

MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

LTSS Care Partners, LLC.

(LTSS-CP)

Report prepared by The Public Consulting Group: December 2020



PUBLIC
CONSULTING GROUP

TABLE OF CONTENTS

DSRIP MIDPOINT ASSESSMENT HIGHLIGHTS & KEY FINDINGS	3
LIST OF SOURCES FOR INFOGRAPHIC.....	4
INTRODUCTION	5
MPA FRAMEWORK.....	5
METHODOLOGY	6
CP BACKGROUND.....	7
SUMMARY OF FINDINGS.....	7
FOCUS AREA LEVEL PROGRESS	7
1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT	8
On Track Description	8
Results	8
Recommendations	9
2. INTEGRATION OF SYSTEMS AND PROCESSES	11
On Track Description	11
Results	11
Recommendations	13
3. WORKFORCE DEVELOPMENT	15
On Track Description	15
Results	16
Recommendations	17
4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE	18
On Track Description	18
Results	19
Recommendations	20
5. CARE MODEL	20
On Track Description	20
Results	21
Recommendations	22
OVERALL FINDINGS AND RECOMMENDATIONS	24
APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL	26
APPENDIX II: METHODOLOGY.....	27
DATA SOURCES.....	27
FOCUS AREA FRAMEWORK	27

ANALYTIC APPROACH	28
DATA COLLECTION	29
Key Informant Interviews	29
APPENDIX III: ACRONYM GLOSSARY	30
APPENDIX IV: CP COMMENT	32

DSRIP Midpoint Assessment Highlights & Key Findings LTSS Care Partners, LLC (LTSS-CP)



A Long-Term Services and Supports Community Partner

Organization Overview

LTSS-CP brings together seven community-based organizations, within one consortium. The seven member organizations serve children and adults (ages 3-64) with long-term services and supports (LTSS) needs. LTSS-CP collaborates with ACOs/MCOs to improve care coordination, avoid duplication of services, and target limited resources to the right enrollees at the right time.

SERVICE AREA



POPULATIONS SERVED

- ▶ LTSS-CP's primary service area is the Greater Boston area, including Boston, Revere, Somerville, Quincy, Malden and Brockton.
- ▶ LTSS-CP serves a diverse population with various needs including intellectual/developmental disabilities, autism, brain injury, and a variety of chronic physical and behavioral health (BH) conditions.

1,168

**Members Enrolled
as of December 2019**

FOCUS AREA

Organizational Structure and Engagement
Integration of Systems and Processes
Workforce Development
Health Information Technology and Exchange
Care Model

IA FINDINGS

● On Track ● Limited Recommendations
● On Track
● On Track
● On Track ● Limited Recommendations
● Opportunity to Improve with Recommendations

IMPLEMENTATION HIGHLIGHTS

- LTSS-CP shares a comprehensive care management report with member organizations on a weekly basis. The report serves as a one stop supervision and quality tool for member organizations.
- In 2019, the Director of Program Services launched the Risk Management Committee on behalf of both LTSS CP and CCP. The committee meets monthly to review critical incident reports for trends, with a focus on mitigating risk for members and staff.
- LTSS-CP offers a robust training program leveraging subject matter experts across member organizations and MassHealth trainings and hosting a quarterly learning collaborative for care coordinators and supervisors.

Statewide Investment Utilization:

- Student Loan Repayment Program, 3 Care Coordinators, 1 LPN/RN participating
- Special Projects Program
- Community Health Worker Trainings
- Technical Assistance
- CP Recruitment Incentive Program

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of five focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator¹ (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (<https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download>).

The question addressed by this assessment is:

To what extent has the CP taken organizational level actions, across five areas of focus, to transform care delivery under an accountable and integrated care model?

This report provides the results of the IA's assessment of the CP that is the subject of this report. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage the CP to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

MPA FRAMEWORK

The MPA findings cover five "focus areas" or aspects of health system transformation. These were derived from the DSRIP logic model (Appendix I) by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes
3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. The CP actions are broad enough to be accomplished in a variety of ways by different organizations, and the scope of the IA is to assess progress, not to determine the best approach for a CP to take.

The focus area framework was used to assess each entity's progress. A rating of "On track" indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated "On track with limited recommendations" or, in the case of

¹ The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

more substantial gaps, “Opportunity for improvement.” See Methodology section for an explanation of the threshold setting process for the ratings.

Table 1: Framework for Organizational Assessment of CPs

Focus Area	CP Actions
Organizational Structure and Governance	<ul style="list-style-type: none"> CPs established with specific governance, scope, scale, & leadership CPs engage constituent entities in delivery system change
Integration of Systems and Processes	<ul style="list-style-type: none"> CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement, and outreach) CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	<ul style="list-style-type: none"> CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	<ul style="list-style-type: none"> CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)
Care Model	<ul style="list-style-type: none"> CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))

METHODOLOGY

The IA employed a qualitative approach to assess CP progress towards DSRIP goals, drawing on a variety of data sources to assess organizational performance in each focus area. The IA performed a desk review of participants’ submitted reports and of MassHealth supplementary data, covering the period of July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018. These included Full Participation Plans, annual and semi-annual reports, budgets, and budget narratives. A supplementary source was the transcripts of KIIs of CP leaders conducted jointly by the IA and the IE.

