MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Lowell Community Health Center d/b/a Greater Lowell Behavioral Health Community Partner

(Lowell CHC CP)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

DSRIP Midpoint Assessment Highlights & Key Findings

Lowell Community Health Center Community Partner (Lowell CHC CP) d/b/a Greater Lowell Behavioral Health Community Partner

PUBLIC CONSULTING GROUP

A Behavioral Health Community Partner

Organization Overview

The Lowell CHC CP is a partnership between Lowell CHC, a Federally Qualified Health Center founded in 1970, and its two Affiliated Partners: Lowell House, Inc. (LHI) and the Mental Health Association of Greater Lowell, Inc. LHI offers treatment options and care management services, and is currently co-locating with Lowell CHC to deliver fully-integrated behavioral health services.

SERVICE AREA

POPULATIONS SERVED

- Lowell CHC serves predominantly low-income, immigrant, and refugee populations, with a majority of its patients at or below 200% of the Federal Poverty Level and approximately two in five speaking a language other than English.
- The CHC supports more than 5,000 individuals annually, with co-morbidities and mental health challenges such as post-traumatic stress disorder, anxiety, depression, and pediatric diagnoses.

723

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- Lowell's Clinical Application Administrator transitioned the CP to a new care management platform without causing system down-time.
- Quality Management and Data Analytics staff created a set of standing operational reports for leadership and staff to monitor performance.
- The Lowell CHC CP Wellness Coach hosts individual and group health wellness classes, including Healthy Cooking Classes and Walking Group Workshops.
- Lowell CHC CP staff made significant in-roads developing relationships with ACO based nurses, CHWs and social workers through weekly meetings, case consultation, and hospital rounds.

Statewide Investment Utilization:

- Student Loan Repayment Program, 2 Care Coordinators and 1 LPN/RN participating
- 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 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]

Lowell Community Health Center (Lowell CHC), d/b/a Greater Lowell Behavioral Health Community Partner, is a behavioral health (BH) CP.

The Lowell CHC CP is a partnership between Lowell CHC, a Federally Qualified Health Center founded in 1970, and its two Affiliated Partners (APs): Lowell House, Inc. (LHI) and the Mental Health Association of Greater Lowell, Inc. (MHA).[3] Collectively, the three partners provide evidence based BH care coordination, care management, and BH services and supports to more than 7,600 residents in Northern Massachusetts annually. LHI co-locates with Lowell CHC at their main location to deliver fully integrated BH and SUD treatment services. In their capacity as a BH CP, Lowell CHC provides supports to high needs individuals.

Lowell CHC CP's primary service area is Greater Lowell. Lowell CHC CP serves individuals with serious mental illness (SMI) and substance use disorders (SUD) as well as long-term services and supports (LTSS) needs. Members often present with co-occurring conditions, including chronic medical illness, post-traumatic stress disorder, anxiety, and depression. Lowell CHC CP serves an ethnically diverse population; with many immigrants, and/or refugees of Southeast Asian descent. A majority of the population served live at or below 200% of the federal poverty level[4] approximately two in five are best served in a language other than English, with the highest need languages being Spanish, Portuguese, Khmer, and Swahili.

As of December 2019, 723 members were enrolled with Lowell CHC CP[5].

[2] Background information is summarized from the organizations Full Participation Plan.
[3] Some CPs enter into agreements with Affiliated Partners: organizations or entities that operate jointly under a formal written management agreement with the CP to provide member supports.
[4] The Federal Poverty level is defined annually by the Department of Health and Human Services and used to calculate eligibility for Medicaid. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/
[5] Community Partner Enrollment Snapshot (12/13/2019).

SUMMARY OF FINDINGS

The IA finds that Lowell CHC CP 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

FOCUS AREA LEVEL PROGRESS

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

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

Results

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

Executive Board

The Lowell CHC CP program is led by a Board of Governors. The Board is chaired by the lead agency, Lowell CHC, and includes the Senior Director of the CP, representatives from agency partners as voting members, and an ACO representative as a non-voting member. The Board of Governors approved the development of workgroups to accomplish the scope of work set forth in the Community Partner Contract: an IT Workgroup, a Clinical and Quality Workgroup, and an Outreach and Engagement Workgroup. Workgroups meet weekly and use a task management platform to share information and stay on task. The Board of Governors reviews all decisions.

