

MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Eliot Community Human Services, Inc
(Eliot)

Report prepared by The Public Consulting Group: December 2020



PUBLIC
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DSRIP Midpoint Assessment Highlights & Key Findings

Eliot Community Human Services Inc.
(Eliot)

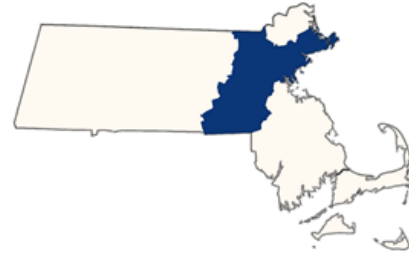


A Behavioral Health Community Partner

Organization Overview

Eliot provides care coordination and care management across the continuum of behavioral health (BH) services in its service network to adults with serious mental illness (SMI) and/or substance use disorders (SUD).

SERVICE AREA



POPULATIONS SERVED

- ▶ Eliot's CP population is frequently impacted by poverty and trauma and has needs related to transportation, housing, financial concerns, and family turmoil that create BH treatment barriers.
- ▶ More than half of the CP's population experiences comorbid medical conditions and/or has co-occurring substance use and mental health disorders. Many individuals in the population have been involved with multiple providers over time, frequently discontinuing from treatment or relapsing, and may have difficulty engaging with providers.

1,850
Members Enrolled
as of December 2019

FOCUS AREA

IA FINDINGS

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

IMPLEMENTATION HIGHLIGHTS

- Eliot's initiatives with ACO/MCO partners include care plan exchange, clinical case reviews, processes for identification of referrals through "referral meeting" forums and embedding CP staff with ACOs.
- Eliot created custom databases that combine data from MassHealth, ACOs/MCOs, its care management platform, and its electronic health record to identify potential members and efficiently engage them in BH CP services.
- Eliot improved communication and collaboration within their care teams and with other providers by embedding CP staff in several Eliot Behavioral Health programs, outpatient clinics, and emergency services.

Statewide Investment Utilization:

- Student Loan Repayment Program, 2 Care Coordinators and 1 LPN/RN participating
- Certified Peer Specialist Trainings
- Community Health Worker Trainings

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

Eliot Community Human Services, Inc. (Eliot) is a behavioral health (BH) CP.

Eliot is a sole entity CP currently serving areas north and west of Boston. Eliot provides care coordination supports for MassHealth members with serious mental illness (SMI) and/or substance use disorder (SUD).

Eliot's primary service area is greater Boston, Northern and Central Massachusetts including Somerville, Revere, Gloucester, Lowell, Lynn, Malden, Salem, Woburn, Framingham, and Waltham. Eliot's member population experiences extensive and often long-term challenges that impact their physical and mental health, family life, ability to maintain employment, and living situations. The majority have co-occurring SUD and mental health disorders. More than half have comorbid medical conditions, with a third receiving some level of long-term services and supports (LTSS). Members may have inadequate housing, difficulty accessing transportation, financial concerns and/or family turmoil that create barriers to engaging in treatment. Most members have received services from multiple healthcare and supportive services providers over many years, frequently discontinuing or relapsing for reasons including, but not limited to, distrust of the healthcare system and an aversion to service providers.

As of December 2019, 1,850 members were enrolled with Eliot³.

SUMMARY OF FINDINGS

The IA finds that Eliot 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
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track with limited recommendations

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

³ 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).⁴
- ✓ **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 Eliot is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

Eliot has a leadership team comprised of four director level staff, representing administrative and clinical staff. The leadership team maintains a compliance workplan that outlines the management, reporting, and administrative requirements in the CP program contract. This workplan includes action steps, targets dates, and the person responsible for each requirement. To ensure program compliance, Eliot reports that the workplan is reviewed by CP leadership monthly.

Eliot is a single entity CP, with no CP-Affiliated Partners. However, Eliot leverages its Director of Innovation to engage with community organizations collaborating with Eliot in the CP program. This

⁴ 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.

Director holds positions on community steering committees, meets regularly with community providers, and builds relationships with partner ACO/MCOs.

