

# MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

## **Community Partner Report:** **Behavioral Health Network, Inc.** **(BHN)**

Report prepared by The Public Consulting Group: December 2020

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## DSRIP Midpoint Assessment Highlights & Key Findings

Behavioral Health Network, Inc. (BHN)



A Behavioral Health Community Partner

### Organization Overview

BHN began as the Child Guidance Clinic in 1938 and is now one of the largest community-based service organizations in Western Massachusetts. Services include 11 licensed Mental Health (MH) and Substance Use Disorder (SUD) outpatient clinics. There are three Emergency Psychiatric Services crisis units that provide coverage to six Emergency Departments (EDs) and three Crisis Stabilization/Respite sites.

### SERVICE AREA



### POPULATIONS SERVED

- ▶ BHN's primary service areas include Springfield, Holyoke, and Westfield. Roughly half of the residents of Springfield and Holyoke are racial minorities, nearly half are not primary English speakers, and one third or more live below the Federal Poverty Level (FPL).
- ▶ Roughly one-tenth of Westfield residents are a racial minority and/or live below the FPL; approximately 16% speak a language other than English. Westfield has a growing refugee population, bringing additional linguistic and cultural diversity.

**1,910**

Members Enrolled  
as of December 2019

### FOCUS AREA

### IA FINDINGS

Organizational Structure & Engagement

● On Track

Integration of Systems & Processes

● On Track

Workforce Development

● On Track

Health Information Technology & Exchange

● On Track

Care Model

● On Track

### IMPLEMENTATION HIGHLIGHTS

- BHN achieved high retention rates for CP program staff and nursing staff.
- BHN reduced average wait time for new primary care appointments for members, in some cases from six months to less than 30 days.
- BHN reduced the number of outstanding care plans by sharing care plan tracker spreadsheets with key ACO contacts.
- BHN created dashboards to provide real-time information to staff and managers on productivity and care plan exchange.
- BHN deployed a health education platform which gives engaged members access to patient education videos and other resources related to care plan goals.

#### Statewide Investment Utilization:

- Student Loan Repayment Program, 3 Care Coordinators participating
- Community Mental Health Center Behavioral Health Recruitment Fund, 1 slot awarded
- Certified Peer Specialist Trainings
- CP Recruitment Incentive Program

*A complete description of the sources can be found on the reverse/following page.*

**LIST OF SOURCES FOR INFOGRAPHIC**

Organization Overview	A description of the organization as a whole, not limited to the Community Partner role.
Service area maps	Shaded area represents service area based on zip codes; data file provided by MassHealth.
Members Enrolled	Community Partner Enrollment Snapshot (12/13/2019)
Population Served	Paraphrased from the CPs Full Participation Plan.
Implementation Highlights	Paraphrased from the required annual and semi-annual progress reports submitted by the CP to MassHealth.
Statewide Investment Utilization	Information contained in reports provided by MassHealth to the IA

## INTRODUCTION

Centers for Medicare and Medicaid Services' (CMS') requirements for the MassHealth Section 1115 Demonstration specify that an independent assessment of progress of the Delivery System Reform Incentive Payment (DSRIP) Program must be conducted at the Demonstration midpoint. In satisfaction of this requirement, MassHealth has contracted with the Public Consulting Group to serve as the Independent Assessor (IA) and conduct the Midpoint Assessment (MPA). The IA used participation plans, annual and semi-annual reports, and key informant interviews (KIIs) to assess progress of Community Partners (CPs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018.

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of five focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator<sup>1</sup> (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (<https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download>).

The question addressed by this assessment is:

*To what extent has the CP taken organizational level actions, across five areas of focus, to transform care delivery under an accountable and integrated care model?*

This report provides the results of the IA's assessment of the CP that is the subject of this report. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage the CP to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

## MPA FRAMEWORK

The MPA findings cover five "focus areas" or aspects of health system transformation. These were derived from the DSRIP logic model (Appendix I) by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes
3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. The CP actions are broad enough to be accomplished in a variety of ways by different organizations, and the scope of the IA is to assess progress, not to determine the best approach for a CP to take.

The focus area framework was used to assess each entity's progress. A rating of "On track" indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated "On track with limited recommendations" or, in the case of

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<sup>1</sup> The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

more substantial gaps, “Opportunity for improvement.” See Methodology section for an explanation of the threshold setting process for the ratings.

Table 1: Framework for Organizational Assessment of CPs

Focus Area	CP Actions
<b>Organizational Structure and Governance</b>	<ul style="list-style-type: none"> <li>CPs established with specific governance, scope, scale, &amp; leadership</li> <li>CPs engage constituent entities in delivery system change</li> </ul>
<b>Integration of Systems and Processes</b>	<ul style="list-style-type: none"> <li>CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)</li> <li>CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)</li> <li>CPs establish structures and processes for joint management of performance and quality, and problem solving</li> </ul>
<b>Workforce Development</b>	<ul style="list-style-type: none"> <li>CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports</li> </ul>
<b>Health Information Technology and Exchange</b>	<ul style="list-style-type: none"> <li>CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))</li> </ul>

## METHODOLOGY

The IA employed a qualitative approach to assess CP progress towards DSRIP goals, drawing on a variety of data sources to assess organizational performance in each focus area. The IA performed a desk review of participants’ submitted reports and of MassHealth supplementary data, covering the period of July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018. These included Full Participation Plans, annual and semi-annual reports, budgets and budget narratives. A supplementary source was the transcripts of KIIs of CP leaders conducted jointly by the IA and the IE.

The need for a realistic threshold of expected progress, in the absence of any pre-established benchmark, led the IA to use a semi-empirical approach to define the state that should be considered “On track.” As such, the IA’s approach was to first investigate the progress of the full CP cohort in order to calibrate expectations and define thresholds for assessment.

Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans and annual and semi-annual reports. This horizontal review identified a broad range of activities and capabilities that fell within the focus areas, yielding specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item and its relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality of entities. Items that had been accomplished by only a small number of CPs were considered to be

promising practices, not expectations at midpoint. This calibrated the threshold for expected progress to the actual performance of the CP cohort as a whole.

Qualitative coding of documents was used to aggregate the data for each CP by focus area, and then coded excerpts were reviewed to assess whether and how each CP had met the defined threshold for each focus area. The assessment was holistic and did not require that entities meet every item listed for a focus area. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and no need for remediation was identified. When evidence from coded documents was lacking for a specific action, additional information was sought through a keyword search of KII transcripts. Prior to finalizing the findings for an entity, the team convened to confirm that thresholds had been applied consistently and that the reasoning was clearly articulated and documented.