The need for a realistic threshold of expected progress, in the absence of any pre-established benchmark, led the IA to use a semi-empirical approach to define the state that should be considered “On track.” As such, the IA’s approach was to first investigate the progress of the full CP cohort in order to calibrate expectations and define thresholds for assessment.

Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans and annual and semi-annual reports. This horizontal review identified a broad range of activities and capabilities that fell within the focus areas, yielding specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item and its relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality of entities. Items that had been accomplished by only a small number of CPs were considered to be

promising practices, not expectations at midpoint. This calibrated the threshold for expected progress to the actual performance of the CP cohort as a whole.

Qualitative coding of documents was used to aggregate the data for each CP by focus area, and then coded excerpts were reviewed to assess whether and how each CP had met the defined threshold for each focus area. The assessment was holistic and did not require that entities meet every item listed for a focus area. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and no need for remediation was identified. When evidence from coded documents was lacking for a specific action, additional information was sought through a keyword search of KII transcripts. Prior to finalizing the findings for an entity, the team convened to confirm that thresholds had been applied consistently and that the reasoning was clearly articulated and documented.

See Appendix II for a more detailed description of the methodology.

CP BACKGROUND²

LTSS Care Partners, LLC (LTSS-CP) is a long-term services and supports (LTSS) CP.

LTSS-CP is a consortium comprising seven community-based member organizations. Collectively, the seven member organizations serve over 70,000 people in Eastern Massachusetts. All member organizations have experience serving children and adults, ages 3-64, with complex LTSS needs. LTSS-CP collaborates with ACOs/MCOs to improve care coordination, reduce duplication of services, target limited resources to the right enrollees at the right time, and promote more integrated person-centered care.

LTSS-CP's primary service area is the Greater Boston area, including the cities/towns of Boston, Revere, Somerville, Quincy, Malden, and Brockton. LTSS-CP serves individuals with physical disabilities, intellectual/development disabilities, including autism and traumatic brain injury; severe mental illness (SMI); and people with disabilities under the age of 65 who are enrolled in One Care.

As of December 2019, 1,168 members were enrolled with LTSS-CP³.

SUMMARY OF FINDINGS

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

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

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

³ Community Partner Enrollment Snapshot (12/13/2019).

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

✓ **Executive Board**

- has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and
- is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).⁴

✓ **Consumer Advisory Board (CAB)**

- has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.

✓ **Quality Management Committee (QMC)**

- has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

The IA finds that LTSS-CP is **On track with limited recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

LTSS-CP has a central leadership team that is comprised of the CP's Executive Director, Director of Operations, and Director of Program Services. The leadership team manages the implementation of the LTSS CP program and compliance with the program contract. The leadership team meets monthly and oversees the development of processes, tools, and workflows that support each of the CP's member organizations and their work with assigned members. The leadership team also reviews program successes, challenges, risk mitigation strategies, and financial performance data.

The LTSS-CP leadership team maintains ongoing communication and collaboration with its member organizations. The CP leadership team meets with each member organization's executive team monthly to review CP program successes, barriers, and solutions.

Consumer Advisory Board

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.

LTSS-CP's CAB met twice in 2019. LTSS-CP experienced challenges recruiting engaged members to join the CAB. LTSS-CP identified members who expressed interest in participating on the CAB; however, these potential members have not attended subsequent meetings. LTSS-CP tasked its care coordinators with recruiting potential CAB members and accompanying members to their first CAB meeting. LTSS-CP also attempted to mitigate barriers to CAB participation by offering members a stipend for travel or childcare.

To improve CAB participation LTSS-CP engaged the Boston Center for Independent Living (BCIL), a member organization, to manage CAB development and facilitation. In December 2019, BCIL entered into a new subcontract with LTSS-CP that suspends BCIL's care coordination responsibilities and allows the member organization to focus its efforts on the CAB.

Quality Management Committee

LTSS-CP established a QMC that reviews key performance metrics and is responsible for overseeing the CP's QI initiatives. The QMC reviews performance data in comparison to established benchmarks and best practices and makes recommendations to the CP leadership team. The QMC's members provide valuable context to the performance metrics results, including variables such as data availability, quality, and validity as well as variances in populations and ACO regions.

LTSS-CP developed a QI initiative focused on improving performance on the CP engagement and annual treatment plan completion measure. The QMC reviews member outreach and engagement data collected in the CP's care management platform to measure the success of QI initiatives and develop further process improvement efforts. The CP tracks outreach and engagement contacts made with members, member adherence to scheduled appointments, and member participation in the development of care plans in the care management platform.

Recommendations

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

- developing a successful strategy for recruiting members to participate in the CAB.

