MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

North Region LTSS Partnership (NRLP)

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 8
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 12
3. WORKFORCE DEVELOPMENT 14
On Track Description 14
Results 15
Recommendations 15
4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE 17
On Track Description 17
Results 18
Recommendations 19
5. CARE MODEL 19
On Track Description 19
Results 20
Recommendations 22
OVERALL FINDINGS AND RECOMMENDATIONS 24

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL 25

APPENDIX II: METHODOLOGY 26
DATA SOURCES 26
FOCUS AREA FRAMEWORK 26

ANALYTIC APPROACH 27
DATA COLLECTION 28
Key Informant Interviews 28
APPENDIX III: ACRONYM GLOSSARY 29
APPENDIX IV: CP COMMENT 31

DSRIP Midpoint Assessment Highlights & Key Findings

Northeast Region LTSS Partnership (NRLP)

PUBLIC CONSULTING GROUP

A Long-Term Services and Supports Community Partner

Organization Overview

NRLP is a collaborative led by lead agency Greater Lynn Senior Services (GLSS) in concert with Affiliated Partners Bridgewell, Inc. and Northeast ARC, Inc. GLSS has more than 40 years of experience delivering care management support to aging adults and people with disabilities.

SERVICE AREA

POPULATIONS SERVED

- NRLP serves individuals ages 3-64 with a range of complex behavioral health and long-term services and supports needs, including traumatic brain injury/cognitive impairments, physical disabilities, intellectual/developmental .

623

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- NRLP improved communications with its ACO partners with the implementation of a new care management platform.
- NRLP transitioned responsibility for care transitions to a nurse, which improved hospital communications and leads to more appropriate follow-ups.
- NRLP's Quality Management Committee assessed their care coordination policies and procedures against the NCQA-identified best practices and developed recommendations to better align NRLP practices with these standards.

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]

North Region LTSS Partnership (NRLP) is a long-term services and supports (LTSS) CP.

NRLP is a partnership of three human services agencies led by Greater Lynn Senior Services (GLSS) in concert with its Affiliated Partners (APs), Bridgewell, Inc. and Northeast ARC, Inc.[3] NRLP collaborates with key subcontractors, EMARC and NuPath for expertise on specific populations such as those with developmental disabilities. As an LTSS CP, NRLP coordinates care for MassHealth members with LTSS needs, in partnership with ACOs, across Northern Massachusetts.

NRLP's primary service area includes Beverly, Gloucester, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, and Woburn. NRLP's population includes members ages 3-64 with complex BH needs, brain injury, physical disabilities, and intellectual and/or developmental disabilities (I/DDs), as well as older adults (ages 65+) with LTSS needs, and children and youth (ages 3-21) with LTSS needs.

As of December 2019, 623 members were enrolled with NRLP[4].

SUMMARY OF FINDINGS

The IA finds that NRLP is considered On track or On track with limited recommendations in five of five focus areas.

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track with limited recommendations
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] Some CPs enter into agreements with Affiliated Partners: organizations or entities that operate jointly under a formal written management agreement with the CP to provide member supports.

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

Executive Board

NRLP has convened an operations group that is comprised of the Chief Operating Officer and other senior staff from each AP. The operations group meets bi-weekly to discuss staffing, MassHealth requirements, Documented Processes with ACOs/MCOs, committee reports, CP policy and procedure development, electronic health record (EHR) configuration, communication and technology sharing across the APs.

NRLP centralized CP operations at one location, creating a home base for CP staff. NRLP originally intended to establish three individual CP offices however, based on member volume, NRLP reports that this structure was not warranted. By centralizing CP operations, NRLP indicates that it was able to increase administrative efficiency and reduce costs while increasing collaborations amongst the APs and CP staff.

Consumer Advisory Board

NRLP recruited six enrollees to participate on the CAB. CAB members review and offer guidance on aspects of program implementation. To facilitate participation on the CAB, NRLP provides members with transportation[5] and translation supports.

NRLP care coordinators leveraged relationships with assigned members to recruit them for participation on the CAB. Coordinators addressed members' unstable home environments prior to recruitment, if needed. To ensure CAB membership is informed by the community profile, NRLP focused recruitment efforts on members representing different geographic, household, and sociodemographic characteristics who were willing to volunteer their time to the CAB. NRLP's CAB recruitment is ongoing as is their effort to mitigate barriers to members' participation, such as scheduling and childcare.