See Appendix II for a more detailed description of the methodology.

## CP BACKGROUND<sup>2</sup>

Behavioral Health Network, Inc. (BHN) is a regional provider of comprehensive behavioral health services for adults, children, and families. BHN began as the Child Guidance Clinic in 1938 and is now one of the largest community-based service organizations in Western Massachusetts. BHN core services include 11 licensed mental health (MH) and substance use disorder (SUD) outpatient clinics covering parts of Hampden and Hampshire County. There are also three Emergency Psychiatric Services crisis units that provide coverage to six emergency departments (EDs) and three crisis stabilization/respite sites. Over the past five years, BHN has worked with regional healthcare partners to provide integrate services in over a dozen primary care practices and Federally Qualified Health Centers (FQHCs).

BHN's primary service area includes Springfield, Westfield, and Holyoke. The population is demographically and geographically diverse. Roughly half of the residents of Springfield and Holyoke are racial minorities, nearly half are not primary English speakers, and one third or more live below the federal poverty level (FPL). Roughly one-tenth of Westfield residents are a racial minority and/or live below the FPL; somewhat more (approximately 16%) speak a language other than English. Westfield has a growing refugee population, bringing additional linguistic and cultural diversity.

As of December 2019, 1,910 members were enrolled with BHN<sup>3</sup>.

## SUMMARY OF FINDINGS

The IA finds that BHN is On track in five of five focus areas.

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track
Workforce Development	On track
Health Information Technology and Exchange	On track
Care Model	On track

<sup>2</sup> Background information is summarized from the organizations Full Participation Plan.

<sup>3</sup> Community Partner Enrollment Snapshot (12/13/2019).



## FOCUS AREA LEVEL PROGRESS

The following section outlines the CP's progress across the five focus areas. Each section begins with a description of the established CP actions associated with an On track assessment. This description is followed by a detailed summary of the CP's results across all indicators associated with the focus area. This discussion includes specific examples of progress against the CP's participation plan as well as achievements and or promising practices, and recommendations where applicable. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage CPs to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must be taken in accordance with program guidance and contractual requirements.

### 1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

#### ***On Track Description***

Characteristics of CPs considered On track:

- ✓ **Executive Board**
  - has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and
  - is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).<sup>4</sup>
- ✓ **Consumer Advisory Board (CAB)**
  - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.
- ✓ **Quality Management Committee (QMC)**
  - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

#### ***Results***

The IA finds that BHN is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

#### **Executive Board**

BHN has a functioning Board of Directors that is responsible for the overall strategic direction and operations of the organization. BHN also has an Executive Committee empowered by the Board that directly supervises the CEO on daily management. BHN describes their leadership structure as consisting of a Chief Operating Officer and Senior Vice President (VP) who oversee all service delivery, as well as a VP of Administration, a VP of Human Resources, a VP of Quality, a VP of Healthcare Integration, and a VP of Substance Use Disorder (SUD), suggesting there is participation from administrative and clinical arms.

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<sup>4</sup> Some CPs enter into agreements with Affiliated Partners: organizations or entities that operate jointly under a formal written management agreement with the CP to provide member supports.

BHN does not have any Affiliated Partners or Consortium Entities.

## Consumer Advisory Board

BHN's CAB began meeting regularly in 2019<sup>5</sup>; seven MassHealth members attended most meetings. BHN implements three promising practices to facilitate CAB meetings. They provide lunch to members as an incentive for their participation, reimburse members for travel, and allot unstructured time during meetings for member feedback and suggestions. Member feedback has already resulted in production of new voicemail messages for care coordination staff and the implementation of staff check-ins to potentially prevent burnout. Members have suggested BHN provide more options for appointment times to align with their clients' availability and find ways to support members who struggle with urges to participate in unhealthy behaviors.

BHN's recruitment efforts for the CAB are informed by the community profile. Specifically, they seek to engage more members from outside the Springfield area. In 2019, they report having a waitlist of 144 members to serve on the CAB.

*CP Administrator Perspective: "Members participated in a brief presentation on ACCS services and supports followed by review, discussion and approval of the integration vision statement. During the discussion portion of the meeting, members articulated frustration in reaching his or her care coordinator. This discussion initiated a review of the current process and phone scripts when care coordinators are unavailable to take a member phone call. Voice mail messages were revised, and the phone message now includes the supervisor name and contact information as well as the main number. This will allow a member to contact the supervisor if they are unable to get a response from [their] care coordinator."*

## Quality Management Committee

BHN established a BH CP QMC that is chaired by the Population Senior Health Manager and accountable to the VP of Quality, who reports to the Board of Directors. The QMC is a ten-member multi-disciplinary team composed of managers, care coordinators, clinical care managers, and a member of BHN's central quality division. The QMC meets quarterly and focuses on three areas of improvement: ACO outcomes and process measures, workflow and process improvement, and member satisfaction. BHN has focused on meeting quality metrics related to follow-up on emergency department (ED) and inpatient admissions. They implemented a manual data collection tool and a series of reports to focus on hospitalizations.

BHN has a robust reporting structure. The information systems team worked with the quality analyst to develop comprehensive dashboards using data derived from BHN's care management software and EHR to show the member's progression through the care planning process and assist with tracking Qualifying Activities<sup>6</sup> (QAs). The quality analyst, who serves on the QMC, monitors the data collection process for the BH CP program and assures data is flowing between systems and coded appropriately.

## Recommendations

The IA has no recommendations for the Organizational Structure and Engagement focus area.

Promising practices that CPs have found useful in this area include:

### ✓ Executive Board

<sup>5</sup> Across the CP cohort, the IA found that most CPs began convening their CABs in year two of the program because they were still recruiting members to serve on the CAB in year one.

<sup>6</sup> Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow-up after discharge, and health and wellness coaching.

- holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
- conducting one-on-one quarterly site visits with APs and CEs;
- holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)<sup>7</sup> Joint Operating Committee;
- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

#### ✓ **Consumer Advisory Board**

- seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;
- adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;
- hosting meetings in centrally located community spaces that are easy to get to and familiar to members;
- adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members;
- limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff;
- sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls;
- incentivizing participation by paying members for their time, most often through relevant and useful gift cards;
- incentivizing participation by providing food at meetings; and
- presenting performance data and updates to CAB members to show how their input is driving changes in the organization.

#### ✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;

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<sup>7</sup> For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

- scheduling regular presentations about best practices related to quality metrics;
- adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
- integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
- ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential QI initiatives through the appropriate channels.

## 2. INTEGRATION OF SYSTEMS AND PROCESSES

### *On Track Description*

Characteristics of CPs considered On track:

#### ✓ **Joint approach to member engagement**

- has established centralized processes for the exchange of care plans;
- has a systematic approach to engaging Primary Care Providers (PCPs) to receive sign-off on care plans;
- exchanges and updates enrollee contact information among CP and ACO/MCO regularly; and
- dedicates staff resources to ensure timely (usually daily) reviews of ACO/MCO spreadsheets to assist with outreach and engagement efforts.

#### ✓ **Integration with ACOs and MCOs**

- holds meeting with key contacts at ACOs/MCOs to identify effective workflows and communication methods;
- conducts routine case review calls with ACOs/MCOs about members; and
- dedicates staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).

#### ✓ **Joint management of performance and quality**

- conducts data-driven quality initiatives to track and improve member engagement;
- has established comprehensive care plan review processes with ACOs/MCOs to support care coordinators in their effort to engage PCPs in comprehensive care plan review; and
- disseminates audit reports to each member organization, in some cases using an interactive dashboard to disseminate data on key quality metrics.

### **Results**

The IA finds that BHN is **On track with no recommendations** in the Integration of Systems and Processes focus area.

### **Joint approach to member engagement**

BHN has established centralized processes for the exchange of care plans. BHN's enterprise exchange engine is used to automate the transmission of member care plans out to practices for signature, and the transmission of signed care plans back into the care management platform. BHN's quality assistants serve as administrative points of contact for care plan exchange, supporting care coordinators by ensuring care plan dissemination and receipt. After care plans are completed, quality assistants conduct medical record review to ensure the CP has proper member consent, and correct automatic pathways for data exchange with the member's PCP.

BHN has a systematic approach for working with PCPs around member engagement. In 2019, BHN recognized a need for more timely care plan review by PCPs and put QI plans in place to reduce the number of unsigned care plans outstanding. The CP began sharing care plan transmission tracker spreadsheets with key ACO contacts and deployed their Engagement Manager and care coordinators out to practices to advocate for earlier new patient appointments for members. These strategies were successful in lessening the wait time for PCP appointments and reducing the number of unsigned care plans lost in transmission. BHN additionally utilizes a care plan cover page with CP contact information and important dates to make this information easily accessible to ACO/PCP contacts.

BHN's transition coordinator and engagement and retention manager regularly update and exchange enrollee contact information with ACOs/MCOs. The transition coordinator, hired in 2018, serves as the primary point of contact for ACO/MCO partner referrals. This role maintains ongoing communication with ACO/MCO partners to review prospective members, discuss BHN's care coordination capacity, and research any treatment history the member may have with BHN. BHN's engagement and retention team adds to member contact information and supports BHN care teams by following up on hard-to-reach members.

### **Integration with ACOs and MCOs**

As a provider of integrated behavioral health (BH) services, BHN embeds staff in more than a dozen primary care practices and six area hospitals and medical centers including Baystate, Mercy and Holyoke Medical Center. BHN has strengthened clinical integration by incorporating BH CP staffing into the preexisting team model, and by merging leadership over Primary Care, Behavioral Health and Care Management so that Team Leaders now have blended roles. BH CP staff at these sites have badge access, access to daily schedules to track member appointments, co-located workspace with primary care staff, and regularly attend operational meetings which facilitates effective workflows and communication methods.

For BH CP teams not co-located at a health center, staff have built relationships with ACO/MCO complex care management and transition of care teams. BH CP teams hold routine case review meetings with ACO teams to identify common members, coordinate roles and responsibilities, and develop strategies to address complex member needs. At the executive level, BHN leadership holds weekly ACO Integration meetings with one ACO.

To promote seamless integration and follow-up, BHN employs a Quality Coordinator dedicated to monitoring ADT data through real-time event notifications. BHN receives this information from various sources including via ENS integrated into their Care Management Platform, through ACO/MCO reporting, and through BHN's shared EHR which shows admissions to other levels of care provided by BHN. The Quality Coordinator parses these notifications twice daily and initiates the process of notifying the appropriate care team.

### **Joint management of performance and quality**

BHN has taken steps to track and improve member engagement. The CP's performance dashboards track metrics such as conversion rate (number of activities completed by a BHN care coordinator that

are billable) and days of the week that are more or less productive, and identify members who require multiple care planning activities per month or members who have not received contact attempts in a given timeframe. In 2020, BHN produced a report that displays rates of timely completion of PCP-signed care plans. BHN's information system infrastructure is anchored by an enterprise exchange engine that integrates with the EHR. The enterprise exchange engine allows BHN to electronically distribute reports to all stakeholders, including ACOs, MCOs, MassHealth, and other providers by connecting to their Secure File Transfer Protocol (SFTP) sites or through secure email. BHN has reported they have the capacity to share data with ACOs/MCOs around shared savings, Medical Expense Ratio, reduced hospitalizations, and other metrics for care management programs. BHN leadership holds weekly integration meetings with at least some of the partnering ACOs to exchange updates, reduce duplication and collaborate on mutual issues.

*CP Administrator Perspective: "Our goal had been to reduce the amount of care plans that were outstanding (beyond 2 weeks); the average amount ranged between 100-150. Upon review of the reasons for the delays, we recognized two common themes including: members not connected with primary care physicians willing to sign plans and plans being "lost" in transmission between our systems and our ACO key contacts. We put quality improvement plans in place to manage these issues. The first issue, members who did not have an active PCP relationship/had not been seen in years by the practice they were attributed to, was resolved by targeting members and practices where getting a new patient appointment was either challenging or not timely. We identified practices where the new patient appointments being offered were 6+ months in the future and deployed our Engagement Manager out to the practices with the member and care coordinator to advocate for earlier appointments. This approach proves to be very successful and we have members who were able to go from a 6 month wait to a wait that was less than 30 days. In order to improve upon the transmission of plans, we did a thorough review of plans that we had listed as "sent" and created spreadsheets to share with ACO key contacts which listed the plan transmission status. The key contacts use the spreadsheets to communicate with our Quality Assistant on the expected turnaround time for plans. We have less than 50 plans at this point that are outstanding beyond 2 weeks and many are pending primary care appointments within the next month."*

## Recommendations

The IA has no recommendations for the Integration of Systems and Processes focus area.

