

MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Behavioral Health Partners of Metrowest LLC (BHPMW)

Report prepared by The Public Consulting Group: December 2020



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DSRIP Midpoint Assessment Highlights & Key Findings

Behavioral Health Partners of Metrowest LLC (BHPMW)

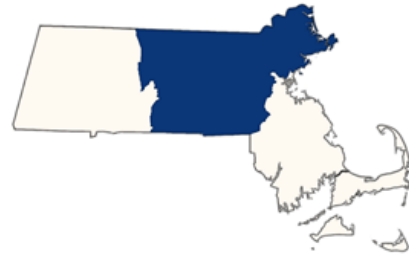


A Behavioral Health Community Partner

Organization Overview

BHPMW is a collaboration that draws on the long-standing relationships among four partner agencies: Advocates, South Middlesex Opportunity Council (SMOC), Spectrum Health Systems, and Wayside Youth & Family Support Network.

SERVICE AREA



POPULATIONS SERVED

- ▶ BHPMW's primary service area includes Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester, Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Woburn.
- ▶ This service area encompasses rural, urban and suburban communities with a variety of marginalized populations such as LGBTQ, immigrant, and minority groups. Many of the cities and towns served by BHPMW experience significant disparities in health and social outcomes.

2,650

**Members Enrolled
as of December 2019**

FOCUS AREA

IA FINDINGS

Organizational Structure & Engagement	● On Track	● Limited Recommendations
Integration of Systems & Processes	● On Track	
Workforce Development	● On Track	
Health Information Technology & Exchange	● On Track	● Limited Recommendations
Care Model	● On Track	● Limited Recommendations

IMPLEMENTATION HIGHLIGHTS

- BHPMW established monthly care plan and clinical discussion meetings with two partner ACOs.
- BHPMW increased their care plan completion rate using the Plan-Do-Study-Act (PDSA) quality improvement methodology.
- BHPMW developed a daily eligibility report to identify newly eligible members.
- BHPMW worked with one health center to create an appointment "Fast Track" to reduce wait times for members.

Statewide Investment Utilization:

- Student Loan Repayment Program, 3 Care Coordinators and 1 RN/LPN participating
- Special Projects Program
- Community Mental Health Center Behavioral Health Recruitment Fund, 2 slots awarded
- Certified Peer Specialist Trainings
- Community Health Worker Trainings
- Technical Assistance
- 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 Evaluator¹ (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

¹ 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
Organizational Structure and Governance	<ul style="list-style-type: none"> CPs established with specific governance, scope, scale, & leadership CPs engage constituent entities in delivery system change
Integration of Systems and Processes	<ul style="list-style-type: none"> CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	<ul style="list-style-type: none"> CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	<ul style="list-style-type: none"> 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)
Care Model	<ul style="list-style-type: none"> 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))

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 BACKGROUND²

Behavioral Health Partners of MetroWest LLC (BHPMW) is a behavioral health (BH) CP.

BHPMW is a collaboration among four agencies – the Consortium Entities (CEs) – Advocates, South Middlesex Opportunity Council (SMOC), Spectrum Health Systems, and Wayside Youth & Family Support Network. In addition, Family Continuity (FC) is an Affiliated Partner (AP).³ The missions of the agencies share the overarching purpose of providing person-centered services that meet individuals and families where they are, partnering with them to address health-related challenges and supporting them in leading healthy, sustainable lives.

BHPMW's primary service area includes Athol, Framingham, Gardner-Fitchburg, Southbridge, Waltham, Worcester, Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, and Woburn. This service area encompasses rural, urban, and suburban communities with a variety of marginalized populations such as individuals who identify as LGBTQ+, immigrant, and racial and ethnic minority groups. Many of the cities and towns served by BHPMW experience significant disparities in health and social outcomes. A large percentage of people served by the five partner agencies are individuals and families with low incomes, most of whom are enrolled in MassHealth and/or Medicare. The CE agencies serve approximately 90,000 people annually. In their capacity as a BH CP, the CEs provide care coordination supports to the highest need individuals.

As of December 2019, 2,650 members were enrolled with BHPMW⁴.

SUMMARY OF FINDINGS

The IA finds that BHPMW is On track or On track with limited recommendations in five of five focus areas.