Consumer Advisory Board

Lowell CHC CP established a CAB in 2019 but has struggled with low attendance. Lowell CHC CP held two CAB meetings in July and October of 2019. In July, Lowell CHC CP made reminder calls and offered transportation to members[6], but only one member attended. The meeting was facilitated by the CP Wellness Coach. In October, eleven members attended the CAB meeting; all were Spanish speakers. The Community Health Worker (CHW) Supervisor provided interpretation for members.

Lowell CHC CP's care teams continue to recruit members for the CAB.

Quality Management Committee

Lowell CHC CP has established a multi-disciplinary QMC that meets quarterly. The QMC is composed of quality managers, clinical representatives, the BH CP Program Director, and a data analyst. The QMC develops processes for data collection, reviews performance data on established quality measures, and brings potential QI initiatives to the Executive Board. The Board prioritizes QI initiatives and tracks the effectiveness of interventions, making corrective actions as needed.

Lowell CHC CP's QMC uses dashboards to track performance on quality measures. In 2019, Lowell CHC CP engaged in a QI initiative to decrease the time it takes for an assigned member to become engaged. The QMC established baselines and employed strategies to improve engagement including increasing outreach hours to nights and weekends and providing staff with additional training on assessment and care planning. As a result of these interventions, the Lowell CHC CP program increased the number of fully engaged members and decreased the time from member assignment to engagement. Lowell CHC CP reports they have similar processes in place for QI initiatives related to annual primary care visits, hospital readmissions, and member experience.

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;

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

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

✓ **Consumer Advisory Board**

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

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- 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

[7] 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.

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

Joint approach to member engagement

Lowell CHC CP's intake coordinator and Clinical Applications Administrator (CAA) facilitate the care plan exchange process by routinely monitoring the commonly used data exchange channels including SFTP, a secure file-sharing app, or fax.

The intake coordinator builds and maintains relationships with key contacts at the ACOs/MCOs to obtain sign-off on member care plans. To maintain these relationships the intake coordinator meets with nurses from Wellforce in partnership with Fallon Community Health Plan (FLN Wellforce) who

are co-located at Lowell CHC four times weekly. The intake coordinator also maintains contact with Atrius's Behavioral Health Team which has strong contacts with its PCP practices and reaches out to other ACOs/MCOs by phone and email. Lowell CHC CP has difficulty sharing information with PCPs outside of Lowell CHC as these providers are unsure how the BH CP and ACO roles differ. Members of Lowell CHC CP's care teams spend time researching key contacts within PCP practices prior to outreach to engage them in the Interdisciplinary Care Team (ICT) from the outset.

All Lowell CHC, CP staff have access to Lowell CHC's electronic health record (EHR). Lowell CHC CP nurses, intake coordinator, and Wellness Coach also have access to Lowell General Hospital's EHR, allowing them to update member contact information.

As previously mentioned, the Lowell CHC CP intake coordinator and CAA monitor data exchange channels daily for new transmissions from ACO/MCO partners which includes referral spreadsheets. Once Lowell CHC CP receives member lists, the Outreach Team locates and engages assigned members in care coordination supports. The Outreach Team has proven to be more effective than having care coordination staff attempt outreach to hard-to-reach members while simultaneously providing care coordination to engaged members.

Integration with ACOs and MCOs

Lowell CHC CP program's co-location with FLN Wellforce at Lowell CHC and at Lowell General Hospital helped establish effective workflows and communication methods. Lowell CHC CP leadership and FLN Wellforce leadership hold monthly meetings to discuss mutual expectations and strategize on behalf of high-risk members or members with high emergency department (ED) or hospital utilization.

