adolescent patients with depression.

Performance Indicators

- 1) Rate of Tufts-CHA-attributed members 12 – 17 years 364 days of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using the PHQ-2 and PHQ-9 during the measurement year.
 - Tufts-CHA’s 2018 baseline rate is 1.14%.
 - Its goal for the 2019 = remeasurement period is 40.0%.
- 2) Rate of Tufts-CHA-attributed members 12-17 years 364 days of age years of age on the date of the encounter who screened positive for clinical depression using a standardized tool during the measurement year.
 - Tufts-CHA’s 2018 baseline rate is 30.6%.

- 3) The rate of Tufts-CHA-attributed members 12-17 years 364 days of age = on the date of the encounter who screened positive for clinical depression with a treatment plan.
- Tufts-CHA's 2018 baseline rate is 90.0%.
 - Its goal for the 2019 remeasurement period is 40%.

Intervention

Tufts-CHA is moving forward with the integration of PHQ-2 and PHQ-9 screening into primary care workflows for adolescents. Implementation will include:

- Focus groups to identify barriers to adoption of the depression screening protocols, and
- Trainings with medical assistants and primary care providers regarding the screening protocol. Medical assistants complete the screening and advise the PCC.

Tufts-CHA is training and integrating mental health staff into its clinics that includes Family Care Partners, Integrated Child Therapists (PhD or LICSW), and Psychiatrists. Their availability at each clinic will vary and so the handoff and follow-up process will vary depending on which team member is available. Furthermore, they will play a role in educating PC Staff regarding mental health care such that PC staff will also provide parental education and the process will not be dependent on presence of mental health staff. Together PC staff and mental health staff will work as a team to implement this workflow.

A registry of patients with depression has been developed for Tufts-CHA to use proactively for depression management. This registry allows Tufts-CHA integrated behavioral staff to proactively identify members who screen positive and follow up with these members during a depressive episode, as well as to keep track of these members' progress over time.

Performance Improvement Project Evaluation

KEPRO evaluates an ACP's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with Cambridge Health Alliance received a rating score of 99% on this Performance Improvement Project.

Exhibit 15: Tufts-CHA PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 14.3 | 96% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 4.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 4.0 | 12.0 | 12.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 27 | 81 | 80.3 | 99% |

Plan & Project Strengths

- Tufts-CHA is commended for including family care partners as significant drivers in developing education materials.
- Tufts-CHA training with staff members on an ongoing basis.

Recommendations & Opportunities for Improvement

- KEPRO noted that because its first intervention (develop its depression screening protocol) had not been implemented as of its September 15th report, it will have minimal (if any) implementation during 2019, which will be the data-year for CHA's first remeasurement. That is, Tufts-CHA screening protocol will not be operational for a 2019 remeasurement year during which interventions are typically operational.
- Although this intervention has not yet been implemented, CHA should have been conducting small tests of change on the proposed screening platforms and workflows to make improvements to the deliverables prior to implementation.
- KEPRO has advised Tufts-CHA to clearly define the expected endpoints (that is, final goals or outcomes) for this intervention. All quality improvement activities should then focus on ensuring that the outcomes for this intervention are achieved.
- CHA was advised to ensure that its practitioner protocols for depression screenings meet the CBHI requirements for well-child visits.

FALLON 365 CARE – IMPROVING THE RATE OF DEPRESSION SCREENINGS AND FOLLOW-UP PLANS FOR THE FALLON 365 CARE POPULATION

Rationale for Project Selection

“The role and impact of depression on an individual and the system can be multifaceted. Adolescents with depression may exhibit problems in school performance, daily living, and functioning such as impaired social and interpersonal relationships. Research demonstrates that rates of major depression increase significantly during adolescent years into adulthood and early onset of major depressive disorder (MDD) in adolescents is associated with higher risks of suicide attempt, death by suicide, and MDD recurrence in youth and adulthood. The National Vital Statistics Reports on "Deaths: Leading Causes for 2016," reported the leading cause of death for the population aged 1-44 was unintentional injuries, with suicide being the second leading cause of death for age group 10-24. In adults, other than the usual symptoms of depression that you would expect to observe, it can also affect the entire body, particularly when not treated.”

Project Goals

Member-Focused

- Increase member completion of depression screening by 10% above the 2018 baseline rate of 20.53% through the use of tablet computer screening technology.

Provider-Focused

- Increase the rate of provider offices administering the PRIME MD – PHQ-2, PHQ-9, PSC-17, or other approved screening tools by 10% above the 2018 baseline of 20.53%.
- Increase the rate of provider follow-up for members identified as having a positive screening by 10% above the baseline rate of 69.23%.

Performance Indicators

- 1) The rate of ACPP patients aged 12 – 64 on the date of the encounter, with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year.
 - Fallon 365’s 2018 baseline rate is 20.53%.
 - Its goal for the 2019 remeasurement period is 22.58%.

- 2) The rate of ACP members aged 12 – 64 on the date of the encounter, with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year and, if screened positive, a follow-up plan is documented on the date of the positive screen.
- Fallon 365's 2018 baseline rate is 69.23%.
 - Its goal for the 2019 remeasurement period is 76.15%.

Interventions

Fallon 365 implemented tablet computer-based depression screening. Fallon 365 is training staff appropriately to utilize tablet computers to complete screenings for clinical depression with the goal of improving the organizations overall screening rates, as well as follow-up for positive screens. The screening administration protocol is that members/parents self-administer the questionnaire.

As data from the tablet screening are entered into the electronic medical record, there is a pop-up provider notification in the medical record to alert providers to a positive screening. Quarterly data are collected and monitored to compare screening rates before implementation of this intervention to the rates obtained using tablets.

During the course of implementing the tablet-based screening protocol, Fallon 365 learned that members were not completing the screening process. Staff were deployed to the waiting room to observe patients complete the screen. They learned that members had insufficient time in the waiting room to finish answering the questions on the screen. Fallon 365 modified its practices to allow sufficient time for patients to complete the screen.

Performance Improvement Project Evaluation

KEPRO evaluates an ACP's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon 365 received a rating score of 99% on this Performance Improvement Project.

Exhibit 16: Fallon 365 Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 8 | 89% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 15 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6.0 | 18.0 | 18.0 | 100% |
| Baseline Indicator Performance Rates | 5.0 | 15.0 | 15.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 40 | 120 | 119 | 99% |

Plan and Project Strengths

- KEPRO commends Fallon 365 for implementing the new workflows at a pilot site first, making modifications as required, and then transferring them to other sites.
- Fallon 365 is commended for observing the process of patients inputting data into the screening tool to determine the possible root causes of challenges, making appropriate modifications, and tracking the effect.

Recommendations & Opportunities for Improvement

- Fallon 365 is encouraged to further explore the clinical characteristics of its member population to potentially guide the development of targeted interventions.

TUFTS HEALTH TOGETHER WITH ATRIUS HEALTH – IMPROVING THE RATE OF DEPRESSION SCREENING AND FOLLOW UP FOR ADOLESCENTS AND ADULTS

Rationale for Project Selection

“Major depression is one of the most common mental disorders in the United States. According to the National Institute of Mental Health, an estimated 16.1 million adults aged 18 or older in the United States had at least one major depressive episode in the past year in 2015. This number represented 6.7% of all U.S. adults. As a result, depression is among the leading causes of disability in persons 15 years or older, accounting for \$30–50 billion in lost productivity and direct medical costs annually in the U.S. A 2016 profile of health among Massachusetts adults by the Massachusetts Department of Public Health shows that 19% of the overall population in Massachusetts reported having been diagnosed with depressive disorder. Screening for depression is an important initial step in identifying and treating individuals with depression. Depression screening in the Primary Care setting in particular is crucial as this is oftentimes where an individual will first present whether it is for a routine or sick-visit. Almost two-thirds of patients with depression receive some type of care in the Primary Care setting. Due to the importance of identifying individuals with depression early on and subsequently treating those who yield a positive screen, [Tufts-Atrius] will focus on depression screening and follow up.”

Project Goals

Member-Focused

- Increase the rate of initial depression screening among adolescent and adult members.
- Improve the rate of treatment for patients screening positive for depression.
- Improve the rate of follow-up screening after a positive screen.

Provider-Focused

- Improve pre- and at-visit workflows to enable depression screening.
- Improve alerts and reminders for initial and follow-up screening.
- Improve education and training of treatment options.

Performance Indicators

1. The rate of ACPP-attributed members 12 to 64 years of age on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year.
 - Tufts-Atrius’s 2018 baseline rate is 21.6%.
 - Its goal for the 2019 remeasurement period is 33%.

2. The rate of patients yielding a positive score for depression during the most recent screen.
 - Tufts-Atrius's 2018 baseline rate is 16.2%.
3. The rate of patients with a positive depression score who have a treatment plan.
 - Tufts-Atrius's 2018 baseline rate is 66.7%.
 - Its goal for the 2019 remeasurement period is 70.0%.

Interventions

Tufts-Atrius adopted clinical guidelines for depression screening and treatment and conducted extensive provider training. A webinar offering Continuing Medical Education (CME) units, The Management of Depression in Primary Care, was presented to providers and later made available to providers on demand. Psychopharmacology-focused training was offered in Atrius Internal Medicine departments. Behavioral Health also hosted a session on psychopharmacological issues and offered CMEs as well. Other department-based trainings were offered in Ob/Gyn and Pediatrics.

In its EQR report, KEPRO noted that Tufts-Atrius has not describe any protocol for measuring the adoption of the clinical guidelines among PCPs. KEPRO recommended that Tufts-Atrius measure (perhaps by survey) the extent to which its guidelines are being adopted by providers.

Atrius Health modified its electronic medical record system to accommodate and facilitate depression screening and treatment.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together With Atrius Health received a rating score of 100% on this Performance Improvement Project.

Exhibit 16: Tufts-Atrius PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 4.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 3.7 | 33.0 | 33.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 26.7 | 102 | 102 | 100% |

Plan & Project Strengths

- Tufts-Atrius is commended for incorporating evidence-based guidelines into its electronic medical record platform.

Recommendations & Opportunities for Improvement

- Tufts-Atrius does not describe any protocol for measuring the adoption of the clinical guidelines among PCPs. KEPRO recommends that Tufts-Atrius measure (perhaps by survey) the extent to which its guidelines are being adopted by providers.

TUFTS HEALTH TOGETHER WITH BOSTON CHILDREN'S ACO – INCREASING SCREENING FOR CLINICAL DEPRESSION WITH DOCUMENTATION OF FOLLOW-UP PLANS AFTER A POSITIVE SCREEN

Rationale for Project Selection

“Major depression is one of the most common mental disorders in the United States. According to the National Institute of Mental Health, an estimated 16.1 million adults aged 18 or older in the United States had at least one major depressive episode in the past year in 2015. As a result, depression is among the leading causes of disability in persons 15 years or older, accounting for \$30–50 billion in lost productivity and direct medical costs annually in the U.S. Lifetime prevalence rate of major depressive disorder (MDD) in adolescents have been estimated to range from 15% to 20% which is comparable with the lifetime rate of MDD in adult population, suggesting that depression in adults begins in adolescence. “

Project Goals

Member-Focused

- Increase rates of screening for depression using one of the following age-appropriate screens during well child exams approved by MassHealth, i.e., PSC17, MFQ, PHQ9, and PHQ2.
- Improve documentation of appropriate follow-up plans after a positive screen for depression.
- Reduce duration and severity of depressive episodes in affected teens by facilitating identification of patients in need of a referral to a behavioral health specialist.

