MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Merrimack Valley Community Partnership (MVCP)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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DSRIP Midpoint Assessment Highlights & Key Findings

Merrimack Valley Community Partnership (MVCP)

PUBLIC CONSULTING GROUP

A Long-Term Services and Supports Community Partner

Organization Overview

MVCP is a collaboration between Elder Services of the Merrimack Valley (ESMV) and Northeast Independent Living Program, Inc. (NILP). In 2004, ESMV and NILP established The Merrimack Valley Aging & Disability Resource Consortium (MV ADRC). Together, they are a resource for information and provide advocacy on issues related to aging and living with a disability.

SERVICE AREA

POPULATIONS SERVED

- MVCP's population is comprised of individuals with complex LTSS needs including individuals with co-existing behavioral health needs, individuals with physical disabilities, individuals with intellectual and/or developmental disabilities including autism, older adults (up to age 64) with LTSS needs, children and youth (ages 3 – 21) with LTSS needs.

602
Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- MVCP monitors and shares care plan completion and sign off data with the ACOs and health plans weekly.
- MVCP continues to use warm handoffs between ACO care managers and MVCP navigators. The MVCP intake coordinator and a consistent navigator maintain effective communication with inpatient facilities.
- MVCP utilizes a secure text messaging platform that improves the connection, communication and care coordination between the MVCP navigators and the ACO care team.

Statewide Investment Utilization:

- Technical Assistance
- CP Recruitment Incentive Program

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1: Framework for Organizational Assessment of CPs

Focus Area	CP Actions
Organizational Structure and Governance	• CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	• CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • CPs establish structures and processes for joint management of performance and quality, and problem solving
Workforce Development	• CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	• CPs develop health information technology and exchange (HIT/HIE) infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP, and externally (e.g. Accountable Care Organizations (ACOs), Managed Care Organizations (MCOs); behavioral health (BH), long term services and supports (LTSS), and specialty providers; social service delivery entities)
Care Model	• CPs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))

METHODOLOGY

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

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

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

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

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

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

CP BACKGROUND[2]

The Merrimack Valley Community Partnership (MVCP) is a long-term service and supports (LTSS) CP.

MVCP is a collaboration between Elder Services of the Merrimack Valley (ESMV) and Northeast Independent Living Program, Inc. (NILP), that together established The Merrimack Valley Aging & Disability Resource Consortium (MV ADRC). ESMV is a private non-profit agency that provides services, programs, education, and assistance to older adults, adults with disabilities, families, and caregivers. NILP is a consumer/peer run Independent Living Center, providing advocacy and services to people with disabilities in the greater Merrimack Valley and Northern Region who wish to live as independently as possible in the community. Together, the entities serve as a community resource for information and advocacy on issues related to aging and living with a disability. As a LTSS CP, MVCP provides supports to high need individuals.

MVCP's primary service area includes Greater Lawrence, Lowell, and Haverhill. MVCP's population comprises of individuals with complex LTSS needs including individuals with co-occurring behavioral health (BH) needs, brain injury or cognitive impairments, physical disabilities, and intellectual disabilities and developmental disabilities (including autism), as well as older adults (up to age 64) and children and youth (ages 3 – 21).

As of December 2019, 602 members were enrolled with MVCP[3].

SUMMARY OF FINDINGS

The IA finds that MVCP 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 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	On track with limited recommendations

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

FOCUS AREA LEVEL PROGRESS

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Executive Board**
    - has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and
    - is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).[4]
- ✓ **Consumer Advisory Board (CAB)**
    - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.
- ✓ **Quality Management Committee (QMC)**
    - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

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

Executive Board

MVCP has a governing board comprising leadership from both the lead entity, ESMV, and the Affiliated Partner (AP), NILP. The governing board meets monthly allowing partner organizations to make programmatic decisions and achieve consensus on CP operations. MVCP reports that its existing relationship with its AP predates the CP program and that the partnership has remained collaborative throughout the CP program implementation.

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.