Lowell CHC CP nurses conduct routine case reviews with other Lowell CHC staff on shared members with medical complexity as well as on potential enrollees for CP program. Lowell CHC's social worker collaborates with the Lowell CHC CP clinical manager to complete warm handoffs during a care transition. Lowell CHC CP staff co-located at Lowell General Hospital participate in daily huddles with hospital staff to review high-risk member cases who have been or are currently in Lowell General Hospital's ED or inpatient units. Additionally, Lowell CHC CP CHWs and the Lowell CHC CP Wellness Coach work together with ACO CHWs to connect shared members with community resources. Lowell CHC CP's consistent presence as well as their ability to update contact information helps strengthen their relationships with hospitals, EDs, and their primary ACO, FLN Wellforce.

In 2019, Lowell CHC CP achieved greater integration with external ACO/MCO partners. The intake coordinator attends quarterly meetings with THPP Atrius, THPP BIDCO, AHP MVACO, PHACO, and Lahey ACO. Recently, Tufts Health Public Plan MCO requested quarterly meetings become monthly to discuss high-risk members.

Lowell CHC CP receives event notification through an ENS integrated into their care management platform. The platform updates daily to include new inpatient utilization and admissions; Lowell CHC CP staff access these notifications in their workflow for the day.

> CP Administrator Perspective: "*There is greater sharing amongst the Primary Care/ACO/BH CP Nurses for care collaboration, discharge planning, care transition and mutual sharing with the CHWs for resource and supportive measures. Collectively, this work has enhanced the Nursing relationship with members and with the community of providers involved with the member. Via a trusting relationship, members are more open to the Nursing team providing education on "what is happening in their bodies", imparting medical information and making in-roads to improving health outcomes collaboratively with the member. Through strategic intervention to work with members who have been in the ED/hospital, Nurses and CHWs are helping members to better understand options for care, other than the ED, if medically appropriate."*

Joint management of performance and quality

Lowell CHC CP reports formulating data-driven QI initiatives using data from ACO partners. Lowell CHC CP gained access to FLN Wellforce's Reporting Sandbox[8], which allowed them to formulate baseline performance data on ED and inpatient utilization for 70% of their members. When combined with data collected through event notifications in their EHR, Lowell CHC CP identified the need for a deliberate strategy related to outreach, engagement, and care coordination for members experiencing homelessness. Lowell CHC CP implemented hospital rounds to improve engagement with members experiencing homelessness in which a Lowell staff member checks in at local EDs Monday through Saturday to connect members with care coordination supports during their visit. Additionally, Lowell CHC CP began meeting with Lowell General Hospital's BH Engagement Team to identify and strategize the provision of supports for members who are not currently engaged, but who would benefit from CP supports.

Lowell CHC CP refined their workflows to allow electronic PCP signatures and developed systems to push member data to staff as alerts to reduce administrative burden and to aid in receiving sign-off on member care plans from PCPs.

Lowell CHC CP uses performance dashboards to track engagement, Qualifying Activities[9], and claims data. Performance dashboards show member and encounter data including active or inactive status, care coordination or disenrollment status, success of outreach attempts, completed document status, and claims data. Lowell CHC CP uses these dashboards to report to the Board of Governors which includes representatives of member organizations.

> CP Administrator Perspective: *"Having the CAA [Clinical Applications Administrator] attend staff meetings regularly to celebrate documentation successes as well as set goals for documentation with the staff has been a motivator and resulted in improved billing and payment. The CAA auditing on a weekly basis and setting a course for correction right away has helped in developing focused documentation training for existing and new employees, as well as highlighting potential opportunities for system improvements."*

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;

[8] The data sandbox is an isolated testing environment where staff can perform analyses used for reporting purposes without affecting live application data collected and stored in the providers' EHR and care management platform.
[9] 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.

- 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 Lowell CHC CP is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

Lowell CHC CP has no persistent vacancies but experiences difficulties in hiring and retaining staff. Staff leaving to pursue higher education or other career paths is a source of high turnover. Lowell CHC CP responded to these challenges by encouraging employee referrals, sponsoring a variety of opportunities for professional development, and paying overtime to current employees with increased caseloads.

Lowell CHC CP hired a vendor to support recruitment activities for nursing and social work positions. The vendor tracks and sponsors jobs to allow greater visibility to Lowell CHC CP's advertised positions. Lowell CHC CP also publishes their positions with the National Association of Social Workers, Massachusetts Chapter (NASW-MA) and in *Social Work Voice*. Lowell CHC CP also partners with local CHW training programs and local schools to attract graduates.

