MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

PUBLIC CONSULTING GROUP

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DSRIP Midpoint Assessment
Highlights & Key Findings
Care Alliance of Western Massachusetts (CAWM)

A Long-Term Services and Supports Community Partner

Organization Overview
CAWM is a partnership of seven agencies working together to connect consumers with long-term services and supports (LTSS). CAWM provides person-centered care coordination services for individuals ages 3-64. The Affiliated Partners have over four decades of experience coordinating home and community resources and care across a broad spectrum of health and social services.

SERVICE AREA

POPULATIONS SERVED

▶ CAWM's primary service area includes Hampden, Hampshire, Berkshire, and Franklin Counties. CAWM also provides services to residents of Athol, Petersham, Phillipston, and Royalston in Worcester County.

▶ CAWM serves individuals with complex LTSS and BH needs, including individuals with physical disabilities, with intellectual and/or developmental disabilities, including autism. CAWM serves children and youth (ages 3 – 21) and older adults (up to age 64) with LTSS needs.

1,209
**Members Enrolled
as of December 2019**

FOCUS AREA	IA FINDINGS	
Organizational Structure and Engagement	● On Track	
Integration of Systems and Processes	● On Track	
Workforce Development	● On Track	● Limited Recommendations
Health Information Technology and Exchange	● On Track	● Limited Recommendations
Care Model	● On Track	● Limited Recommendations

IMPLEMENTATION HIGHLIGHTS

- CAWM's clinical care managers collaborate with some practices to perform joint first visits with new members.
- CAWM developed protocols and workflows for a monthly disenrollment process to make caseloads more manageable.
- CAWM centralized communication regarding document transmission, tracking and review within their data team.
- CAWM hired a Transitions Coach to follow up on admission, discharge, and transfer alerts and initiate a rapid and timely response from all care team members after an emergency department visit or inpatient stay.

Statewide Investment Utilization:

o Student Loan Repayment Program, 3 Care Coordinators participating
o Certified Peer Specialist Trainings
o Community Health Worker Trainings
o Technical Assistance
o 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[1] (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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[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	• CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	• 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	• CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	• 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	• 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 BACKGROUND[2]

Care Alliance of Western Massachusetts (CAWM) is a long-term services and supports (LTSS) CP.

CAWM is a partnership of seven agencies working together to connect consumers with LTSS. CAWM provides person-centered care coordination services for MassHealth enrollees ages 3-64 with complex LTSS needs. The seven Affiliated Partners (APs) have over four decades of experience coordinating home and community-based care across a broad spectrum of health and social services agencies in Western Massachusetts.[3]

CAWM's primary service area includes Hampden, Hampshire, Berkshire, and Franklin Counties. CAWM also provides services to residents of Athol, Petersham, Phillipston, and Royalston in Worcester County. CAWM serves individuals with behavioral health needs or complex LTSS needs due to traumatic brain injury, physical disabilities, and intellectual or developmental disabilities (ID/DD), including autism. Approximately one third of CAWM's members are non-English speakers and over 30% of the member panel are children.

As of December 2019, 1,209 members were enrolled with CAWM[4].

SUMMARY OF FINDINGS

The IA finds that CAWM 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
Integration of Systems and Processes	On track
Workforce Development	On track with limited recommendations
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track with limited recommendations

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[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).

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 CAWM is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

CAWM has a Board of Directors that meets regularly. The Board keeps abreast of CAWM's work with ACO/MCO partners and Executive Office of Health and Human Services (EOHHS) and reviews staffing changes, revenue and expense projections, enrollment, participation and engagement rates, and QI work. CAWM's lead agency, WestMass Elder Care Inc., conducts needs assessments to determine the level of unmet need in CAWM's service area. The Board monitors progress on regional goals by reviewing the results from these quarterly needs assessments. CAWM has five active APs. In 2019, two of the APs remained in the legal partnership but are not actively working with members due to low referral volume and staff turnover. CP leadership holds monthly meetings with all partners and schedules one-on-one site visits with each partner on a regular basis.

Consumer Advisory Board

CAWM's CAB began holding quarterly meetings in March of 2019 and reports that an increasing number of members attended each meeting throughout the year with nine members participating in December. CAB members include ACO/MCO enrollees and family members of enrollees.