Promising practices that CPs have found useful in this area include:

### ✓ Joint approach to member engagement

- adopting systems, preferably automated, that process new ACO member files instantaneously, inputting member information in the applicable platform and reconciling those members with existing eligibility lists, enabling the CP to engage with the new member list without delay;
- redesigning workflows and automated notifications so that receipt of a comprehensive assessment from an ACO/MCO partner generates a new outreach attempt;
- establishing on-demand access to full member records through partners' EHRs;
- tracking members' upcoming appointments through partners' EHRs to enable staff to connect with members in the waiting room prior to their appointment;
- negotiating fast track primary care appointments with practice sites to ensure that members receive timely care and to enable PCPs to engage with and sign off on the member's care plan;

- collaborating with interdisciplinary staff, such as CE and AP program managers, clinical care managers, nurses, and care coordinators to develop a promising practices toolkit for PCP engagement and care plan sign-off;
- hiring a dedicated community liaison to build relationships with PCPs and educate them about the benefits provided by the CP program;
- embedding care coordination staff at PCP practices, particularly those that require an in-person visit as a prerequisite for care plan sign off;
- determining the date of the member's last PCP visit within a month of that member's assignment, and proactively scheduling an appointment on behalf of any member who has not had a PCP visit in the prior 12 months;
- developing a single point of contact for ACO/MCO partner referrals to review prospective members, research previous treatment history, and to strategize on how to accommodate new members with current CP care team capacity;
- identifying a lead member organization or CP care team to align with each ACO/MCO partner to promote and facilitate relationship building between CP care teams and ACO/MCO clinical staff; and
- implementing a real-time communication tool such as secure texting to communicate with ACO practices about shared members.

✓ **Integration with ACOs and MCOs**

- attending regularly occurring case conferences with PCPs to review member cases and obtain PCP sign-off on care plans;
- collaborating with state agencies to improve management of mutual members. For example, creating an FAQ document to explain how the two organizations may effectively work together to provide the best care for members or conducting complex case conferences;
- scheduling joint visits with the PCP, ACO/MCO clinical care team representative, and the CP care coordinator to present a unified team to the member and establish distinct support roles and who the member can contact in to address various needs; and
- collaborating with PCP practice sites so that CP care coordinators are invited to meet with members onsite prior to their clinical appointments.

✓ **Joint management of performance and quality**

- monitoring process metrics associated with member outreach and engagement such as the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff;
- sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding, and members who have unsigned care plans that are due or overdue;
- having clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of those plans prior to submission to PCPs for sign-off;



- developing dashboards that combine data from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement;
- generating a reminder list of unsigned care plans for ACO and MCO key contacts;
- maintaining a dedicated web portal to share information with CP care teams across member organizations. Shared information includes contact information of primary care practices; the LTSS/BH provider network and local social services providers; training materials; and policies and procedures;
- developing a daily report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to identify members' ACO assignment changes and keep the members' records in the EHR up to date; and
- embedding staff at local Emergency Departments (EDs) to improve outreach to members not engaged in regular care, particularly members experiencing homelessness, and connect them to care coordination supports.

### 3. WORKFORCE DEVELOPMENT

#### *On Track Description*

Characteristics of CPs considered On track:

##### ✓ **Recruitment and retention**

- does not have persistent vacancies in planned staffing roles;
- offers a variety of incentives to attract candidates and retain staff, and uses a variety of mechanisms to recruit and retain staff; and
- employs tactics to ensure diversity in the workplace and design staff incentives and performance bonuses around CP priorities such as enrollee engagement, signed care plans and intensive care coordination.

##### ✓ **Training**

- develops policies and procedures to ensure staff meet the contractual training requirements and offer training to all new staff based on program requirements; and
- holds ongoing (often monthly) training to ensure staff are up to date on best practices and advancements in the field.

#### *Results*

The IA finds that BHN is **On track with no recommendations** in the Workforce Development focus area.

##### **Recruitment and retention**

BHN does not note any persistent vacancies in their staffing model. They achieved this level of retention in part through periodic raises, occasional year-end bonuses, and staff-wide incentive payments when the CP program meets its performance targets.

BHN prioritizes hiring internal staff transfers over new hires to limit turnover. As a result, a majority of the care coordination positions required for BHN to be fully staffed for program go-live were filled by

internal hires. BHN also recruits staff from the community through online networking, job boards, and their agency website. BHN's student internship program workforce pipeline is their most successful staffing strategy. Each year, BHN hosts and trains more than 100 interns, some of whom choose to stay on with BHN as full-time employees after they graduate.

BHN used the DSRIP Statewide Investment (SWI) 1a, the Student Loan Repayment Program, to incentivize recruitment of qualified staff, providing tuition reimbursement for two care coordinators and one registered nurse. BHN matched the SWI to expand the tuition reimbursement offer to recruit a second RN. BHN also participates in the state Massachusetts Loan Repayment Program and the National Health Service Corps (NHSC) loan repayment program. BHN offers bonuses to staff whose referral results in a sustained new hire. To attract crucial bilingual candidates, BHN recruits from Puerto Rico and provides relocation incentives.

BHN uses DSRIP funds to provide career development opportunities, such as community health worker (CHW) training and mock training exercises to improve managerial skills. However, BHN also attempts to increase retention by recognizing training burden, allowing experienced staff members to test out of training exercises in favor of more advanced training modules.

## **Training**

BHN has a robust training framework built around a set of core competencies. They offer online and in-person training modules designed to achieve proficiency in core competencies and a supervisory framework to monitor the application of these skills and behaviors. New staff are trained in all contractually required elements, including motivational interviewing, cultural competency, and person-centered treatment planning in the first week.

BHN's web-based learning management platform measures staff progress completing learning modules, setting clear expectations that are easy to track. Staff are required to achieve 80% competency to satisfy each training requirement. Lead care coordinators are responsible for ensuring their staff are kept up to date on their training requirements.