MVCP established a CAB that meets quarterly. MVCP reports that the initial group of engaged members serving on the CAB are no longer engaged in CP supports. To solidify membership and create membership continuity from meeting to meeting, MVCP continues to recruit members engaged with MVCP supports to participate on the CAB. MVCP provides members with education about the function of the CAB and has used its community events as an opportunity to recruit additional members.

MVCP reports that members' short-term relationship with the CP program poses a challenge to CAB participation. It is difficult for the CP to keep individuals interested in participating on the CAB after they no longer receive supports from the CP. In response to this challenge, MVCP has focused its CAB membership recruitment efforts on individuals with an indirect relationship to the CP program but who are knowledgeable stakeholders and consumers of MassHealth LTSS. Additionally, MVCP has started recruiting the caregivers and family members of current and former CP members to participate on the CAB.

Quality Management Committee

MVCP established a QMC that meets monthly. This interdisciplinary committee monitors CP performance for quality improvement opportunities, develops strategies and timelines for interventions that improve quality and cost-effectiveness, tracks the effectiveness of implemented interventions, and makes modifications to existing improvement strategies.

The QMC oversees MVCP's QI performance and tracks whether the CP has met its improvement objectives related to clinical quality, coordination of care, access to services, and enhanced member experience. The QMC reviews medical record, consumer and provider feedback, utilization review data, and survey data to monitor CP quality improvement efforts. The QMC reports its activities and results to the MVCP governing board.

Recommendations

The IA encourages MVCP 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:

- seek strategies to maintain a balance of engaged members and family members for participation 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 MVCP is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

MVCP and all ACO/MCO partners have documented processes for the exchange of care plans and other member files. MVCP's documented processes include the transmission of member files through secure methods of communication such as Secure File Transfer Protocol (SFTP), a secure file-sharing application, and secure email. MVCP reports that it has established identified points of contact internally and at partner organizations to promote collaborative communication about shared members.

MVCP developed a systematic approach to engage PCPs in the review and sign-off on members' care plans. The approach relies on a single point of contact at MVCP who has built relationships with the ACO's key contacts. These key relationships facilitate the care plan transmission process. MVCP

reports that establishing their internal single point of contact has resulted in PCPs returning completed and signed care plans within the agreed upon seven to ten-day timeframe.

MVCP exchanges member contact information and other member data with ACOs/MCOs. For shared members, MVCP navigators and ACO/MCO care managers directly share updated member information with one another. MVCP also implemented a secure text messaging platform with one ACO partner as an additional means of communication and care coordination. MVCP reports that regularly scheduled meetings with ACO/MCO partners provide another channel for bilateral exchange of information.

To assist with outreach and engagement efforts, MVCP has tasked the CP's quality assurance staff person with the review of ACO/MCO member information spreadsheets. The quality assurance staff member reviews the spreadsheets twice a week, resolving discrepancies to ensure MVCP files contain accurate information.

Integration with ACOs and MCOs

MVCP attends quarterly meetings and regularly scheduled team meetings with ACO/MCO partners. MVCP uses these forums to share information on shared members, develop solutions to operational challenges, and identify ways that the partner organizations can support one another and their shared members.

MVCP conducts routine case review calls with one ACO partner. CP navigators and ACO Care Managers convene on a biweekly basis to discuss shared members and identify strategies to better coordinate care. In addition, when possible, MVCP navigators conduct joint in-person member visits and calls with ACO care managers. MVCP reports that conducting these visits in parallel with ACO partners allows for increased contact with the enrolled member as the care coordination staff can leverage calls scheduled by either MVCP or the ACO to contact and engage with the member.

To facilitate clinical integration with ACOs/MCOs, MVCP receives ENS/ADT notifications from two vendors and is in the process of contracting with an additional vendor. CP navigators receive real-time ENS/ADT notifications through the MVCP care management platform. Additionally, the CP intake coordinator reviews emergency department (ED) reports from some ACO partners received via SFTP. The intake coordinator then sends these reports to the appropriate navigators for follow-up with assigned members.