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

✓ Executive Board

- holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
- conducting one-on-one quarterly site visits with APs and CEs;
- holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)⁵ Joint Operating Committee;

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

Joint approach to member engagement

LTSS-CP implemented a centralized process to exchange care plans and other member files with ACO/MCO partners through Secure File Transfer Protocols (SFTP), secure email, and a secure file-sharing app.

LTSS-CP designated each of its member organizations as the primary contact for one of the CP's partner ACOs to better engage PCPs in care plan sign-off, facilitate relationship building and promote communication between CP staff, ACOs, and PCP contacts. Although LTSS-CP observed success with this approach, they continued to have trouble achieving timely care plan sign-off for members who have not been seen by a PCP in the past year. Some ACO partners connect CP staff and the ACO's PCP practices by inviting PCP practice staff to the CP and ACO's quarterly meetings. CP staff

market the LTSS-CP program at the PCP level and share its provider-specific marketing brochure whenever possible.

LTSS-CP exchanges member contact information with ACO/MCO partners during quarterly in-person meetings and through LTSS-CP's ENS portal. The ENS portal gives LTSS-CP care coordinators access to member contact information and identifies other healthcare providers the member has recently visited. LTSS-CP uses this portal to update member contact information and identify where members are receiving services as another means of establishing contact with the individual.

LTSS-CP's intake team reviews ACO enrollment and outreach status report spreadsheets on a weekly basis and evaluates the files for invalid or missing datapoints.

Integration with ACOs and MCOs

LTSS-CP attends quarterly meetings with partner ACOs/MCOs. These meetings address specific members' cases and facilitate the sharing of clinical information. LTSS-CP maintains ongoing communication with ACO/MCO partners outside of quarterly meetings to continue to achieve integrated care for shared members. LTSS-CP conducts monthly clinical case review meetings with four ACO/MCO partners and monthly administrative check-ins with an additional four ACO/MCO partners.

LTSS-CP integrated ENS/ADT notifications into its care management platform, allowing CP staff to review notifications daily. Access to ENS/ADT notifications provide LTSS-CP care coordinators with real-time data for members who are admitted, discharged, or transferred to a provider who is subscribed to one of the two contracted ENS/ADT vendors. For providers not contracted with these ENS/ADT vendors, LTSS-CP does not generally receive real-time care data for these members as ACO/MCO direct alerts are typically not received in real time.

CP Administrator Perspective "LTSS-CP has identified a lead Member Organization to align with each ACO/MCO. The goal in implementing this structure has been to further promote and facilitate relationship building and communications between specific Member Organization Care Teams and ACO/MCO clinical staff and LTSS-CP continued to make strides with particular ACOs/MCOs in this regard in this reporting period. Some ACOs have in turn acknowledged LTSS-CP as a preferred CP."

Joint management of performance and quality

LTSS-CP implemented a QI initiative to improve member outreach and engagement. The CP tracks member outreach and engagement attempts, members' attendance at scheduled appointments, members' participation in care plan development, and LTSS care plan approval and sign-off.

LTSS-CP reports that its care plan approval rate improved in 2019 due to the implementation of a tool to help care coordinators navigate the various submission requirements of LTSS-CP's 11 ACO partners. However, LTSS-CP continues to experience challenges achieving care plan sign-off for members who have not been seen by a PCP in the past year. To mitigate this challenge, LTSS-CP arranged to have some PCPs sign-off on care plans prior to seeing CP members. LTSS-CP then makes it a goal to have the individual seen by the PCP within the year. The CP has not been able to make this arrangement with all PCPs, as some providers insist that they must see the member prior to signing off on the care plan.

LTSS-CP distributes weekly audit reports to member organizations. LTSS-CP hired a data analyst who developed the audit report which leverages the data contained within the care management platform. The audit report flags issues related to member engagement milestones, missing documentation, and activity coding and gives care teams the opportunity to correct errors in advance of CP billing. The CP uses the audit report as a supervision tool for member organizations by tracking

errors identified in the audit reports, ensuring that workflows are consistent, and determining areas that require additional training. LTSS-CP also built a dashboard that allows CP leadership and staff to view performance data and is used to inform program strategy.

Recommendations

The IA has no recommendations for the Integration of Systems and Processes focus area.

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

✓ **Joint approach to member engagement**

- adopting systems, preferably automated, that process new ACO member files instantaneously, inputting member information in the applicable platform and reconciling those members with existing eligibility lists, enabling the CP to engage with the new member list without delay;
- redesigning workflows and automated notifications so that receipt of a comprehensive assessment from an ACO/MCO partner generates a new outreach attempt;
- establishing on-demand access to full member records through partners' EHRs;
- tracking members' upcoming appointments through partners' EHRs to enable staff to connect with members in the waiting room prior to their appointment;
- negotiating fast track primary care appointments with practice sites to ensure that members receive timely care and to enable PCPs to engage with and sign off on the member's care plan;
- collaborating with interdisciplinary staff, such as CE and AP program managers, clinical care managers, nurses, and care coordinators to develop a promising practices toolkit for PCP engagement and care plan sign-off;
- hiring a dedicated community liaison to build relationships with PCPs and educate them about the benefits provided by the CP program;
- embedding care coordination staff at PCP practices, particularly those that require an in-person visit as a prerequisite for care plan sign off;
- determining the date of the member's last PCP visit within a month of that member's assignment, and proactively scheduling an appointment on behalf of any member who has not had a PCP visit in the prior 12 months;
- developing a single point of contact for ACO/MCO partner referrals to review prospective members, research previous treatment history, and to strategize on how to accommodate new members with current CP care team capacity;
- identifying a lead member organization or CP care team to align with each ACO/MCO partner to promote and facilitate relationship building between CP care teams and ACO/MCO clinical staff; and
- implementing a real-time communication tool such as secure texting to communicate with ACO practices about shared members.