Lowell CHC CP offers a vast number of professional development opportunities to attract and retain staff. Lowell CHC currently houses the Community Health Education Center (CHEC), a well-known regional resource for public health education. CHEC gives Lowell CHC CP staff access to certification programs, CHW education, advanced seminars and workshops, and networking luncheons. Lowell CHC CP provides an annual 2% raise to its staff and holds celebrations and events to build morale.

Despite difficulties in hiring, Lowell CHC CP has a diverse workforce. Lowell CHC CP hired multicultural CHWs with peer specialty experience to conduct outreach. Lowell CHC CP partners with their ACOs/MCOs to track the demographic, cultural, and epidemiological profiles of their service areas which informs their hiring priorities. Lowell CHC CP partners with community-based organizations to leverage opportunities for targeted recruitment and works to expand their reach by increasing attendance at job fairs in bilingual communities.

Training

New staff at Lowell CHC CP participate in an initial training period that includes online and in-person training modules, role-playing, and shadowing the senior staff. The Lowell CHC CP program leverages a proprietary online training curriculum to assist staff complete all required training. The Director of Training and Compliance at Lowell House (an AP) assigns due dates for training and tracks staff participation within the system to ensure contract compliance.

Lowell CHC CP holds ongoing training to ensure staff are kept up to date on best practices and advancements in the field. Staff attend a weekly training using didactic or role-playing methodologies to learn best practices surrounding comprehensive assessment and person-centered care plan development, the process for inpatient detox referral, and how to perform outreach. Within Lowell CHC's CHEC, several Lowell CHC CP staff members completed the CHW certificate program and participated in the Comprehensive Outreach Education Certificate Program, which positions CHWs to apply for a state license.

Lowell CHC CP staff also take advantage of external training opportunities. The Lowell CHC CP Wellness Coach graduated from the *Bridging the Gap* training program in 2019, a 40-hour, nationally recognized professional medical interpreter training program. Several CHWs completed a *Mental Health First Aid* training and Lowell CHC CP sent staff to the University of Massachusetts *Care Management Certification* training. Additionally, staff have been trained in trauma-informed care, naloxone administration, and system navigation/codes specific to Lowell CHC and Lowell House's EHR.

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 of out of basic training exercises and instead participate in more advanced training modules;
    - instituting a management training program to provide lower level staff a path to promotion;
    - allowing flexible work hours and work from home options for care coordination staff;
    - striving to maintain a balanced ratio of care coordinators to members served, to avoid unmanageable workloads and staff burnout;

- offering retention bonuses to staff that are separate from performance-based bonuses; and
- participating in SWI loan assistance for qualified professional staff.

✓ **Training**

- providing staff with paid time to attend outside trainings that support operational and performance goals;
- assessing the effectiveness of training modules at least annually to ensure that staff felt the module's objectives were met and that staff are getting what they need to fill knowledge or skill gaps;
- updating training modules on an annual basis to ensure they reflect the latest best practices;
- developing a learning management system that tracks staff's completion of required trainings and provides online access to additional on-demand training modules;
- including role-playing exercises in trainings to reinforce best practices of key skills;
- partnering with local educational institutions to provide staff access to professional certification training programs;
- providing new staff with opportunities to shadow experienced care coordinators in the field prior to taking on their own caseload to build tangible skills and foster relationships between team members; and
- making use of online trainings designed and offered by MassHealth.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

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

- uses ENS/ADT alerts and integrates ENS notifications into the care management platform.

✓ **Interoperability and data exchange**

- uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
- uses Mass HIway[10] 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

[10] Mass HIway 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 Lowell CHC CP is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

In 2019, Lowell CHC CP adopted a new care management platform to document, import and extract data more efficiently. The new care management platform also allows Lowell CHC CP to integrate ENS alerts into the system. The care management platform is updated daily to include ED and inpatient utilization and admissions. These alerts are pushed directly into the task list of the care coordinator assigned to the member or a general event report is generated in the system to alert care coordinators of the admission.