Quality Management Committee

NRLP convened a QMC comprising leadership from the quality assurance department of each AP. The QMC meets monthly. In 2019, NRLP implemented a QI initiative focused on caregiver burnout. To assess caregiver strain, the QMC developed a survey and protocols for its implementation, administration, and analysis. The QMC reviewed preliminary results of this QI initiative in December 2019 and determined that the survey captures the intended data. The QMC then developed follow-up protocols and a database for recording results.

Recommendations

The IA has no recommendations for the Organizational Structure and Engagement focus area.

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

✓ **Executive Board**

- holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
- conducting one-on-one quarterly site visits with APs and CEs;
- holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[6] Joint Operating Committee;
- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

[5] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[6] For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

- ✓ **Consumer Advisory Board**
    - seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;
    - adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;
    - hosting meetings in centrally located community spaces that are easy to get to and familiar to members;
    - adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members;
    - limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff;
    - sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls;
    - incentivizing participation by paying members for their time, most often through relevant and useful gift cards;
    - incentivizing participation by providing food at meetings; and
    - presenting performance data and updates to CAB members to show how their input is driving changes in the organization.
- ✓ **Quality Management Committee**
    - establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
    - scheduling regular presentations about best practices related to quality metrics;
    - adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
    - integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
    - ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential QI initiatives through the appropriate channels.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of CPs considered On track:

- ✓ **Joint approach to member engagement**
    - has established centralized processes for the exchange of care plans;
    - has a systematic approach to engaging Primary Care Providers (PCPs) to receive sign-off on care plans;
    - exchanges and updates enrollee contact information among CP and ACO/MCO regularly; and
    - dedicates staff resources to ensure timely (usually daily) reviews of ACO/MCO spreadsheets to assist with outreach and engagement efforts.
- ✓ **Integration with ACOs and MCOs**
    - holds meeting with key contacts at ACOs/MCOs to identify effective workflows and communication methods;
    - conducts routine case review calls with ACOs/MCOs about members; and
    - dedicates staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).
- ✓ **Joint management of performance and quality**
    - conducts data-driven quality initiatives to track and improve member engagement;
    - has established comprehensive care plan review processes with ACOs/MCOs to support care coordinators in their effort to engage PCPs in comprehensive care plan review; and
    - disseminates audit reports to each member organization, in some cases using an interactive dashboard to disseminate data on key quality metrics.

Results

The IA finds that NRLP is **On track with limited recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

NRLP has Documented Processes to transmit comprehensive needs assessments, care plans, and member information with all or nearly all its ACO/MCO partners. NRLP's Documented Processes include the transmission of information through secure methods of communication such as Secure File Transfer Protocols (SFTPs), a secure file-sharing app, and secure email. NRLP reports that hiring a Program Supervisor who is a licensed nurse and certified care manager helped facilitate communication with ACOs/MCOs and align these organizations' perspectives of the CP program.

NRLP reports varied success implementing a systematic care plan review process, indicating that the efficiency of the care plan review process is dependent on the establishment of a Documented Process with the ACO/MCO and NRLP's access to accurate PCP contact information. NRLP cites

inaccurate PCP contact information and frequent changes to the assigned PCP contact person as challenges preventing timely care plan sign-off.

The NRLP Coordination Manager reviews ACO/MCO enrollment spreadsheets and discusses members' enrollment status with identified contacts at ACO/MCO partners. NRLP's Coordination Manager identifies high-risk members and ensures that efforts were made to contact these members before any action to disenroll them is taken by the partner organization. To assist coordination of member engagement, the Coordination Manager also provides ACOs/MCOs with a list of CP members with signed participation forms on a weekly basis. NRLP reports that these lists identify the members whose comprehensive assessments should be prioritized.

Integration with ACOs and MCOs

NRLP attends quarterly meetings with ACO/MCO partners. These meetings address programmatic issues and discuss individual member's cases. NRLP reports finding collaborative solutions to challenges during these forums. Outside of established quarterly meetings, NRLP staff engage directly with ACO/MCO staff to discuss members and ensure coordination of care. NRLP care coordinators regularly meet with their ACO/MCO counterparts to communicate about specific member issues. NRLP care coordinators also conduct home visits with members in parallel with ACO nurse care managers to increase efficiency and complete the members' comprehensive assessments and care plans. The NRLP Coordination Manager regularly works with their counterparts at the ACOs/MCOs to troubleshoot issues and share updates. NRLP is participating in the CP/ACO care plan learning collaborative, where staff will be able to discuss issues and develop solutions.