Consumer Advisory Board

Eliot established and maintained a CAB representing the members it serves. The CAB began meeting in October of 2018 and has continued to meet quarterly. CAB members offered feedback about their experience with peer support, recovery coaching, housing, rehabilitation services, and other opportunities for member involvement with the CP.

Eliot engaged the CAB to strategize how to gather information related to members' experiences with the CP program. Based on CAB input, Eliot's Quality Director created a draft member survey which the CP plans to implement.

Quality Management Committee

Eliot's QMC is composed of executive leaders and follows a reporting structure to review outcomes and monitor progress. The QMC meets quarterly.

Eliot's QMC and IT department supports the CP's review of team processes, program policies and procedures, staff training needs, and performance data to inform performance improvement opportunities. Eliot reports that the combined efforts of the QMC and the CP's electronic health record (EHR) vendor has resulted in the development of process improvements. Such improvements include the identification of gaps in CP data collection that, once addressed, could inform future service delivery, outcomes, and process improvements. The QMC generates a monthly report that tracks member initiation, engagement, utilization, and satisfaction for the leadership team to review and act upon as needed. Eliot uses the Lean Value Stream Mapping framework to identify and make workflow improvements within the CP.

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.

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

Joint approach to member engagement

Eliot implemented a centralized process to exchange care plans and other member files with ACO and MCO partners. This Documented Process includes the exchange of member files via Secure File Transfer Protocols (SFTP), secure email, a secure file-sharing application, and Mass HIway.⁶ Eliot transitioned the non-clinical responsibilities of sending care plans to providers, tracking care plan statuses, and receiving approved care plans to administrative staff members to optimize clinical staff time. Eliot participates in a Care Plan Learning Collaborative with three ACOs and works with PCP offices to identify solutions to barriers that impede PCP approval of care plans.

Eliot has Documented Processes with each ACO/MCO partner to exchange contact information for assigned and engaged members. Eliot tasks administrative staff with confirming member eligibility and updating member contact information through the review of ACO/MCO enrollment spreadsheets and ENS/ADT notifications on a daily basis.

Integration with ACOs and MCOs

Eliot schedules quarterly meetings with partner ACO/MCOs to identify effective workflows and communication methods to manage member care coordination. At these meetings, Eliot shares data

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

and member information with partner organizations and discusses ACO/MCO specific initiatives such as care plan exchange, member referrals, and bi-directional referral for services. Eliot's Director of Behavioral Health Innovation is responsible for the development of business relationships with partner ACOs, MCOs, the Massachusetts Executive Office of Health and Human Services (EOHHS), and other partner organizations.

Eliot has implemented clinical case review forums with ACO/MCO partners to discuss shared members and identify members able to enroll in the BH CP program. Eliot has also attended meetings with ACOs to review newly initiated members to the program.

Eliot has assigned administrative staff to the daily review of real-time ENS/ADT notifications and implemented specific workflows to manage information received via ENS/ADT feeds. Eliot reports that daily ENS/ADT reviews ensure timely access for direct care staff who can respond to member needs effectively and efficiently.

Eliot Administrator Perspective: "With more service providers "at the table", BH CP is able to maintain a role consistent with care coordination and care management while providing some direct care where needed [outside the CP role]. More importantly, we've been able to use this skill to effectively 'reach in' to services available within our ACO/MCOs continuum of care. For example, with high need members with complex medical care needs - we have been able to convey these situations to ACOs who have in turn assigned additional service for the member."

Joint management of performance and quality

To track and improve member engagement, Eliot created a custom database that combines data from EOHHS, ACO/MCOs, its care management platform and EHR. Eliot uses this database to help identify and engage potential BH CP members. Additionally, the database generates reports that identify specific touchpoints members have within the Eliot Behavioral Health Network and within its ACO/MCO partners' networks. These reports are used by Eliot care teams to manage member engagement.

Eliot works with a Technical Assistance (TA) vendor to analyze claims and utilization data to compare cost, disease severity, and other utilization measures to better understand their assigned population's health needs. The TA vendor created reports for each ACO/MCO partner to inform the collaborative process of developing customized care approaches with each entity.