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

² Background information is summarized from the organizations Full Participation Plan.

³ 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.

⁴ Community Partner Enrollment Snapshot (12/13/2019).

Care Model

On track with limited recommendations

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).
- ✓ **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 BHPMW is **On track with limited recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

BHPMW has a Governing Body Executive Team, comprising leadership from the CEs, APs, and an Operations Team composed of senior operations staff. The Operations Team convened a Workflow Workgroup that supports CEs and APs with implementation of the CP program. The Governing Board Executive Team holds quarterly meetings, and the Operations Team holds monthly meetings. Senior operations staff also participate in a Billing Workgroup, Reporting Workgroup, and Marketing, and a Communications Workgroup for further oversight.

BHPMW conducts site visits at each CE and AP on quarterly basis (approximately) to assess each provider's implementation of contract requirements and offer consultation and Technical Assistance (TA) to partners. Results of individual site visits are reported to the Governing Body Executive Team.

CP Administrator Perspective: "A couple of my staff do provider site visits, so that ... we are transparent about everything as a group, I also do individual site visits to address provider-specific needs and challenges, etc. We use data in all of this, so from the very beginning, we design reports, so that every time we talk with our providers, we have data on how many people they have [and] what their performance is on engagement and care plans...I believe we have extremely robust systems and culture for working with our provider partners. We always talk about how we are one integrated program...We [don't] just get the contract, assign people out, and the providers pretty much figure out how they're going to meet the contract's requirements...It's one program, one set of policies and procedures, one philosophy, one everything. It's very much a consistent program."

Consumer Advisory Board

BHPMW has established a CAB with fourteen members. Only one CAB member identifies as an engaged enrollee; all other members are caregivers and/or family members. BHPMW's CAB met five times in 2019, and at least five members attended every meeting.

In 2019, BHPMW hired a peer specialist to assist with planning for the CAB and began the practice of presenting data from the QMC to CAB members at every meeting. It is unclear if the CP was either unsuccessful in recruiting engaged members to reflect their member population or if BHPMW intended to have primarily caregivers and family members as members.

Quality Management Committee

BHPMW's 16 member QMC consists of BHPMW leadership, leadership from each of the CEs and APs, the Medical Director, and the Program Data Analyst. In 2018 and 2019, BHPMW's main quality initiative focused on maximizing the number of assigned members who became fully engaged. BHPMW utilized the Plan–Do–Study–Act (PDSA) cycle approach to implement "360 care plans in 30 Days," in which staff tried new strategies to increase the number of care plans signed and returned. In 2019, BHPMW's QMC met four times to review the rate of return for participation forms, assessments, and care plans.

BHPMW has an established reporting structure in place to review outcomes and progress on their QI initiatives. BHPMW's Program Data Analyst prepares monthly reports and conducts in-depth analyses for the QMC to demonstrate which interventions have led to the most progress.

Recommendations

The IA encourages BHPMW to review its practices in the following aspects of the Organizational Structure and Engagement focus area, for which the IA did not identify sufficient documentation to assess progress:

- seek strategies to maintain a balance of engaged members and family members for participation in the CAB.

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

✓ Executive Board

- 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)⁵ 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;
- scheduling regular presentations about best practices related to quality metrics;

⁵ 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.

- 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 BHPMW is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

BHPMW has a centralized administrative coordination team to transmit care plans on behalf of CEs and APs care coordination staff to accommodate variation in ACO/MCO documented data exchange processes. BHPMW administrative coordinators retrieve information from ACO/MCO secure file transfer protocol (SFTP) sites, send member data files to ACO/MCOs, and facilitate communication with staff at CEs and APs. The majority of BHPMW's ACO/MCO partners require that the CP submit care plans via their SFTP sites, another secure file transfer application, or fax. BHPMW reports the highest number of Care plans signed with Reliant Medical Group in partnership with Fallon Health due to regular "face to face" meetings, which they consider a best practice. Other ACOs that have been highly responsive to care plan signing include Wellforce in partnership with Fallon Health and Atrius Health, in partnership with Tufts Health Public Plans.