Provider-Focused

- Improve rates of depression screening at Tufts-BCH community-based practices (Pediatric Physicians' Organization at Boston Children's Hospital (PPOC) practices).
- Improve rates of documenting plans for follow up after a positive screen at PPOC practices.

Interventions

In 2018, Tufts-BCH embarked on the streamlining of workflows for depression screening and documentation of a follow-up plan. The network determined that documentation of follow-up plans would become mandatory in the event of a positive depression screen. The electronic medical record (EMR) was modified to accommodate this change in practice. A dashboard was added on which providers could review their rate of behavioral screening and identify patients requiring screening.

After the change to the EMR, the rate of follow-up plan documentation skyrocketed to above 97% in some months. The Tufts-BCH quality team felt that the stakes were high enough for patients with a positive screen that it was worth mandating a response. There was no pushback from providers regarding the workflow requirement of documenting a follow-up plan after a positive screen.

Tufts-BCH's required documentation of a follow-up plan also supported the version of the MassHealth depression screening and follow-up quality measure ("Depression Screening and Follow-Up for Adolescents and Adults"). However, during 2018, there was ongoing discussion and confusion between Tufts-BCH and its clinics about the specifications of the measure, including whether the follow-up component required documentation of a follow-up plan or a follow-up behavioral health encounter. Due to the confusion, the Pediatric Physicians' Organization at Children's (PPOC) removed the technical requirement to document a follow-up plan in October 2018.

MassHealth finalized the quality measure specifications in winter 2019 ("Screening for Depression and Follow-Up Plan"), clarifying that the follow-up component required documentation of a follow-up plan, rather than a behavioral health encounter. In response, in the spring of 2019, PPOC reinstated the EMR tool to require documentation of follow-up.

Tufts-BCH's quality improvement initiatives involve data-driven assessment of barriers to change. This project is a component of the PPOC's Behavioral Health Integration Program (BHIP). BHIP meets regularly with PPOC practices offers learning communities for interested clinicians. The BHIP team supports offices as they work to integrate behavioral health services within primary care offices and is acutely aware of the difficulties pediatric primary care practices and mental health clinicians have in detecting and treating adolescents with depression, given current societal stigma, medical-legal regulations, and other developmental difficulties working with this population.

These learning communities are opportunities for the BHIP team to engage with practices, share best practices, and hear concerns or suggestions from actual providers. Tufts-BCH reports that its educational opportunities are well attended by the PPOC practices not only because they offer valuable teaching, but because they give practices the opportunity to share with each other their barriers and successes when confronting teens and young adults with mental health concerns. The constant contact of the BHIP team with PPOC practices has generated a deep understanding of the barriers to screening for depression that are ongoing across the PPOC practice network, and their input has informed the barrier analysis presented here.

Performance Indicators

1. The rate of Tufts-BCH-attributed members 12-64 years of age on the date of the encounter with a well visit during the measurement year and no prior diagnosis of depression who are screened for clinical depression using a standardized tool during the measurement year.
 - Tufts-BCH's 2018 baseline rate is 80.6%.

- Its goal for the 2019 measurement period is 85%.
2. The rate of Tufts-BCH-attributed members 12-64 years of age on the date of the encounter with a well visit during the measurement year and no prior diagnosis of depression who screened positive at least once for clinical depression using a standardized tool during the measurement year.
 - Tufts-BCH's 2018 baseline rate is 16.3%.
 3. The rate of Tufts-BCH-attributed members 12-64 years of age on the date of the encounter with a well visit during the measurement year and no prior diagnosis of depression who screened positive at least once for clinical depression using a standardized tool during the measurement year and have a follow-up plan documented on the date of the positive screen.
 - Tufts-BCH's 2018 baseline rate is 36.6%.
 - Its goal for the 2019 measurement period is 75%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with Boston Children's ACO received a rating score of 100% on this Performance Improvement Project.

Exhibit 17: Tufts-BCH PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 4.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 4.0 | 12.0 | 12.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 26 | 78 | 78 | 100% |

Plan & Project Strengths

- Tufts-BCH is commended for its effort to evaluate depression screening rate performance at the practice level, as well as focusing on regional differences in screening rates.
- Tufts-BCH did an excellent job of describing the interventions and modifications made in response to providers' concerns about challenges related to data entry.
- Tufts-BCH is commended for its use of learning collaboratives to promote the use of its EMR screening tools and responding to positive screens.

Recommendations & Opportunities for Improvement

- KEPRO recommends that Tufts-BCH ensure its pediatricians are familiar with the Children's Behavioral Health Initiative screening requirements.

WELLFORCE CARE PLAN – IMPROVING THE RATE OF DEPRESSION SCREENINGS AND FOLLOW-UP PLANS FOR THE WELLFORCE CARE PLAN POPULATION

Project Rationale

“ ... Adolescents with depression may exhibit problems in school performance, daily living, and functioning such as impaired social and interpersonal relationships. Research demonstrates that rates of major depression increase significantly during adolescent years into adulthood and early onset of major depressive disorder (MDD) in adolescents is associated with higher risks of suicide attempt, death by suicide and MDD recurrence in you adulthood. Lastly, the National Vital Statistics Reports on "Deaths: Leading Causes for 2016," reported the leading cause of death for the population aged 1-44 was unintentional injuries, with suicide being the second leading cause of death for age group 10-24. In adults, other than the usual symptoms of depression that you would expect to observe, it can also affect the entire body, particularly when not treated ... Identifying and treating depression early may proactively prevent a myriad of emotional and medical issues, thus improving the individual's quality of life while, at the same time, having the ability of decreasing the burden on the health care system.”

Project Goals

Member-Focused

- Increase the number of members screened for depression during the PCP annual [examination] and/or pertinent office visits 5% over the 2018 calendar year baseline of 9%.
- Increase the number of members receiving a follow-up plan after a positive depression screening by 5% over the 2018 calendar year baseline of 37.5%.

Provider-Focused

- Offer education to providers and clinical office staff, with at least 80% participation, to increase depression screening assessment.
- Improve clinical staff and provider workflows to adhere to depression evidence-based guidelines (EBGs). For each practice/department, a minimum of 15 records will be audited and demonstrate 70% level of compliance with EBGs.
- Providers will increase depression screenings conducted during encounters with MassHealth ACPP members as evidenced by an increase of 5% over the 2018 calendar year baseline that will be calculated following the first year of data collection.
- Providers will increase rates of follow up for Fallon-Wellforce members who screen positive on the PHQ-9 by an increase of 5% over the 2018 calendar year baseline that will be calculated following the first year of data collection.

Performance Indicators

1. The rate of Fallon-Wellforce members aged 12-64 on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year.
 - Fallon-Wellforce's 2018 baseline performance is 9.0%.
 - Its goal for the 2019 remeasurement period is 9.5%.
2. The rate of Fallon-Wellforce members aged 12-64 on the date of the encounter with an outpatient visit during the measurement year and screened for clinical depression using a standardized tool during the measurement year and, if screened positive, a follow-up plan is documented on the date of the positive screen.
 - Fallon-Wellforce's 2018 baseline performance is 37.5%.
 - Its goal for the 2019 remeasurement period is 39.4%.

Interventions

- Fallon-Wellforce implemented the Patient-Centered Medical Home depression workflow at those practices that use the eClinicalWorks electronic medical record. The system triggers a task that tracks patients needing follow up. It also requires providers to document a follow-up plan for all patients with a positive depression screen.
- Using a train-the-trainer approach, the Quality Improvement Specialist trained charge nurses from each primary care department at Lowell Community Health Center on the depression screening and follow-up measure requirements. Based on staff feedback about the need to identify patients who require screening, a modification was made in the electronic medical record to alert staff that a depression screening is due.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon-Wellforce received a rating score of 100% on this Performance Improvement Project.

Exhibit 18: Fallon-Wellforce PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 15 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 4 | 12 | 12 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 26 | 78 | 78 | 100% |

Plan & Project Strengths

- KEPRO commends Fallon-Wellforce for its small tests of change including the workflow change to ensure that all appropriate patients are screened. It is also commended for the biweekly sampling of patient charts to assess practice adherence.

Recommendations & Opportunities for Improvement

- None identified.

SUBSTANCE USE DISORDERS

MY CARE FAMILY - INCREASE THE INITIATION AND ENGAGEMENT IN TREATMENT (IET) RATES FOR MY CARE FAMILY WITH A NEW EPISODE OF ALCOHOL OR OTHER DRUG (AOD) ABUSE OR DEPENDENCE

Rationale for Project Selection

“The prevalence and utilization data presented above indicate that alcohol and drug abuse are high volume and high-risk conditions among [the] My Care Family population. In addition, when reviewing the IET rates, My Care Family is experiencing a downward trend, and performing below the 2018 Medicaid Quality Compass 75th percentiles. Based on these findings, My Care Family is going to focus this PIP on increasing initiation and engagement rates of adolescents and adult members with a new episode of AOD. Through this PIP, My Care Family is also addressing the substance abuse and opioid epidemic that poses significant economic and public health challenges for communities across the Commonwealth of Massachusetts and the nation.”

Project Goals

Member-Focused

- To increase by 5% over baseline (CY18) the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis.
- To increase by 5% over baseline (CY18) the percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.

Provider-Focused

- Improve medical and BH providers’ knowledge of IET measure requirements and referral resources for the ACPP population, as evidenced by provider responses to My Care Family’s post-training provider survey.
- Increase primary care providers’ use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues, as evidenced by the percent of PCPs using SBIRT during the measurement period.

Interventions

In partnership with its behavioral health vendor, Optum, My Care Family is offering education to medical and behavioral health providers on the IET measure and referral options for members with substance use disorders. This training uses multiple approaches to reach providers including in-person training, email, and video.

My Care Family developed a process workflow for use by PCP providers for the evaluation of patient needs in order to direct them to the most appropriate care management or substance use support program. Using a predictive modeling algorithm, My Care Family generates a monthly list of high-risk members with a new episode of substance abuse and attempts with the goal of engaging them in care management and treatment.

This intervention is being piloted at the Greater Lawrence Family Health Center and will include training PCP providers on the SBIRT protocol. In addition, My Care Family is developing a report that documents total and positive pre-screenings, total full screenings, number of members referred to My Care Family care management or substance use support treatment, and number of members who accessed outpatient suboxone treatment.

The SBIRT screening tool was integrated as part of routine primary care first as a pilot and then at multiple sites. Primary care providers received information about available referral resources.

Performance Indicators

- 1) The rate of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization or medication treatment within 14 days of diagnosis.
 - My Care Family's 2018 baseline performance rate is 34.53%.
 - Its goal for the 2019 remeasurement period is 36.27%.
- 2) The number of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.
 - My Care Family's 2018 baseline performance rate is 11.89%.
 - Its goal for the 2019 remeasurement period is 12.48%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACP's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. My Care received a rating score of 100% on this Performance Improvement Project.