✓ **Integration with ACOs and MCOs**

- attending regularly occurring case conferences with PCPs to review member cases and obtain PCP sign-off on care plans;
- collaborating with state agencies to improve management of mutual members. For example, creating an FAQ document to explain how the two organizations may effectively work together to provide the best care for members or conducting complex case conferences;

- scheduling joint visits with the PCP, ACO/MCO clinical care team representative, and the CP care coordinator to present a unified team to the member and establish distinct support roles and who the member can contact in to address various needs; and
- collaborating with PCP practice sites so that CP care coordinators are invited to meet with members onsite prior to their clinical appointments.

✓ **Joint management of performance and quality**

- monitoring process metrics associated with member outreach and engagement such as the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff;
- sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding, and members who have unsigned care plans that are due or overdue;
- having clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of those plans prior to submission to PCPs for sign-off;
- developing dashboards that combine data from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement;
- generating a reminder list of unsigned care plans for ACO and MCO key contacts;
- maintaining a dedicated web portal to share information with CP care teams across member organizations. Shared information includes contact information of primary care practices; the LTSS/BH provider network and local social services providers; training materials; and policies and procedures;
- developing a daily report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to identify members' ACO assignment changes and keep the members' records in the EHR up to date; and
- embedding staff at local Emergency Departments (EDs) to improve outreach to members not engaged in regular care, particularly members experiencing homelessness, and connect them to care coordination supports.

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of CPs considered On track:

✓ **Recruitment and retention**

- does not have persistent vacancies in planned staffing roles;
- offers a variety of incentives to attract candidates and retain staff, and uses a variety of mechanisms to recruit and retain staff; and
- employs tactics to ensure diversity in the workplace and design staff incentives and performance bonuses around CP priorities such as enrollee engagement, signed care plans and intensive care coordination.

✓ Training

- develops policies and procedures to ensure staff meet the contractual training requirements and offer training to all new staff based on program requirements; and
- holds ongoing (often monthly) training to ensure staff are up to date on best practices and advancements in the field.

Results

The IA finds that LTSS-CP is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

LTSS-CP had no persistent vacancies in planned staff roles. As of 2019, LTSS-CP had only one unfilled care coordinator position that was newly added in anticipation of additional member referrals. LTSS-CP's recruitment strategy includes outreach at career fairs, trade organizations, community-based organizations, colleges, certificate programs, and culture centers. Additionally, LTSS-CP recruits through digital and other media advertising strategies. LTSS-CP calls on member organizations to inform targeted advertising specific to their geographic and demographic communities. LTSS-CP hired bilingual and multilingual care team staff to meet the language accessibility needs of their members.

LTSS-CP participates in the DSRIP Statewide Investment (SWI) Student Loan Repayment incentive to recruit qualified staff. This incentive has helped LTSS-CP attract care coordinators in a competitive labor marketplace.

After recruiting and fully staffing most CP member organizations, LTSS-CP shifted their focus to staff retention. To retain CP staff, LTSS-CP hosts employee recognition activities, maintains a professional development fund for CP staff, encourages participation in learning collaboratives, and offers CP staff the opportunity to complete a certificate program in non-profit leadership. Additionally, LTSS-CP holds an LTSS Care Coordinator forum monthly as well as a monthly Office Hours call where the LTSS-CP staff from various member organizations can network with fellow care coordinators and receive additional support in the delivery of the LTSS-CP program. Similarly, LTSS-CP holds staff celebrations that are used to increase morale and build cohesion.

Training

LTSS-CP uses a centralized training program to promote consistency in service delivery across all member organizations. All new CP staff attend a required training to ensure they meet the training requirements of the CP program⁶. LTSS-CP developed an annual refresher training for all staff to reinforce CP program training topics.

LTSS-CP leverages subject matter experts from its member organization to provide staff with ongoing trainings. The CP established a quarterly learning collaborative for care coordinators and supervisors to support ongoing learning, process improvements, and create an avenue for sharing best practices. Additionally, LTSS-CP has staff complete MassHealth trainings as needed.

CP Administrator Perspective: "While LTSS-CP and its seven Member Organizations continued to prioritize recruitment in [2019], new focus was placed on staff retention and staff development."

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

LTSS-CP streamlined its New Hire Orientation from a four-day to three-day event. And two Learning Collaboratives were further developed in this budget period, the LTSS Forum for Care Coordinators and another monthly collaborative specific for LTSS Supervisors.”