BHN established a steering committee focused on training to develop modules on best practices and advancements in the field. In 2019, BHN's Director of Integrated Learning implemented weekly education sessions to address areas affecting BH CP quality metrics such as outreach and engagement, follow-up after hospital discharges, and development of care plans. Additional trainings have included a course on common presentation of Serious Mental Illness (SMI) and SUD, strategies for engaging these individuals and training on outreach safety protocols. Staff are given paid time off to attend outside trainings. In 2020, BHN plans to begin conducting grand rounds as a teaching tool.

## **Recommendations**

The IA has no recommendations for the Workforce Development focus area.

Promising practices that CPs have found useful in this area include:

### **✓ Promoting diversity in the workplace**

- compensating staff with bilingual capabilities at a higher rate.
- establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
- advertising in publications tailored to non-English speaking populations;
- attending minority focused career fairs;
- recruiting from diversity-driven college career organizations;

- tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
- implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
- advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers; and
- recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.

#### ✓ **Recruitment and retention**

- implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;
- assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;
- conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention;
- making staff retention a priority initiative of the QMC to leverage existing quality improvement structures and engage leadership to monitor progress towards retention goals;
- implementing opportunities for peer mentoring and other supports; For example, scheduling office hours that allow care coordinators to network and receive support from experienced staff and/or have direct communication with CP leadership;
- reducing staff training burden by allowing experienced staff to test out of basic training exercises and instead participate in more advanced training modules;
- instituting a management training program to provide lower level staff a path to promotion;
- allowing flexible work hours and work from home options for care coordination staff;
- striving to maintain a balanced ratio of care coordinators to members served, to avoid unmanageable workloads and staff burnout;
- offering retention bonuses to staff that are separate from performance-based bonuses; and
- participating in SWI loan assistance for qualified professional staff.

#### ✓ **Training**

- providing staff with paid time to attend outside trainings that support operational and performance goals;
- assessing the effectiveness of training modules at least annually to ensure that staff felt the module's objectives were met and that staff are getting what they need to fill knowledge or skill gaps;

- updating training modules on an annual basis to ensure they reflect the latest best practices;
- developing a learning management system that tracks staff's completion of required trainings and provides online access to additional on-demand training modules;
- including role-playing exercises in trainings to reinforce best practices of key skills;
- partnering with local educational institutions to provide staff access to professional certification training programs;
- providing new staff with opportunities to shadow experienced care coordinators in the field prior to taking on their own caseload to build tangible skills and foster relationships between team members; and
- making use of online trainings designed and offered by MassHealth.

## 4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

### *On Track Description*

Characteristics of CPs considered On track:

- ✓ **Implementation of EHR and care management platform**
  - uses ENS/ADT alerts and integrates ENS notifications into the care management platform.
- ✓ **Interoperability and data exchange**
  - uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
  - uses Mass Hlway<sup>8</sup> to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.
- ✓ **Data analytics**
  - develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and
  - reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

### **Results**

The IA finds that BHN is **On track with no recommendations** in the Health Information Technology and Exchange focus area.

#### **Implementation of EHR and care management platform**

BHN's EHR Director managed system integration between BHN's EHR, and their new care management software in 2017. BHN designed architecture for all incoming and outgoing data streams in house during this period. BHN contracts with an ENS provider to receive ADT notifications

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<sup>8</sup> Mass Hlway is the state-sponsored, statewide, health information exchange.

from participating hospitals; these alerts are fully integrated into their care management platform, however BHN also receives notifications from ACO/MCO reporting, through pre-existing relationships with inpatient units, through BHN crisis services, and through BHN's shared EHR that shows admissions to detox, and other levels of care provided by BHN. These ADT notifications are manually sorted and assigned to care teams by a quality coordinator.

As a result of the system being entirely configured by BHN with no vendor, a business analyst and BHN's Quality Coordinator dedicate resources to rigorous audits of staff documentation and system clicks to document discrepancies between service delivery and outputs. This process has produced higher quality of data and increased the number of QAs.<sup>9</sup>

### **Interoperability and data exchange**

To ensure secure and reliable data exchange, BHN invested in a piece of software separate from their care management platform that allows for data exchange with all partners. The enterprise exchange engine (EIE) software can automatically retrieve files from partner SFTP sites and move them directly into the BHN network. The EIE also supports other secure transport options such as secure email and the transmission of unstructured document types, such as flat files or pdfs. This technology allows BHN to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email. In their most recent progress report, BHN reports they are able to share and/or receive member contact information, comprehensive needs assessments, and care plans electronically with all ACOs, MCOs, and PCPs.

BHN is a full participant in Mass Hlway<sup>10</sup> and can send and receive messages on the HIE via a Direct Trust Accredited Health Information Services Provider (HISP) connection with Mass Hlway. BHN is developing and testing an ADT feed from their EHR to the regional HIE, Pioneer Valley Information Exchange (PVIX). The feed will allow PVIX participants to have access to real-time notification of shared patient events as well as push direct messages with attached Consolidated Clinical Document Architecture documents to providers not participating in the PVIX.

BHN teams currently have access to Baystate Health Center's EHR, and Holyoke Health Center's EHR, to review records, supplement the care plan, and send notifications to the providers directly to request additional information.

### **Data analytics**

BHN's dashboards were developed through collaboration between the Information Systems team and the Quality Department. The customizable dashboards show not only the raw numbers of QAs (billable) by staff member, but also program-specific trends that help managers design appropriate interventions. Dashboards track performance metrics such as conversion rate (number of activities completed by a BHN care coordinator that are billable), days of the week that are more or less productive, as well as population health measures such as the number of admissions and transitions among the CP member cohort. Dashboards are refreshed on demand for senior leadership and twice daily to all supervisors.

Another tool in BHN's analytic toolkit is their ability to create, view and monitor workflows in their care management platform using meta-data tagging. Supervisors have created task lists for care coordinators focused on high-risk individuals, intake for new enrollees, and tiered follow-up activities

<sup>9</sup> Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow-up after discharge, and health and wellness coaching.

<sup>10</sup> Mass Hlway is the state-sponsored, statewide, health information exchange.

for individuals with different functional needs. Supervisors are able to monitor progress in these workflows using meta data attached to tasks.

In January 2019, BHN piloted a design intervention to increase productivity of staff during low billing months. Using their analytic capabilities, leadership was able to track QAs<sup>11</sup> by staff member and compare this number to individual caseloads.