BHPMW has streamlined the work required to assess the accuracy of ACO/MCO spreadsheets. Dedicated staff, including a Billing Specialist, an Eligibility Specialist, and an ACO Specialist, reconcile information provided in ACO/MCO spreadsheets and conduct outreach to members experiencing a transition in care. BHPMW runs an eligibility report daily to find out which members are newly eligible or ineligible. The billing specialist and the eligibility specialist work together to monitor progress and keep care coordinators informed about the eligibility of their members. Additionally, care coordinators and ACOs/MCOs regularly exchange member contact information.

BHPMW reported challenges collaborating with some PCPs to provide care for enrollees with a history of substance abuse. Some PCPs require members with substance use disorder (SUD) history to prove they are not actively using before signing care plans. Despite this challenge, BHPMW has had success building PCP relationships. BHPMW staff meet monthly with complex care managers from Wellforce PCP practices. BHPMW leadership negotiated a "FastTrack" for primary care appointments with one practice site and now holds monthly meetings with this ACO partner. In 2019, BHPMW worked with CE and ap program managers, clinical care managers, nurses, and care coordinators to develop a Tool Kit of promising practices related to PCP engagement and care plan sign-off. The toolkit instructs care coordinators and registered nurses (RNs) to call the PCP office where the member is a patient immediately following the initial assessment. On this call, BHPMW staff explain the CP's program, obtain a medication and diagnoses list for the member, and remind the PCP office that the care plan requires sign-off and must be returned by fax or secure email. BHPMW staff also attempt to schedule an appointment on behalf of their member during this first phone call.

BHPMW Administrator Perspective: "We run the eligibility report every day to find out which members are newly eligible and newly ineligible for that day, as well as members who continue to be ineligible. For the newly eligible and ineligible members, the Eligibility Specialist identifies the assigned CC (care coordinator) and sends a letter informing them of changes in their Enrollee's eligibility, and [provides] instructions on how they can proceed. The Eligibility Specialist then emails these letters as an attachment to Program Managers to distribute to their CCs. This way CCs can help Enrollees call MassHealth to resolve issues. The Enrollees with continued ineligibility are then stored in SharePoint as the staff has already been informed of them."

Integration with ACOs and MCOs

BHPMW has Documented Processes for data exchange and engagement with ACO/MCO partners. BHPMW holds quarterly meetings with 13 ACO/MCO partners and has consistent care plan and clinical discussion meetings with two ACOs: Reliant Medical Group (twice a month) and Wellforce (once a month). With Reliant Medical Group, BHPMW care coordinators attend in-person meetings with a Nurse Care Manager to receive sign-off on care plans and use meetings to have clinical discussions about high inpatient utilization. BHPMW considers these meetings to be a best practice because they have resulted in the highest rate of signed care plans among all ACO/MCO partners. BHPMW staff additionally have a good working relationship with Atrius ACO's Complex Care Manager Supervisor and attends in-person meetings with Wellforce PCP care teams. BHPMW will

soon begin regularly attending Wellforce care team meetings at Lowell General Hospital. Tufts MCO and Merrimack Valley ACO have set up meetings with BHPMW to discuss members with a high utilization of care. Recognizing the need for more collaboration with ACO/MCO partners, BHPMW engaged a consultant to assist in developing an overall ACO/MCO strategy to improve relationships with their 13 partners.

BHPMW receives ENS notifications daily via their electronic health record (EHR) and is in the process of configuring additional notification systems with other vendors. BHPMW care coordination staff monitor all sources of event notification to make timely contact with members while they are in an inpatient setting.

Joint management of performance and quality

BHPMW has data-driven QI initiatives related to member engagement, and routinely shares data on key performance indicators (KPIs) with ACOs/MCOs during scheduled meetings. In 2018, BHPMW executed a PDSA cycle on increasing the number of care plans sent to PCPs in 30 days. The CP shared best practices around increasing the number of care plans sent with all APs and CEs. BHPMW's data analytics department developed several spreadsheets and reports to share with ACOs/MCOs, APs and CEs identifying trends related to the number of care plans exchanged and the CP's engagement rate for assigned members.

To support care coordinators in their effort to engage PCPs, BHPMW developed an audit process to assess compliance with PCP standards. Clinical care managers audit individual care coordinators once or twice a month, focusing on documentation of member needs in care plans and coaching them on upcoming action items for each of their members. Clinical care managers also have access to weekly trended data reports on care plans and comprehensive health assessment metrics to identify improvement strategies within their own teams.

