MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Lahey Health Behavioral Services (LHBS)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Lahey Health Behavioral Services (LHBS)

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A Behavioral Health Community Partner

Organization Overview

LHBS provides mental health counseling, addiction treatment, and family and school-based services. Lahey serves adults, teens, families, and children in more than 30 communities. Services include outpatient mental health clinics; inpatient and outpatient treatment and prevention for drug and alcohol problems; school- based programs; and community education and prevention initiatives.

SERVICE AREA

POPULATIONS SERVED

- LHBS's primary service area includes the greater Boston area, the North Shore (including Cape Ann) and the Merrimack Valley of Massachusetts.
- LHBS serves individuals serious mental illness and/or substance use disorders, as well as individuals, families, teens, and children struggling with behavioral health disorders, and/or problems related to drugs and alcohol.

1,447

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	Limited Recommendations
Health Information Technology & Exchange	On Track	Limited Recommendations
Care Model	Opportunity to Improve with Recommendations	

IMPLEMENTATION HIGHLIGHTS

- LHBS administered a grocery gift card client incentive in 2019. Enrollees earn the gift cards based on progress they make towards goals in their care plan or when they meet milestones in the engagement process.
- LHBS implemented processes to track and, if needed, improve the progression of enrollee care plans, better collaborate with ACOs, and establish goals for each CP team and their members.
- LHBS built trust and increased engagement with high-risk individuals by demonstrating integration with community organizations such as needle exchange programs, homeless shelters, long-term services and supports programs and ACO providers.

Statewide Investment Utilization:

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

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of five focus areas which are outlined below. This model was developed by MassHealth and the Independent 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

[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]

Lahey Health Behavioral Services (LHBS) provides a range of outpatient, inpatient, and residential care options, including individual and group-based therapy for mental health and substance use disorder (SUD), SUD treatment, mobile crisis teams for BH emergencies, inpatient psychiatric treatment and school-based programs for children and teens. As a BH CP, LHBS organizes care and facilitates communication across medical, behavioral health and long-term services, including pharmacy providers, agencies and social supports.

LHBS's primary service area includes the greater Boston area, the North Shore (including Cape Ann), and the Merrimack Valley of Massachusetts. LHBS serves individuals ages 21 years and older with serious mental illness (SMI) and/or substance use disorder (SUD), as well as individuals and families with complex BH needs.

As of December 2019, 1,447 members were enrolled with LHBS[3].

SUMMARY OF FINDINGS

The IA finds that LHBS is On track or On track with limited recommendations in four of five focus areas. LHBS has an Opportunity to improve with recommendations in one focus area.

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	Opportunity to improve with recommendations

FOCUS AREA LEVEL PROGRESS

The following section outlines the CP's progress across the five focus areas. Each section begins with a description of the established CP actions associated with an On track assessment. This description is followed by a detailed summary of the CP's results across all indicators associated with the focus area.

[2] Background information is summarized from the organizations Full Participation Plan.
[3] Community Partner Enrollment Snapshot (12/13/2019).

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

Executive Board

LHBS is governed by the LHBS Executive Board, which has the structure and staffing in place to manage the CP program and oversee the delivery of CP supports to eligible members. LHBS' Vice President of Ambulatory and Community Services provides executive oversight to the LHBS CP program. The CP's Director reports to LHBS' Vice President of Ambulatory and Community Services.

LHBS's leadership team meets with the CP Director on a monthly basis to review programmatic and financial factors that impact the program. Additionally, LHBS' Chief Medical Officer meets with the CP leadership team to discuss strategy and the sustainability of the CP program.

Consumer Advisory Board

In 2018, LHBS established a founding committee to recruit, interview, and appoint CAB members. The committee identified potential members who would bring a diversity of backgrounds and

[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.

experiences to the CAB. This committee drafted the CAB charter and policies that dictate member term limits, voting rules, documentation of meetings, and open meeting guidelines.

In 2019, LHBS held two CAB meetings at their corporate office. The CAB's current objective is to increase CAB membership. Current members proposed engagement solutions to LHBS leadership, including simplifying the CAB member application form and hosting CAB meetings in accessible, community-based locations. In response to CAB members' suggestions, LHBS scheduled two CAB meetings at different sites in the community. Consistent CP member participation in CAB meetings remains a challenge. However, LHBS is still able to identify members' priorities through this forum and communicate them to CP leadership.