Eliot is working to improve their comprehensive care plan review process with the ACOs/MCOs through a learning collaborative. Eliot has found that having a Documented Process and a single point of contact with the partner ACO streamlines the exchange and sign-off of member care plans. Conversely, Eliot reports that care plan transmission requires additional follow-up when the Documented Process for transmission does not include a single point of contact or when the ACO/MCO has a limited relationship with the PCP practice site.

Eliot Information Technology (IT) resources create reports from its care management platform to capture progress on performance metrics. These reports track measures tied to quality, access, outcomes, and total cost of care as well as internal measures including achievement of member goals and member satisfaction.

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

Recruitment and retention

Eliot reports that it has been able to maintain sufficient staffing levels. Eliot has recruited CP staff using three full-time recruiters, sign-on bonuses, and internship programs with local colleges and universities. To retain CP staff, Eliot has a bonus and incentive system that offers sustained salary increases based on industry market changes, merit, and annual increases. Additionally, Eliot facilitates employees' professional development by providing financial support to obtain clinical licenses, internal trainings, and access to continuing education units for licensed staff. Eliot also retains staff using DSRIP Statewide Investment (SWI) opportunities for the Student Loan Repayment Program

Eliot uses a variety of mechanisms to recruit staff with diverse and multilingual backgrounds. Eliot currently employs several bilingual staff members to meet the needs of their CP member population and continues to recruit and hire diverse staff. Eliot recruits staff through cultural centers, social media outlets, and staff referrals, and implemented a 6% salary differential for qualified applicants who have bilingual capabilities. Eliot reports that its BH network employs over 200 staff who speak 20 different languages, reflecting the communities it serves.

Training

In compliance with the CP program contract, Eliot developed an initial training for all new staff that covers the program requirements. Eliot's new staff training exposes staff members to core competency training, service elements, service continuum, and population needs. During these trainings, staff members learn strength-based approaches to treatment, BH management, cultural competency, accessibility and accommodations, independent living and recovery principles, motivational interviewing, health and wellness principles, person-centered planning processes, and trauma-informed care. New staff members also complete an additional 40 hours of orientation training in complex care management and coordination with their respective team through an online training platform.

Eliot runs ongoing trainings to ensure staff are kept up to date on best practices and advancements in the field. In addition to annual refresher trainings, Eliot developed a partnership with Boston College for staff to complete Advanced Clinical Certificate programs. These certificate programs cover dialectical behavioral therapy, cognitive behavioral therapy, harm reduction, recovery oriented practice, illness management and recovery, person-centered planning, motivational interviewing, and cognitive behavioral therapy for post-traumatic stress disorder. Eliot also encourages clinical staff to attend accredited continuing educational opportunities to increase their skill sets and maintain licensure. Eliot uses DSRIP SWI opportunities to engage staff in Peer Specialist Training and Recovery Coach Supervisor Training opportunities.

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 Hlway⁷ 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

⁷ Mass Hlway is the state-sponsored, statewide, health information exchange.

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

Implementation of EHR and care management platform

Eliot implemented a care management platform and EHR. Eliot connected to statewide ENS/ADT notifications and has devoted staff resources to the daily reviews of these feeds to ensure direct care staff have timely access to notifications and are able to respond to member needs.

Interoperability and data exchange

Eliot has the capability to exchange member files via SFTP, secure email, a secure file-sharing application, and Mass Hlway.⁸ Eliot reports that the method of data exchange varies based upon the established Documented Processes with the specific ACO or MCO partner. Eliot has established its connection to Mass Hlway through its care management platform. Eliot reports that it is able to receive member contact information, comprehensive assessments, and care plans electronically from all or nearly all ACOs, MCOs, and PCPs.

To further interoperability and data exchange efforts, Eliot established read-only access to one ACO partner's EHR. Eliot continues to have discussions with other ACO partners about establishing access to their EHRs. In addition, Eliot IT continues to collaborate with ACO/MCO partners to discuss methods for integrating CP care plans into the ACO/MCO EHR.