To facilitate clinical integration NRLP subscribed to ADT notifications through its care management platform. NRLP navigators receive and send timely program information through this system. NRLP reports that access to ADT feeds facilitate communication with ACO partners and promote collaboration amongst the partner organizations to manage shared members.

> CP Administrator Perspective: *"NRLP has worked hard to achieve greater collaboration with all its partners and has managed a degree of success in this regard with each of the twelve ACOs/MCOs for which we provide LTSS. There are, however, several partners with which collaboration around member care coordination has been greater and more consistent and which, not surprisingly, has produced better outcomes for our shared consumers. These ACO/MCO partners have typically identified NRLP as a preferred provider."*

Joint management of performance and quality

To support NRLP care coordinators in the care plan review process, NRLP maintains a spreadsheet that describes all established Documented Processes with ACOs/MCOs. NRLP updates the spreadsheet on a regular basis and makes it available to CP staff through an intranet platform. Care coordinators are notified directly when any Documented Process is updated.

NRLP leverages its care management platform to generate internal performance reports that display progress towards programmatic benchmarks. NRLP intends to adapt these reports to align with MassHealth's quality management metrics and track its performance accordingly.

Recommendations

The IA encourages NRLP to review its practices in the following aspects of the Integration of Systems and Processes focus area, for which the IA did not identify sufficient documentation to assess progress:

- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts.

- developing data-driven QI initiatives to track and improve member engagement.

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

Recruitment and retention

NRLP does not report any persistent vacancies in planned staff rolls. NRLP has a variety of recruitment mechanisms to hire CP staff. NRLP advertises open CP positions on internal job boards, on ACO/MCO partner job boards, at regional and statewide coalitions and advocacy groups, at local colleges and universities, and in professional journals. NRLP ensures that job postings are published in fully accessible formats with clearly delineated job descriptions and include a preference for bilingual and bicultural capable staff that reflect the population served by NRLP.

NRLP incentivizes recruitment and retention of CP staff through student loan repayment opportunities, a robust benefits package, and schedule flexibility. NRLP reports leveraging three student loan repayment slots through the DSRIP Statewide Investment Program (SWI) to recruit qualified individuals who have growth potential within NRLP's program. Additionally, NRLP reports that its benefits package is an asset in the recruitment and retention process. NRLP offers CP staff flexible schedules after six months of employment. NRLP reports that this flexibility is valuable to staff members.

NRLP reports no staff turnover in 2019. To retain staff, NRLP maintains a career ladder and offers staff professional development opportunities. In addition, NRLP allocated funds to implement performance bonuses for staff members who achieve goals related to member outreach and engagement. NRLP also promotes staff retention by maintaining a supportive environment for CP staff through regular case reviews, team meetings, one-on-one supervision meetings, and stress reduction activities.

Training

NRLP's training committee developed an initial eight-day training program for new CP staff. All Aps implemented this new hire training program. The training includes education from subject matter experts from each CP partner entity.

NRLP and its APs provide ongoing monthly trainings that focus on key issues affecting the member population such as securing appropriate community resources and meeting health-related social needs. Additionally, NRLP requires care coordination staff to complete online learning modules. NRLP has also covered costs for care coordination staffs' attendance at external Community Health Worker (CHW) trainings.

Recommendations

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

- employing tactics to increase diversity in the workplace.

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[7] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.

✓ **Data analytics**

- develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and

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

- reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Results

The IA finds that NRLP is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

NRLP has implemented a care management platform across all APs and has contracted with two vendors to receive ADT and ENS notifications. NRLP has integrated ENS/ADT notifications into the care management platform.

NRLP transitioned care management platform vendors in 2019. NRLP utilized Technical Assistance to assist with the transition to its new care management platform. NRLP reports that this process was complex and required significant assessment to determine what technology elements were not working and identify solutions to mitigate these issues. During the transition period, NRLP staff identified errors in its previous care management platform vendor's algorithms which then required a robust quality assurance process before inputting data into the new care management platform. The transition to the new care management platform has increased NRLP's confidence in its technological capacity and ability to report on real-time data.