*CP Administrator Perspective: "BHN's use of data derived from [the Care Management platform] became increasingly sophisticated in 2019. We spent several months during the winter 2018-2019 refining our workflows, capturing previously missed QA's, retraining staff, and rigorously performing quality assurance reconciling between our system and the resultant output. By March, we had a set of standard reports that were sent daily to managers to track performance with much higher confidence in the data that was contained therein than reports used in prior months."*

## Recommendations

The IA has no recommendations for the Health Information Technology and Exchange focus area.

Promising practices that CPs have found useful in this area include:

- ✓ **Implementation of EHR and care management platform**
  - adopting enterprise exchange software that automatically retrieves files from partner SFTPs and moves them into the CP's EHR.
- ✓ **Interoperability and data exchange**
  - developing electronic information exchange capabilities that enable a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email; and
  - connecting with regional Health Information Exchanges (HIEs).
- ✓ **Data analytics**
  - designing a data warehouse to store documentation and performance data from multiple sources in a central location that can underwrite a performance dashboard;
  - incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress;
  - updating dashboards daily for use by supervisors, management, and the QMC; and
  - incorporating Healthcare Effectiveness Data and Information Set metrics into dashboards to support integration with ACO/MCO partners.

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<sup>11</sup> Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow-up after discharge, and health and wellness coaching.

## 5. CARE MODEL

### *On Track Description*

Characteristics of CPs considered On track:

✓ **Outreach and engagement strategies**

- ensures staff are providing supports that are tailored to and reflective of the population racially, ethnically and linguistically;
- uses peer supports and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities; and
- has a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations.

✓ **Person-centered care model**

- ensures goals are documented in the care plan so that the team is engaged in supporting the enrollee towards achieving goals; and
- uses person-centered modalities so that care coordinators can assist enrollees in setting health and wellness goals.

✓ **Managing transitions of care**

- manages transitions of care with established processes including routine warm handoffs between transitions of care teams and CP care team.

✓ **Improving members' health and wellness**

- standardizes processes for connecting members with community resources and social services.

✓ **Continuous quality improvement (QI)**

- has a structure for enabling continuous QI in quality of care and member experience.

### **Results**

The IA finds that BHN is **On track with no recommendations** in the Care Model focus area.

#### **Outreach and engagement strategies**

Visits with BHN staff are, when possible, adapted to accommodate a member's disability and language needs. To meet the needs of their member population, BHN employs bilingual care coordinators and contracts with vendors to provide telephone translation and in-person translation services. BHN utilizes a translation software package with artificial intelligence technology to capture linguistic nuances and constantly improve translation of care plan documents. BHN also provides access to auxiliary aids and services, such as documents that are accessible to those who are blind or have low vision. BHN has peer specialists to reach members, employing their own past members, and recruiting additional peers from the National Alliance on Mental Illness and Recovery Learning Communities.

BHN identified staff anxiety surrounding in-home outreach as a challenge and responded with additional training and a revised job description to attract more seasoned candidates. BHN currently employs care coordinators whose time is dedicated to outreach in EDs, detoxification units, and

inpatient units. These staff report to the Transitions Coordinator. BHN tries to approach reluctant members through an established clinical contact, such as a past primary care physician.

### **Person-centered care model**

BHN's treatment plans incorporate member goals. BHN care coordinators engage the individual and their support system in creating care plan goals, and BHN has training modules on best practices in person-centered planning, motivational interviewing, trauma-informed care, recovery models, and strategies for engaging with SMI and SUD. BHN's treatment plans additionally address barriers to meeting goals, proposed interventions to overcome barriers and include a section on how care team members will intervene if a member is experiencing a medical or BH crisis. BHN reports that members' accommodation needs are captured in the assessment, and BHN staff incorporate a "problem, goal, intervention" framework into the member care plan to address any identified accommodation needs.

### **Managing transitions of care**

Through rigorous tracking, BHN has found that transitions of care are extremely high in their BH CP population, with 20% of members experiencing a transition in any given 30-day period. In 2019, BHN established Transitions of Care teams, comprised of Licensed Practical Nurses (managing medical admissions and ED encounters) and CHWs (managing acute BH episodes), that are dispatched in response to event notifications distributed by the dedicated staff member in the care management platform. Transitions of Care teams directly contact the admitting hospital unit for inpatient admissions to collaborate on discharge planning. BHN also has continued to use an embedded staff model in which one dedicated staff member (CHW or LPN) within CP care teams primarily handles follow-up activities for individuals transitioning in a 60-90 day period. Supervisors/team leaders or nurse care managers within CP teams consult on care planning and treatment decisions and take the lead on coordinating with higher levels of care and primary care providers during member transitions.

BHN is notified of member transitions from various sources. BHN receives this information via ENS integrated into their care management platform, through ACO/MCO reporting, and through BHN's shared EHR which shows admissions to other levels of care provided by BHN. The Quality Coordinator parses these notifications twice daily and initiates the process of notifying the appropriate care team.

### **Improving members' health and wellness**

At their primary location, BHN facilitates a Whole Health Action Management group, tobacco cessation programs, a walking group, and mindfulness activities onsite. Staff embedded in primary care clinics offer a range of groups around health behavior change, and leadership is looking to expand this initiative to meet the needs of their inpatient population. To support health literacy, BHN recently deployed a health education platform to deliver written and visual resources to members. BHN continues to monitor the impact of wellness initiatives and self-management programs for the BH CP program.

In 2020, BHN nurse care managers have provided all members with education about the flu vaccine and offered to administer this vaccine in member homes. Care coordinators worked to reach out to members to gauge their level of preparedness for the COVID-19 pandemic, prioritizing high-risk members with complex medical conditions.

To address social determinants of health, BHN employs housing specialists to serve members and educate staff on how best to meet members' housing needs.



## Continuous quality improvement

The BHN Quality Department administers the Mental Health Statistics Improvement Program Survey as a mechanism to enable continuous QI in quality of care and member experience. The Mental Health Statistics Improvement Program Survey is an evidence-based tool designed to assess consumer satisfaction in six domains: General Satisfaction, Access, Outcomes, Social Connectedness, Cultural Sensitivity, and Participation in Treatment. BHN leadership analyzes these results to consistently refine workforce development needs.

Additionally, BHN tracks individual progress as well as cohort-level measures within their EHR to identify opportunities to reduce avoidable hospitalizations and ED visits and boost CP Accountability Scores. BHN's Fiscal Contract Manager assists in modeling the optimal team composition and BHN's Director of Integrated Learning monitors additional training needs.