Exhibit 19: AllWays My Care PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 4.3 | 13.0 | 13.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rate | 5 | 15 | 15 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 28.3 | 85 | 85 | 100% |

Plan & Project Strengths

- My Care Family effectively used its population analysis to identify members who may be more difficult to engage. As a result it was able to inform its activities to best meet the needs of the members. This resulted in an increase of Spanish-speaking capabilities, primary care training, and the addition of the emergency department navigator role.
- KEPRO commends My Care Family for tracking alcohol or other drug abuse or dependence diagnoses and PCP referrals based on performance measure specifications via predictive modeling to address those members with the highest need.
- KEPRO commends My Care Family for piloting interventions at one site then learning, improving, and transferring them to other sites.

Recommendations & Opportunities for Improvement

- None identified.

BEHAVIORAL HEALTH FOLLOW UP POST-DISCHARGE

BE HEALTHY PARTNERSHIP – USE OF A HOSPITAL-BASED TRANSITION OF CARE TEAM (TOC) TO ENSURE FOLLOW UP WITHIN SEVEN DAYS AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Rationale for Project Selection

“Approximately seventy percent of patients seen at Community Health Centers (CHCs) have one or more behavioral health diagnoses. People with mental health conditions have a lower life expectancy and poorer physical health outcomes than the general population. This is due to a combination of socioeconomic and health system factors, especially lack of integrated care across service settings (*International Journal of Integrated Care*, 2018; 18(1): 1-12). Lack of timely and adequate patient follow-up increases the likelihood that patients will disengage care resulting in readmissions, self-harm, and medication and medical care non-compliance (*Early Interv Psychiatry* 12/2016; 10(6): 468-475).”

Project Goals

Member-Focused

- Decrease hospital readmissions for mental health within seven or thirty days.
- Increase the number of completed follow-up visits within seven days following discharge.

Provider-Focused

- Increase the number of contacts made to identified patients for the TOC program.
- Increase the number of appointments made for members post-discharge within seven days of discharge.
- Improve information provided to behavioral health and primary care providers by means of the patient discharge summary.

Interventions

The Be Healthy Partnership implemented a Transition of Care Program in which a social worker meets high-risk and high-utilizing patients in the inpatient unit. They follow up with the patient within 48 hours of discharge, preferably at the patient’s home, to ensure the coordination of care. If the social worker is unable to reach the patient by phone, they attempt a home visit. Ultimately, a warm hand-off is made to the patient’s primary care team.

Performance Indicators

- 1) The rate of patients 6 to 64 years of age as of the date of discharge who had a follow-up visit with a mental health practitioner within 7 days after discharge.
 - The Be Healthy Partnership's 2018 baseline performance rate is 53.9%.
 - Its goal for the 2019 remeasurement period is 57.70%.
- 2) The rate of patients 18 to 64 years of age with an acute inpatient stay during the measurement year that were followed by an acute unplanned readmission for any diagnosis within 30 days.
 - The Be Healthy Partnership's 2018 baseline performance rate is 2.4%.
 - Its goal for the 2019 remeasurement period is 9.5%.
- 3) The rate of members 18 to 64 years of age who were hospitalized for the treatment of selected mental illness diagnoses contacted by a member of the TOC team within 48 hours of discharge.
 - The Be Healthy Partnership's 2018 baseline performance rate is 10.3%.
 - Its goal for the 2019 remeasurement period is 34.5%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. The Be Healthy Partnership received a rating score of 96% on this Performance Improvement Project.

Exhibit 20: HNE-BeHealthy PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Intervention | 5 | 15 | 12 | 80% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 2 | 6 | 6 | 100% |
| Performance Indicator Parameters | 6.0 | 19.0 | 19.0 | 100% |
| Baseline Indicator Performance Rates | 4.3 | 13.0 | 13.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 5 | 83% |
| Overall Validation Rating Score | 27.3 | 83 | 80 | 96% |

Plan & Project Strengths

- KEPRO commends the Be Healthy Partnership for its innovative approach to engaging patients.

Recommendations & Opportunities for Improvement

- Because the rate of successful contacts made to identify members is 10.3%, KEPRO recommends additional strategies be developed to increase the rate of follow up. KEPRO suggests considering the use of other means for communicating with patients, e.g., texting, and then testing to see if the response rates increase.
- KEPRO recommends that the Be Healthy Partnership further detail its plan for addressing some of the challenges of this PIP, e.g., staffing limitations and a homeless member population.

BMC HEALTHNET PLAN COMMUNITY ALLIANCE – INCREASE THE RATE OF FOLLOW-UP VISITS WITHIN SEVEN DAYS OF DISCHARGE FOR MEMBERS HOSPITALIZED FOR A MENTAL ILLNESS

Rationale for Project Selection

“Approximately one in five adults in the United States will experience a mental illness (i.e. depression, anxiety, bipolar disorder, schizophrenia) in a given year. Approximately one in five children, either currently or at some point during their life, has had a seriously debilitating mental illness. Over half of U.S. adults will be diagnosed with at least one mental illness in their lifetime (<https://www.cdc.gov/mentalhealth/learn/index.htm>). In 2017, Boston Medical Center HealthNet Plan (BMCHP) identified 1,950 hospitalizations of MassHealth members 6 years of age and older for mental illness. Providing follow-up behavioral health care is essential to ensure a member's successful transition back to the community and reduce the likelihood of readmission. Community Alliance’s rate for the Follow-Up After Hospitalization for Mental Illness (FUH) (45%) is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 75th percentile (45.79%). Follow-up care within 7 days after hospitalization provides continuity of care, an opportunity to monitor the mental health status of the member, review his/her medications, reinforce treatment plans and maintain and extend improvement (<https://www.premiera.com/documents/031689.pdf>). “

Project Goals

Member-Focused

- Educate members to help communicate to them the importance of engaging in ongoing outpatient services, to provide information to them regarding mental health services available, and to support follow-up compliance.
- Ensure members get timely outpatient follow up after inpatient hospitalization discharge and engage in ongoing outpatient services to meet members’ needs.

Provider-Focused

- Bridge the gap between inpatient and outpatient facilities.
- Enable proactive outreach to patients to help navigation and encourage engagement.

Interventions

- BMCHP-BACO sites receive daily lists of patients who have been discharged from an inpatient psychiatric facility. Initially, the sites conduct outreach to these patients to provide education on the importance of follow-up treatment.
- Because of low rates of patient contact, the outreach process was centralized so that one person was responsible for patients discharged from high-volume facilities.

- BMCHP-BACO collected four weeks of data and identified 96 patients on Beacon's reports for outreach by clinical staff to support scheduling follow-up appointments. Out of these 96 patients, outreach workers were able to connect with 19 patients at participating inpatient psych facilities, and then helped schedule 3 appointments. Other ACPP sites reported similarly low outreach rates for outreach and referral.
- In an effort to improve these rates of outreach and referral, outreach is now being conducted at patient-attributed BMCHP-BACO sites.
- A part-time Beacon Health Options care manager has been embedded at high-volume facilities to improve patient engagement.

Performance Indicators

The rate of members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who have a follow-up visit with a mental health practitioner within 7 days of discharge, not including visits that occur on the date of discharge.

- BMCHP-BACO's baseline 2018 performance rate is 43.19%.
- Its goal for the 2019 remeasurement period is 45.79%, the 2018 NCQA Quality Compass Medicaid HMO 75th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Community Alliance received a rating score of 95% on this Performance Improvement Project.

Exhibit 20: BMCHP-BACO PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 7 | 78% |
| Update to PIP Topic and Goals | 3 | 9 | 7 | 78% |
| Progress in Implementing Interventions | 5 | 15 | 15 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 5 | 15 | 15 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 27 | 81 | 77 | 95% |

Plan & Project Strengths

- BMCHP-BACO is commended for its innovative approach of piloting transportation assistance to patients in need as this was previously mentioned as a contributing factor for patients not engaging in behavioral health follow up post-hospitalization.
- BMCHP- BACO has been working diligently to improve its rate of outreach contact and referral for post-discharge follow-up treatment. Given that this outreach and referral intervention began just two months prior to submitting its report on baseline performance results, BMCHP- BACO has made clear its intention to improve the rates of member contact and referral by working closely with its participating inpatient and outpatient providers.
- Specifically, BMCHP- BACO is continuing to track a count of the following metrics: BMCHP patients hospitalized for mental illness, patients who received follow-up appointment within 7 days, patients who showed/no showed to the appointment.
- In addition, BMCHP-BACO is regularly seeking feedback from participating sites to inform its continuous quality improvement efforts.

Recommendations & Opportunities for Improvement

- KEPRO suggests modifying the plan for “continued focus on strengthening relationships with behavioral health partners to improve access to timely, accurate information” to also include promoting more timely access to care.

BMC HEALTHNET PLAN MERCY ALLIANCE – INCREASE THE RATE OF FOLLOW-UP VISITS WITHIN SEVEN DAYS OF DISCHARGE FOR MEMBERS HOSPITALIZED FOR A MENTAL ILLNESS

Rationale for Project Selection

“Approximately one in five adults in the United States will experience a mental illness (i.e. depression, anxiety, bipolar disorder, schizophrenia) in a given year. Approximately one in five children, either currently or at some point during their life, has had a seriously debilitating mental illness. Over half of U.S. adults will be diagnosed with at least one mental illness in their lifetime (<https://www.cdc.gov/mentalhealth/learn/index.htm>). In 2017, Boston Medical Center HealthNet Plan identified 1,950 hospitalizations of MassHealth members 6 years of age and older for mental illness. Providing follow-up behavioral health care is essential to ensure a member's successful transition back to the community and reduce the likelihood of readmission. BMCHP-Mercy's Follow-Up After Hospitalization for Mental Illness (FUH) rate, 49%, is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 90th percentile (54.13%).”

Project Goals

Member-Focused

- To decrease or eliminate the stigma of mental illness and support follow-up compliance, educate members about available behavioral health services available.
- Facilitate a connection to mental health peer supports.

Provider-Focused

- Educate providers about practices for follow-up care with high-volume inpatient facilities.
- Create and transmit a daily report of psychiatric admissions of BMCHP-Mercy patients to the BMCHP-Mercy team and high-volume inpatient providers, allowing proactive facilitation of care management and follow up with seven days of discharge.
- Establish improved access to outpatient behavioral health care through collaboration with community partner site(s) or build an open access-focused capacity in an outpatient clinic.

Interventions

- BMCHP-Mercy provided education to the leadership, admissions department staff, providers, and social workers at a high-volume inpatient facility about the initiative and its importance.

- To forge a stronger working relationship and encourage ongoing communication, BMCHP-Mercy facilitated a meeting between the facility, a high-volume outpatient provider, and Community Support Program (CSP) workers.
- The inpatient facility developed operational workflows to identify patients at admission and begin the process of aftercare planning on the first day of treatment. Each morning, projected discharge dates are reviewed for after care planning and scheduling purposes.
- CSP workers meet with patients in advance of discharge. BMCHP-Mercy is exploring other ways to begin outreach to the patient's community-based therapist shortly after admission, rather than waiting until discharge.
- BMCHP-Mercy plans to develop a process for educating patients about aftercare resources and how their assigned CSP worker is available to support their access to post-discharge services.