CP Administrator Perspective: *"The overall operational impact of the [technical assistance vendor]'s support as well as the transition to [care management platform] has been highly significant in improving NRLP capacities in general, which has in turn, launched a trend of improving program outcomes. While much of this success will continue to unfold in subsequent [budget periods], NRLP is gratified that several ACO/MCO partners have identified us as "preferred" CPs and have indicated an interest in working more closely with us on a number of program-related issues."*

Interoperability and data exchange

NRLP has the capability to exchange member files via SFTP, secure email, and a secure file-sharing application. NRLP has also worked with one ACO partner to implement an expedited communications protocol through secure text messaging, and is seeking to develop strategies for interoperability with other ACO/MCO partners.

NRLP reports that it can receive member contact information, comprehensive assessments, and care plans from all or nearly all ACOs and MCOs. NRLP reports that it can receive care plans from most PCPs but that they receive member contact information and comprehensive assessments from very few PCPs.

Data analytics

NRLP reports that implementing a new care management platform has increased its ability to produce reports that reflect CP performance. NRLP has leveraged this capability to develop program benchmarks and prepare for the tracking of key data points in alignment with MassHealth quality management metrics.

Recommendations

The IA encourages NRLP 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;
- connecting to Mass HIway[8] to improve coordination and delivery of care, avoid readmissions, and enhance communication among partners; and
- convening a multidisciplinary team to develop a data dashboard that oversees documentation and performance on key quality metrics.

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;

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

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

Outreach and engagement strategies

NRLP has developed an Outreach Team, headed by a care coordinator, that assumes responsibility for initial contact with assigned members. This team includes call center staff who make outreach attempts via telephone and provide after-hours support to the program and its members. To connect with members who are not easily reached telephonically, the Outreach Team will make unplanned visits to community locations to engage potential members. To further NRLP's community outreach capabilities, NRLP has engaged in a Technical Assistance project focused on improving consumer outreach and sustained engagement with a focus on minorities and hard to reach populations. In 2019, the TA vendor taught six training and canvassing sessions focused on hands-on outreach and conducting unplanned member visits.

To promote member engagement, NRLP has also implemented an incentive program that provides members with gift cards for participating in CP programming and meeting identified milestones. In October 2019, a similar incentive program was deployed for CP staff; NRLP staff members who achieved outreach and engagement benchmarks had the opportunity to earn quarterly performance bonuses. NRLP also has staff trained as CHWs who can support members through the provision of CP supports and activities.

Person-centered care model

Care coordinators work with members to complete a Social Determinants Assessment (SDA) during the intake process. The care coordinator uses the information collected in the SDA and the member's personal preferences to create the member's care plan. The care coordinator works with the member to achieve the defined goals, meeting monthly to work on goals. CP care coordinators further support

members' achievement of goals by providing additional support such as going to social services offices with members, submitting community-based referrals, and connecting with members' PCPs to obtain durable medical equipment and referrals.

NRLP uses decision support techniques to create the framework for the member's care plan, exploring how the member wants to live their life, what their key goals are, and developing strategies to achieve their desired results. NRLP reports that this approach ensures that the member is at center of the care plan, as a whole person, with uniquely defined goals that reflect the individual's capabilities and complexities.

In addition to CP-related goals, NRLP records members' health and wellness goals in the care plan to ensure that the member is receiving necessary health coaching and symptom management support. NRLP reports that this approach also ensures that the member's care team is kept apprised of potential negative changes in medical conditions.

> CP Administrator Perspective: "*In many ways, NRLP CP Coordinators (CPCs) have hit their stride in the care coordination component of the program. CPCs have many stories to share about how they have engaged members around true problem-solving across multiple dimensions of the social determinants of health. Often integrating resources to address simultaneous issues such as housing, food scarcity, health advocacy, legal issues, mobility, parenting and family dynamics, education and workplace concerns, promoting healthier behaviors and more manageable daily routines, CPCs have fashioned sustained relationships with members that seem to effectively foster longer-term engagement.*"

Managing transitions of care

To support members through transitions of care, NRLP uses ADT notifications to identify when members are hospitalized. Notifications alert the Care Transitions Nurse, who leads the warm handoff from the clinical setting to NRLP's team, implementing the initial care transitions intervention, liaising with clinical staff, and providing ongoing support to the member and CP care coordinator around transition issues. NRLP reports that the Care Transitions Nurse also tracks ADT notifications to identify NRLP members with new diagnoses or care needs. The Care Transitions Nurse then checks-in with care coordinators about assisting identified members with these new needs.