BHN has already undertaken specific actions to improve quality of care and member experience. One continuous QI project involved developing systems and processes to reduce member wait times for PCP appointments. Other actions BHN has implemented to improve quality of care and member experience include employing housing specialists in response to member needs and implementing a CAB suggestion to give members a reliable point of contact outside the ED if they are in crisis.

## Recommendations

The IA has no recommendations for the Care Model focus area.

Promising practices that CPs have found useful in this area include:

### ✓ Outreach and engagement strategies

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
- providing free transportation options for members to engage with services<sup>12</sup>;
- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

### ✓ Person-centered care model

- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
- setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
- developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and

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<sup>12</sup> CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

- allowing members to attend care planning meetings by phone or teleconference.
- ✓ **Managing transitions of care**
  - assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
  - establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
  - meeting an enrollee in person once care coordinators receive alerts that they were admitted;
  - visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges<sup>13</sup>;
  - establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
  - having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.
- ✓ **Improving members' health and wellness**
  - allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;
  - negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and
  - contracting with national databases for community resources to develop a library of available supports.
- ✓ **Continuous quality improvement**
  - providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;
  - administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;
  - scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and
  - creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

## OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that BHN is On track across all five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

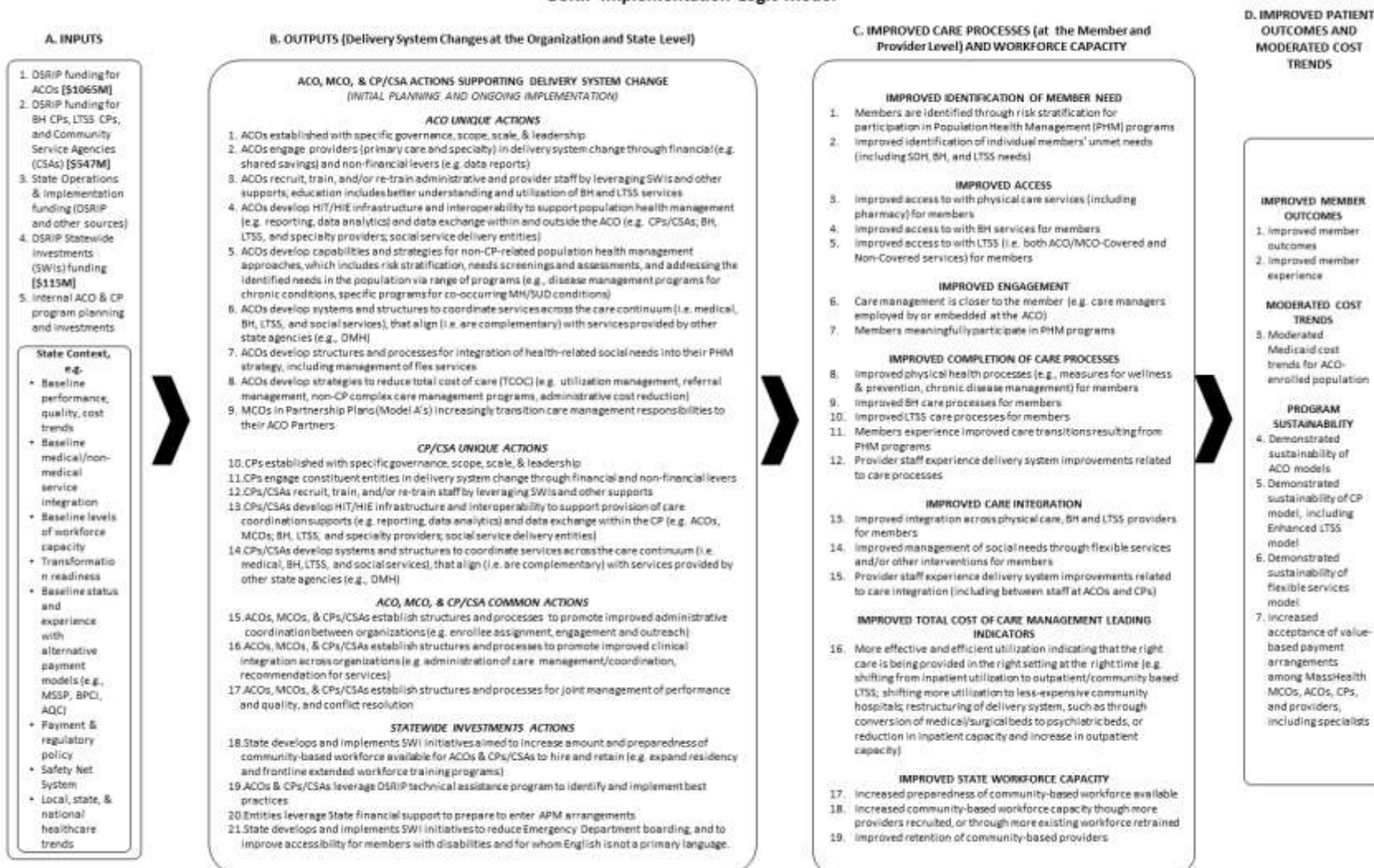
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<sup>13</sup> Where members have authorized sharing of SUD treatment records.

- Organizational Structure and Engagement
- Integration of Systems and Processes
- Workforce Development
- Health Information Technology and Exchange
- Care Model

# APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL

## DSRIP Implementation Logic Model



## APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, and key informant interviews (KIIs) to assess progress of Community Partners (CPs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018.

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator<sup>14</sup> (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (<https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download>).

The question addressed by this assessment is:

*To what extent has the CP taken organizational level actions, across five areas of focus, to transform care delivery under an accountable and integrated care model?*

### DATA SOURCES

The MPA drew on multiple data sources to assess organizational performance in each focus area, including both historical data contained in the documents that CPs were required to submit to MassHealth, and newly collected data gathered by the IA and/or IE. The IA performed a desk review of documents that CPs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. The IE developed a protocol for CP Administrator KIIs, which were conducted jointly by the IA and the IE.

List of MPA data sources:

Documents submitted by CPs to MassHealth covering the reporting period of July 1, 2017 through December 31, 2019:

- Full Participation Plans
- Semi-annual and Annual Progress Reports
- Budgets and Budget Narratives

Newly Collected Data

- CP Administrator KIIs

### FOCUS AREA FRAMEWORK

The CP MPA assessment findings cover five “focus areas” or aspects of health system transformation. These were derived from the DSRIP logic model, by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes

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<sup>14</sup> The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. This framework was used to assess each CP's progress. A rating of On track indicates that the CP has made appropriate progress in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the CP was rated "On track with limited recommendations" or, in the case of more substantial gaps, "Opportunity for improvement."