Data analytics

To oversee documentation and performance on key quality metrics, Eliot's Quality Management and IT staff generate reports from its internal care management platform and EHR that track progress on CP performance and provide continuous performance feedback to the care teams. Additionally, Eliot has contracted with a TA vendor to analyze CP claims and utilization data to identify strategies to enhance service delivery, improve population health outcomes, track the impact of interventions, and inform future service delivery.

Eliot's Quality Management division is responsible for analyzing CP data and performance reports to inform performance improvement initiatives. Eliot's internal QI plan is based upon Lean philosophy and continuous QI. Eliot uses Value Stream Mapping to understand the care team process, the team members responsible for identified goals of care, and identify opportunities for improvement.

Eliot Administrator Perspective: "... we have begun analyzing member information that can guide outreach and further support the people we serve. The population that we are serving often has had sporadic engagement with both medical and behavioral health providers resulting in frequent emergency room visits, missed opportunities for preventive care, and fragmented treatment. Through our current efforts we have identified cohorts of individuals with complex needs and significant service utilization, potential correlations with health status and demographic data, emergency department facilities with high member usage, targeted projects with ACO/MCO to meet the needs of members."

⁸ Mass Hlway is the state-sponsored, statewide, health information exchange.

Recommendations

The IA encourages Eliot 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; and
- using ENS/ADT alerts and integrating ENS notifications into the care management platform.

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

Outreach and engagement strategies

Eliot ensures that staff are providing supports that are tailored to and reflective of the member population. Eliot reports that it currently employs several bilingual staff members to meet the needs of the CP member population and continues to recruit and hire diverse staff. Eliot reports that the Eliot BH network employs over 200 staff who speak 20 different languages, reflecting the communities it serves.

To assist members during the provision of CP supports Eliot utilizes motivational interviewing, peer specialists, and recovery coaches throughout member outreach, engagement, and care coordination.

Eliot contacts assigned members who are hard to reach telephonically by embedding BH CP staff in Eliot's outpatient clinics and emergency service locations. The embedded CP staff are able to identify members to enroll in the CP program and work directly with the ACO/MCO to track the member's engagement with the CP program. Additionally, Eliot hired an Engagement Specialist who is responsible for outreach to newly referred and "difficult to reach" members. The Engagement Specialist utilizes the internal ENS/ADT notifications and ACO/MCO member files to identify updated member contact information.

Person-centered care model

Eliot CP care coordinators are trained in person-centered care planning and ensure that care plans reflect the member's goals, in their own words. The Eliot person-centered treatment plan has quarterly objectives and bi-annual goals. CP staff record member progress, interventions, and barriers in service notes. To ensure that the member's care team is engaged in supporting the member towards the achievement of their goals, the Eliot CP team shares the finalized treatment plans with the ACO, MCO, and other providers involved in supports and treatment of the member.

In addition, Eliot reports convening care team meetings to review the member's progress towards care plan goals; PCP, ACO, and MCO staff members are encouraged to attend. Member goals and action steps are continually assessed and adjusted, if needed, due to changes in care needs or for

other reasons identified by the member or the care team. Eliot also encourages family participation in care planning and other aspects of service delivery.

To assist members with setting health and wellness goals, Eliot care coordinators utilize a peer support health and resiliency framework. Eliot reports that this framework is a person-centered, motivational interviewing-based approach that encourages members to make positive health and wellness choices and set appropriate health-related goals.

Managing transitions of care

To support members through transitions of care Eliot created the Care Transitions Team (CTT) and hired a Care Transitions Manager to oversee the effort. The CTT is composed of the BH CP nurse care managers and is tasked with building relationships with hospitals, ACO/MCO complex care management teams, primary care practices, and community resources. The CTT is divided into three teams, geographically, to promote relationships between CTT staff and local providers. The CCT receives daily ENS/ADT notification reports and deploys staff accordingly.

Additionally, Eliot has embedded BH CP staff within several Eliot BH programs including Adult Community Clinical Services, outpatient clinics, and emergency services. Eliot reports that this resulted in increased communication and collaboration between BH CP care teams and providers. Eliot reports that members are assigned via warm handoff from the clinical site to CP care managers who begin the assessment and person-centered treatment planning process.