To encourage participation, CAWM offers CAB members the ability to participate by phone, sends reminder letters two weeks in advance, calls members the day before to confirm their attendance, and reimburses members for participation with gift cards.

CAWM includes a recruitment notice in the enrollment packet members receive when they first join the CP program. CAWM translates enrollment packets into multiple languages and bilingual staff provide translation during CAB meetings. Translation services ensure that members with diverse linguistic capabilities can participate, allowing CAB members to reflect CAWM's service population.

Quality Management Committee

CAWM formed a QMC comprised of CAWM Board members and other staff. The QMC established a Quality Improvement Plan and provides a quality report to CAWM's Board on a quarterly basis. CAWM's central data team monitors quality metrics such as time to complete the outreach and engagement cycle and time to complete comprehensive assessments and care plan sign-off. The central data team shares these quality reports with care teams and the QMC. CAWM reports performing Plan, Do, Study, Act (PDSA) cycles in accordance with their Quality Improvement Plan.

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**

- 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.

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[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.

✓ **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;

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

Joint approach to member engagement

In 2019, CAWM formed a centralized data team to handle all communication and administrative work with ACO/MCO partner practices including receipt, transmission, and tracking of member contact information and member data files. The CAWM data team supports care coordinators across AP organizations by managing the flow of comprehensive assessments and care plans and communicating regularly with ACOs/MCOs to obtain PCP signatures on care plans and exchange documents in accordance with contract timelines. Members of CAWM's data team also review member documents for accuracy, flagging missing data and tasks that require follow-up.

CAWM engages PCPs primarily by serving as a resource for the PCP care teams. At some practices, CAWM care coordinators attend interdisciplinary team meetings with PCP staff and collaborate with ACO staff to hold first visits with members as a unified care team. Additionally, CAWM's clinical care coordinator from the central data team routinely provides consultation and requests information from PCPs about medically complex members. To increase awareness of the CAWM program, the data team educates PCPs about LTSS CP benefits. CAWM reports that they continue to develop single point of contact processes for PCPs and ACOs/MCOs so that all providers that are part of a member's care team know that a first meeting with the member has been scheduled.

CAWM receives all ACO/MCO referral files electronically and maintains a running dialogue with ACO/MCO partners regarding their capacity to accept new members. The data team uploads member information contained in ACO/MCO spreadsheets to CAWM's electronic health record (EHR)

so that CP care teams can access it to conduct outreach. The data team is available every day to review and upload ACO/MCO member files and receive ad hoc requests from partners through a dedicated email account and phone line.

> CAWM Administrator Perspective: "*A success of CAWM has been to centralize our communication regarding document transmission, tracking and review within the Data Team, securely, timely and with quality standards guiding the daily work. A regular schedule of tracking and communication with ACOs /MCOs regarding document status within contractual timelines is also in place.*"

Integration with ACOs and MCOs

CAWM attends monthly and quarterly check-in meetings with all ACO/MCO partners to align goals, review measure outcomes, and discuss how CAWM's team can assist ACO primary care teams and other ancillary teams (i.e. transitions of care, complex care management, intensive care management). During these meetings, CAWM leadership gains insight into partners' processes and communication strategies and learns how to work with partner teams to meet member needs.

Frontline staff learn ACO/MCO workflows during monthly training meetings. CAWM invites ACO/MCO partner care teams to these monthly training meetings to clarify roles, strengthen care team integration, and afford CP care coordinators time to discuss past or current cases with ACO/MCO partner teams.

CAWM staff review complex cases in monthly or bi-weekly meetings with ACO care teams. CAWM care coordinators also participate in interdisciplinary teams with some PCPs and report that this framework creates opportunities for a more comprehensive case review process. In the interdisciplinary team model, PCP practices invite CAWM staff to connect with difficult to reach members prior to the member's scheduled PCP visit. Members of the PCP team and CAWM nurses and care coordinators then collaborate on the member's care and perform joint follow-up visits. Joint visits with CP care coordinators and either ACO/MCO clinical care teams or PCP staff introduce the member to their care team as a unit and clarify each provider's role so the member knows who to contact to address different needs. CAWM's LTSS CP nurse provides assessment, evaluation, and consultation without duplicating the efforts of PCP clinical staff. CAWM participates in interdisciplinary team meetings with five sites in one ACO network and with three other ACO partners either in-person or by phone. CAWM participates in joint visits to members' homes with three ACO partners.