Quality Management Committee

LHBS has a Quality Safety Advisory Committee that reports up to the Quality and Safety Council. The Quality and Safety Council is chaired by the Chief Medical Officer, Vice Presidents, and other key leaders including the CP program Director. The Council meets quarterly and is primarily responsible for the success of LHBS's quality assurance and performance improvement program and for ensuring that there is measurable improvement in LHBS's engagement rates and member satisfaction outcomes.

The Quality and Safety Advisory Committee meets monthly and presents progress on quality and safety indicators to the Quality and Safety Council in a dashboard during quarterly meetings. LHBS hired a Data Analyst to develop baseline and internal performance measures and to monitor progress towards LHBS's quality benchmarks. The analyst is also responsible for identifying areas for improvement.

In 2019, LHBS implemented a QI initiative focused on improving member engagement. LHBS also focused on other quality metrics such as timely review of annual treatment plans, rate of member attendance at annual PCP visits, and follow-up after hospitalization for mental illness within seven days of discharge.

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;

[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.

- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

✓ **Consumer Advisory Board**

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

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- 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 LHBS is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

LHBS implemented a centralized process to exchange care plans and other member files with ACO/MCO partners. These Documented Processes include the exchange of member files via secure file transfer protocols (SFTPs), secure email, and a secure file-sharing application. To improve operational and clinical inefficiencies, LHBS renegotiated and updated Documented Processes with five ACOs and continues to update processes with additional partner organizations.

To engage PCPs in care plan sign-off, LHBS developed a release of information form that alleviates the communication barrier between the CP and PCP offices. LHBS asks members who sign the CP participation form to also sign a release of information for their other healthcare providers, including their PCP. LHBS uses the release of information form to initiate engagement with a member's PCP to begin the care plan review and approval process.

LHBS regularly exchanges and updates member contact information with ACOs/MCOs. LHBS care coordinators document all stakeholders involved in the member's care team and log activity notes that detail communications and member information exchanges between the CP and the member's providers. LHBS also collaborates with its ACO/MCO partners to verify shared members' last known addresses and contact information.

To facilitate member outreach and engagement, LHBS staff manually download member referral and enrollment files from ten ACO/MCO partners' SFTPs on a regular basis. LHBS reported that retrieving monthly and daily enrollment files from individual ACOs/MCOs is a laborious process; LHBS has since switched care management platforms to automate this process.

> LHBS Administrator Perspective: "*…the release is not just for providers, but it's also, if you want us to talk to your pastor, we'll do that. If you want us to talk to anybody, we'll go ahead and talk to them. So, besides just the participation form that MassHealth mandates, we do the release of information. And then, we don't just hold onto the release and let it become dust. We basically created this provider communication form, so [they can identify anyone they give] us release to speak to, [and] we send them a five question [form]… you know, like, when was the last time you saw the person, what's your relationship with them, and if there are any providers [included in the client's list], can you send us a summary of the last time you saw them, just to gauge where the client is in the process, so if our client has never been to see a primary care doctor -- …[receipt of] the care plan [is not] the first time that the PCP is hearing from us.*"

Integration with ACOs and MCOs

LHBS attends quarterly meetings with ACO/MCO partners to build relationships with key ACO contacts, discuss program operations, and share clinical information. LHBS leadership works with marketing and communication experts to increase and sustain ACO/MCO partners' awareness of the program's capacity to provide care management supports for shared members with BH needs in the Northeast service area.

LHBS engages a multi-disciplinary team of registered nurses, care coordinators, and clinical care managers in weekly clinical case reviews and care planning meetings with PCPs, ACOs, and MCOs. LHBS also implemented monthly rounds with most of its ACO/MCO partners to discuss high-risk members. LHBS's criterion for high-risk members include members who have had a recent hospitalization, a new medical or BH diagnosis, frequent admissions to hospitals or treatment centers, recent exposures to trauma, recent overdose or relapse, or demonstrably low adherence to medication.

To further achieve clinical integration, LHBS connected to ENS/ADT notifications through its care management system vendor. Integration of ENS/ADT notifications into its care management platform allows LHBS staff to review notifications in real time.