Performance Indicator

The number of discharges identified in the denominator with a follow-up visit with a mental health practitioner within 7 days after discharge, not including visits that occur on the date of discharge.

- BMCHP-Mercy's 2018 baseline rate is 54.27%.
- Its goal for the 2019 remeasurement period is 57.7%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Mercy Alliance received a rating score of 96% on this Performance Improvement Project.

Exhibit 22: BMCHP-Mercy PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 7 | 78% |
| Progress in Implementing Interventions | 5 | 15 | 15 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 5 | 83% |
| Overall Validation Rating Score | 29 | 84 | 81 | 96% |

Plan & Project Strengths

- BMCHP-Mercy is commended for including peer support as a resource in this initiative.
- BMCHP-Mercy is commended for the development of a quality improvement process through which it plans to make incremental changes to one or more key intervention activities over periodic intervals. It has defined a robust plan for evaluating the intervention activities.
- BMCHP-Mercy reports challenges with identifying a concrete date for discharge for many patients. A number of variables come into play:
 - Provider recommendations,
 - Delays in insurance authorizations,
 - Patient cooperation or lack thereof
 - Patients who are homeless, and
 - Challenges scheduling with private community providers that do not have centralized scheduling resources and mental health clinics that have an existing relationship with the patient.

In response to these barriers, BMCHP-Mercy is adopting a Lean management approach, which is an established set of quality improvement strategies that help create a maximum value for patients by optimizing the effectiveness of member outreach and post-discharge service access.

Recommendations & Opportunities for Improvement

- KEPRO recommends that BMCHP-Mercy further detail member and provider goals ensuring they are measurable and achievable.

BMC HEALTHNET PLAN SIGNATURE ALLIANCE – INCREASE THE RATE OF FOLLOW-UP VISITS WITHIN SEVEN DAYS OF DISCHARGE FOR MEMBERS HOSPITALIZED FOR A MENTAL ILLNESS

Rationale for Project Selection

“Approximately one in five adults in the United States will experience a mental illness (i.e. depression, anxiety, bipolar disorder, schizophrenia) in a given year. Approximately one in five children, either currently or at some point during their life, has had a seriously debilitating mental illness. Over half of U.S. adults will be diagnosed with at least one mental illness in their lifetime (<https://www.cdc.gov/mentalhealth/learn/index.htm>). In 2017, Boston Medical Center HealthNet Plan (BMCHP) identified 1,950 hospitalizations of MassHealth members 6 years of age and older for mental illness. Providing follow-up behavioral health care is essential to ensure a member's successful transition back to the community and reduce the likelihood of readmission. Signature Alliance’s rate for the Follow-Up after Hospitalization for Mental Illness (FUH) (51%) is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 90th percentile (54.13%). Follow-up care within 7 days after hospitalization provides continuity of care, an opportunity to monitor the mental health status of the member, review his/her medications, reinforce treatment plans and maintain and extend improvement (<https://www.premiera.com/documents/031689.pdf>).”

Project Goals

Member-Focused

- Ensure members get timely outpatient follow up after inpatient hospitalization discharge and engage in ongoing outpatient services to meet members’ needs.

Provider-Focused

- Bridge gap in communication between inpatient facilities and outpatient clinics on shared patients to enable scheduling of post-discharge appointments within 7 days for shared members.
- Enable proactive outreach to patients to help navigation and encourage engagement.

Interventions

On a daily basis, each care team receives a list of members who have been discharged from mental illness-related inpatient hospitalization. Social workers conduct outreach to each patient on the day of discharge. If the patient does not have a follow-up appointment, the social worker assists with scheduling. A note is placed in the electronic record indicating the need for a follow-up appointment. This note is routed to the patient’s primary care provider’s office. Because BMC HealthNet Plan Signature Alliance has no outpatient behavioral health

providers in its system, it is exploring developing relationships with other local systems and accountable care organizations.

Performance Indicators

The rate of members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who have a follow-up visit with a mental health practitioner within 7 days of discharge, not including visits that occur on the date of discharge.

- BMCHP-Signature's 2018 baseline performance rate is 52.02%.
- Its goal for the 2019 remeasurement period is 54.13%, the 2018 NCQA Quality Compass Medicaid HMO 90th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Signature Alliance received a rating score of 89% on this Performance Improvement Project.

Exhibit 23: BMCHP-Signature PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 7 | 78% |
| Update to PIP Topic and Goals | 3 | 9 | 7 | 78% |
| Progress in Implementing Interventions | 5 | 15 | 12 | 80% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 4 | 66% |
| Overall Validation Rating Score | 28 | 84 | 75 | 89% |

Plan & Project Strengths

- KEPRO commends BMCHP-Signature for the outreach to each patient before discharge to ensure that a 7-day follow-up appointment is scheduled. This facilitates mitigation of barriers, such as advanced arrangements for transportation, as needed, and ensuring correct post-discharge contact information.

Recommendations & Opportunities for Improvement

- KEPRO suggests the use of technology, e.g., texting, in care coordination, as the intervention is reliant on phone calls.
- KEPRO recommends the development of other strategies to ensure follow-up appointments are scheduled before patients are discharged.
- KEPRO recommends that project goals, both member- and provider-focused, be further detailed to ensure they are measurable and achievable.
- KEPRO recommends further analysis be conducted about the clinical characteristics of the member population to permit the design of focused interventions.
- KEPRO recommends that additional detail be provided about projects strengths, challenges, and next steps.

BMC HEALTHNET PLAN SOUTHCOAST ALLIANCE – INCREASE THE RATE OF FOLLOW-UP VISITS WITHIN SEVEN DAYS OF DISCHARGE FOR MEMBERS HOSPITALIZED FOR A MENTAL ILLNESS

Rationale for Project Selection

Approximately one in five adults in the United States will experience a mental illness (i.e. depression, anxiety, bipolar disorder, schizophrenia) in a given year. Approximately one in five children, either currently or at some point during their life, has had a seriously debilitating mental illness. Over half of U.S. adults will be diagnosed with at least one mental illness in their lifetime (<https://www.cdc.gov/mentalhealth/learn/index.htm>). In 2017, Boston Medical Center HealthNet Plan (BMCHP) identified 1,950 hospitalizations of MassHealth members 6 years of age and older for mental illness. Providing follow-up behavioral health care is essential to ensure a member's successful transition back to the community and reduce the likelihood of readmission. Southcoast Alliance's rate for the Follow-Up After Hospitalization for Mental Illness (FUH) (48%) is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 90th percentile (54.13%). Follow-up care within 7 days after hospitalization provides continuity of care, an opportunity to monitor the mental health status of the member, review his/her medications, reinforce treatment plans and maintain and extend improvement (<https://www.premiera.com/documents/031689.pdf>).

Project Goals

Member-Focused

- Communicate importance of engaging in ongoing outpatient services, provide information regarding mental health services available, and support follow up compliance.
- Ensure members get timely outpatient follow up after inpatient hospitalization discharge and engage in outpatient services to meet members' needs.
- Support patients in navigating an often confusing landscape of appointments post-hospital discharge.

Provider-Focused

- Bridge the gap in patient care between the behavioral health facility and outpatient providers.

Interventions

- Behavioral health (BH) providers have been embedded in five BMCHP-Southcoast practice sites. By embedding BH providers into its primary care sites, BMCHP-Southcoast plans to bridge visits to its Medicaid ACP patients if the inpatient BH facility is not able to secure an outpatient provider appointment with their current BH provider within seven days of their

discharge from the facility. These BH embedded providers will then do a warm handoff either to the patient's new or current provider. BMCHP-Southcoast believes that this protocol will ensure continuous, high touch patient care for its highly vulnerable patient population.

- BMCHP-Southcoast is pursuing a clinical affiliation with a large outpatient behavioral health provider to improve member access to behavioral health providers.

Performance Indicators

The rate of members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who have a follow-up visit with a mental health practitioner within 7 days of discharge, not including visits that occur on the date of discharge.

- BMCHP-Southcoast's baseline performance rate is 55.17%.
- Its goal for the first remeasurement is 57.7%, the 2017 NCQA Quality Compass Medicaid New England Region HMO 90th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP-Southcoast received a rating score of 94% on this Performance Improvement Project.

Exhibit 24: BMCHP-Southcoast PIP Rating

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 8 | 89% |
| Update to PIP Topic and Goals | 3 | 9 | 7 | 78% |
| Progress in Implementing Interventions | 5 | 15 | 13 | 87% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 29 | 87 | 82 | 94% |

Project & Plan Strengths

- KEPRO commends BMCHP-Southcoast for the outreach to each patient before discharge to ensure that a seven-day follow-up appointment has been scheduled. This facilitates mitigation of barriers such as lack of transportation and incorrect contact information.

Recommendations & Opportunities for Improvement

- KEPRO recommends testing other channels of member communication to determine if they have received an appointment for a follow-up visit or if they did not attend a scheduled appointment. Channels may include text messages, letters, or phone calls as appropriate.
- In addition to BMCHP-Southcoast's data collection systems, the provider could represent another source of data about patient appointment attendance.
- KEPRO recommends further describing the clinical characteristics of the BMCHP-Southcoast population as it could inform intervention design.
- BMCHP-Southcoast has not described how small tests of change are being used for activities.
- BMCHP-Southcoast highlights challenges to implementation. Minimal description is offered about how these challenges are being addressed through small tests of change.
- KEPRO recommends that project goals, both member- and provider-focused, be further detailed to ensure they are measurable and achievable.

DOMAIN 2: POPULATION & COMMUNITY NEEDS ASSESSMENT AND RISK STRATIFICATION

ASTHMA

BMC HEALTHNET PLAN COMMUNITY ALLIANCE – IMPROVING ASTHMA CONTROL AND MEDICATION ADHERENCE

Rationale for Project Selection

“BMC HealthNet Plan Community Alliance’s Asthma Medication Ratio is below the NCQA Quality Compass Medicaid HMO 25th percentile ... Without proper management, asthma can result in frequent emergency department visits, hospitalization, and premature deaths.”

Project Goals

Member-Focused

- Member awareness of asthma-related triggers, awareness of the differences between asthma controller and rescue medications, as well as appropriate use of the medications.
- Medication adherence support.

Provider-Focused

- Asthma-focused care coordination and ambulatory engagement.
- Provider education (escalation, appropriate prescribing patterns, asthma assessment, BMCHP formulary guide).

Interventions

BMCHP-BACO reported one intervention that is a pharmacy-led asthma adherence program that has the goal of improving asthma control by ensuring that patients with persistent asthma have access to controller inhalers, and are appropriately using them. By ensuring consistent access to asthma controller medications and providing routine outreach, BMCHP-BACO expects its pharmacy teams to lead patients to an improved asthma medication ratio (AMR).

BMCHP- BACO reported that in early 2019, their outreach staff contacted 151 patients below Asthma Medication Ratio (AMR) goal threshold, defined as a ratio of controller medications to total asthma medications of 0.50 or greater. Out of those eligible for tis PIP, 83 patients had

previously been enrolled in the program, and 47 had been classified as “not enrolled” due to issues such as diagnosis documentation errors, metric eligibility and discontinuation of insurance. To improve enrollment rates and outreach to eligible patients, BMCHP-BACO pulled monthly refreshes for ACO eligibility into its AMR outreach report to make it easier for pharmacists to identify eligible patients. BMCHP-BACO staff made 692 outreach calls to patients, and by July 2019, its enrollment rates had increased to 330. BMCHP-BACO staff worked with these patients to get new controller prescriptions, refill prescriptions, and even connect them to advanced ambulatory care as needed.