Improving members' health and wellness

To promote member health and wellness, Eliot offers members access to health and wellness coaching. Eliot provides education related to prevention and management of chronic medical conditions and the reduction of high-risk behaviors and health risk factors, such as smoking, inadequate nutrition, and infrequent exercise. Eliot also maintains bi-directional communication with the other programs within the Eliot BH network, creating linkages to additional services to meet members' health and wellness needs.

Eliot developed processes for connecting members with community resources and social services. Eliot developed relationships with clinical providers in the service area through the implementation of embedded BH CP staff and delivering education to providers about the CP program. To support members' housing needs, Eliot subscribes to a housing service database that supports its housing related work with members who are homeless or in unstable housing.

Continuous quality improvement

To ensure continuous QI in member experience, Eliot has developed a member survey, based on CAB feedback, to gather information regarding members' experiences with the CP program

To identify strategies to enhance service delivery and improve population health outcomes, Eliot is working with a TA vendor to analyze CP claims and utilization data. Further, Eliot's Quality Management division uses Lean Value Stream Mapping to understand the care team process, the team members responsible for identified goals of care, and to identify opportunities for improvement.

Recommendations

The IA encourages Eliot 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 Eliot 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
- Workforce Development

The IA recommends that Eliot 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:

Health Information Technology and Exchange

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
- using ENS/ADT alerts and integrating ENS notifications into the care management platform.