Joint management of performance and quality

To track and improve member engagement, LHBS's Quality Team maintains a dashboard that demonstrates progress towards established performance targets for completed care plans, member engagement, and collaboration with ACOs. The Quality Team reviews performance on these measures on a quarterly basis and initiates QI initiatives to address gaps.

LHBS care coordinators had difficulty obtaining PCP sign-off on care plans through their electronic transmission documented process. LHBS improved the sign-off process by implementing a system where care coordinators bring care plans to their member's PCP appointment to obtain an in-person sign-off. The in-person sign-off process improved the care plan return rate. Additionally, LHBS implemented a feature in its care management platform that tracks care plan approvals from PCPs

and generates follow-up reminders for LHBS staff when the care plan is approaching its approval due date.

LHBS hired a Data Analyst to evaluate, report, and monitor key performance and quality metrics and a claims analyst to perform quality control and assist with resolving discrepancies within the claims data. On a monthly basis, LHBS holds a billing meeting to review the process to track and resolve denials and re-submit Qualifying Activities (QAs)[6] to MassHealth. LHBS is a single entity CP with no member organizations, therefore the CP does not generate audit reports for any other organization.

> LHBS Administrator Perspective: "*A top strategic priority for BILH Behavioral Services is to become a top partner of choice for MassHealth ACOs such that the transition to the post-DSRIP market is successful and sustainable. In order to do this, we must work to develop a successful track record of excellence in service delivery and achievement of improved outcomes and high quality while decreasing total cost of care. As a CP, we receive referrals from a variety of ACOs, and need to work to earn a reputation for not only quality and outcomes but also partnership and collaboration of the Mass Health ACOs."*

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;

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

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

Recruitment and retention

LHBS onboarded 30 new staff members in 2019 but reports that they continue to operate with vacancies in up to 20% of planned staff roles. To recruit staff, LHBS attended job fairs, utilized online job boards, implemented targeted recruitment strategies including direct mail and open house advertising, and leveraged its internship program. LHBS offers an employee referral bonus, signing bonuses, and flexible work locations to incentivize employment.

To retain staff, LHBS implemented annual bonuses, employee training opportunities, internal promotions, and adapts workplace policies and procedures in response to staff feedback. All staff receive an annual performance review to ensure that they are meeting productivity standards. LHBS formed the LHBS Engagement Team (LET), a group of LHBS staff from all divisions, to seek feedback from colleagues and meet monthly to review the ideas, needs, and concerns of the LHBS workforce. The LET aims to enhance communication, promote engagement, and provide solutions to day-to-day challenges. In addition to the work of the LET, LHBS identifies ways to retain staff through bi-annual engagement surveys, an annual employee engagement week, and staff town hall meetings. Additionally, LHBS has hired more lead care coordinators to support care coordinators with their

assigned members' engagement journeys. This new position creates a career pathway for the advancement of experienced care coordinators.

LHBS recruited multilingual and multicultural staff who can communicate with members in Spanish, French, Greek, Swahili, Khmer, and Haitian Creole. Within the LHBS system there are numerous staff who have lived experiences with SMI and/or SUD to reflect and connect with their service population.

Training

LHBS has an onboarding training program for CP staff that covers contractually required program elements and addresses the needs of the member population. LHBS trains staff on medical care management, medication reconciliation, health and wellness coaching, the identification and provision of flexible services, post-discharge follow-up, the electronic health record (EHR), and all protocols and workflows.

LHBS also makes numerous continuing education courses available to staff. LHBS staff attended continuing education courses focused on confidentiality, personality disorders, risk and suicide assessment, and navigation changes. In 2019, all LHBS staff completed an online trauma-informed care certificate program. Additionally, LHBS encourages staff to participate in monthly learning collaboratives with ACO partners.

Recommendations

The IA encourages LHBS 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:

- exploring additional recruitment and retention strategies to avoid persistent vacancies in planned positions.

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

Implementation of EHR and care management platform

LHBS implemented a new care management platform in December 2019. LHBS's initial system was not configured to address clinical needs or programmatic requirements such as ENS. LHBS reports the implementation of the new platform was supported through structured project planning with clear timelines and milestones. LHBS met weekly with its care management platform vendor throughout the transition. Additionally, more than 50 LHBS staff completed a series of five trainings on the new care management platform.

