MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

South Shore Community Partnership

(South Shore)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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A Behavioral Health Community Partner

Organization Overview

SSCP is a partnership between Aspire Health Alliance and Spectrum Healthcare Systems. Aspire provides education, treatment and recovery services. Spectrum provides addiction treatment services, including inpatient detoxification, residential rehabilitation, medication-assisted treatment, outpatient counseling, and peer recovery support.

SERVICE AREA

POPULATIONS SERVED

▶ SSCP serves high-risk populations, such as substance-using women, young adults, criminal offenders, and individuals with complex physical, mental, and social needs, including mental illness, substance use disorders, and co-occurring disorders.

▶ SSCPs target population mirrors the general population in the Quincy area: the majority identify as White/Caucasian, one in ten as Asian and one in ten as African American. English is the predominant language, followed by Spanish, Cantonese, Mandarin, Creole/French, and Vietnamese.

1,038
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	
Health Information Technology and Exchange	● On Track	● Limited Recommendations
Care Model	● On Track	● Limited Recommendations

IMPLEMENTATION HIGHLIGHTS

- SSCP performs outreach to potential enrollees admitted to the hospital and participates in discharge planning for members who are in the hospital.
- SSCP established a warm handoff process for urgent referrals from ACO/MCOs for members coming out of psychiatric hospitals, addiction programs, or who are in crisis.
- SSCP established more manageable and predictable referrals by building strong relationships with ACO/MCO partners. These relationships also help their mutual members receive integrated care.

Statewide Investment Utilization:

o Student Loan Repayment Program, four Care Coordinators participating

o Community Mental Health Center Behavioral Health Recruitment Fund, 1 slot awarded

o Certified Peer Specialist Trainings

o Technical Assistance

o 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

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[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]

South Shore Community Partnership (South Shore) is a behavioral health (BH) CP.

South Shore is a partnership between Aspire Health Alliance (Aspire) [3] and Spectrum Healthcare Systems (Spectrum), with Aspire as the lead and Spectrum as the Affiliated Partner (AP).[4] Aspire, formerly South Shore Mental Health provides education, treatment, and recovery services to 16,000 clients annually. Spectrum offers a continuum of addiction treatment services, including inpatient detoxification, residential rehabilitation, medication for addiction treatment (MAT), outpatient counseling, and peer recovery support. As a BH CP, South Shore provides high-quality care coordination for adult MassHealth members who have complex physical, BH, and social needs.

South Shore's primary service area is Greater Boston and the South Shore of Massachusetts. South Shore has two hubs - one in Quincy and one in Weymouth - and covers 13 Greater Boston towns: Braintree, Cohasset, Dedham, Hingham, Hull, Milton, Norwood, Norwell, Quincy, Randolph, Scituate, Westwood, Weymouth. South Shore serves high-risk populations, such as women experiencing substance use disorders (SUDs), young adults, justice-system involved individuals, and individuals with co-occurring disorders. The population served by South Shore mirrors the general population in the Quincy area; the majority are White/Caucasian (over 70%), with 10% identified as Asian and 10% identified Black/African American. English is the predominant language, followed by Spanish, Cantonese, Mandarin, Creole/French, and Vietnamese.

As of December 2019, 1,038 members were enrolled with South Shore[5].

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[2] Background information is summarized from the organizations Full Participation Plan.
[3] Aspire Health Alliance is part of two Behavioral Health Community Partnership programs in MassHealth's Delivery System Reform Incentive Payment program: South Shore Community Partnership and Southeast Community Partnership, LLC.
[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.
[5] Community Partner Enrollment Snapshot (12/13/2019).

SUMMARY OF FINDINGS

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

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

FOCUS AREA LEVEL PROGRESS

The following section outlines the CP's progress across the five focus areas. Each section begins with a description of the established CP actions associated with an On track assessment. This description is followed by a detailed summary of the CP's results across all indicators associated with the focus area. 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 South Shore is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

South Shore's governing body is comprised of senior representatives from consortium entities (CEs) Aspire and Spectrum. The governing body includes Spectrum's Chief Executive Officer, Spectrum's Chief Operating Officer, Aspire's Chief Executive Officer, Aspire's Vice President of Outpatient Services and an independent member. South Shore's governing body oversees the Leadership and Quality Management Team (LQMT) and the Consumer Advisory Board (CAB).