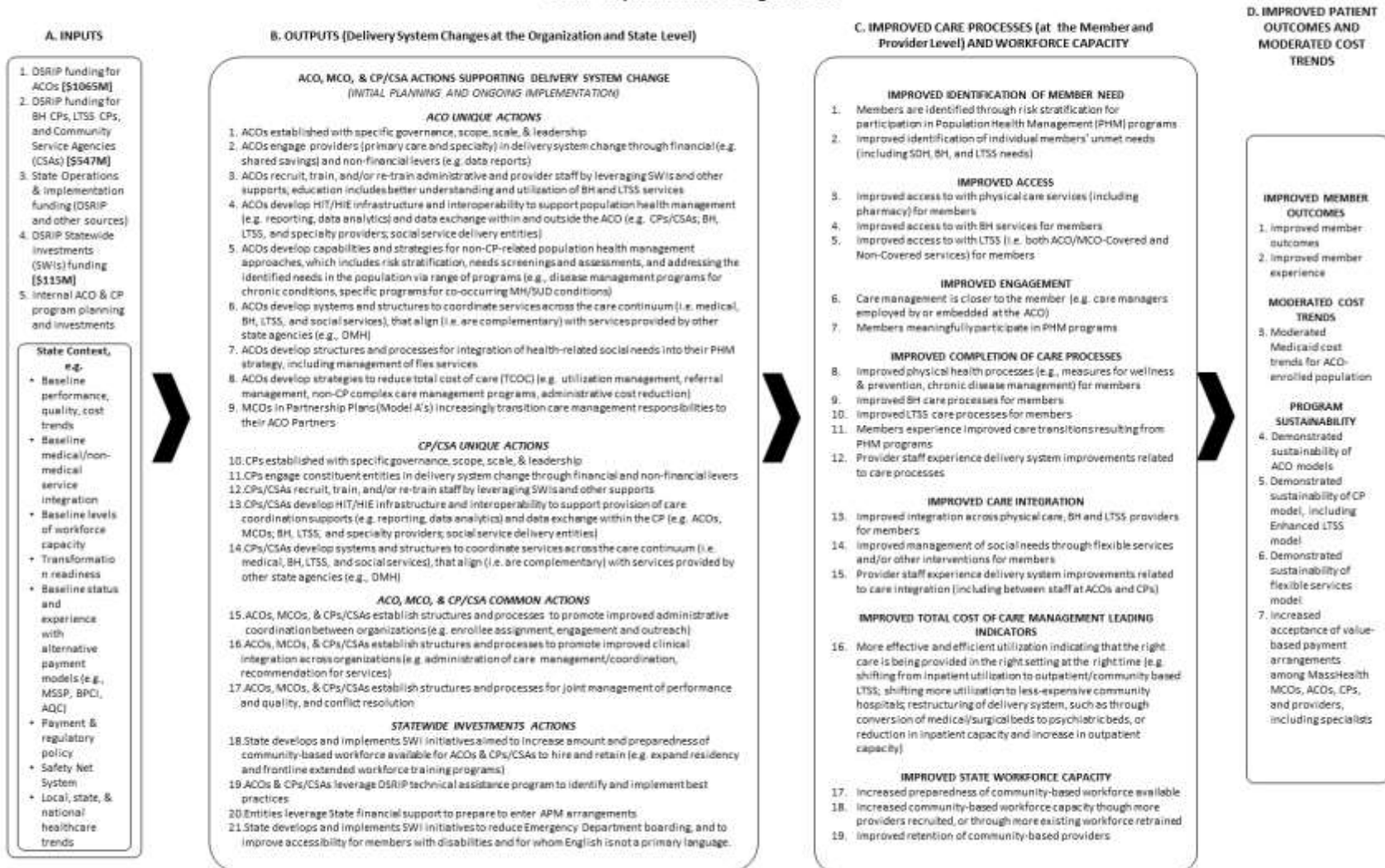
Care Model

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

Eliot 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 Request for Change

In reference to the Health Information Technology and Exchange recommendation on page 19, “*using ENS/ADT alerts and integrating ENS notifications into the care platform*”: The recommendation may incorrectly reflect our status during the assessment period. Eliot had ENS notifications integrated into the care platform during the period of assessment.

CP Comment

Eliot BH CP is pleased to provide additional information on our Health Information Technology & Exchange and Care Model.

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files (page 19)

Eliot BH CP’s approach for receiving files from ACO partners is to have our operations team review files first before notifying our CP care managers and triage information to other team members. This has proven to reduce the amount of noise that could otherwise have caused notification fatigue as we have found some documents are sent multiple times in error which creates confusion. We’ve implemented a thoughtful/purposeful and intentional first pass to ensure notifications are high value. Our operations team monitors SFTP, Dropbox and other file submissions with a high degree of precision within established workflows (daily, more frequently, if needed). This allows maximum efficiency and decreases interruptions in tasks.

- using ENS/ADT alerts and integrating ENS notifications into the care platform (page 19)

Eliot BH CP integrated ENS/ADT notifications into the care platform in January 2019 (Patient Ping) as part of enhancements in the eHana platform with additional notification integration set for February 2020 (CMT/PreManage). eHana is Eliot’s vendor for both our BH CP’s Care Coordination platform as well as the larger agency EMR/EHR. This has proven to be highly advantageous for our BH CP’s work with eHana and builds on our previous relationship and knowledge of the capabilities with our EMR/EHR. In addition, Eliot BH CP secured independent agreements with all ENS/ADT vendors to ensure we had direct and timely access to notifications. Our BH CP is able to accept data from multiple sources (Patient Ping, CMT, Individual ACOs, our own programs like ACCS) and clean/de-duplicate this data to provide our CP staff with a high quality and complete picture of ED Visits/Inpatient Events, for example.

- Increasing standardization of processes for connecting members to community resources and social services where applicable (page 21)

Eliot's approach to providing service/care is to be responsive to member's urgent and immediate needs upon assignment once we are able to reach the individual. Our critical need response involves rapid assessment and connecting members with resources and services responsive to food insecurity, housing instability, safety needs including domestic violence or psychiatric emergencies, lack of access to medication or medical care, interruptions in benefits such as MassHealth, for example. Simultaneously staff begin completing the full assessment and creation of a person centered care plan. Similarly, our Care Transitions Team (CTT) receives and reviews ENS/ADT notifications each morning and triages the team of nurses and care managers to connect with members and staff in EDs/Inpatient settings in real time. This is another avenue where resource and social service assessment occurs with an eye toward connecting members with needed medical, behavioral health, health & wellness and social supports. Using each team member's specific skill set, nurses and care managers collaborate to coordinate these efforts to ensure referral and member access to care in the most efficient and effective ways possible. High value outcomes have resulted for members and other provider partners who have had touch points with CTT. Their well developed workflows and growing relationships with medical care facilities has further supported this work.