Additionally, NRLP provides members with a "Passport to Health," which serves as the member's advance directive during healthcare emergencies and transitions of care. This document contains health and personal information for the member and identifies the individual's emergency contacts. NRLP asks members to keep this passport on hand and give it to EMTs, ED personnel, or any other staff present at transition points.

Improving members' health and wellness

NRLP reports that each AP has health education capabilities, including skilled nurses and social workers who are experienced in delivering health and wellness programming. NRLP makes these staff available to CP care coordinators for training or consultation related to the provision of health education and coaching to CP members.

Continuous quality improvement

NRLP's QMC meets monthly to review program progress, track quality metrics, and design and oversee the implementation of QI initiatives. This committee is chaired by NRLP's Evaluations Director and its membership includes the most senior quality management professionals from each of NRLP's APs.

NRLP reports that the QMC assessed its policies and procedures against the National Committee for Quality Assurance (NCQA) and identified best practices for LTSS care coordination. The assessment

included reviewing general CP policies and procedures, Documented Processes, the person-centered care planning process, LTSS care plans, and defined health and wellness outcomes measures. At the end of the assessment, the QMC developed recommendations to better align internal practices with the NCQA standards and outlined next steps for implementation.

NRLP also participates in the MassHealth LTSS CP workgroup. NRLP reports that this opportunity has been useful for discussing shared issues, understanding the range of available options to mitigate issues, and identifying suggested solutions that strengthen the efficiency of the CP program.

To ensure continuous QI in member experience, NRLP maintains a high-functioning CAB in which members are given an opportunity to review and offer guidance on aspects of program implementation.

Recommendations

The IA encourages NRLP 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:

- reviewing service offerings and assess member needs to ensure staff are providing services that are tailored to and reflective of the population racially, ethnically, and linguistically; 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 services[9];
- 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

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

- allowing members to attend care planning meetings by phone or teleconference.

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
- meeting an enrollee in person once care coordinators receive alerts that they were admitted;
- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[10];
- 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.

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

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that NRLP is On track or On track with limited recommendations across all five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Organizational Structure and Engagement

The IA encourages NRLP 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:

Integration of Systems and Processes

- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts.
- developing data-driven QI initiatives to track and improve member engagement.

Workforce Development

- employing tactics to increase diversity in the workplace.