ENS notifications are available in CAWM's EHR daily. Some PCPs do not utilize any ENS, and CAWM relies on these practices to provide notifications through other channels. The CAWM data team has a process in place for timely review, notification, and follow-up that involves CAWM's Transition Coach and care coordinators as appropriate.

Joint management of performance and quality

In addition to providing administrative support to CAWM's care coordinators, CAWM's central data team monitors CP performance on key metrics such as engagement rate, comprehensive assessment and care plan completion and approval rate, number of care transition activities performed in response to member discharges, and cycle time for outreach and participation in the CP program. In February 2019, CAWM increased member engagement productivity through a series of data driven PDSA cycles. This suggests the CP has implemented data-driven quality initiatives to track and improve member engagement.

RN and licensed practical nurse (LPN) staff complete comprehensive care plan reviews for the CAWM program. CAWM's clinical care coordinator (who is an RN) attends interdisciplinary meetings, provides consultation services to ACO/MCO partners on complex member cases, and reviews all comprehensive assessments and care plans for thoroughness and clarity. CAWM built this clinical

position into their staffing model to adequately understand the significance of members' medical needs and elevate their services, as necessary.

CAWM's EHR automatically imports eligibility files and enrollment rosters from EOHHS and ACO/MCO partners as well as claims data from EOHHS. CAWM's centralized data team manages disenrollment data and keeps CAWM leadership up to date with enrollment numbers, total cost of care (TCOC), and fiscal sustainability at monthly meetings. Metrics on comprehensive assessments, care plan completion and approval, care transition and discharge activities, and cycle time for outreach and participation are conveyed to CAWM care teams during monthly all-staff meetings.

> CAWM Administrator Perspective: "*Having seven partners requires consistent and frequent communication amongst the partners, members and ACO/MCO partners. Use of consistent messaging is strongly encouraged and reinforced at monthly training and best practice sessions with care coordinators. EHR training and reinforcement of the member journey as documented in the software is a regular area of communication and review as well through @carealliancecewma.org email and EHR messaging.*"

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 CAWM is **On track with limited recommendations** in the Workforce Development focus area.

Recruitment and retention

CAWM had no persistent staff vacancies but did experience turnover in the Program Director, care coordinator, and other supervisory positions during the first half of the program. Despite this turnover, CAWM maintains an adequate number of care coordinators. CAWM's APs recruit staff internally through their organization's website and externally through online job boards affiliated with local newspapers and other dedicated job sites.

CAWM applied for three loan repayment spots for care coordinators through the Statewide Investment 1a. CAWM APs participate in compensation surveys to measure their employee compensation packages compared to other area agencies. Surveys show that CAWM APs' benefit packages are comparable to or better than similar organizations. Additionally, CAWM reports they provide staff with opportunities for professional development, mentoring, peer learning and support, and promotions as retention incentives. Furthermore, CAWM holds regular monthly meetings which allows care coordinators time to network, pose questions, and get to know each other.

CAWM's review of ACO/MCO member profiles and the population demographics of CAWM's service area indicated a critical need to hire bilingual/multilingual, multi-cultural care coordinators that reflect their target population. CAWM updated job descriptions to include a preference for bilingual/multilingual candidates and flagged this issue with other CP partner organizations at their monthly leadership meetings. CAWM successfully hired care coordinators who could speak Spanish, Arabic, and Russian.

CAWM Administrator Perspective: "*Two other areas of competency which we have learned are quite important are other relevant work or lived experience with the subsets of member populations as well as knowing local resources. For example, hiring a new CC [care coordinator] to primarily cover members in Berkshire County was successful and improved collaboration with the primary ACO in the area when the hire spoke Spanish and had several years of work experience with families as well as children with special needs and an in depth working knowledge of Berkshire County resources.*

Training

CAWM held multiple in-person trainings to onboard new staff in April of 2017. Trainings covered all contractually required topics including cultural competence; accessibility and accommodations; independent living and recovery principles; motivational interviewing; the conflict of interest policy; health and wellness principles; the person-centered planning process; and the scope of LTSS and eligibility criteria for coverage in the MassHealth State Plan. Initial training included a full day of technical training for all care coordinators and supervisors to build skills in the program's EHR and care management platform.