BMCHP-BACO reported that its protocol for identifying PIP-eligible members and reaching out to those not previously enrolled in their Asthma Adherence Pilot has shown success, in that it increased the number of eligible member-enrollees from 83 enrolled in February 2019 to 330 patients enrolled in June 2019 (an increase of nearly 400%). Beyond improving rates of AMR member enrollment, BMCHP-BACO will use its performance indicators to determine whether its AMR program is effective in improving asthma medication controller medication ratios.

Performance Indicators

- 1) The rate of members with asthma that have a medication ratio of 0.50 or greater.
 - The 2018 baseline rate is 56.29%.
 - BMCHP-BACO’s goal for the 2019 remeasurement period is 67.52%, the 2017 Quality Compass Medicaid HMO 90th percentile.
- 2) The rate of members with asthma that have achieved a Proportion of Days Covered of at least 75% for the asthma controller medications.
 - The 2018 baseline rate is 33.88%.
 - BMCHP-BACO’s goal for the 2019 remeasurement period is 35.6%, the 2018 NCQA Quality Compass Medicaid HMO 50th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP- BACO received a rating score of 95% on this Performance Improvement Project.

Exhibit 25: BMCHP-BACO's PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 8 | 89% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 14 | 93% |
| Performance Indicator Data Collection | 2 | 10 | 10 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 30 | 90 | 86 | 95% |

Project & Plan Strengths

- BMCHP-BACO is commended for the development of a quality improvement process that includes different aspects of the process including pharmacy liaisons and data.
- Another strength of this program is that it works via pharmacy liaisons and clinical pharmacists, thus intending to relieve the PCPs and practice staff with some of the patient follow-up and medication adherence work they are doing
- BMCHP-BACO is also promoting clear and open communication between pharmacy team and its practice sites to ensure transparency, which includes ongoing data sharing and reporting.

Opportunities for Improvement & Recommendations

- BMC HealthNet Plan Community Alliance should improve its project goals by operationally defining each goal to make them more measurable and achievable.
- KEPRO recommends assessing the effectiveness of its provider education by examining changes in prescribing practice behavior post-intervention. If results show PCP engagement continues to be an issue, KEPRO recommends designing additional interventions that will promote provider engagement in its provider protocols for asthma medication management.

- KEPRO recommends reviewing each intervention activity to determine whether the activity improved member and/or provider behavior as expected.

BMC HEALTHNET PLAN MERCY ALLIANCE – IMPROVING ASTHMA CONTROL AND MEDICATION ADHERENCE

Rationale for Project Selection

“According to data from national and state surveillance systems administered by the Center for Disease Control and Prevention, the prevalence of asthma among the US population has increased from 7.8% in 2015 to 8.3% in 2016. In Massachusetts, the prevalence is higher at 10% of the population (https://www.cdc.gov/asthma/most_recent_data.htm). In December 2017, BMCHP identified 19,934 MassHealth members (12.06%) with asthma, which is slightly higher than the prevalence in Massachusetts. BMC HealthNet Plan Mercy Alliance’s rate for the Asthma Medication Ratio (AMR) (61%) is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 50th percentile (62.28%). Without proper management, asthma can result in frequent emergency department (ED) visits, hospitalization and premature deaths.”

Project Goals

Member-Focused

- Provide member education to increase awareness of asthma-related triggers and the difference between asthma controller and rescue medications as well as the appropriate use of the medications.
- Ensure that patients receive appropriate medication to minimize the effect of asthma on patient life.

Provider-Focused

- Implement asthma-focused care coordination and treatment protocols.

Performance Indicators

1. The rate of members with persistent asthma who have a medication ratio of 0.50 or greater during the measurement year.
 - BMCHP-Mercy’s 2018 baseline rate was 54.27%.
 - Its goal for 2019 is 67.52%.
2. The rate of members with persistent asthma who achieved a Proportion of Days Covered (PDC) of at least 75% for asthma controller medications.
 - BMCHP-Mercy’s 2018 baseline rate was 36.30%.
 - Its goal for 2019 is 43.06%.

Interventions

- A pulmonologist addressed a meeting of Adult Medicine providers about asthma management from the perspective of the primary care provider.
- BMCHP-Mercy implemented a rescue inhaler zero-refill policy for pure asthmatics, i.e., individuals with COPD-asthma and chronic bronchitis-asthma comorbidities are excluded from the policy.
- A provider-facing alert was implemented in the electronic medical record that reminds providers, in the event of a second patient refill request within four months, of the importance of office follow up.
- BMCHP-Mercy tracks patients' asthma medication ratios monthly and provide reports to practices on successes and gaps.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP-Mercy received a rating score of 95% on this Performance Improvement Project.

Exhibit 26: BMCHP PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 6 | 67% |
| Progress in Implementing Intervention | 5 | 15 | 14 | 93% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6.0 | 18.0 | 18.0 | 100% |
| Baseline Indicator Performance Rates | 4.0 | 12.0 | 12.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 28 | 84 | 80 | 95% |

Plan & Projects Strengths

- KEPRO commends BMCHP-Mercy for acknowledging opportunities to coordinate with community-based asthma-related interventions and address contextual realities that affect asthma control such as housing.
- BMCHP Mercy Alliance is commended for using risk-coding as part of describing the clinical picture of members that are the focus of this project.

Recommendations & Opportunities for Improvement

- The development of an additional intervention with activities focused on patient self-management of their condition inclusive of education would make this initiative more robust and well-rounded.
- KEPRO recommends that BMCHP-Mercy further detail its member- and provider-focused goals ensuring that they are measurable and achievable.
- KEPRO recommends including the description of the iterative small tests of change in its March 2020 submission.
- KEPRO recommends that BMCHP-Mercy document the number and percentage of providers participating in this Performance Improvement Project as well as the number of patients affected.

BMC HEALTHNET PLAN SIGNATURE ALLIANCE – IMPROVING ASTHMA CONTROL AND MEDICATION ADHERENCE

Rationale for Project Selection

“BMCHP’s asthma prevalence rate is 12.06%, above the Massachusetts rate. BMC HealthNet Plan Signature Alliance’s rate for the Asthma Medication Ratio (AMR) (54%) is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 25th percentile (56.85%). Without proper management, asthma can result in frequent emergency department (ED) visits, hospitalization, and premature deaths.”

Project Goals

- BMC HealthNet Plan Signature Alliance did not write their goals as goal statements, but rather intervention summaries, e.g., “Pharmacy-led outreach to members to help members navigate prescription fills, refills, and medication-related questions.”

Interventions

BMC HealthNet Plan Signature Alliance implemented an asthma medication protocol. After identifying a patient who have an asthma controller medication ratio of less than 0.50 during the measurement year. The BMCHP-Signature pharmacy team entered a task for the primary care department alerting them to an upcoming opportunity for patient with asthma. The pharmacy team conducted outreach to the member, provided counseling, and removed any existing barriers to care such as transportation to the pharmacy. The team confirmed that the member kept their appointment and followed up as necessary. The patient was contacted two weeks before the expiration of a prescription. A key challenge in implementing this intervention has been provider engagement, but BMCHP-Signature reports having made strides in this area over time.

Performance Indicators

- 1) The rate of members with asthma that have a medication ratio of 0.50 or greater.
 - BMCHP-Signature reported a 2018 baseline rate of 52.44%.
 - Its goal for 2019 is 67.52%, the 2017 NCQA Quality Compass Medicaid HMO 90th percentile.
- 2) The rate of members with asthma that have achieved a Proportion of Days Covered (PDC) of at least 75% for the asthma controller medications.
 - BMCHP-Signature reported a 2018 baseline rate of 31.10%.
 - Its goal for 2019 is 35.60%, the 2018 NCQA Quality Compass Medicaid HMO 50th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMC HealthNet Plan Signature Alliance received a rating score of 92% on this Performance Improvement Project.

Exhibit 27: BMCHP-Signature PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 7 | 78% |
| Update to PIP Topic and Goals | 3 | 9 | 6 | 67% |
| Progress in Implementing Interventions | 5 | 15 | 15 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 4 | 67% |
| Overall Validation Rating Score | 28 | 84 | 77 | 92% |

Plan & Project Strengths

- KEPRO commends BMCHP-Signature for using the pharmacy team to track and initiate outreach to patients with asthma to ensure appropriate medications are prescribed and picked up by the patient. Several steps for tracking have been defined and a process was developed for contacting patients using both digital and phone options

Recommendations and Opportunities for Improvement

KEPRO recommends:

- Clarification on provider goal 1, describing the entities involved in care coordination and ambulatory engagement, and

- the addition of two goals that address appropriate medication prescribing practice by providers well as the tracking of Asthma Medication Ratio (AMR) for each member by provider. These goals should be measurable and achievable.
- KEPRO recommends that BMCHP-Signature explore the clinical characteristics of the member population, which could inform the health plan of interventions.
- KEPRO recommends the development of a plan to engage providers, in this case, the pharmacy team and primary care physician (PCP) clinical support staff involved in the intervention.
- KEPRO recommends that BMCHP-Signature create member and provider goals and ensure that they are measurable and achievable.

BMC HEALTHNET PLAN SOUTHCOAST ALLIANCE – IMPROVING ASTHMA CONTROL AND MEDICATION ADHERENCE

Rationale for Project Selection

“In December 2017, BMCHP identified 19,934 MassHealth members (12.06%) with asthma, which is slightly higher than the prevalence in Massachusetts. BMC HealthNet Plan Southcoast Alliance’s rate for the Asthma Medication Ratio (AMR) (50%) is below the National Committee for Quality Assurance (NCQA) Quality Compass Medicaid HMO 25th percentile (56.85%). Without proper management, asthma can result in frequent emergency department (ED) visits, hospitalization and premature deaths.”

Project Goals

Member-Focused

- Awareness of asthma-related triggers, awareness of the difference between asthma controller and rescue medications, as well as the appropriate use of the medications.

Provider-Focused

- Proper diagnosis and treatment path.

Interventions

BMCHP-Southcoast is taking a multi-pronged approach to improve its asthma medication ratio rate. The default number of refills for relief medications was changed from eleven to zero. It undertook a provider education campaign and also completed a pilot test of the asthma control test (ACT) screening tool and electronic medical record alerts with two providers. Based on the success of the pilot, the ACT will be implemented in all primary care practices. Providers were presented with anecdotal stories about inhaler stockpiling, which was sufficient to convince them to set a no-refill policy. The results of this change will be shared at committee meetings, in newsletters, and in provider education materials.

Performance Indicators

1. The rate of members with asthma that have a medication ratio of 0.50 or greater.
 - BMCHP-Southcoast reported a baseline 2018 rate of 54.05%.
 - Its goal for 2019 is 67.52%, the 2017 NCQA Quality Compass Medicaid HMO 90th percentile.
- 2) The rate of members with asthma that have achieved a Proportion of Days Covered (PDC) of at least 75% for the asthma controller medications.