LHBS has access to ADT feeds with several ACOs to support outreach activities in real time.

Interoperability and data exchange

LHBS exchanges member files via SFTP, secure email, and a secure file-sharing application. LHBS is able to share and/or receive member contact information, comprehensive assessments, and care plans electronically from all or nearly all ACOs and MCOs. LHBS is able to share and/or receive comprehensive needs assessments and care plans from some PCPs. However, LHBS is only able to share and/or receive member contact information electronically with very few (or no) PCPs.

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

Data analytics

LHBS developed performance metrics that are discussed at each staff meeting. LHBS's care management platform generates several real time performance reports that allow each care team to monitor their progress towards meeting specified metrics.

LHBS hired a Data Analyst to facilitate progress towards performance targets for quality measures, evaluate data for progress towards goals and signals of success, assist with resolving discrepancies in LHBS's performance data, and maintain fidelity to the program's contract. The Data Analyst is responsible for monitoring progress on quality metrics related to member engagement, care plan completion, annual primary care visits, and follow-up after hospitalization for mental illness on an ongoing basis. On a quarterly basis LHBS's Quality Team generates a report that demonstrates progress towards LHBS's established performance targets.

In addition, the care management platform is equipped with clinical logic to capture, manage, and report QAs[8]. LHBS continues to monitor expenditures, QAs, enrollments for reconciliation, and status purposes.

Recommendations

The IA encourages LHBS 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 member files;
- using ENS/ADT alerts to respond to member transitions in real-time by integrating ENS into the care management platform;
- developing a plan to increase active utilization of Mass HIway.

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;

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

- 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 LHBS has an **Opportunity to improve with recommendations** in the Care Model focus area.

Outreach and engagement strategies

LHBS ensures that staff are providing supports that are tailored to and reflective of the member population. LHBS hired staff who reflect the demographic diversity of the member population and who can communicate with members in Spanish, French, Greek, Swahili, Khmer, and Haitian Creole. LHBS also contracted with an interpretation service to support members with language accessibility

needs not met by CP or agency staff. The interpretation service is available 24 hours a day, seven days a week via a smartphone app, allowing care coordinators to use the service while working in the community with members. Additionally, LHBS has staffing coverage outside of regular business hours. Expanded hours enable LHBS staff to meet the scheduling needs of members who may not be reachable during the day. All engaged members are provided with a member handbook that outlines members' rights, ensuring that they are informed of their rights related to accessible service delivery.

LHBS hired an Engagement Specialist who has been tasked with engaging members who are newly assigned to LHBS. The Engagement Specialist makes five attempts to contact the member via telephone and if unsuccessful assigns a care coordinator to connect with the potential member in-person, either at their home or at a community-based location. Engagement Specialists use a script and conduct an immediate needs assessment to facilitate enrollment into the CP program. These staff are also trained in motivational interviewing and other techniques for effectively engaging members.

To contact members who are not easily reached telephonically, LHBS works with community-based organizations to conduct enrollee outreach. LHBS reports that many potential CP members have relationships with other LHBS Health programs, such as Acute Treatment Services, or have developed trusting relationships with community programs like needle exchanges or homeless shelters. Deploying CP staff to these service locations has increased the LHBS's outreach and engagements opportunities.

Person-centered care model

LHBS's approach to care planning is to ensure that members have the opportunity to develop a person-centered care plan that emphasizes their strengths, LTSS needs, and priorities. LHBS's staff brings together the natural and formal supports that have an active role in the member's life.

LHBS emphasizes a culture of member-centered engagement and provides staff with ongoing training focused on meeting members where they are, literally and figuratively, and centering engagement on this principle. Care coordination staff assess members for immediate needs and look for the root cause of members' needs during outreach.

Members' goals are based on their identified needs and immediate needs assessment results. Goals are then further discussed with the member in order to identify the interventions that will help the member accomplish their goals. The care coordinator then helps the member identify which interventions they will complete with the care coordinator and which interventions they will need to collaborate with BH or medical providers on. This process is completed in a disability and culturally competent manner and adheres to wraparound[9] principles.