CAWM uses a proprietary online training curriculum to ensure all staff receive annual refresher training on contractually required topics.[6]

In addition to content level training, CAWM holds monthly meetings on topics specific to the CP program such as changes to the EHR, changes in program implementation, outreach/engagement strategies, tactics for filling out care plans, and proper documentation techniques. Every meeting includes technical training to improve use of the EHR and care management platform and exchange resources to address social determinants of health.

Some of CAWM's APs provide supplemental training for all CP staff. For example, WestMass Elder Care Inc. held a training on guardianship in 2019 that was open to care coordination staff from all AP agencies.

Recommendations

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

- implementing performance bonuses around CP priorities such as enrollee engagement, signed care plans, and intensive care coordination.

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;

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[6] Training topics required by EOHHS as part of the BH CP contract include cultural competency, accessibility and accommodations, independent living and recovery principles, MassHealth State Plan LTSS and eligibility criteria, motivational interviewing, trauma-informed care, conflicts of interest, health and wellness principles, Person-Centered Treatment Planning processes, using curriculum approved by EOHHS.

- 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 of 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 HIway[7] 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 CAWM is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

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[7] Mass HIway is the state-sponsored, statewide, health information exchange.

Implementation of EHR and care management platform

In 2019, CAWM integrated ENS notifications into their EHR system. Notifications are refreshed nightly and provide ADT information from EDs, inpatient units, and rehabilitation facilities. The data team established a workflow for timely review of all ENS notifications.

Interoperability and data exchange

CAWM connects to their ACO/MCO partners in a variety of ways. The data team exchanges information with partners via their EHR/care management platform, SFTP, secure file sharing apps, secure fax, auditor login support, encrypted PDF exports, and HIE including the Pioneer Valley Information Exchange (PVIX) and Mass HIway[8]. Care coordinators use secure texting with BMC BeHeathy practice and hospital staff and encrypted Transport Layer Security (TLS)[9] email to connect with their counterparts on ACO/MCO provider teams.

CAWM reports it can share and/or receive member contact information, comprehensive needs assessments and care plans electronically with all ACOs, MCOs, and PCPs.

Data analytics

CAWM's EHR/care management platform is capable of querying EOHHS data and submitting structured outcomes reports and data extracts in specified formats to EOHHS and ACOs/MCOs. CAWM's Data Team tracks comprehensive assessments, care plans, and ENS alerts to provide data on engagement cycle time and to support required follow-up activities. CAWM completed a Technical Assistance (TA) project funded through Statewide Investment 5a with an approved vendor to pull claims level data directly in the member charts within their EHR/care management platform. This allows staff to understand members' medical histories and calculate TCOC. CAWM has been approved for a second TA project to do quality reporting through dashboards in their EHR/care management platform.

CAWM's data team shares data on key metrics of engagement with AP teams, the QMC, and senior leadership monthly.

Recommendations

The IA encourages CAWM 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.

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[8] Mass HIway is a statewide health information exchange.
[9] TLS is a protocol that encrypts and delivers email securely, for both inbound and outbound email traffic.

- ✓ **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 CAWM has an **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

After reviewing ACO/MCO member profiles to assess the language needs of the member population, CAWM hired bilingual care coordinators who speak either Spanish, Russian, or Arabic, as these languages were most common in the service area. CAWM continues to work to address the language needs of their members, particularly after recognizing that members' demand for language support was greater than anticipated. CAWM also employs a workforce that is experienced in working with many different member populations such as children, older adults, persons with ID/DD, substance use disorders (SUD), physical disability, and/or cognitive impairment. Two of CAWM's staff were trained as CHWs through a training offered by Berkshire Fallon Health Collaborative in 2019.

CAWM's strategy for contacting members that cannot be reached by phone relies on the cooperation of PCPs. CAWM developed an interdisciplinary model with some PCPs that allows CP staff to make in-person contact for hard-to-reach members following a recent PCP visit, with member permission.

Person-centered care model

During the care planning process, CAWM care coordinators meet with members to discuss members' needs, goals, current supports, and any cultural preferences. Care coordinators provide members with all care options, including self-directed care programs, and discuss with the member any strategies or interventions identified by the comprehensive assessment. All goals, preferences, and interventions are documented in the member's care plan.

CAWM stratifies the LTSS CP panel into subgroups (i.e., children, medically complex, need for more psychosocial support) and assigns members to care coordinators who are experienced working with these populations to support members' needs more effectively. All CAWM CP staff are trained in cultural competence, accessibility and accommodations, independent living and recovery principles, and motivational interviewing.