Recommendations

The IA has no recommendations for the Workforce Development focus area.

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

✓ **Promoting diversity in the workplace**

- compensating staff with bilingual capabilities at a higher rate.
- establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
- advertising in publications tailored to non-English speaking populations;
- attending minority focused career fairs;
- recruiting from diversity-driven college career organizations;
- tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
- implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
- advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican, and the Hispanic Social Workers; and
- recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.

✓ **Recruitment and retention**

- implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;
- assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;
- conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention;
- making staff retention a priority initiative of the QMC to leverage existing quality improvement structures and engage leadership to monitor progress towards retention goals;
- implementing opportunities for peer mentoring and other supports; For example, scheduling office hours that allow care coordinators to network and receive support from experienced staff and/or have direct communication with CP leadership;
- reducing staff training burden by allowing experienced staff to test out of basic training exercises and instead participate in more advanced training modules;

- instituting a management training program to provide lower level staff a path to promotion;
- allowing flexible work hours and work from home options for care coordination staff;
- striving to maintain a balanced ratio of care coordinators to members served, to avoid unmanageable workloads and staff burnout;
- offering retention bonuses to staff that are separate from performance-based bonuses; and
- participating in SWI loan assistance for qualified professional staff.

✓ **Training**

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

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

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

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

✓ **Interoperability and data exchange**

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

- uses Mass Hlway⁷ to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.

✓ **Data analytics**

- develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and
- 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 LTSS-CP is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

LTSS-CP transitioned to a new care management platform in 2019. The CP has implemented the new care management platform across all member organizations. LTSS-CP has subscribed to ENS/ADT notifications through two vendors and has integrated these notifications into its care management platform.

Interoperability and data exchange

LTSS-CP has the capability to exchange member files via SFTP and secure email. In its most recent progress report LTSS-CP reports that it can share and/or receive member contact information, comprehensive assessments, and care plans electronically from all or nearly all ACOs and MCOs. LTSS-CP can share and/or receive care plans electronically from most PCPs and is able to share and/or receive comprehensive needs assessments and member contact information electronically with some PCPs.

To further interoperability and data exchange efforts, LTSS-CP has successfully gained read-only access to one of its partner ACO's EHR. LTSS-CP reports that access to the ACO's EHR has promoted increased integration of care for shared members.

Data analytics

LTSS-CP has built a dashboard tracking Qualifying Activities⁸. Reports on CP performance are generated using data from the dashboard and the care management platform. Staff provide reports to the QMC and the LTSS-CP's Board of Directors. To further LTSS-CP's data analytics capabilities, LTSS-CP hired a Director of Quality and Analytics who oversees data analytics, trend reporting, the development of key performance indicators, QI initiatives, and progress towards established performance goals.

In addition, LTSS-CP is engaged in a Technical Assistance (TA) project funded through SWI 5a. The TA vendor evaluated the LTSS-CP's data needs and developed a strategy to build a data warehouse that brings together claims, demographic, enrollment, and care coordination data. The project has resulted in the development of a logic model, a conceptual data model, and a list of reports that

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

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.

LTSS-CP is using to guide the normalization of data collection and transfer of information to a data warehouse.

Recommendations

The IA encourages LTSS-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 Hlway.

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

Outreach and engagement strategies

To meet the needs of its CP membership, LTSS-CP employs staff who are bilingual and multilingual and have expertise serving people with complex LTSS and medical needs. The CP has successfully recruited staff who are fluent in Spanish, Mandarin, Cantonese, and Vietnamese. LTSS-CP has also contracted with interpretation services to support members with language needs not met by CP staff. In 2019, LTSS-CP expanded its access to translation services and contracted with an additional interpretation services vendor so that CP care coordinators have access to interpretation services when working in the community with members. LTSS-CP has also hired a care coordinator with experience serving members who identify as LGBTQ.

To contact assigned members who are not easily reached telephonically, LTSS-CP uses text-messaging and home visits to conduct outreach. The CP reports that this approach has been more effective than phone calls and mailings.

Person-centered care model

LTSS-CP focuses on addressing members' patterns of unhealthy behaviors and barriers to change by providing education and skill training, addressing lack of resources, and using motivational interviewing to promote sustained health behavior change. LTSS-CP engages the member's existing support system in care planning to promote the member's trust in the process. To ensure that health and wellness goals are incorporated into the member's care plan, care coordinators, with the member's consent, reach out to other care team members. Care coordinators ask the member's PCP, therapist, family members, and visiting nurse providers to share recommended goals for the member's care plan. The care coordinator also references the member's ACO comprehensive assessment to identify any additional goals. The care coordinator then works with the member to customize the collected goals to align with the member's personal goals.

Goals and interventions are documented in the member's care plan and are reviewed during every check-in with the member. Care coordinators consistently evaluate whether a member can follow

through on agreed upon interventions and determine whether increased support is needed to achieve specified goals.