Interoperability and data exchange

Lowell CHC CP established SFTP sites to ensure care plans can be easily shared with providers. The CAA checks all SFTP sites daily but notes that some ACO/MCO partners still send care plans through a secure file-sharing app or by fax, increasing the time it takes to process the information. Lowell CHC CP is able to share and/or receive member contact information electronically from all ACOs and MCOs and some PCPs and is able to share and/or receive comprehensive needs assessments and care plans electronically with all ACOs, MCOs, and PCPs.

The Lowell CHC CP program shares an EHR with Lowell CHC. All Lowell CHC CP staff from partner agencies can access the EHR via a secure connection to retrieve members' records or to document new information generated during an encounter. Lowell CHC CP nurses, the intake coordinator, and Wellness Coach, who are co-located with ACO teams, additionally have access to Lowell General Hospital's EHR so they can document the discharge planning process in members' records.

Data analytics

In 2018, Lowell CHC CP hired a quality management and data analytics staff member to utilize existing data collection infrastructure to provide leadership with information they can use for programmatic decision making. This staff member pulled data from the care management platform, Lowell CHC, and Lowell House's EHRs to create standing operational reports for Lowell CHC CP leadership and staff. The set of standardized weekly and monthly reports show staff productivity, member engagement, approaching due dates, and upcoming appointments.

In 2019, Lowell CHC CP created two dashboards for the Board of Governors to track performance and outcomes. The outcomes dashboard tracks CP engagement, annual primary care visits, avoidable utilization through hospital readmission rates, and member experience.

> CP Administrator Perspective: *"During the reporting period, the Program Director, intake coordinator and the CAA made efforts to decrease the administrative burden on the front line staff by developing reports and systems in which data was "pushed" to staff within the platform rather than staff needed to seek and retrieve the information on their own through chart review in the various systems available."*

Recommendations

The IA encourages Lowell CHC CP 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
- 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;
- 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 Lowell CHC CP has an **On track with no recommendations** in the Care Model focus area.

Outreach and engagement strategies

Lowell CHC CP ensures staff are providing supports that are tailored to the population by employing CHWs, peer supports, and recovery coaches with specific backgrounds that are reflective of the population served. Lowell CHC CP finds that CHWs are essential in addressing disparities in access to health care and providing warm hand-offs to community-based resources. Lowell CHC CP CHWs accompany members to appointments, conduct home visits, perform direct community outreach, and assist with hospital rounds.

Lowell CHC CP emphasizes in-person outreach. Nearly half of Lowell CHC CP's members sign a participation plan via community/home visit outreach. Lowell CHC CP's designated Outreach Team mails letters, makes routine phone calls to hard-to-reach members and conducts home visits. The Outreach Team also has direct outreach strategies which include working with local homeless shelters and performing periodic outreach to tent communities, bridges, and local parks. Lowell CHC CP reports that members are contacted on a schedule and receive multiple iterations of contact throughout the day to garner interest. Lowell CHC CP has found that in-person follow-up meetings with initially reluctant members improve trust and boost engagement.

Person-centered care model

Lowell CHC CP begins the assessment and treatment planning process by having the nurse, who is part of the clinical care team, review medical records and any available documentation regarding the members needs and conditions. Staff then summarize any medical needs and medications for the Lowell CHC CP care coordinator or CHW. The Lowell CHC CP care coordinator or CHW will complete the care plan with the member to ensure their care plan includes goals and objectives, specific action steps to achieve goals, a method for tracking progress, referral needs to obtain care and services, educational needs, and if necessary, a crisis plan.

Lowell CHC CP care teams use role play in weekly strategy meetings to practice person-centered modalities, such as motivational interviewing and cultural competency while completing a care plan or comprehensive assessment. To reduce duplication of efforts and alleviate stress for the member of having to attend multiple care planning meetings, Lowell CHC CP care coordinators invite ACO care teams to interdisciplinary member care planning sessions or invite the ACO/MCO to participate in separate BH needs meetings with Lowell CHC CP staff after they have spoken to the member. Additionally, Lowell CHC CP leaders have begun to invite Lowell CHC staff to weekly CP staff meetings to form mutually beneficial partnerships and increase the number of interdisciplinary care plan meetings.