Managing transitions of care

CAWM has a dedicated Transition Coach who is responsible for parsing ENS/ADT notifications and completing all follow-up activities with members and members' families. The Transition Coach identifies new member supports and works with care coordinators on updating member care plans post transition. CAWM also works closely with Baystate Health's inpatient Transitions of Care team, which follows members for 30 days post-admission based on their stratified panel. This relationship has produced warm handoffs between Baystate's Transitions of Care team and CAWM's LTSS CP team.

Improving members' health and wellness

In providing care coordination services, CAWM has had success in their role as an expert in community resources, access, and problem solving. CAWM staff work to ensure that all issues related to social determinants of health are coordinated by the LTSS CP. Digital libraries of area resources are maintained in CAWM's EHR system, in shared folders, and in the members only section on CAWM's website. CAWM is also a charter member of 413Cares which is a collaborative effort led by the Public Health Institute of Western Massachusetts that gives providers access to an online searchable database of community resources.

CAWM staff have access to shared training materials on legal guardianship processes, the federal Supplemental Nutrition Assistance Program, housing voucher applications, individualized care plans available through Department of Developmental Services (DDS), educational resources and

Individualized Education Programs (IEPs), local food and shelter resources, and guidance on navigating the MassHealth customer service center for member eligibility concerns. CAWM staff regularly access these training resource libraries when working with members.

> CAWM Administrator Perspective: "*[CAWM's successes include:] Working with many families who have complex dynamics and one or more enrolled members [who need help accessing] services which are available to them through the Department of Education, school settings and other community resources; [helping members] access adaptive equipment such as raised toilet seats, commodes and shower chairs which can greatly improve quality of life/personal care routines, and carrying out ADL and IADL tasks as well as making the home environment safer for the consumer and their caregivers.*
>
> *Care coordinators express a significant number of member issues and interventions revolving around housing instability issues…Care coordinators work with members and primary care team/other involved professionals/specialists to all get on the "same page" of understanding a complete picture of the member's situation which may be at the root cause of frequent hospitalizations."*

Continuous quality improvement

CAWM's active and engaged CAB contributes to continuous quality and member experience improvement. CAB members with multiple complex needs have requested more time with individual care coordinators and CHWs and have provided valuable feedback on the ACO comprehensive assessment, stating that it is lengthy and time consuming to complete.

Additionally, CAWM utilizes the Model for Improvement to operationalize quality of care initiatives. The Model for Improvement provides a framework for organizational change as well as specific tools for improvement. CAWM uses cause and effect diagrams, root cause analysis (RCA) and PDSA techniques for rapid cycle time improvement and for the creation of consistent processes that lead to higher quality care. The System and Quality Analyst will share quality reports, which align with the Quality Improvement Plan, with the QMC and the CAB regularly.

Recommendations

The IA encourages CAWM 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:

- developing a strategy to reach members that cannot easily be reached by phone by going to community locations; and

- establishing processes that make warm handoffs between Transitions of Care teams and CP care team routine.

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[10];

- 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 discharges[11];

- 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

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[10] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[11] Where members have authorized sharing of SUD treatment records.

- 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 CAWM is On track or On track with limited recommendations 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:

- Organizational Structure and Engagement

- Integration of Systems and Processes

The IA encourages CAWM 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:

Workforce Development

- implementing performance bonuses around CP priorities such as enrollee engagement, signed care plans, and intensive care coordination.

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

- developing a strategy to reach members that cannot easily be reached by phone by going to community locations; and

- establishing processes that make warm handoffs between Transitions of Care teams and CP care team routine.