Care coordinators are further supported by centralized eligibility processes. BHPMW runs eligibility reports daily and employs an eligibility specialist to alert CE and AP care teams of changes in member status. Daily notification on member eligibility reduces the number of care plans rejected for eligibility reasons.

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 BHPMW is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

BHPMW does not report any persistent vacancies and uses a variety of incentives to attract and recruit qualified staff. To hire key nursing positions and other clinical staff, BHPMW uses the staffing

firm of one of its CEs. Additionally, BHPMW initiated employee referral bonuses and recruitment bonuses for new nurses.

There is evidence BHPMW prioritizes hiring diverse staff and employs specific strategies to attract candidates from diverse communities. Strategies include advertising in local native language newspapers, reaching out to area colleges, working with existing multilingual and multi-cultural staff to identify potential employees, and connecting with professional membership groups to seek out diverse candidates. These activities occur alongside more conventional methods of recruitment such as online advertising, networking with local colleges, and traditional print advertising.

To retain staff, BHPMW provided mid-year and end of the year retention bonuses, as well as extensive performance bonuses to staff that achieved outreach and engagement milestones, such as the most first-time face-to-face meetings with members per month. BHPMW also provided student loan repayment through Statewide Investment 1a (SWI) to two care coordinators and one RN.

Beyond direct monetary incentives, BHPMW has lowered caseloads for care coordinators and created a new position, the Senior Care Coordinator, to create a career ladder for employees. The CP also reports their CEs and APs have an open-door policy in place to ensure staff concerns are addressed in a timely and appropriate manner.

BHPMW Administrator Perspective: "We had one RN and two care coordinators receive tuition reimbursement, and that is really fantastic. I mean, the RN got the funding said to me it is life-changing, and she is so committed, and she will stay here probably forever. And she is, you know, a young, excellent RN, and same with the care coordinators. So, with all the talk in the state and across the country around workforce tuition reimbursement is probably maybe the single greatest, most effective tool I have seen in making an impact on helping us to retain staff."

Training

BHPMW conducted an initial in-person orientation and training for approximately 50 staff from across their CEs and one AP. The five-day training covered all contractually required topics. BHPMW recorded all sessions to ensure future hires receive the same required training. BHPMW provides individual and group supervision on an ongoing basis to promote staff development.

To track compliance, the CEs and APs report their training logs to the BHPMW Director of Population Health Management. The CAB and Peer Support Specialists identified a need for a comprehensive Training Manual so BHPMW engaged the Center for Health Impact, a non-profit community-based organization, to develop one. The manual utilizes a "train the trainer" model to ensure that each of BHPMW's BH CP partners has one trainer who can facilitate and orient new staff to the BH CP model of care.

BHPMW reports holding in-person refresher trainings on evidence-based practices, in some cases utilizing outside trainers, at least annually. There is also evidence that BHPMW trained their staff on the new care management software in 2018. In 2019, BHPMW utilized Frontline Workforce statewide investments to sponsor several staff members' participation in the 80-hour Core Competency Community Health Worker training provided by the Center for Health Impact.

BHPMW Administrator Perspective: "Based on feedback from the Consumer Advisory Board (CAB), Peer Support Specialists and other new staff members [in 2019], we have engaged the Center for Health Impact, a Non-Profit Community Organization in Central Massachusetts, in developing a BHPMW BHCP 101 Training Manual. The manual will include core modules required by MassHealth and will utilize a "train the trainer" model to ensure that each of our partners has one trainer who can facilitate and orient new staff to the BHCP model of care. Each module will be divided into 3-hour segments that include a short competency test questionnaire at the end of each module."

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 Hlway⁶ to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.

⁶ Mass Hlway is the state-sponsored, statewide, health information exchange.

✓ **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 BHPMW is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

BHPMW transitioned to a new care management platform in 2019 due a change in business practices by the CP's former vendor. Despite this change, BHPMW reports that they were able to fully integrate ENS notifications into their new platform in 2019. The CP is working towards engaging with other ENS vendors in order to expand the number of hospitals the CP can receive notifications from.