LHBS staff use this information to create person-centered care plans that are unique to the member and reflect their individual needs, while meeting contractual requirements. LHBS care coordinators record care plan goals in its care management platform. LHBS views the care plans as dynamic documents that will be updated at least annually based on members' progress towards goals.

Managing transitions of care

To manage members' transitions of care, LHBS developed workflows that address each type of presentation and/or admission to treatment. Upon notification of a member's presentation to an inpatient facility through ADT feeds, LHBS's registered nurses (RNs) are responsible for contacting the provider site and identifying the clinical contacts throughout the member's care at the inpatient

[9] The "wraparound process" emphasizes: family voice and choice; and is collaborative, team-based, community-based, strengths-based, culturally competent, individualized, unconditional, and outcome-based.

site. This has led to better collaboration and follow-up regarding the member's presentation and/or admission to treatment.

After the RN has established contact with the inpatient facility, the RN works with the member's assigned Clinical Care Manager and establishes LHBS's role in the care planning process. LHBS is then integrated into discussions about the member and helps plan for the member's transition to another level of care or home with follow-up and planned appointments. LHBS reports that this workflow promotes collaboration and transparency amongst the member's providers and care team and supports the member's next steps in treatment, follow-up, and adherence to their care plan.

LHBS also expanded its regular communication with providers to include members' PCPs and other medical and social service providers by using LHBS's provider communication form. LHBS's form promotes integrated care while also preventing issues from "falling through the cracks." Additionally, a shift in LHBS's governance structure has further facilitated transition of care efforts. LHBS's CP program was realigned under the Ambulatory and Community Services Division, which has increased collaboration among programs and led to a workflow that fast tracks appointments for CP members.

Improving members' health and wellness

LHBS established linkages to community resources within the Northern region to refer members to providers and services that will help them achieve their health and wellness goals. LHBS established and continues to grow relationships with housing agencies, fuel assistance programs, and faith-based and social services organizations. LHBS further facilitates members' achievement of their health and wellness goals through its education programming including the health and wellness group that meets biweekly to address a range of medical and BH topics.

Continuous quality improvement

LHBS's Quality Safety Advisory Committee is the primary mechanism facilitating continuous QI in quality of care and member experience. However, LHBS also holds quarterly strategic planning sessions. These meetings are held off-site with senior leadership to assess programmatic, financial, and community factors impacting the program. Leadership use these meetings to strategize on new initiatives and opportunities to better coordinate care and achieve long term program sustainability. Additionally, LHBS's Quality Team reviews performance quarterly and identifies performance gaps requiring QI initiatives.

LHBS engages their CAB to gather input on operations, however LHBS struggles with low member participation at this time, which prevents the CAB from being a reliable mechanism for identifying opportunities to improve member experience.

> LHBS Administrator Perspective: "*Over the past year, we have drawn from a strong portfolio of best practices from our experience in offering care coordination and care management. These best practices that were highlighted in our initial Full Participation Plan include providing tailored training to our staff, putting "boots on the ground," conducting face-to-face visits , embedding staff in outpatient practices and forging partnerships with community providers such as, shelters and Centers for Independent Living (CILs)."*

Recommendations

The IA encourages LHBS 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:

- using Peer Support and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities;

- increasing standardization of processes for connecting members to community resources and social services where applicable; and
- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

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];

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

- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

✓ **Improving members' health and wellness**

- allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;
- negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and
- contracting with national databases for community resources to develop a library of available supports.

✓ **Continuous quality improvement**

- providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;
- administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;
- scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and
- creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that LHBS is On track or On track with limited recommendations across four of 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 LHBS 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

- exploring additional recruitment and retention strategies to avoid persistent vacancies in planned positions.