Managing transitions of care

LTSS-CP has developed a routine for warm handoffs between clinical care teams and the CP. LTSS-CP aims to collaborate with the member's support system, including other known providers, to maximize connections and engage in warm handoffs whenever possible. LTSS-CP care coordinators make themselves available during members' discharge planning. Care coordinators bring insight about the member's home and natural support system and help providers develop a realistic discharge plan that includes additional supports or accommodations that the member might need. LTSS-CP care coordinators also monitor the success of the discharge plan, identify gaps in the plan, and assess the member's adherence to the discharge plan during the member's three-day, post-discharge follow-up appointment.

CP Administrator Perspective: "When a Care Coordinator is involved, their perspective can be very valuable to discharge planning. Often times a Care Coordinator has been to an Enrollee's home and can ...offer critical insights into how realistic a plan might be or what additional supports or accommodations may be needed. As an example, a Care Coordinator often knows whether an Enrollee can navigate the essential features of the apartment/ house with the DME [durable medical equipment] being prescribed."

Improving members' health and wellness

Through coaching, LTSS-CP care coordinators encourage members to engage in self-management of chronic health conditions and routine use of preventative healthcare services. Care coordinators also connect members with community-based recovery support groups, community workshops, and online information and support resources that focus on issues such as stress reduction and relapse prevention.

Continuous quality improvement

LTSS-CP launched the Risk Management Committee in 2019 to enable continuous QI in quality of care. The Committee is chaired by the Director of Program Services and includes representation from LTSS-CP and its member organizations. The Committee meets monthly to review critical incident reports for trends and focuses on developing strategies to mitigate risk for members and staff whenever possible. LTSS-CP's QMC enables continuous QI in quality of care by developing QI initiatives focused on outreach and engagement, member attendance at scheduled appointments, and care plan approval.

To improve member experience, LTSS-CP advocates for resources within MassHealth to address ongoing eligibility issues, however LTSS-CP has struggled with CAB participation and does not report on an alternative structure for integrating member feedback into its QI processes.

Recommendations

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

- developing a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations;
- using Peer Support and/or Community Health Workers (CHWs) to support CP members throughout the provision of CP supports and activities;

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

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

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
- providing free transportation options for members to engage with services⁹;
- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

✓ **Person-centered care model**

- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
- setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
- developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery, and social needs; and
- allowing members to attend care planning meetings by phone or teleconference.

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
- meeting an enrollee in person once care coordinators receive alerts that they were admitted;
- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges¹⁰;

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

¹⁰ 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 LTSS-CP is On track or On track with limited recommendations across four out of five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Integration of Systems and Processes
- Workforce Development

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

Organizational Structure and Engagement

- developing a successful strategy for recruiting members to participate in the CAB.

Health Information Technology and Exchange

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
- developing a plan to increase active utilization of Mass Hlway.