Table 1. Framework for Organizational Assessment of CPs

Focus Area	CP Actions
<b>Organizational Structure and Governance</b>	<ul style="list-style-type: none"> <li>CPs established with specific governance, scope, scale, &amp; leadership</li> <li>CPs engage constituent entities in delivery system change</li> </ul>
<b>Integration of Systems and Processes</b>	<ul style="list-style-type: none"> <li>CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)</li> <li>CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)</li> <li>CPs establish structures and processes for joint management of performance and quality, and problem solving</li> </ul>
<b>Workforce Development</b>	<ul style="list-style-type: none"> <li>CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports</li> </ul>
<b>Health Information Technology and Exchange</b>	<ul style="list-style-type: none"> <li>CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))</li> </ul>

## ANALYTIC APPROACH

The CP actions are broad enough to be accomplished in a variety of ways by different CPs, and the scope of the IA is to assess progress, not to prescribe the best approach for an CP. Moreover, no pre-established benchmark is available to determine what represents adequate progress at the midpoint. The need for a realistic threshold of expected progress led the IA to use a semi-empirical approach to define the state that should be considered On track. Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans, which identified a broad range of activities and capabilities that fell within the logic model actions. This provided specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item, and relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality

of CPs. Items that had been accomplished by only a small number of CPs were considered to be emerging practices, and were not included in the expectations for On track performance. This calibrated the threshold for expected progress to the actual performance of the cohort as a whole.

Qualitative coding of documents to focus areas, and analysis of survey results relevant to each focus area, were used to assess whether and how each CP had accomplished the actions for each focus area. The assessment was holistic, and as such did not require that CPs meet every item on a list. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and there are no recommendations for improvement. Where evidence was lacking in the results of desk review and survey, keyword searches of KII interview transcripts were used to seek additional information. Prior to finalizing the findings for an entity, the multiple reviewers convened to confirm that thresholds were applied consistently, and that the reasoning was clearly articulated and documented.

A rating of On track indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for improvement.

## **DATA COLLECTION**

### ***Key Informant Interviews***

Key Informant Interviews (KII) of CP Administrators were conducted in order to understand the degree to which participating entities are adopting core CP competencies, the barriers to transformation, and the organization's experience with state support for transformation.<sup>15</sup> Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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<sup>15</sup> KII were developed by the IE and conducted jointly by the IE and the IA. The IA utilized the KII transcripts as a secondary data source; the IA did not perform a full qualitative analysis of the KII.

## APPENDIX III: ACRONYM GLOSSARY

ACPP	Accountable Care Partnership Plan
CP	Accountable Care Organization
ADT	Admission, Discharge, Transfer
AP	Affiliated Partner
APR	Annual Progress Report
BH CP	Behavioral Health Community Partner
CAB	Consumer Advisory Board
CCCM	Care Coordination & Care Management
CCM	Complex Care Management
CE	Consortium Entity
CHA	Community Health Advocate
CHEC	Community Health Education Center
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CSA	Community Service Agency
CWA	Community Wellness Advocate
DMH	Department of Mental Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
ENS	Event Notification Service
EOHHS	Executive Office of Health and Human Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HLHC	Hospital-Licensed Health Centers
HRSN	Health-Related Social Need
HSIMS	Health Systems and Integration Manager Survey
IA	Independent Assessor
IE	Independent Evaluator
JOC	Joint Operating Committee
KII	Key Informant Interview
LGBTQ	lesbian, gay, bisexual, transgender, queer, questioning
LCSW	Licensed Independent Clinical Social Worker
LPN	Licensed Practical Nurse
LTSS CP	Long Term Services and Supports Community Partner
MAeHC	Massachusetts eHealth Collaborative
MAT	Medication for Addiction Treatment
MCO	Managed Care Organization



MPA	Midpoint Assessment
NCQA	National Committee for Quality Assurance
OBAT	Office-Based Addiction Treatment
PCP	Primary Care Provider
PFAC	Patient and Family Advisory Committee
PHM	Population Health Management
PT-1	MassHealth Transportation Program
QI	Quality Improvement
QMC	Quality Management Committee
RN	Registered Nurse
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SVP	Senior Vice President
SWI	Statewide Investments
TCOC	Total Cost of Care
VNA	Visiting Nurse Association

## APPENDIX IV: CP COMMENT

Each CP was provided with the opportunity to review their individual MPA report. The CP had a two week comment period, during which it had the option of making a statement about the report. CPs were provided with a form and instructions for submitting requests for correction (e.g., typos) and a comment of 1,000 word or less. CPs were instructed that the comment may be attached as an appendix to the public-facing report, at the discretion of MassHealth and the IA.

Comments and requests for correction were reviewed by the IA and by MassHealth. If the CP submitted a comment, it is provided below. If the CP requested a minor clarification in the narrative that added useful detail or context but had no bearing on the findings, the IA made the requested change. If a request for correction or change had the potential to impact the findings, the IA reviewed the MPA data sources again and attempted to identify documentation in support of the requested change. If documentation was identified, the change was made. If documentation was not identified, no change was made to the report but the information provided by the CP in the request for correction is shown below.

### CP Comment

BHN is on track with no recommendations in all focus areas. Thank you for the feedback noted in promising practices under each area. The following are comments related to promising practices in the report.

Organizational structure and development: Our quality department continues to develop as we move into a pay for reporting year. In the fall of 2019 BHN put into place multiple reports that were able to provide visual almost real time tracking of members contacted attempts, caseload sizes, and team performance. These tools were instrumental in supporting staff to provide effective high quality care management to members served.

Integration of Systems and Processes: Member engagement with primary care providers continues to be essential to the timely completion of the care plan. BHN has worked with ACO contacts to ensure that care plans are signed in a timely way to target the 122 day quality measure.

Workforce Development: BHN is as flexible as possible in promoting staff development and satisfaction.

Health Information Technology and Exchange: No additional comments

Care Model: Nursing is central to BHN's care transitions model, both in screening the notifications that members are in the hospital and then in triaging whether or not it is clinically appropriate for the nurse to do the follow-up, the care coordinator, a clinician, community health worker, or LPN. The team adapts the approach based on member need.