Interoperability and data exchange

BHPMW has configured an SFTP server hosted by their dual EHR/care management platform. The CP reports challenges in getting ACOs/MCOs to utilize their SFTP. As a result, BHPMW relies on their administrative team to access all SFTP and other secure file sharing applications of their ACO/MCO partners on behalf of care coordinators. BHPMW is connected to Mass HIway as an additional method of communication. BHPMW has access to Reliant Medical Group's EHR to support care coordination and follow up after hospitalization efforts. In their most recent progress report, BHPMW reported they are able to share and/or receive member contact information, assessments, and care plans electronically from all or nearly all ACOs and MCOs and from most PCPs.

Data analytics

BHPMW's care management platform is the primary data collection mechanism and reporting tool for the CP. BHPMW's IT and data analytics staff continually work with their care management vendor to design necessary reports and dashboards within the platform. BHPMW's Data Analyst and Director of Population Health/Quality Management are responsible for analyzing data. They produce weekly care plan and comprehensive health assessment trended data reports for program managers and care managers for performance management. Reports describe member status and eligibility, enrollment/disenrollment, comprehensive assessment completion rates, daily event notification receipts, care plan completion rate, and breakdown and number of Qualifying Activities⁷ performed.

Progress towards goals is reported to BHPMW's QMC by the Director of Population Health. The Director of Population Health actively works with the QMC to design interventions and provide expertise on the quality of data collected and reported.

BHPMW began working on a population health project with a TA vendor in 2019. The project will create a centralized data repository for MassHealth claims data and data collected from the care management platform. With the overall aim of improving quality of care and reducing total cost of care, the repository will allow the CP to better understand their members' utilization and cost patterns in order to target their care coordination activities more efficiently.

⁷ 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.

Recommendations

The IA encourages BHPMW to review its practices in the following aspects of the Health Information Technology and Exchange focus area, for which the IA did not identify sufficient documentation to assess progress:

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files.

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.

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 BHPMW has an **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

BHPMW, and its CEs and APs, were successful in hiring diverse staff who speak various languages to reflect the CP's multilingual member population. BHPMW is working to increase staff awareness around accessibility of written information through a core training module, the *Accessibility and Accommodations Module*. The module addresses the CP's oral interpretation services and the availability of member forms in non-English languages or written in formats to accommodate individuals with special accessibility needs.

BHPMW reports employing Peer Support Specialists throughout the provision of CP supports to reach members struggling with mental health challenges. BHPMW utilizes their provider network to conduct direct outreach specifically to engage members with SUD. Staff regularly meet with these members through Acute Treatment Services (ATS) and other 24-hour levels of care. BHPMW's CE, Advocates, has established protocols with three local ATS programs to identify and contact members in a HIPAA⁸ compliant manner before they are discharged from these settings. Other CEs operate residential programs and sober houses, which gives BHPMW staff access to these members in these settings as well.

To encourage participation in the BH CP program and build trust between members and BHPMW staff, BHPMW provides free cell phones to members through a state-funded cellular service provider. BHPMW then asks members who are initially reluctant to participate in the program if a care coordinator may call at a regular interval to check in on their wellbeing.

Person-centered care model

BHPMW care plans incorporate members' goals, with a particular focus on social determinants of health and navigating the healthcare delivery system. Goals are written in first-person, for example, "I need help finding a new psychiatrist that accepts Medicaid" or "I need a safer place to live." Care coordinators assist members in identifying manageable steps to achieve goals. Care plans also incorporate the member's preferences, needs, and cultural considerations.

BHPMW staff utilize person-centered modalities, such as the *Brief Negotiated Interview*, a tool which has its roots in motivational interviewing. BHPMW also offers person-centered treatment planning refresher courses to highlight best practices for plan approval. BHPMW care coordinators involve all

⁸ Health Insurance Portability and Accountability Act

members of the care team in the care planning process and work to ensure care planning visits are conducted in a manner that accommodates disabilities and language needs.