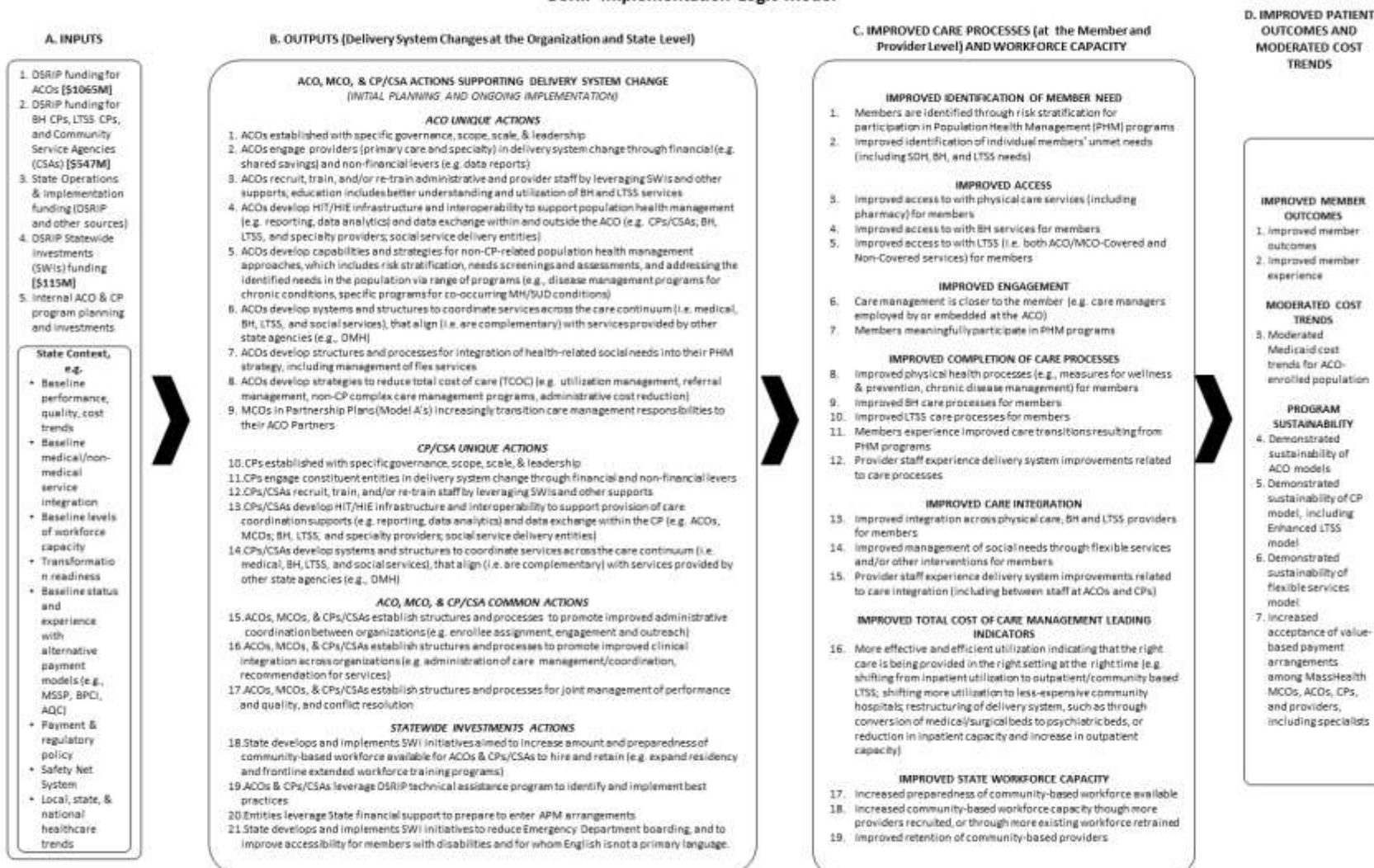
Care Model

- developing a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations;
- using Peer Support and/or Community Health Workers (CHWs) to support CP members throughout the provision of CP supports and activities;
- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB; and
- increasing standardization of processes for connecting members to social services where applicable.

LTSS-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

DSRIP Implementation Logic Model



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, and key informant interviews (KIIs) to assess progress of Community Partners (CPs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018.

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator¹¹ (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (<https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download>).

The question addressed by this assessment is:

To what extent has the CP taken organizational level actions, across five areas of focus, to transform care delivery under an accountable and integrated care model?

DATA SOURCES

The MPA drew on multiple data sources to assess organizational performance in each focus area, including both historical data contained in the documents that CPs were required to submit to MassHealth, and newly collected data gathered by the IA and/or IE. The IA performed a desk review of documents that CPs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. The IE developed a protocol for CP Administrator KIIs, which were conducted jointly by the IA and the IE.

List of MPA data sources:

Documents submitted by CPs to MassHealth covering the reporting period of July 1, 2017 through December 31, 2019:

- Full Participation Plans
- Semi-annual and Annual Progress Reports
- Budgets and Budget Narratives

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

The CP MPA assessment findings cover five “focus areas” or aspects of health system transformation. These were derived from the DSRIP logic model, by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes

¹¹ The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. This framework was used to assess each CP's progress. A rating of On track indicates that the CP has made appropriate progress in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the CP was rated "On track with limited recommendations" or, in the case of more substantial gaps, "Opportunity for improvement."

Table 1. Framework for Organizational Assessment of CPs

Focus Area	CP Actions
Organizational Structure and Governance	<ul style="list-style-type: none"> CPs established with specific governance, scope, scale, & leadership CPs engage constituent entities in delivery system change
Integration of Systems and Processes	<ul style="list-style-type: none"> CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement, and outreach) CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	<ul style="list-style-type: none"> CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	<ul style="list-style-type: none"> CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)
Care Model	<ul style="list-style-type: none"> CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))

ANALYTIC APPROACH

The CP actions are broad enough to be accomplished in a variety of ways by different CPs, and the scope of the IA is to assess progress, not to prescribe the best approach for an CP. Moreover, no pre-established benchmark is available to determine what represents adequate progress at the midpoint. The need for a realistic threshold of expected progress led the IA to use a semi-empirical approach to define the state that should be considered On track. Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans, which identified a broad range of activities and capabilities that fell within the logic model actions. This provided specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item, and relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality

of CPs. Items that had been accomplished by only a small number of CPs were considered to be emerging practices and were not included in the expectations for On track performance. This calibrated the threshold for expected progress to the actual performance of the cohort as a whole.

Qualitative coding of documents to focus areas, and analysis of survey results relevant to each focus area, were used to assess whether and how each CP had accomplished the actions for each focus area. The assessment was holistic, and as such did not require that CPs meet every item on a list. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and there are no recommendations for improvement. Where evidence was lacking in the results of desk review and survey, keyword searches of KII interview transcripts were used to seek additional information. Prior to finalizing the findings for an entity, the multiple reviewers convened to confirm that thresholds were applied consistently, and that the reasoning was clearly articulated and documented.

A rating of On track indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for improvement.

DATA COLLECTION

Key Informant Interviews

Key Informant Interviews (KII) of CP Administrators were conducted in order to understand the degree to which participating entities are adopting core CP competencies, the barriers to transformation, and the organization's experience with state support for transformation.¹² Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

¹² KII were developed by the IE and conducted jointly by the IE and the IA. The IA utilized the KII transcripts as a secondary data source; the IA did not perform a full qualitative analysis of the KII.