CAWM 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
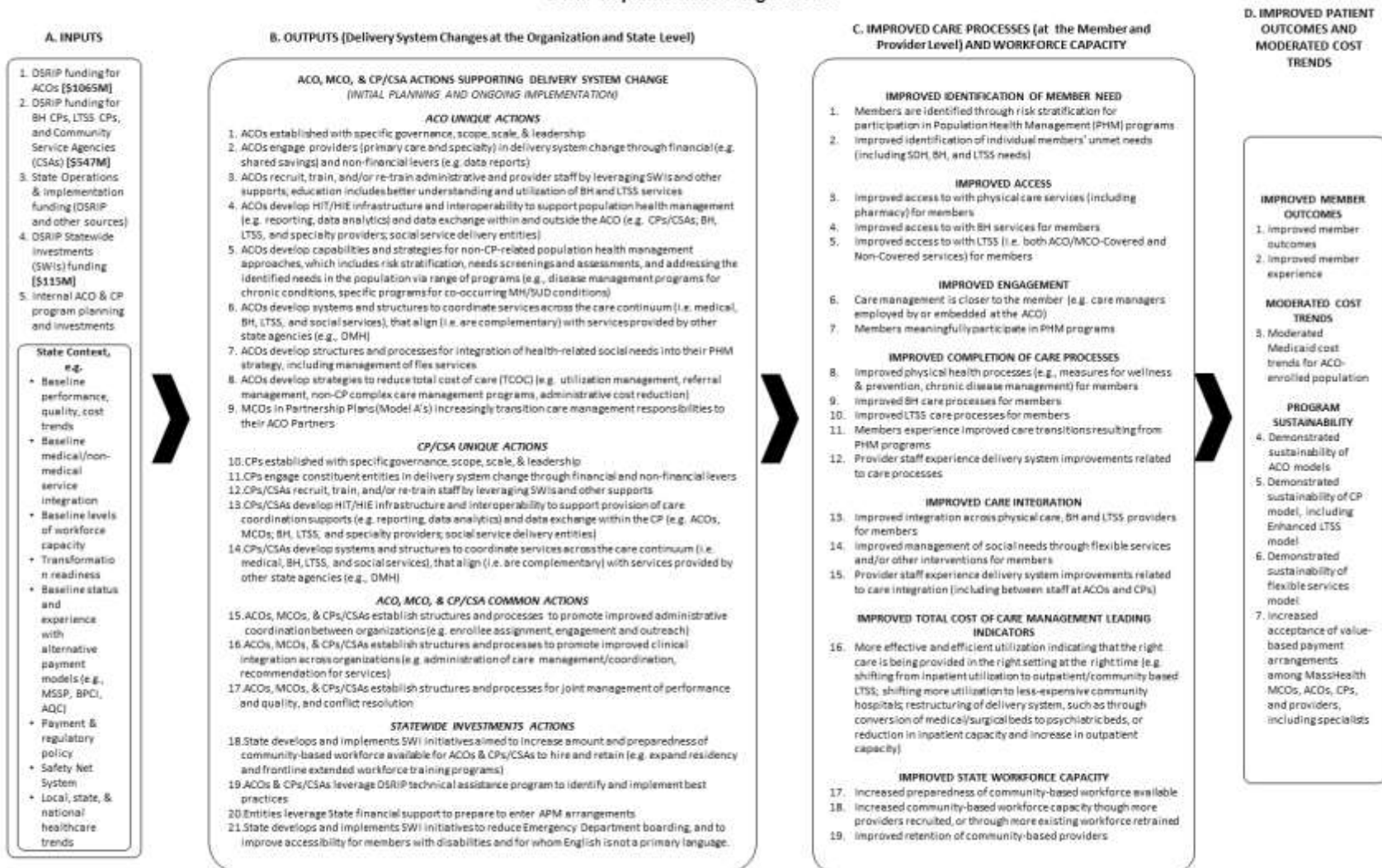
APPENDIX II: METHODOLOGY

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 Evaluator[12] (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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[12] 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	• CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	• 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	• CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	• 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	• 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.[13] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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[13] 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

PCG, the IA has found CAWM On Track in the two focus areas of Organizational Structure and Engagement as well as in Integration of Systems and Processes. Comments are offered by CAWM in relation to the three focus areas of Workforce Development, Health Information Technology and Exchange and Care Model where limited recommendations were made. Comments below also respond to the promising practices that are outlined all five focus areas of the report in the report. For the period of the Midpoint assessment, 7-1-2017 to 12-31-2019, practices in place for CAWM are noted in the comments below.

Organizational Structure and Engagement:

PROMISING PRACTICES:

- Care Coordinators meet more than once a week as a group as does the Data Team;

- Central Admin positions are in place (Claims and Data teams);

- CAB are invited, reminded and meet by phone, video or in person with a facilitator conducting the meeting in English and Spanish. All attendees receive a gift card; and,

- Best practices, PDSA and data from multiple sources is presented to the QM Committee.