Managing transitions of care

Lowell CHC CP developed a variety of strategies to screen for and manage member care transitions. At Lowell General Hospital, Lowell CHC CP's intake coordinator, Wellness Coach and nursing team have a morning huddle with ACO hospital staff to plan out strategy for members who are in the ED or inpatient unit that day. The strategy is then shared with the larger Lowell CHC CP team for outreach and care coordination by the appropriate CP staff.

The Lowell CHC CP program receives word of some admissions through ENS notifications that are refreshed daily. The intake coordinator reviews all ENS alerts with the Transitions of Care team, assigns each event a rating based on the likelihood the member will have a readmission, and then determines which team member is best suited to conduct follow-up with the member. Follow-up activities are tracked in a spreadsheet maintained by the Transitions of Care team. In some cases, Lowell CHC's registered nurses collaborate with the Transitions of Care team by contacting the member's PCP to verify medication orders and review whether all prescriptions have been filled correctly by the member.

Lowell CHC CP also connects with members experiencing a care transition through hospital rounds in which a Lowell CHC CP staff member physically checks in at local ED's Monday through Saturday to identify and meet members in need of care coordination supports. While the Wellness Coach or care coordinator are present at the hospital with the member, the Transitions of Care team meets with ACO key contacts by phone to review the member's care plan.

Improving members' health and wellness

Lowell CHC CP care teams use a proprietary comprehensive assessment tool with supplemental questions to assess an individual's social service needs. Assessment domains include transportation; equipment needs for daily living; housing/environment, income and financial security; professional goals; risk factors for abuse, neglect, and food insecurity; and nutrition, wellness, and exercise.

Lowell CHC CP began hosting individual and group health and wellness classes in 2019. In conjunction with the Lowell CHC licensed dietician, the Lowell CHC CP Wellness Coach held a series of healthy cooking classes, which consisted of five weekly classes, held for 90 minutes each, in which a group of participants worked together to create a simple healthy meal that could be replicated at home. Members then shared the meal together. In conjunction with the Lowell CHC Diabetes Educator, the Wellness Coach held a series of walking group workshops, where a group of members and staff met and took walks together increasing the duration over time. Throughout the walk, the Wellness Coach or Diabetes Educator socialized with the members and educated them on the benefits of exercise.

Lowell CHC CP maintains an active Health and Wellness Committee that provides staff training on Executive Order 509 nutrition standards[11], educates members on chronic disease management, and connects members to tobacco cessation programs. Most recently, Lowell CHC CP formed a BH CP Engagement team designed to locate, stabilize, and build a network of social services organizations for disenfranchised and/or members experiencing homelessness.

[11] Executive Order 509 (EO 509), *Establishing Nutrition Standards for Food Purchased and Served by State Agencies*, is a component of Mass in Motion, a statewide wellness initiative. EO 509 requires certain state agencies within the Executive Department to follow nutrition standards developed by the Department of Public Health when purchasing and providing food and beverages, whether directly or through contract, to agency clients/patients.
https://www.mass.gov/files/documents/2016/09/ts/eo509-fact-sheet.pdf

Continuous quality improvement

Lowell CHC CP ensures continuous QI in member experience by actively tracking CAB feedback and member experiences in a dashboard generated by their care management platform. This reporting provides a consistent lens through which program leadership can view interventions.

Lowell CHC CP's multidisciplinary QMC enables continuous QI in quality of care by developing QI initiatives to bring to the Executive Board. Lowell CHC CP's Quality Management Plan incorporates one QI project from four quality domains each year of the Demonstration. These domains include care integration, population health, avoidable utilization, and member experience. Information on QI projects are shared with frontline staff during weekly operational and strategy meetings.

Recommendations

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

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

- ✓ **Outreach and engagement strategies**
    - acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
    - creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
    - providing free transportation options for members to engage with services[12];
    - 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;

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

- 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[13];
- 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 Lowell CHC CP 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

[13] Where members have authorized sharing of SUD treatment records.