The governing body meets quarterly and is responsible for the management of South Shore including: allocation and distribution of DSRIP funds; oversight of CP practices, policies, and processes; and management of the CP program contract requirements.

The LQMT is responsible for the day-to-day management of South Shore. The LQMT is comprised of quality officers from both Aspire and Spectrum and Aspire's Director of Integrated Care, who serves as the facilitator of the LQMT. The LQMT convened in November 2017 and meets on monthly basis.

Consumer Advisory Board

South Shore established a CAB that is comprised of eight members. The LQMT and frontline South Shore staff were responsible for recruiting CAB members who are reflective of the South Shore population. Two of the CAB members are CP members currently engaged in supports and an additional two members are former members who are in recovery. The CAB began meeting in January 2019 and continues to meet monthly.

For its first initiative, the CAB helped South Shore update its promotional membership flyer. The CAB provided feedback on how to make it easier for new members to understand the CP program and identify the supports South Shore offers.

Quality Management Committee

To monitor CP quality measures, South Shore created the Quality Improvement Workgroup. The Divisional Director of Quality, Compliance, and Improvement leads this workgroup and its membership includes program directors, systems administrators, and the Director of Integrated Care.

In 2018, South Shore established its first QI initiative focused on improving member engagement. The LQMT oversees this QI initiative, with the assistance of South Shore's quality assurance analyst and data analyst. The LQMT assesses progress based on data from program operations, person-centered treatment plans, quality measures, and members' health outcomes.

> CP Administrator Perspective: "*In summary, the key lessons learned in [2019] are the importance of fostering strong relationships with ACOs/MCOs to provide integrated care for our mutual members, building a designated workgroup to monitor quality measures, and developing internal teams and procedures to manage changes in the program as they effect billing and finance.*"

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.

✓ **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;

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[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.

- 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 South Shore is **On track with limited recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

South Shore implemented a centralized process to exchange care plans and other member files with ACO/MCO partners. Documented Processes include the exchange of member files via Secure File

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Transfer Protocols (SFTP), secure email, and Mass HIway.[7] South Shore also has centralized processes for the exchange of monthly outreach status reports and enrollment/disenrollment files with ACOs/MCOs through South Shore's care management platform. South Shore staff review these shared files on a regular basis. South Shore also receives member referrals from ACO/MCO partners on a monthly basis. The referrals sent by partner organizations often contain more thorough member contact information and identify other providers on the member's care team. Additionally, South Shore embedded care coordinators in one ACO partner's offices and at a local community health center once a week. South Shore positioned a Mandarin-speaking care coordinator at a local health center to work directly with potential members who present to that location and do not speak English. South Shore finds that these strategies facilitate member outreach and engagement and promote close collaboration with partners.

South Shore program nurses are the primary liaisons with PCPs. South Shore engages PCPs in care plan sign-off using the PCP's requested method including consultations, phone calls, or electronic sharing of information. South Shore also works with ACO/MCO case managers, social workers, and community health workers to advance the delivery of integrated care and further engage with PCPs.

> CP Administrator Perspective: "*South Shore is working closely with Tufts BIDCO and South Cove Community Health Center to embed a care coordinator in their office once/week to work with members and staff there to facilitate referrals to our CP and close collaboration through face-to-face meetings in the health center.*"

Integration with ACOs and MCOs

South Shore attends monthly meetings with three ACO partners in the South Shore and Greater Boston regions. At these meetings, South Shore and the ACO partner discuss member cases and strategies to integrate care for shared members. The monthly meetings also build the relationship between the South Shore and ACO care teams. South Shore works with THPP Atrius on a preferred relationship pilot program. For the remaining ACO/MCO partners, South Shore attends quarterly meetings. South Shore and ACO/MCO partners use this quarterly forum to assess the effectiveness of Documented Processes, share key contact information, review the care management processes for shared members, address issues in program implementation, and resolve problems in the workflows between South Shore and the ACOs, MCOs, or PCPs.

In addition to the case conferences that take place during monthly meetings with South Shore's three ACO partners in the Greater Boston and South Shore region, South Shore also conducts case review conferences with individual PCPs who participate with Steward Medicaid Care Network, Inc. and Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan.