Integration of Systems & Processes: While some aspects of systems and processes are in the control of CAWM as a CP, others depend upon ACO/MCO systems and processes and data made available by MassHealth.

PROMISING PRACTICES:

- Systems and Processes continue to improve by implementing TA projects approved in 2019 and 2020 including the development of dashboards

- Automated systems are available in eHana and are continually improving. EVS is used

- PCP visits and oral health visits are tracked and scheduled as available

- Coretext (secure texting is used) with ACOs which use this tool

- Discharge information is automated except when the ACO/MCO does not share

- Case Conferences and joint visits are conducted based on the ACO/MCO model

- Reports and reminders are sent to ACO/MCOs regarding outstanding Comprehensive Assessments and Unsigned care plans

Workforce Development:

RECOMMENDATION: CAWM does not utilize performance bonuses for staff achieving enrollee engagement, signed care plans and intensive care coordination. Staff are trained individually and collectively to focus on member needs and completion of milestones required by the contract within governing timeframes and frequencies. Each member of the team and each partner team's performance is monitored. Performance Improvement Plans have been put into place on an individual or team level as needed.

PROMISING PRACTICES:

- Staff with bilingual capabilities are compensated at a higher rate;

- Profile of members is used to inform hiring objectives;

- Applicants are assessed based on skill sets in addition to credentials;

- Peer mentoring, networking, role plays and group supervision is used;

- Flex schedules and remote work is used;

- Balanced ratio of staff to caseload is monitored;

- Paid time for training is in place including accessing training at educational institutions; and,

- Training modules are assessed and updated/LMS & on line MH training used.

Health Information Technology and Exchange:

RECOMMENDATION: CAWM has **systems in place to set monitors and alerts for daily receipt of client files** from both internal staff, MassHealth and ACO/MCO teams whether they are centrally administered or based at the practice level. The IA recommends using SFTP or other compliant and secure technology. The Data Team has workflows and reports that are completed daily. CAWM currently utilizes secure SFTP file exchange/Dropbox with 100% of our ACO partners. We have no SFTP file exchange practice with our MCO practice sites, which represents approximately 18% of our overall member panel. Additionally, these practices with no SFTP technology also are not part of an HIE so the practice model for data exchange is currently limited. There are TLS connections in place with two of the largest referring ACO partners as well to address secure end-to-end daily communications for ease and compliance. The HIE practices are not the root cause of delays in receiving information. *In part, the delays are related to program model structure (CA completion by ACO, care plan completed by LTSS CP) and resources within the ACO teams depending on the structure.*

PROMISING PRACTICES:

We currently are utilizing the majority of promising practices recommended in the assessment. We are beginning our TA project with AHP, which will address a few connected areas, most importantly data repository with which to pull and aggregate information from assessments that will be shared quarterly with our ACO partners. We do participate in auto tagging and other measures listed as this is through our vendor. This interrelates to dashboards. There is a duality of dashboard maintenance, which demonstrates some limitations; key metrics are only able to be updated with a push file upload from the state that has improved its cycle time recently. There are other factors that do provide daily server refresh updates every night. CAWM is not aware of any platform that currently has rights and capabilities of a true bidirectional dynamic feed.

Care Model:

RECOMMENDATIONS: The **strategy used to reach members who cannot be easily reached** by phone is to contact them by text and postal mail. Collaterals at the ACO/MCO and PCP are also contacted to verify correct contact information and upcoming or recent appointments. Care Coordinators go to community locations such as group homes. Homeless individuals constitute a small number of CAWM members. Staff are trained and approach new members respecting their culture and meeting language needs to increase the chances of acceptance by the member and their primary supports.

Processes that make warm hand offs between Transitions of Care teams and the CP care team are in process with two ACO/MCO partners collaborating with CAWM on the Care Plan Integration Initiative. Choosing to participate and reaching out to potential ACO/MCO partners occurred during 2019.

PROMISING PRACTICES:

- Care Coordinators specialize based on member profiles;

- Staff meet member needs outside business hours;

- Short term and long term member needs with attainable goals for the member are part of care planning;

- CAWM has LPN and RN resources on the team;

- Key contacts are established;

- ADT feeds are used to flag inpatient stays and a Transition Coach is assigned; and,

- CAWM became a charter member of 413cares.com in 2019 (Aunt Bertha).