Health Information Technology and Exchange

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of member files;
- using ENS/ADT alerts to respond to member transitions in real-time by integrating ENS into the care management platform;

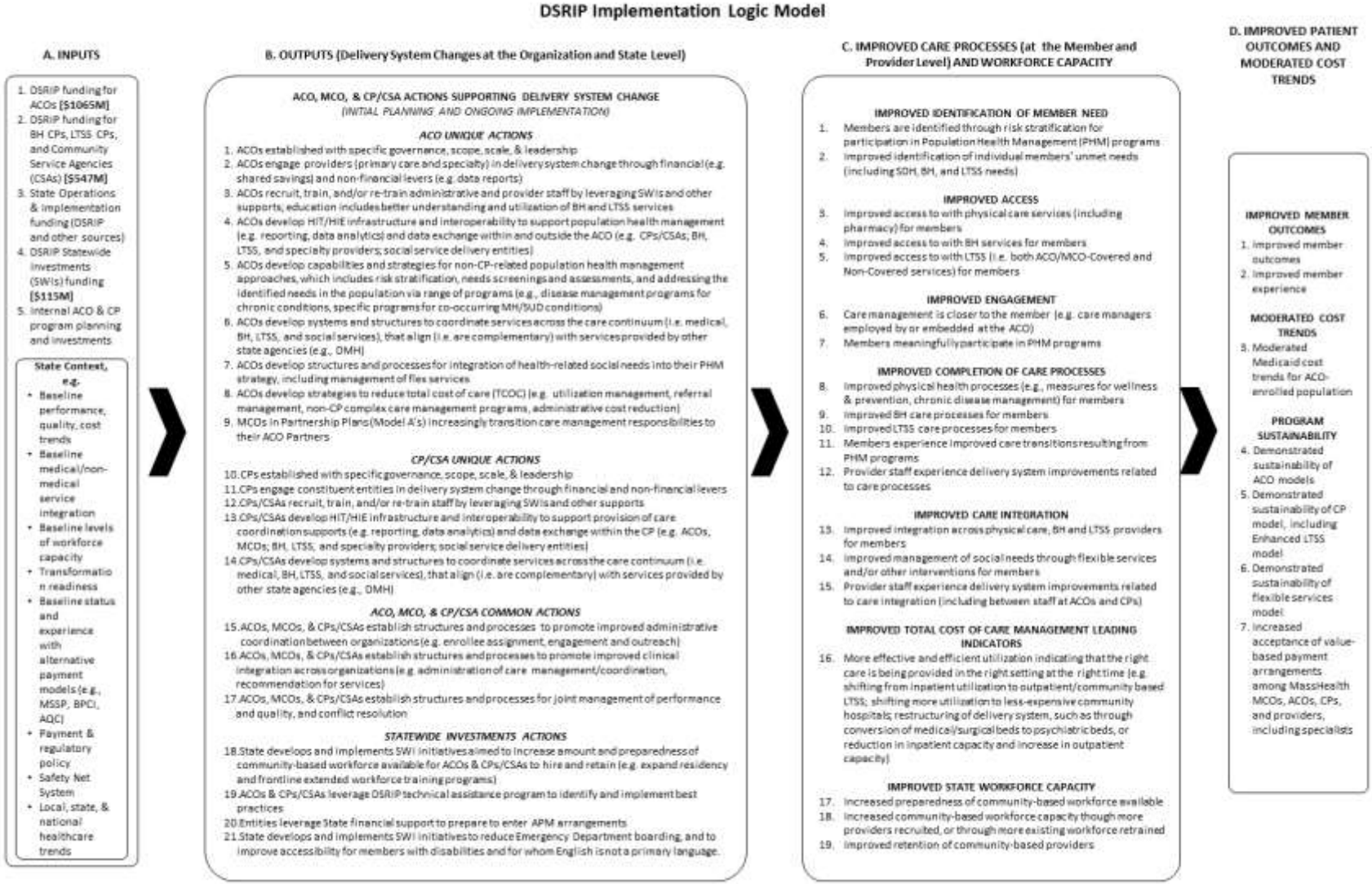
- developing a plan to increase active utilization of Mass HIway.

Care Model

- using Peer Support and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities;
- increasing standardization of processes for connecting members to community resources and social services where applicable; and
- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

LHBS 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



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

[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.

[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

Beth Israel Lahey Health Behavioral Services BHCP began a Milestone Incentive program for clients in October 2019. These incentives are in the form of $20 and $25 gift cards for local grocery stores. Clients are able to earn these gift cards when they complete a milestone in treatment, such as:

1. Attending their annual physical with their PCP
2. Completing their BHCP assessment and care plan with their BHCP Care Coordinator
3. Engaging in an in-person meeting with their BHCP team following a recent discharge
4. Meeting with the BHCP team to discuss and review Graduation from BHCP