- BMCHP Southcoast reported a 2018 baseline rate of 40.83%.
- Its goal for 2019 is 43.06%, the 2018 NCQA Quality Compass Medicaid HMO 75th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. BMCHP-Southcoast received a rating score of 95% on this Performance Improvement Project.

Exhibit 28: BMCHP-Southcoast PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 7 | 78% |
| Update to PIP Topic and Goals | 3 | 9 | 7 | 78% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 6.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 4.0 | 12.0 | 12.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 29 | 81 | 77 | 95% |

Plan & Project Strengths

- BMCHP-Southcoast is commended for the development of a quality improvement process through which it is making incremental changes to one or more key activities.
- BMCHP-Southcoast is commended for developing the physician pilot, convening discussions, and using the physician newsletter for communicating the need to change to a no-refill policy.

- Changing the screening tool from a voluntary to a standard part of the refill authorization process is a promising change in practice.

Recommendations & Opportunities for Improvement

- KEPRO recommends further describing the clinical characteristics of this population as such an analysis could inform it interventions.
- KEPRO recommends that BMCHP-Southcoast further detail member-focused project goals ensuring they are measurable and achievable.

MY CARE FAMILY - INCREASE THE ASTHMA MEDICATION RATIO (AMR) RATE FOR MY CARE FAMILY MEMBERS WITH PERSISTENT ASTHMA 5-64 YEARS OF AGE

Rationale for Project Selection

“The prevalence and utilization data ... indicate that asthma is a high-volume and high-risk condition among our My Care Family population. In addition, when reviewing the Asthma Medication Ratio rates, My Care Family is experiencing a downward trend, and performing below the 2018 Medicaid Quality Compass 75th percentile.

Interventions

My Care Family is implementing a broad-scale member education program that uses a combination of telephonic and in-person counseling and text messaging to teach members with persistent asthma about the proper use of asthma medication and how to self-manage their condition. These activities include, but are not limited to, weekly asthma member-education sessions conducted by Care/Disease Managers at high-volume primary care locations and monthly text messaging to medication non-adherent members. Incentives (allergy-free bedding) are offered to members attending education sessions. Pharmacy staff conduct outreach to members, administer the Asthma Control Test, assess social determinants of health, and complete an environmental screening. Asthma education visits at school-based health centers is planned.

Project Goals

Member-Focused

- To increase by 5% over baseline [2018] the percentage of members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Provider-Focused

- Increase Primary Care Physicians' knowledge of referral resources for their My Care Family panel of members with persistent asthma, as evidenced by an increase in PCP referrals to care and disease management programs.
- Increase Primary Care Physicians' knowledge about the AMR measure requirements and how to use actionable AMR gaps in care reports as evidenced by an increase in their AMR rates.

Performance Indicators

- 1) The rate of members with asthma that have a medication ratio of 0.50 or greater.
 - My Care Family reported a 2018 baseline rate of 61.59%.

- Its goal for its 2019 remeasurement period is 65.03%, the 2018 Medicaid Quality Compass 75th percentile.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. My Care Family received a rating score of 98% on this Performance Improvement Project.

Exhibit 28: My Care Family PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 14.5 | 97% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 5 | 15 | 15 | 100% |
| Baseline Indicator Performance Rates | 5 | 15 | 15 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 26 | 84 | 83.5 | 98% |

Plan & Project Strengths

- My Care Family is commended for implementing an “outside of the box” strategy to engage members.
- My Care Family is commended for comprehensive intervention activities inclusive of digital outreach, pharmacist-led initiatives, as well as visits to multiple sites to reinforce training and tracking of the effect.
- My Care Family is commended for conducting a health equity analysis of members with persistent asthma.

Recommendations & Opportunities for Improvement

- My Care Family is encouraged to apply small tests of change to its interventions to assess their effectiveness.

DIABETES

WELLFORCE CARE PLAN – IMPROVING THE RATE OF HBA1C TESTING IN THE WELLFORCE CARE PLAN DIABETIC POPULATION

Rationale for Project Selection

“Diabetes has the potential of increasing the risk of many serious health conditions. Examples include hypertension, cardiovascular disease, stroke, nephropathy, ketoacidosis, gastroparesis, nerve damage and skin, eye, and foot complications ... Provider and enrollee awareness of their HbA1c and maintaining adequate control of the level has the potential of decreasing the occurrence of some or all of these complications while improving the patients' quality of life and decreasing the burden on the healthcare system.”

Project Goals

Member-Focused

- Achieve a member HbA1c testing rate of 92.7%.

Provider-Focused

- Improve tracking and monitoring of gaps in care for members with diabetes with the involvement of quality personnel.
- Improve communication between specialist and PCP offices with quality team personnel to discuss gaps in care for non-adherent members through in-person meetings or other correspondence.
- Develop reference materials and disseminate them to provider offices related to evidence-based guidelines for diabetic members.
- Identify members with HbA1c values that are $\geq 9\%$ for focused provider outreach and educate providers regarding referrals to disease management and case management programs that are available to assist with disease management strategies.

Interventions

Gaps in care registries were generated for members attributed to the Lowell General Physician Hospital Organization and the Lowell Community Health centers. Providers were encouraged to telephone non-adherent patients. Physician administrators and the Practice Performance Team are developing a remediation intervention plan to address low-performing providers.

Performance Indicators

The percentage of Fallon-Wellforce members 18-64 years of age with diabetes (type 1 and type 2) who had Hba1c testing.

- Fallon-Wellforce's 2018 baseline performance was 83.33%.
- Its goal for the 2019 remeasurement period is 92.7%, the 2018 Medicaid benchmark.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon-Wellforce received a rating score of 100% on this Performance Improvement Project.

Exhibit 28: Fallon-Wellforce PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 15 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 7 | 21 | 21 | 100% |
| Baseline Indicator Performance Rates | 5 | 15 | 15 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 31 | 93 | 93 | 100% |

Plan & Project Strengths

- KEPRO commends Fallon-Wellforce its plan to cross-reference patients who have screened positive for a social determinant of health by the Health-Related Social Needs Screening (HRSN). This will allow further identification of possible determinates that could affect the health needs of these members.

Recommendations & Opportunities for Improvement

- None identified.

BEHEALTHY PARTNERSHIP – IMPROVING OUTCOMES IN DIABETIC PATIENTS THROUGH INTEGRATED CARE MANAGEMENT

Rationale for Project Selection

“Diabetes disproportionately affects vulnerable groups, including racial and ethnic minorities and those at a socioeconomic disadvantage. Diabetes guidelines and treatment goals should include evaluation of and interventions for Social Determinants of Health (SDoH) along with shared decision-making (*Annals of Internal Medicine*, August 2018; 169(4):252). The American Diabetes Association Clinical Practice Guidelines recommends that patient encountering social barriers be provided with support from Community Health Workers (CHWs) and referred to available community resources (*Clin Diabetes*. 2018;36:14-37).”

Project Goals

Member-Focused

- Decrease member HbA1c results.
- Increase the volume of members connected with housing, food, and transportation supports.
- Decrease hospitalizations and emergency department visits due to diabetic complications.

Provider-Focused

- Increase the number of contacts made to identified patients for the Diabetic/SDoH program.
- Increase the number of referrals made for members with identified SDoH issues.
- Increase the number of patients using in-center diabetic services, e.g., group visits and primary care visits.

Interventions

Registries of members with diabetes and housing, food, and transportation issues are shared with Community Health Workers (CHWs) at each of four health centers. The CHW collaborates with the member’s primary care team to identify the appropriate treatment pathway. The CHW then refers the member to the needed community resources and follows up to ensure adherence with the treatment and social plan.

Performance Indicators

1. Members referred to a diabetes management program who are 18 to 64 years of age with type 1 or type 2 diabetes who had HbA1c poor control, i.e., greater than 9.0%.
 - The HNE-BeHealthy 2018 baseline performance rate was 35.2%.
 - Its goal for the 2019 remeasurement period is 30.6%.

2. Inpatient Admission rate for diabetics with SDOH. The rate is limited to the identified members for this project.
 - The HNE-BeHealthy 2018 baseline performance rate was 1202.7/1000. Its goal for the 2019 remeasurement period is 157.2/1000.
3. Members referred to a diabetes management program identified with SDOH referred to a Social Service Agency.
 - HNE-BeHealthy's baseline performance was 51.9%.
 - Its goal for the 2019 remeasurement period has yet to be established.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. HNE-BeHealthy received a rating score of 97% on this Performance Improvement Project.

Exhibit 29: HNE-BeHealthy PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100 |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Intervention | 5 | 15 | 14 | 93% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 8 | 89% |
| Performance Indicator Parameters | 4.6 | 14.0 | 14.0 | 100% |
| Baseline Indicator Performance Rates | 3.6 | 11.0 | 11.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 26.2 | 79 | 77 | 97% |

Plan & Project Strengths

- KEPRO commends HNE-BeHealthy for using Community Health Workers from each practice site as recommended in the clinical guidelines promulgated by the American Diabetes Association and for addressing social determinants of health for the members who are the focus of this PIP.
- This project touches a limited number of patients (30). HNE-Be Healthy is honing its enrollment process to ensure all high-risk members with diabetes are identified and included in this effort. KEPRO supports this activity.

Recommendations & Opportunities for Improvement

- KEPRO recommends that HNE-Be Healthy set targets for outreach, connection, and follow up of patients connecting with community resources in the next report.

HEART DISEASE

BERKSHIRE FALLON HEALTH COLLABORATIVE (FALLON-BFHC) – IMPROVE BLOOD PRESSURE CONTROL IN THE BERKSHIRE FALLON HEALTH COLLABORATIVE POPULATION

Rationale for Project Selection

“Hypertension has the potential of increasing the risk of many serious health conditions. Examples of effects on the body for poorly controlled hypertension include damaged or narrowed arteries, aneurysm, coronary artery disease, enlarged left heart, heart failure, transient ischemic attack, stroke, mild cognitive impairment or dementia, kidney failure, retinopathy, nerve damage, etc. With provider and enrollee awareness of the enrollee's blood pressure, then gaining or maintaining adequate control, there is the potential of decreasing the occurrence of some or all of these complications while improving the patients' quality of life and decreasing the burden on the healthcare system.”

Project Goals

Member Focused

- Increase the percentage of members diagnosed with hypertension who have adequately controlled blood pressure to a baseline rate of 67.2%, which is an increase of 10% from the 2018 baseline rate.
- Increase members' participation in a self-measured blood pressure monitoring program (Get Cuffed Program) by 50% from a baseline of 6% of eligible members.

Provider Focused

- Increase provider referrals to the Get Cuffed Program (self-measured blood pressure) for members with elevated blood pressures by 40% from a baseline rate of 10% of provider referrals.
- Improve accuracy of blood pressure measurement technique by providing provider education and performing post-education assessments, ensuring 100% staff participation in this education.

Interventions

To ensure accuracy in blood pressure measurement, staff were asked to complete the interactive blood pressure education tool available on the American Heart Association's Target Blood Pressure website. Practice managers tracked training completion. In mid-2018, Fallon-BFHC implemented the Get Cuffed program. Referred patients attend a class in which they

learn how to self-monitor blood pressure. They are then sent home with a fitted automatic blood pressure cuff to self-monitor. They are instructed to conduct two readings per day, one in the morning and one in the evening. Seven days later, a program nurse reaches out to the patient to discuss the readings and develop next steps as indicated.