APPENDIX III: ACRONYM GLOSSARY

ACPP	Accountable Care Partnership Plan
CP	Accountable Care Organization
ADT	Admission, Discharge, Transfer
AP	Affiliated Partner
APR	Annual Progress Report
BH CP	Behavioral Health Community Partner
CAB	Consumer Advisory Board
CCCM	Care Coordination & Care Management
CCM	Complex Care Management
CE	Consortium Entity
CHA	Community Health Advocate
CHEC	Community Health Education Center
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CSA	Community Service Agency
CWA	Community Wellness Advocate
DMH	Department of Mental Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
ENS	Event Notification Service
EOHHS	Executive Office of Health and Human Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HLHC	Hospital-Licensed Health Centers
HRSN	Health Related Social Need
HSIMS	Health Systems and Integration Manager Survey
IA	Independent Assessor
IE	Independent Evaluator
JOC	Joint Operating Committee
KII	Key Informant Interview
LGBTQ	lesbian, gay, bisexual, transgender, queer, questioning
LCSW	Licensed Independent Clinical Social Worker
LPN	Licensed Practical Nurse
LTSS CP	Long Term Services and Supports Community Partner
MAeHC	Massachusetts eHealth Collaborative
MAT	Medication for Addiction Treatment
MCO	Managed Care Organization

MPA	Midpoint Assessment
NCQA	National Committee for Quality Assurance
OBAT	Office-Based Addiction Treatment
PCP	Primary Care Provider
PFAC	Patient and Family Advisory Committee
PHM	Population Health Management
PT-1	MassHealth Transportation Program
QI	Quality Improvement
QMC	Quality Management Committee
RN	Registered Nurse
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SVP	Senior Vice President
SWI	Statewide Investments
TCOC	Total Cost of Care
VNA	Visiting Nurse Association

APPENDIX IV: CP COMMENT

Each CP was provided with the opportunity to review their individual MPA report. The CP had a two week comment period, during which it had the option of making a statement about the report. CPs were provided with a form and instructions for submitting requests for correction (e.g., typos) and a comment of 1,000 word or less. CPs were instructed that the comment may be attached as an appendix to the public-facing report, at the discretion of MassHealth and the IA.

Comments and requests for correction were reviewed by the IA and by MassHealth. If the CP submitted a comment, it is provided below. If the CP requested a minor clarification in the narrative that added useful detail or context but had no bearing on the findings, the IA made the requested change. If a request for correction or change had the potential to impact the findings, the IA reviewed the MPA data sources again and attempted to identify documentation in support of the requested change. If documentation was identified, the change was made. If documentation was not identified, no change was made to the report but the information provided by the CP in the request for correction is shown below.

CP Comment

LTSS Care Partners appreciates the recognition this report represents and confirmation that LTSS Care Partners is on track, meeting program requirements and implementing innovative practices in four of the five Focus Areas. Likewise, LTSS Care Partners appreciates the recommendations made specific to LTSS Care Partners within the report as well as the breadth of information shared in relation to best practices across all CPs statewide. This is no doubt invaluable information as we seek to continually improve our services. LTSS Care Partners acknowledges it's initial struggle with successfully launching a Consumer Advisory Board (CAB), and is pleased to report that we have since had a very successful launch of the CAB which has been meeting monthly since September 2020. And while alerts are not set within LTSS Care Partners' SFTP, a manual cycle of checking for files multiple times per day has been in place since the inception of the program.

In regards to failing to earn an "On Track" designation under the Care Model Focus Area, we respectfully note the following: Within our Full Participation Plan and our Semi Annual Report in August 2019, we outline the intensive street outreach strategies we employ, particularly with hard to reach enrollees that are homeless. We leverage our connections with homeless shelters, drop in centers, and other outreach teams and do not hesitate to outreach directly within the community (pre-COVID practice). While those we hire to provide LTSS Care Coordination hold the title of LTSS Care Coordinator, we recruit candidates with the scope of work and experience that CHWs bring to the table. In fact, we have even hired into the role a candidate who was a certified CHW and we have offered to pay for CHW training for those LTSS Care Coordinators interested. And lastly, in terms of standardization of processes for connecting members to social services, we are consistently striving to enhance processes and information in place. As noted in our Full Participation Plan, at the start of the LTSS CP program we developed and implemented a Social Services Assessment tool, and continue to use this standardized tool during the initial intake with each enrollee. And as noted in our Semi Annual report in August 2019, our web portal, as accessed across all six of our Member Organizations, includes an inventory of various social services available to enrollees. Likewise, we publish a weekly eFlash across all Member Organizations that includes new and updated information regarding social services available to our enrollees. In fact, since COVID 19, we have relied heavily on this approach to ensure all Member Organizations have access to the most up to date resources available during this critical time. And finally, we hold a monthly LTSS Forum / Learning Collaborative with LTSS Care Coordinators across our Member Orgs where we often spotlight a social service available and walk the group through the processes for streamlining/expediting access to these services.