Managing transitions of care

BHPMW improved their transitions of care process by integrating event data into their EHR/care management platform in 2019. The CP utilizes ENS notifications that are integrated into their EHR/care management platform, creating an alert on member records and on care team dashboards when any assigned member is admitted to an ED or inpatient facility. A BHPMW nurse or clinical care manager follow-up on all notifications in one business day. The CP has refined their workflows to ensure a BHPMW RN makes the first call to the hospital or ED where a member was admitted because the CP has found RN staff receive the swiftest response from hospital units. Several ACO partners have established a point of contact at hospital units for CP staff to reach out to during member transitions. BHPMW staff have had particular success with embedded Merrimack Valley ACO staff who make contact with members in the ED or inpatient unit directly and then hand off the member to CP staff when members of the CP care team arrive at the hospital.

BHPMW continues to evaluate other ENS providers to identify hospital systems with a relatively high volume of visits from its members. If BHPMW were able to connect to the ENS of one of these hospital systems, they receive more notifications of member admissions.

Improving members' health and wellness

BHPMW staff incorporate health and wellness goals into member care plans and utilize data to tailor health and wellness activities to members' specific medical and social needs. Care coordinators provide education to members on nutrition, weight management, exercise, stress management and smoking; they help members link to wellness and disease management programs available through their CE and AP network and through ACO partners. Care coordinators facilitate members' use of available community-based resources including gyms and farmers' markets by negotiating reduced or no-cost arrangements.

Continuous quality improvement

BHPMW's CAB enables continuous QI in member experience. BHPMW strategizes with CAB members how to engage PCPs and improve member engagement rates. The CAB identified stigma surrounding mental illness in the health system as an issue that detracts from member experience. CAB members brainstormed ways in which the CP program could combat stigma and decrease the number of personal questions asked of members while providing CP based supports and services.

BHPMW's QMC enables continuous QI in quality of care. Staff utilize PDSA cycles to implement interventions, and BHPMW's data analyst evaluates which interventions had the most impact on CP performance metrics. BHPMW is also participating in a TA project that involves aggregating claims data and data from their care management platform in order to study population health outcomes among their enrolled members.

Recommendations

The IA encourages BHPMW to review its practices in the following aspects of the Care Model focus area, for which the IA did not identify sufficient documentation to assess progress:

- increasing standardization of processes for connecting members to community resources and social services where applicable.

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 services⁹;
- 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
- 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 discharges¹⁰;
- 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.

⁹ CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

¹⁰ Where members have authorized sharing of SUD treatment records.

- ✓ **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 BHPMW 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:

- Integration of Systems and Processes
- Workforce Development

The IA encourages BHPMW to review its practices in the following aspects of the focus areas, for which the IA did not identify sufficient documentation to assess or confirm progress:

Organizational Structure and Engagement

- seek strategies to maintain a balance of engaged members and family members for participation in the CAB.

Health Information Technology and Exchange

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files.