- Care Model

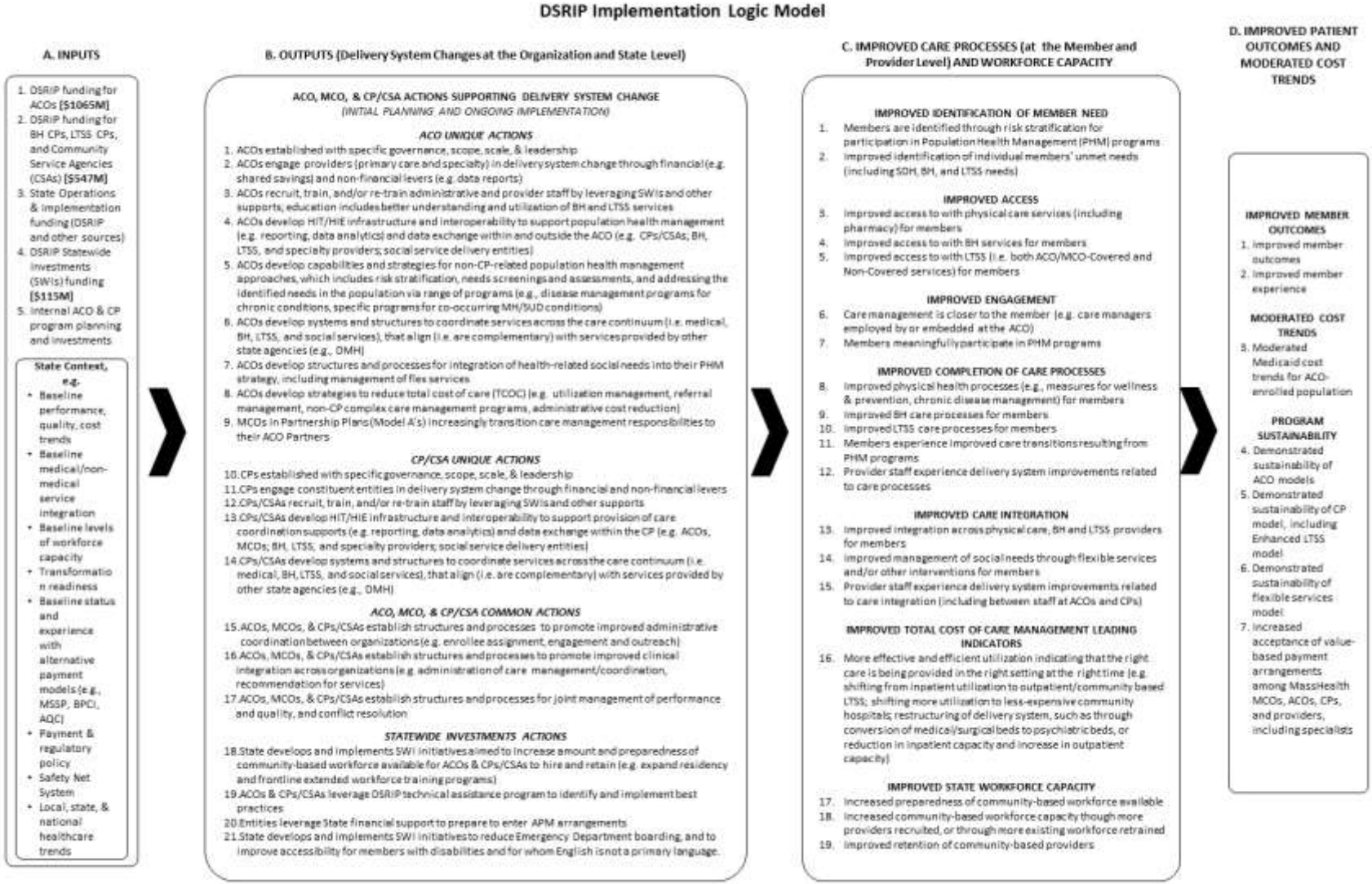
The IA recommends that Lowell CHC CP review its practices in the following aspects of the focus areas, for which the IA did not identify sufficient documentation to assess or confirm progress:

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

Lowell CHC CP 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[14] (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

[14] 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.[15] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[15] 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

None submitted.