South Shore's care coordinators, registered nurses (RNs), and the clinical care manager review daily ENS/ADT notifications. South Shore integrates ENS/ADT notifications into the care management platform which automatically emails updates to program staff. Based on availability, one of the three staff assigned to review the ENS/ADT notifications reaches out to the inpatient facility the South Shore member presents at and begins to work with the clinical team on the member's behalf.

Joint management of performance and quality

South Shore implemented a QI initiative focused on member engagement in 2018. South Shore's Quality Improvement Workgroup reviewed the quality measures associated with this QI initiative, as well as program measures defined by MassHealth and CMS, to ensure their care management platform captures all necessary data elements. The workgroup shared these quality measures with all care coordinators. South Shore care coordinators then created a visual aid that listed the prioritized

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

quality measures. Care teams displayed this aid in team offices to ensure that staff could easily visualize the ways that the South Shore program is seeking to help members. Additionally, South Shore engaged care coordinators in a Care Coordinator Council to write the guidelines and standardized workflows that support each of the quality measures.

To support care coordinators' submission of care plans to PCP offices, South Shore's RN sends the care plan to the identified key contacts within each PCP office. The RN bridges the gap between South Shore and PCP offices and develops productive relationships with those providers. Productive relationship building between South Shore, PCPs, ACOs, and MCOs improves the care plan transmission process and care coordination effort.

In April 2019, South Shore developed a dashboard to oversee program documentation and performance on key quality metrics. South Shore's billing team and Quality Improvement Workgroup established processes for managing denials, conducting research for re-enrollment of members, and monitoring performance on key quality measures.

Recommendations

The IA encourages SSCP 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.

- disseminating audit reports to each member organization or provide member organizations access to program documentation and performance metric dashboard.

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 South Shore is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

South Shore filled all CP program positions with qualified staff, including positions added more recently in response to increased member engagement.

To recruit staff, South Shore posts opportunities on job boards and attends job fairs. South Shore also implemented signing bonuses for key positions, including clinical care managers and RNs. Additionally, South Shore offered four care coordinators loan repayment through the DSRIP Statewide Investment (SWI), Care Coordinator and Registered Nurse/Licensed Practical Nurse Recruitment Incentive program. To retain staff, South Shore creates a rewarding work environment where staff have access to trainings and professional development opportunities and receive recognition for their achievements. For example, South Shore holds an annual celebration for staff to build morale and team cohesion.

South Shore hired a Spanish-speaking care coordinator who works with Spanish-speaking members. South Shore also employs staff who can communicate with members in Mandarin, Cantonese,

Portuguese, French Creole, and Cape Verdean Creole in their effort to ensure diversity in the workplace.

Training

South Shore developed a standardized training program comprised of 12 hours of live training complemented by 15 hours of online training in South Shore's learning management system. In-person trainings focus on program requirements and workflows, the population served, integrating primary care, BH, social determinants of health, motivational interviewing, and trauma-informed care. The online trainings cover physical health management for individuals with mental illness, enhancing communication with medical providers, integrated care treatment planning, and care management.

South Shore provides ongoing monthly trainings to refresh staff knowledge and ensure that they are kept up to date on best practices and advancements in the field.

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[8] 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 South Shore is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

South Shore implemented a care management platform across all member organizations. To ensure that staff can maintain communication with the South Shore team while working in the field, the CP implemented the care management platform's mobile application, patient and provider web portal, and electronic signature functionality. South Shore contracted with an ENS/ADT provider and integrate notifications into the care management platform. South Shore also receives daily ADT reports and direct messages from ACO/MCO partners.

Interoperability and data exchange

South Shore has the capability to exchange member files via SFTP, secure email, care management platform mobile application, and Mass HIway. South Shore reports that the method of data exchange varies based upon the established Documented Processes with the specific ACO or MCO partner. South Shore initially faced challenges accommodating their various partner organizations' preferred data exchange methods however, South Shore's care management platform vendor has been able to adapt its platform over time to accommodate the Documented Processes the CP has negotiated with ACO/MCO partners.

South Shore can share and/or receive member contact information, comprehensive needs assessments, and member care plans electronically from all or nearly all ACO/MCO partners.

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

However, South Shore is not able to share and/or receive member contact information, comprehensive needs assessments, and member care plans electronically from any PCP offices.