Health Information Technology and Exchange

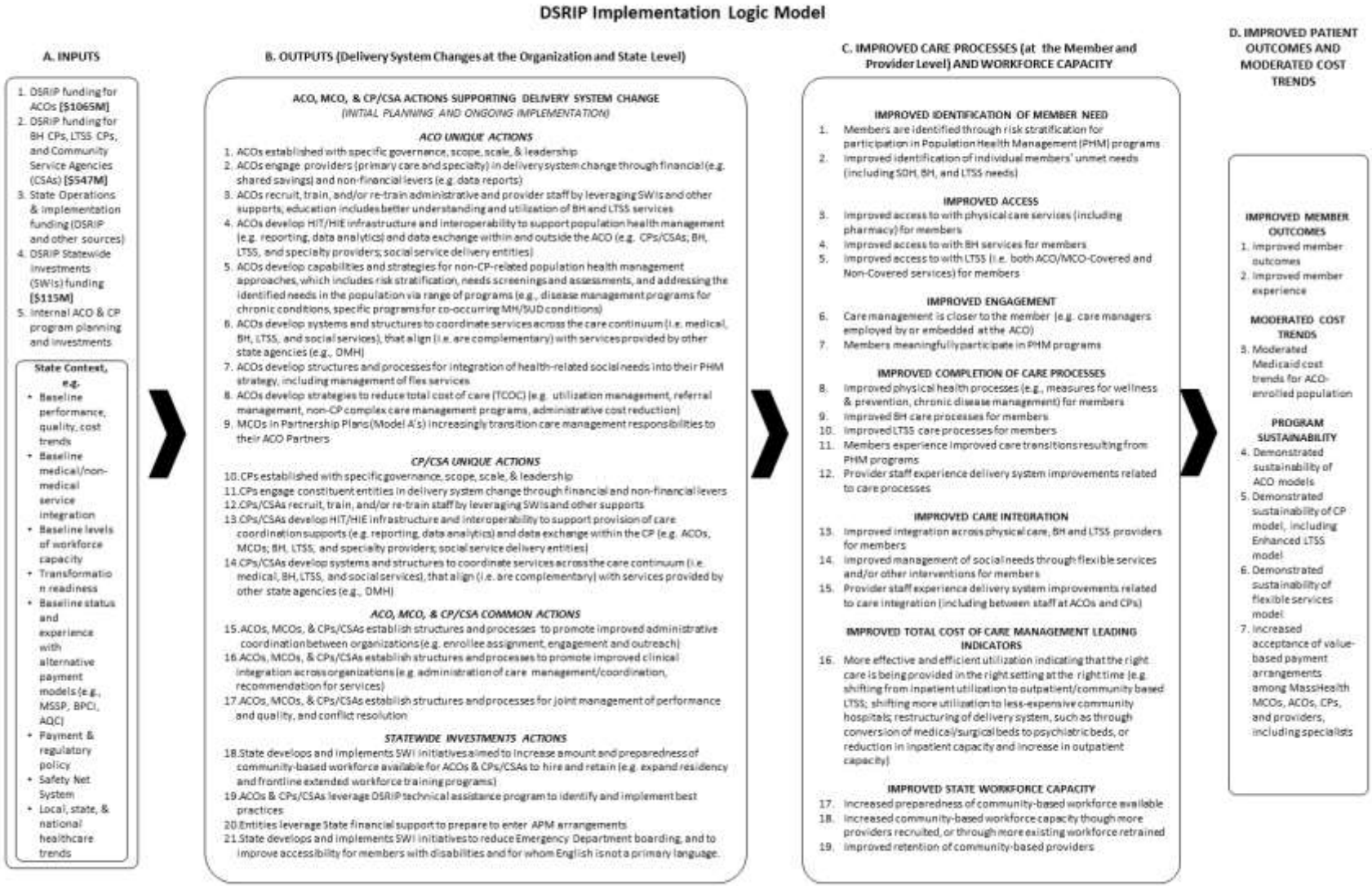
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;
- connecting to Mass HIway to improve coordination and delivery of care, avoid readmissions, and enhance communication among partners; and
- convening a multidisciplinary team to develop a data dashboard that oversees documentation and performance on key quality metrics.

Care Model

- reviewing service offerings and assess member needs to ensure staff are providing services that are tailored to and reflective of the population racially, ethnically, and linguistically; and
- increasing standardization of processes for connecting members to social services where applicable.

NRLP 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[11] (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	• 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.[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

North Region LTSS Partnership (NRLP) is already working to meet the specified recommendations in each key area as detailed below:

Integration of Systems and Processes

- The NRLP Administration Team reviews ACO/MCO referral files on a daily basis, integrates the subsequent information into the eHR, and communicates with Care Coordinators as appropriate to assist with outreach and engagement efforts.
- In 2019, we developed a data-driven QI initiative, focusing on caregiver stress. We have begun to design a framework to measure levels of stress caregivers experience; surveys are conducted on an ongoing basis.

Workforce Development

- NRLP employs tactics to increase diversity in the workplace. Bilingual candidates for all direct care positions are always preferred. We also offer a pay differential for bilingual care coordinators upon hire.
- Currently, 80% of our care coordinators are bilingual (Spanish, Haitian Creole, French) and 100% of our outreach coordinators are bilingual (Spanish). This staffing composition has been in place since fall of 2019.

Health Information Technology and Exchange

- Since the program’s inception, NRLP has used the SFTP to send and receive secure documents. Our Administrative Team receive email notifications whenever a document is uploaded to it. We have also established secure TSL networks with several ACOs.
- In order to improve coordination and delivery of care with our ACO partners, we have connected to the internal communication platforms for Wellforce and Boston Medical Center.
- We have a team representing various parts of the agency working toward the development of a data dashboard that oversees documentation and performance on key quality metrics as identified by MassHealth.

Care Model

- The NRLP Administrative Team routinely works with care coordinators to ensure members are providing services that are tailored to a reflective of the population racially, ethnically, and linguistically. A Nurse Manager reviews all care plans with care coordinators and multiple trainings around disability and cultural awareness are conducted throughout the year.
- In order to increase standardization of processes for connecting members to social services, we have experimented with the creation of a regional resource inventory. Coordinators have also compiled a list of liaisons and points of contact with key social services agencies to facilitate the referral and enrollment process.