Performance Indicators

The rate of members 18-64 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

- Fallon-BFHC's 2018 baseline performance was 61%.
- Its goal for the 2019 remeasurement period is 67.2%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon-BFHC received a rating score of 98% on this Performance Improvement Project.

Exhibit 30: Fallon-BFHC PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 8 | 89% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 14 | 93% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 6 | 18 | 18 | 100% |
| Baseline Indicator Performance Rates | 5 | 15 | 15 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 29 | 87 | 85 | 98% |

Plan & Project Strengths

- Fallon-BFHC uses a wide range of strategies to engage members in the Get Cuffed program.
- KEPRO commends Fallon-BFHC for outlining expected results and modifications to the workflow, with attention given to site variation for referrals to the Get Cuffed program.
- Fallon-BFHC is commended for the implementation of a pilot prior to full roll out to ensure the process is effective and workflows are modified as needed.

Recommendations & Opportunities for Improvement

- None identified.

PREVENTION

FALLON 365 CARE – INCREASING THE HPV IMMUNIZATION RATE FOR ADOLESCENTS AMONG FALLON 365 CARE MEMBERS

Rationale for Project Selection

“The demographics of the Fallon 365 Care consist of 58.67% of the population being under the age of 21. Vaccines help to keep people healthy, are safe and effective, and prevent the spread of disease. Immunizations prevent communicable diseases that can cause long-term illness, hospitalization, and even death. In particular, the importance of the human papillomavirus (HPV) vaccine in this age group is that: 1) it protects against the disease and some cancers, 2) HPV is the most common sexually transmitted infection in the United States and 3) research has demonstrated younger people have a better immune response to the vaccine than those in their late teens and early 20s ... Prevention of these diseases is important because contracting any of these preventable diseases has the potential of decreasing a person's quality of life as well as increasing the burden on the health care system.”

Project Goals

Member-Focused

- 80% of patients/parents will be able to identify the chief reason for vaccinating themselves or their child for HPV following provision of the Massachusetts Department of Public Health HPV Infographic and related clinical discussion.
- Improved acceptance of HPV vaccination by patients/parents as evidenced by a 5% increase from the 2018 baseline rate of 18.81% for the number of 9-12-year olds where the HPV vaccination series has been initiated.

Provider-Focused

- Offer education to 100% of providers and clinical office staff, with at least 80% participation by September 20, 2019, to improve understanding of current [HPV clinical] guidelines.
- Improve HPV vaccination series completion rate in adolescents by age 13 as evidenced by a 10% increase above Fallon 365's 2018 calendar year baseline of 32.5%.

Interventions

- Fallon 365 is sponsoring provider training on motivational interviewing and persuasion techniques that offers Continuing Medical Education units. Providers who fail to increase their vaccination rates by at least 5% will be offered additional education related to motivational interviewing techniques.
- Patients or parents are given an HPV-related infographic. A version is available in Spanish as well. A brief survey is administered to the patients or parents to gather information about the rationale behind their vaccination decisions.

Performance Indicators

- 1) The rate of members who have completed the HPV series on or between the members' 9th and 13th birthdays.
 - Fallon 365's 2018 baseline performance was 32.58%.
 - Its goal for the 2019 remeasurement period is 35.83%.
- 2) The initiation rate of HPV vaccination for members between the ages of 9 and 12.
 - Fallon 365's 2018 baseline performance was 18.81%.
 - Its goal for the 2019 remeasurement period is 19.75%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Fallon 365 received a rating score of 98% on this Performance Improvement Project.

Exhibit 31: Fallon 365 PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 8 | 89% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5 | 15 | 13.5 | 90% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 7 | 21 | 20 | 95% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 8 | 100% |
| Overall Validation Rating Score | 29 | 87 | 85.5 | 98% |

Plan & Project Strengths

- KEPRO commends Fallon 365 for utilizing the HPV Infographic authored by the

Immunization Action Coalition (IAC) for Spanish-speaking members; the Massachusetts Department of Public Health (MDPH) HPV Infographic is not available in Spanish.

- KEPRO commends Fallon 365 for changing the frequency of data collection and analysis to monthly.

Recommendations & Opportunities for Improvement

- Fallon 365 is focused on increasing HPV vaccines rates for a small cohort of its population, those between 9-13 years old. KEPRO suggests it expand the focus of this initiative to all HPV vaccine-appropriate eligible members up to the age of 26, to align with the CDC guidelines.

SOCIAL DETERMINANTS OF HEALTH

TUFTS HEALTH TOGETHER WITH CAMBRIDGE HEALTH ALLIANCE – UTILIZE HEALTH-RELATED SOCIAL NEEDS SCREENING TO IMPROVE MEMBER HEALTH OUTCOMES

Rationale for Project Selection

“[Tufts-CHA] wishes to achieve optimum health outcome for our members by prioritizing members’ ability to cope with their social and physical environment as well as specific illnesses. There is evidence that health outcomes are largely dependent on underlying social, economic, and environmental factors rather than medical interventions alone. Eighty percent of physicians indicate that addressing patients’ social needs is as important as addressing their medical needs. These non-clinical social determinants of health factors have significant prevalence in the Tufts-CHA geography. Health-Related Social Needs Screening, approved by MassHealth, provides a systematic way to review social determinants of health issues our members are currently facing. Findings from the screening can help with identifying members in need of additional support as soon as possible after their enrollment or a visit to their Primary Care Physician.”

Goals

Member-Focused

- Increase member response rate to Social Determinants of Health (SDoH) screening.
- Identify and refer members with SDoH needs to appropriate community resources.
- Leverage SDoH screening results to help stratify members for care management services and support to maximize members’ health care status and independence.

Provider-Focused

- Increase provider knowledge about SDoH screening.
- Make SDoH screening results available electronically to primary care providers (PCPs) at the point of care.
- Improve provider knowledge about available community resources to members.

Interventions

Tufts Health Together with Cambridge Health Alliance incorporated the Connect S SDoH screening tool into its electronic medical record. It is piloting the use of tablet technology to increase the rate of screening. Having been implemented in primary care, Tufts-CHA plans to spread tablets to inpatient and specialty settings. SDoH results are integrated in all complex

care management assessments. Workflows for positive screens have been developed and the After-Visit Summary was enhanced to include a standard list of community services. Tufts-CHA has established working relationships with community service agencies. It is adopting the Aunt Bertha platform, a web-based social service resource directory, to connect patients with social services.

In addition, Tufts-CHA applies risk stratification criteria to claims data to identify complex patients who may need additional care management service support.

Performance Indicators

The rate of Tufts-CHA-attributed members aged 0 to 64 years of age who were screened for health-related social determinants of health during the measurement year.

- Tufts-CHA's 2018 baseline rate is 19.6%.
- Its goal for the 2019 measurement period is 30.0%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPP's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with Cambridge Health Alliance received a rating score of 98% on this Performance Improvement Project.

Exhibit 32: Tufts-CHA PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|--------------|------------------------|---------------|-----------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 8 | 89% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 14.3 | 96% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 3 | 9 | 9 | 100% |
| Baseline Indicator Performance Rates | 4 | 12 | 12 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 25 | 75 | 73.3 | 98% |

Project & Plan Strengths

- Tufts-CHA is commended for the addition of its five new Patient Resource Coordinators that will be available to members who have positive health-related social needs.
- Tufts-CHA is commended for performing multiple small tests of change, including a survey of primary care staff to solicit feedback on workflow implications, use of tablets to complete the screen, and numerous validation tests to ensure data integrity.
- KEPRO commends Tufts-CHA for proactively assisting members connect to support services through an information systems platform, Aunt Bertha, which will be accessible to providers as they interface with members.

Recommendations & Opportunities for Improvement

- While the name of this intervention, as well as the title of this project, references “improve member health outcomes,” Tufts-CHA is using only one performance indicator, i.e., a count of screens. There are no measures of referrals based on positive screens, nor are there measures of member health outcomes for those who screen positive for health-related social needs.

TUFTS HEALTH TOGETHER WITH ATRIUS HEALTH – IMPROVING HEALTH-RELATED SOCIAL NEEDS SCREENING AND FOLLOW UP

Rationale for Project Selection

“Research indicates that health outcomes are largely dependent on underlying social, economic, and environmental factors rather than medical interventions alone. These non-clinical factors, referred to as social determinants of health (SDoH), are particularly prevalent among vulnerable populations such as the Medicaid population. SDoH impact healthcare utilization, cost, and health outcomes, and because of this, there is an increased effort to address SDoH in the healthcare delivery system. Eighty percent of physicians indicate that addressing patients’ social needs is as important as addressing their medical needs.”

Project Goals

Member-Focused

- Increase the rate of SDoH screenings completed by members.
- Refer members with positive SDoH screens to community resources.

Provider-Focused

- Increase provider knowledge and awareness of the importance of SDoH and the value of SDoH screening.
- Improve pre- and at-visit workflows to enable health-related social needs screening.
- Improve clinician acceptance of and confidence in activating the workflow to connect patients with needed community resources.

Interventions

Tufts Health Together with Atrius Health selected a modified version of the PRAPARE health-related social needs screening tool and implemented it in paper form in July 2018. Its use was piloted by one primary care provider and then expanded to all department clinicians. The project team later determined that computer-based screening was more effective than the paper screening form. Tufts-Atrius developed and refined workflows to link patients and families with services that meet their needs. Resources were identified and made available to staff on the Atrius Health intranet.

Performance Indicators

The rate of Tufts-Atrius-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.

- Tufts Health Together with Atrius Health's 2018 baseline rate is 1%.
- Its goal for the 2019 remeasurement period is 12%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACP's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with Atrius Health received a rating score of 100% on this Performance Improvement Project.

Exhibit 33: Tufts-Atrius PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 3 | 9 | 9 | 100% |
| Performance Indicator Parameters | 4 | 12 | 12 | 100% |
| Baseline Indicator Performance Rates | 3 | 9 | 9 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 25 | 75 | 75 | 100% |

Project & Plan Strengths

- Tufts-Atrius describes an excellent use of small tests of change to develop a workflow for the administration of its social needs assessments. Tufts-Atrius is commended for its commitment to improving the quality and effectiveness of these intervention activities.
- KEPRO commends Tufts-Atrius's plan to align the social needs screening with pediatric well visit workflows. This is likely to improve the response rate for screenings, and it will increase pediatric providers' compliance with EPSDT requirements.

Recommendations & Opportunities for Improvement

- With respect to limited housing resources, KEPRO suggests that Tufts-Atrius develop written workflow protocols, as well as scripts for interacting with members, that realistically outline the resource shortages and the best options for maximizing members' access to housing resources. It can be helpful for staff to know what they can't do as well as what they might be able to do to support members.

TUFTS HEALTH TOGETHER WITH BOSTON CHILDREN'S ACO – INCREASING SCREENING FOR HEALTH-RELATED SOCIAL NEEDS (HRSN) USING AN ELECTRONIC DATA CAPTURE SYSTEM

Rationale for Project Selection

“Social, economic, and environmental factors have been associated with a host of health outcomes among children in the United States including prematurity, asthma, obesity, sexually transmitted infections, developmental delays, substance use, depression, and anxiety. Collecting information on social needs is a critical component of understanding population health and developing and implementing interventions to address these needs.”