> CP Administrator Perspective: "*One of the big successes we have had with the ACOs and MCOs is the relationship building that has come out of working collaboratively.... We have learned more about each other and the benefits and challenges of partnering together. [The CP Administrator] was asked to sit on the Board of Directors at the MV ACO. This invitation was validation of the ACOs willingness to collaborate with the CPs and recognition of the value that CPs bring to the program."*

Joint management of performance and quality

MVCP tracks and analyzes medical records, consumer and provider feedback, utilization review data, and survey data through a quality dashboard. The dashboard is reviewed and discussed at each monthly CP governing board meeting. MVCP reviews dashboard data with ACO/MCO partners during scheduled quarterly meetings.

To facilitate the review of members' care plans, MVCP relies on a MVCP staff member to serve as the single point of contact with ACO/MCO partners and coordinate the care plan transmission process. MVCP tracks data related to care plan completion and sign-off. Care plan data is shared with ACOs/MCOs on a weekly basis and discussed at all quarterly meetings. The MVCP reports that there have been few instances when the care plan is not returned from the PCP in the agreed upon

timeframe. In these instances, MVCP has used the quarterly CP-ACO/MCO meeting as a forum to discuss the issue and resolve it collaboratively.

MVCP monitors performance of the CP and individual navigators. The MVCP Program Director, the navigator's supervisor, and the individual navigator review the navigator's performance and quality assurance data on a regular basis. Review sessions allow CP navigators to receive feedback on performance and for CP supervisors to provide coaching on any challenges the individual navigator encounters. Additionally, MVCP staff generate quality assurance reports regarding missing documentation and qualifying activities for the program director to oversee CP program performance and implement process 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;
- 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 MVCP is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

MVCP hired a core group of CP staff prior to the program's go-live date and two additional navigators since that side. MVCP does not report any persistent vacancies in planned staff roles. MVCP has made attempts to adapt staffing levels in response to enrollee volume but has indicated that data access challenges limit predictive modeling thus assumptions are often theoretical.

MVCP has implemented a variety of recruitment mechanisms. MVCP posts open CP positions on internal job boards, MVCP's website, and external job boards. To recruit diverse staff, MVCP advertises with a variety of media platforms tailored towards diverse cultural and linguistic communities. MVCP attends minority outreach job fairs, leverages contacts at other service providers who have bilingual and bicultural staff and participates in local civic events to reach a larger population of potential staff. As an agency, MVCP can support enrollees in 27 different languages.

To recruit and retain CP staff, MVCP created a process enabling navigators to apply to the CP Recruitment Incentive Program (SWI1c). MVCP also provides 10 to 12 professional development trainings annually. In 2019, MVCP implemented a retention bonus for frontline staff based on staff member's longevity with the CP.

> CP Administrator Perspective: *"Our biggest asset is the MVCP team, which consists of a well-rounded group of Navigators who possess a variety of backgrounds, experiences, diversity, and skillsets and care about those they serve. Member voice continues to be a priority for the team. The support staff, which consists of the Data Quality Specialist [and] the Intake Coordinator, are also invaluable to the program. Due to the complexities and youth of this program, a strong, flexible, and committed team approach is required, and MVCP can confidently say we have such a team."*

Training

MVCP developed a training curriculum that meets the contractual requirements of the CP program and prepares CP navigators to serve enrolled members. MVCP reports that all new staff receive training on MVCP's mission, disability awareness, cultural competency, accessibility and accommodation, independent living, recovery principles, motivational interviewing, conflicts of interest, and health and wellness principles.

MVCP staff attend on-going, quarterly trainings through the Northeast Community Collaborative of which MVCP is a part. MVCP uses the online trainings designed by MassHealth as an annual refresher training for all existing CP staff. MVCP also makes use of the trainings offered through the MassHealth DSRIP Technical Assistance (TA) Marketplace. In 2019, MVCP joined with ACO/MCO partners to start an ACO/MCO/CP learning collaborative.