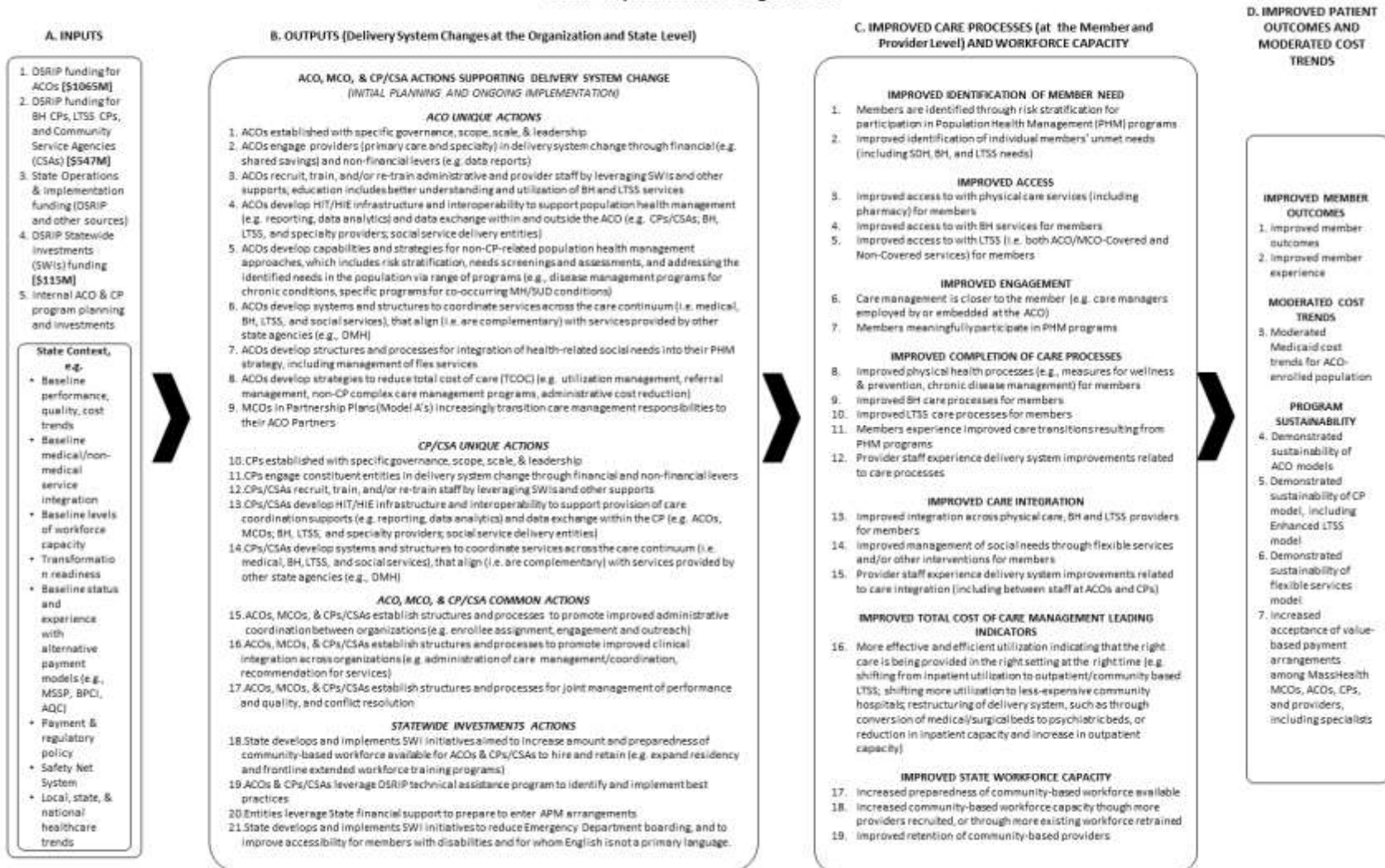
Care Model

- increasing standardization of processes for connecting members to community resources and social services where applicable.

BHPMW should carefully self-assess the areas noted above, and consider the corresponding promising practices identified by the IA for each focus area. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

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 Evaluator¹¹ (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

¹¹ 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
Organizational Structure and Governance	<ul style="list-style-type: none"> • CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	<ul style="list-style-type: none"> • CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	<ul style="list-style-type: none"> • CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	<ul style="list-style-type: none"> • 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)
Care Model	<ul style="list-style-type: none"> • 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))

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.¹² Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

¹² 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

Thank you for your assessment and recommendations. The following includes some additional information about relevant accomplishments prior to 12/31/2019 as well as some clarifying comments.

(1) page 9- Consumer Advisory Board (CAB)- By December 2019, we had 5 Engaged Enrollees involved in our CAB. It was always our intent to prioritize BHCP Enrollees for CAB membership. Our strategy was to include several Peer Specialists, who are also people with lived experience, who work in our BHCP to help begin the CAB and recruit Enrollees, which was effective. These peers comprised many of the initial attendees rather than family members who were identified in the report.

(2) page 16- Training- We also conducted training in December 2019 on Person-Centered Treatment Planning for 40 BHCP staff with Dr. Janis Tondora, a nationally recognized expert on this topic.

(3) page 24- HIT- We utilize all SFTP and other sites used by MassHealth and our ACO/MCO partners for data exchange. We check all of them regularly. Some have alerts built-in. Many of the ACO/MCOs transfer files only monthly rather than daily and we know when they are coming, e.g. assignment files at the beginning of the month.

(4) page 24- Care Model- We have standard referral practices within the BHCP which are well known to staff. It is generally the community resource that dictates how referrals to their programs are made, so we don't have control over standardizing their processes.

Thank you for the opportunity to comment.