Project Goals

Member-Focused

- Increase the rate of screening for social determinants of health using a MassHealth-approved screening tool.
- Use health-related social needs screening to improve access to resources for patients and families with health-related social needs.

Provider-Focused

- Implement comprehensive electronic documentation of health-related social needs screening.
- Conduct analyses of health-related social needs screening results at regular intervals to better understand the health-related social needs of the Tufts-BCH population and support data-informed decision-making.
- Establish clinic systems and workflows to connect patients and families to resources by using results of analyses to educate providers and build partnerships with resource organizations.

Interventions

Tufts-BCH conducted focus groups and interviewed key stakeholders to inform creation of a new social risk screener which was subsequently approved by MassHealth. A paper version of the screen was implemented and response algorithms were developed that, for positive screens, guide providers to the appropriate staff member. Tufts-BCH had planned to migrate to electronic-based medical record screening, but issues related to system compatibility surfaced. Efforts are underway to forge community partnerships with resources relevant to the patient population's needs.

Performance Indicators

1. The rate of Tufts-BCH-attributed members 0 to 64 years of age at the Children's Hospital Primary Care Center with a well visit who were screened for health-related social needs and had screening results documented electronically during the measurement period.
 - Tufts-BCH's 2018 baseline rate is 0%.
 - Its goal for the 2019 remeasurement period is 37.5%.
2. The rate of Tufts-BCH-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
 - Tufts BCH's 2018 baseline rate is 0%.
 - Its goal for the 2019 remeasurement period is to be determined.

Performance Improvement Project Evaluation

KEPRO evaluates an ACPPs performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with Boston Children's ACO received a rating score of 100% on this Performance Improvement Project.

Exhibit 34: Tufts-BCH PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 4.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 4.0 | 12.0 | 12.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 27 | 81 | 81 | 100% |

Plan & Project Strengths

- Tufts-BCH is commended using of small tests of change to improve the readability and ease of interpretation for their social needs screening protocol.

Recommendations & Opportunities for Improvement

- Because the gathering of HRSN screen results will be done through paper forms, Tufts-BCH might consider modifying the title of its first performance indicator as applicable to “electronic documentation of HRSN.”

TUFTS HEALTH TOGETHER WITH BETH ISRAEL DEACONESS CARE ORGANIZATION (BIDCO) – IMPROVING SOCIAL DETERMINANTS OF HEALTH SCREENING AND REFERRAL IN PEDIATRICS AND ADULTS

Rationale for Project Selection

“Tufts Health Together with BIDCO wishes to achieve optimum health outcomes for our members by prioritizing members’ ability to cope with their social and physical environment as well as specific illnesses. There is evidence that health outcomes are largely dependent on underlying social, economic, and environmental factors rather than medical interventions alone. Eighty percent of physicians indicate that addressing patients’ social needs is as important as addressing their medical needs. These non-clinical social determinants of health factors have significant prevalence in the Tufts-BIDCO geography.”

Project Goals

Member-Focused

- Increase member screening for social determinants of health.
- Improve member access to resources to address social determinants of health.

Provider-Focused

- Increase provider knowledge about social determinants of health.
- Increase provider screening for social determinants of health.
- Increase provider knowledge of community resources for members with deficits in social and nutritional determinants of health.

Interventions

Tufts Health Together with BIDCO implemented a pilot at an eight-physician practice in which providers and staff received multi-modal training and education on Social Determinants of Health screening and community resources. This training was modified to become more ongoing and individualized. As of the report date, 16 of 34 independent physician practices have begun training. In addition, Tufts-BIDCO developed workflows for rooming, screening, and referral processes.

Performance Indicators

1. The rate of Tufts-BIDCO-attributed members 0 to 64 years of age who were screened for health-related social needs in the measurement year.
 - Tufts Health Together with BIDCO’s 2018 baseline rate is 12.6%.

- Its goal for the 2019 remeasurement period is 17.6%.
2. The rate of Tufts-BIDCO-attributed members 0 to 64 years of age who were screened positive for health-related social needs and were referred to community resources in the measurement year.
- Tufts Health Together with BIDCO's 2018 baseline rate is 12.6%.
 - Its goal for the 2019 remeasurement period is 17.6%.

Performance Improvement Project Evaluation

KEPRO evaluates an ACP's performance against a set of pre-determined criteria. The Technical Reviewer assigns a score to each individual rating criterion and rates individual standards as either 1 (does not meet item criteria); 2 (partially meets item criteria); or 3 (meets item criteria). A rating score is calculated by dividing the sum of all points received by the sum of all available points. This ratio is presented as a percentage. Tufts Health Together with BIDCO received a rating score of 100% on this Performance Improvement Project.

Exhibit 35: Tufts-BIDCO PIP Rating Score

| Summary Results of Validation Ratings | No. of Items | Total Available Points | Points Scored | Rating Averages |
|--|---------------------|-------------------------------|----------------------|------------------------|
| Population Analysis and Participant Engagement | 3 | 9 | 9 | 100% |
| Update to PIP Topic and Goals | 3 | 9 | 9 | 100% |
| Progress in Implementing Interventions | 5.0 | 15.0 | 15.0 | 100% |
| Performance Indicator Data Collection | 2 | 6 | 6 | 100% |
| Capacity for Indicator Data Analysis | 4 | 12 | 12 | 100% |
| Performance Indicator Parameters | 4.0 | 12.0 | 12.0 | 100% |
| Baseline Indicator Performance Rates | 4.0 | 12.0 | 12.0 | 100% |
| Conclusions and Planning for Next Cycle | 2 | 6 | 6 | 100% |
| Overall Validation Rating Score | 27 | 81 | 81 | 100% |

Plan & Project Strengths

- Tufts-BIDCO has identified quality benchmarks as incentives to engage providers.
- It is commended for its use of motivational interviewing with members.

- Tufts-BIDCO describes a number of areas in which this intervention was improved, such as detailing the specific training methodologies used; incorporating the screening tool into the EMR; the twice-per-week feedback sessions with physician groups to continually improve the workflow process; and the need to support the practitioners in addressing home safety and domestic violence.
- The Tufts-BIDCO PIP team is commended for the excellent and ambitious design of this project and for the implementation progress it has completed to date.

Recommendations & Opportunities for Improvement

- None of note.

APPENDIX 1. CONTRIBUTORS

Performance Measure Validation

Katharine Iskrant, MPH, CHCA, CPHQ

Ms. Iskrant is a member of the National Committee for Quality Assurance (NCQA) Audit Methodology Panel and has been a Certified Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Auditor since 1998. She directed the consultant team that developed the original NCQA Software Certification ProgramSM on behalf of NCQA. She is a frequent speaker at national HEDIS® conferences. Ms. Iskrant received her Bachelor of Arts from Columbia University and her Master of Public Health from UC Berkeley School of Public Health. She is a member of the National Association for Healthcare Quality (NAHQ) and is published in the fields of healthcare and public health.

Performance Improvement Project Reviewers

Bonnie L. Zell, MD, MPH, FACOG

Dr. Zell brings to KEPRO a broad spectrum of healthcare experience as a nurse, an OB/GYN physician chief at Kaiser Permanente, and a hospital Medical Director. She has also had leadership roles in public health and national policy. As a nurse, she worked in community hospitals, served as head nurse of a surgical ward, and was a Methadone dispensing nurse at a medication-assisted treatment program. As OB/GYN chief, she developed new models of care based on patients' needs rather than system structure, integrating the department with psychologists, social workers, family medicine, and internal medicine.

In public health roles as Partnerships Lead at the CDC and Senior Director for Population Health at the National Quality Forum, she advanced strategies to integrate public health and healthcare, engaging healthcare and public health leaders in joint initiatives. As an Institute for Healthcare Improvement (IHI) fellow, Dr. Zell led quality improvement curriculum development, coaching, and training for multiple public health and healthcare institutions.

In February 2015, Dr. Zell co-founded a telehealth company, Icebreaker Health, which developed Lemonaid Health, a telehealth model for delivering simple, uncomplicated primary care accessed through an app and website. Serving as chief medical officer and chief quality officer, she built the systems, protocols, quality standards, and care review processes. Her role then expanded to building partnerships to integrate this telehealth model of care into multiple health systems and study it with national academic leaders.

Dr. Zell continues to have an interest in supporting communities of greatest need. She has published and presented extensively. Currently, Dr. Zell is serving as a healthcare quality coach for Sutter Health and is Chief Medical Officer of Pill Club providing telehealth care for women.

Chantal Laperle, MA, CPHQ, NCQA CCE

Chantal Laperle has over 25 years of experience in the development and implementation of quality initiatives in a wide variety of health care delivery settings. She has successfully held many positions in both public and private sectors using her clinical background to effect change. She has contributed to the development of a multitude of quality programs from the ground up requiring her to be hands on through implementation. She is experienced in The Joint Commission (TJC), National Committee for Quality Assurance (NCQA), the Commission on Accreditation of Rehabilitation Facilities (CARF) and Accreditation Association for Ambulatory Health Care (AAAHC) accreditation and recognition programs. She is skilled in the development of workflows and the use of tools to monitor and succeed within a process as well as coaching teams through the development and implementation process of a project.

Ms. Laperle holds both a Bachelors and a Master's Degree in Psychology. She is a Certified Professional in Health Care Quality (CPHQ) and Certified in Health Care Risk Management. She is also certified in Advanced Facilitation and the 7 Tools of Quality Control through GOAL/QPC, holds a certification as an Instructor for Nonviolent Crisis Intervention (CPI) and is a Certified Content Expert (CCE) through NCQA.

Wayne J. Stelk, Ph.D.

Wayne J. Stelk, Ph.D., is a psychologist with over 40 years of experience in the design, implementation, and management of large-scale health and human service systems. His expertise includes improving the effectiveness and efficiency of managed health services through data-driven performance management systems.

During his tenure as Vice-President for Quality Management and Analytics at the Massachusetts Behavioral Health Partnership (MBHP), Dr. Stelk designed and managed over 150 quality improvement projects involving primary care and behavioral health practices across the state. He is well-versed in creating strategies to improve healthcare service delivery that maximize clinical outcomes and minimize service costs. He also implemented a statewide outcomes management program for behavioral health providers in the MBHP network, the first of its kind in Massachusetts.

After leaving MBHP in 2010, he consulted on several projects involving the integration of primary care with behavioral health care, and improving access to long-term services and supports for health plan members with complex medical needs. Other areas of expertise include implementing evidence-based intervention and treatment practices; designing systems for the measurement of treatment outcomes; and developing data-collections systems for quality metrics that are used to improve provider accountability.

Project Management

Cassandra Eckhof, M.S.

Ms. Eckhof has over 25 years of managed care and quality management experience and has worked in the private, non-profit, and government sectors. Her most recent experience was as the Director of Quality Management at a Chronic Condition Special Needs Plan for individuals with end-stage renal disease. Ms. Eckhof has a Master of Science degree in health care administration and is a Certified Professional in Healthcare Quality.