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[6] 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 MVCP is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

MVCP has implemented a care management platform across all APs and has contracted with two vendors to receive ADT notifications. MVCP is currently in the process of contracting with a third ENS/ADT vendor. MVCP has integrated ENS/ADT notifications into the care management platform.

Interoperability and data exchange

MVCP has the capability to exchange member files via SFTP, secure email, a secure file-sharing application, and Mass HIway. MVCP has also worked with one ACO partner to implement an expedited communications protocol through secure text messaging. MVCP reports that the method of data exchange varies based upon the established documented processes with the specific ACO or MCO partner. MVCP has established its connection to Mass HIway through its care management platform. MVCP reports that it can receive member contact information, comprehensive assessments, and care plans from all or nearly all ACOs and MCOs. MVCP reports that it can receive member contact information and care plans from most PCPs but that MVCP only receives comprehensive assessments from a few PCPs.

Data analytics

MVCP has developed a quality dashboard to track and analyze CP performance. MVCP reports that the Program Director, Program Manager, Data Quality Specialist, and the navigators are responsible

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

for leveraging MVCP's technology platform to generate reports on quality and compliance metrics. The quality dashboard is reviewed and discussed as a standing agenda item at monthly governing board meetings. MVCP also reviews data from the dashboard with individual ACOs/MCOs during quarterly meetings.

Additionally, MVPC reports that a comprehensive program assessment that examines quality management and quality improvement effectiveness, service utilization, cost, quality data, member outcomes, and contract compliance is completed annually. Progress towards goals is reported to the QMC, who determines opportunities for improvement and tracks the success of implemented interventions.

Recommendations

The IA encourages MVCP to review its practices in the following aspects of the Health Information Technology and Exchange focus area, for which the IA did not identify sufficient documentation to assess progress:

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

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

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

- adopting enterprise exchange software that automatically retrieves files from partner SFTPs and moves them into the CP's EHR.

✓ **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 MVCP is **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

MVCP ensures that staff are providing supports that are tailored to and reflective of the member population. MVCP has hired diverse staff and employs four navigators who are bilingual. MVCP reports that with these staff, it can meet the cultural and linguistic needs of its members and conduct culturally sensitive outreach. As an agency, MVCP reports that it can support enrollees in 27 different languages. MVCP has also contracted with an interpretation service to support members with language needs not met by MVCP or agency staff.

Person-centered care model

MVCP navigators ensure that goals are documented in the member's care plan. Navigators work with members to establish both short and long-term goals that each member feels are most important to improving their overall health and quality of life. MVCP reports that navigators encourage members to express their personal feelings about their interests, challenges, and personal desires related to their ability to live healthily and independently in the community. Navigators assist members with establishing specific and measurable goals and record identified goals in the care plan in a culturally and linguistically appropriate manner. MVCP navigators include members' health and wellness goals, as directed by each member's care team, in the member's LTSS CP care plan. CP navigators maintain regular contact with members to discuss progress towards their identified goals and determine next steps.

MVCP provides training on person-centered methods to all MVCP staff. To ensure that staff are equipped to help members set health and wellness goals, staff receive training on member choice, motivational interviewing, person-centered care planning, and other person-centered concepts.

Managing transitions of care

To support members through transitions of care, MVCP has established a process for warm handoffs from ACO care managers to CP navigators. MVCP also reports that maintaining the CP intake coordinator as a consistent point of contact has helped maintain communication about transitions of care between the entities.

With the integration of ENS/ADT notification in the CP's care management platform, MVCP Navigators are able to act on these notifications in real time. When possible, MVCP reports that navigators are included in members discharge planning. To achieve this, the CP navigators have established contacts at two local hospitals and social service departments at long-term care facilities and rehabilitation centers that will work with MVCP navigators through members' care transitions.

Improving members' health and wellness

MVCP and its APs have focused on creating a network of community resources for its members. To help members meet their specific health and wellness goals, navigators identify available programs that could help each member achieve their specified goals then make referrals to the appropriate organizations in accordance with members' preferences. MVCP reports that navigators have been able to educate members about the supports that are available to them; the CP cites specific success connecting members to resources tied to Individualized Education Program (IEP) services. MVCP has also employed a Marketing and Business Development Liaison who has developed strong relationships with providers and community agencies, further developing the resource network available to MVCP members.

In addition to connecting members to community resources and social services, MVCP reports that it provides members with health and wellness coaching to help individuals achieve the goals outlined in their care plan. MVCP members also have access to a variety of evidence-based health and wellness programs offered through its APs, including ESMV's Healthy Living Center of Excellence and NILP.

Continuous quality improvement

MVCP utilizes the Plan, Do, Study, Act ("PDSA") Cycle as a framework for improvement. MVCP reports that program policies and procedures are reviewed regularly to ensure adherence to documented processes and program requirements. Improvements have also been made in response to collected data.

Additionally, MVPC reports that a comprehensive program assessment that examines quality management and quality improvement effectiveness, service utilization, cost, quality data, member outcomes, and contract compliance is completed annually. Progress towards goals is reported to the QMC, who determines opportunities for improvement and tracks the success of implemented interventions. MVCP uses this assessment to ensure that the MVCP quality program is relevant to the population served and results in better member care.

> MVCP Administrator Perspective*: "One of the biggest successes of [2019] has been the relationship building between our navigator team and the CP members.... We are starting to experience the true benefits of this integrated model. Members are successfully accomplishing their goals and becoming more engaged in their care planning. Collaborative relationships have formed with the ACOs/MCOs and care coordination between the ACOs/MCOs and the CP is improving."*

Recommendations

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

- using Peer Support and/or Community Health Workers to support CP members throughout the provision of CP supports and activities;
- developing a community outreach strategy to reach assigned members who cannot easily be reached telephonically.
- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

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

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
- providing free transportation options for members to engage with services[7];
- 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;

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

- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[8];
- 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 MVCP 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:

- Integration of Systems and Processes
- Workforce Development

The IA encourages MVCP 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

- seek strategies to maintain a balance of engaged members and family members for participation in the CAB.

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

Health Information Technology and Exchange

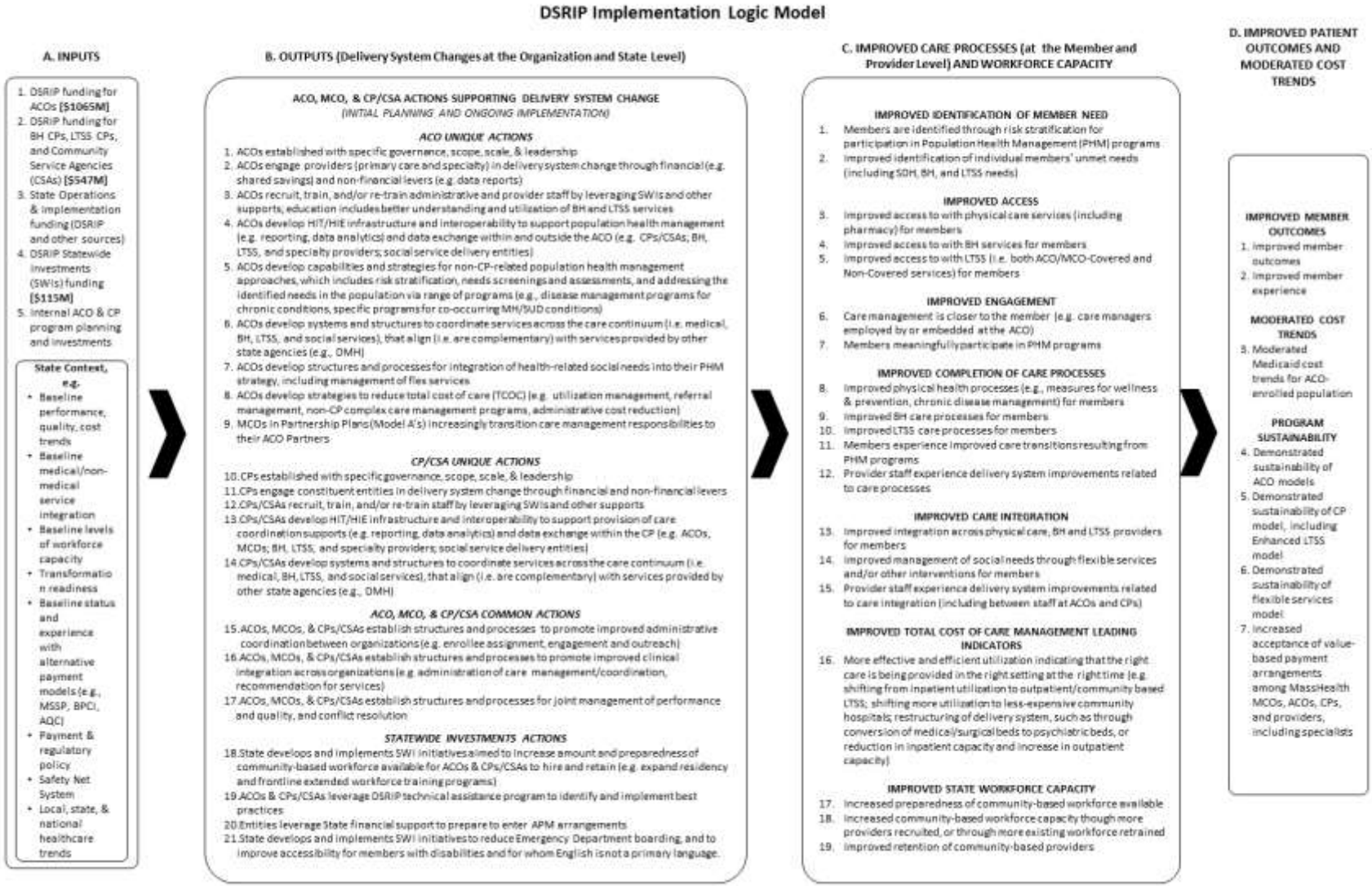
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;

Care Model

- using Peer Support and/or Community Health Workers to support CP members throughout the provision of CP supports and activities;
- developing a community outreach strategy to reach assigned members who cannot easily be reached telephonically.
- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

MVCP 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[9] (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

[9] 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.[10] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[10] 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

Health Information Technology and Exchange - pg.18 We would like to clarify our process around using SFTP or other compliant secure technology to set monitors and alerts for daily receipt of client files.

Part of our CP team includes a full time Intake Coordinator. One of her main daily tasks is checking the various SFTP sites that we work with and quickly retrieving info that is sent to us via SFTP. She is then responsible for using that information and following up, either by promptly sending items to the ACO, and/or keeping our care coordinators immediately informed of any relevant information that comes through including admissions/discharge info, CM assignments, etc. The Program Directors are also responsible for checking the SFTP sites as backup to the Intake Coordinator in her absence.

Care Model – pg. 19 We would like to clarify our process around using peer support and/or community health workers to support the CP members throughout the provision of CP supports and activities and would also like to clarify our community outreach strategy to reach assigned members who cannot easily be reached telephonically.

The role of our care Navigators includes supporting CP members throughout the provision of CP supports and activities. The way that our care model is structured, the role of the care Navigator is interchangeable with that of the community health worker. Our affiliated partner, Northeast Independent Living Center offers a Peer Mentoring Program. When our care Navigators feel a member is appropriate for referral to this program, the Navigator refers to the program and the referral is processed. We feel this is one of the strengths of our CP partnership with NILP. Between the two agencies, we are able to refer to a number of programs that ultimately provide a much richer experience for our CP members.

In order to reach those assigned members who cannot easily be reached telephonically, we have a robust outreach process that includes: unannounced home visits, meeting with the member while the member is at an inpatient setting when possible, and connecting with ACOs/MCOs during case conferences to review and strategize hard to reach members.