Data analytics

In April 2019, South Shore developed a dashboard to monitor performance on quality metrics and oversee program documentation. South Shore's Quality Improvement Workgroup developed the dashboard. This workgroup is led by the Divisional Director of Quality, Compliance, and Improvement and its membership includes program directors, systems administrators, and the Director of Integrated Care.

The LQMT is responsible for overseeing QI for South Shore and uses program outcomes and quality metrics data to set yearly goals. The LQMT uses the data sets established for quality measures and claims data provided by MassHealth to identify areas in need of improvement and develop strategies to address them.

Recommendations

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

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

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

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

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

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

✓ **Interoperability and data exchange**

- developing electronic information exchange capabilities that enable a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email; and

- connecting with regional Health Information Exchanges (HIEs).

✓ **Data analytics**

- designing a data warehouse to store documentation and performance data from multiple sources in a central location that can underwrite a performance dashboard;

- incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress;

- updating dashboards daily for use by supervisors, management, and the QMC; and

- incorporating Healthcare Effectiveness Data and Information Set metrics into dashboards to support integration with ACO/MCO partners.

5. CARE MODEL

On Track Description

Characteristics of CPs considered On track:

- ✓ **Outreach and engagement strategies**

    - ensures staff are providing supports that are tailored to and reflective of the population racially, ethnically and linguistically;

    - uses peer supports and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities; and

    - has a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations.

- ✓ **Person-centered care model**

    - ensures goals are documented in the care plan so that the team is engaged in supporting the enrollee towards achieving goals; and

    - uses person-centered modalities so that care coordinators can assist enrollees in setting health and wellness goals.

- ✓ **Managing transitions of care**

    - manages transitions of care with established processes including routine warm handoffs between transitions of care teams and CP care team.

- ✓ **Improving members' health and wellness**

    - standardizes processes for connecting members with community resources and social services.

- ✓ **Continuous quality improvement (QI)**

    - has a structure for enabling continuous QI in quality of care and member experience.

Results

The IA finds that South Shore has an **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

South Shore ensures that staff are providing supports that are tailored to and reflective of the member population. South Shore hired a Mandarin-speaking care coordinator and employs staff who can communicate with members in Spanish, Cantonese, Portuguese, French Creole, and Cape Verdean Creole. South Shore also contracted with an interpretation service to support members with language needs not met by CP or agency staff.

To outreach to members who are not easily reached telephonically, care coordinators collaborate with other provider entities in the community who can help South Shore find and engage potential members. Care coordinators work with PCPs, clinics, and referral sources to meet with potential members in the community during scheduled office visits. With one community provider, South Shore established an alert system that provides an open line of communication about unreachable members who may present to the community location. South Shore responds to these alerts and attempts to

outreach the individual at the community provider's location. South Shore care coordinators try to meet face-to-face with members whenever necessary and ensure that they meet with members in-person at least quarterly. South Shore offers members gift cards for achieving specific milestones for engagement, such as signing the participation form and completing the person-centered treatment plan.

Person-centered care model

South Shore structures care planning as a collaborative process directed by members in partnership with clinical providers, family members and social networks, key stakeholders, and community-based partners. South Shore care plans incorporate members' physical health, BH and social needs into one integrated plan. Care coordinators document member goals and progress in the care plan. South Shore care coordinators review members' care plans, progress towards goals, and areas of care plans that require additional assistance from supervisors during weekly meetings. South Shore nurses are also engaged in the care planning process, with their role guided by members' goals and defined action steps.

To facilitate the care planning process, South Shore care coordinators are trained in motivational interviewing and trauma-informed care. South Shore views the member as the center of the care team and the care plan will be updated and adjusted as the member's needs change. At minimum, the care plan is revised and updated after six months and then again annually. South Shore care coordinators update the care plan more frequently if the member experiences a significant event or goes through a transition of care.

Managing transitions of care

South Shore reviews ENS/ADT notifications to track when members present to inpatient facilities or EDs. South Shore staff reach out to the hospital or ED as soon as they are aware that a member has presented there. The South Shore nurse is the main liaison between the clinical staff at the hospital and the South Shore staff. The South Shore nurse mobilizes and meets with clinical staff in-person to develop members' discharge plans and after-care plans. The nurse also attempts to meet with members while they are admitted to the facility.

The nurse also supports care coordinators in managing their assigned members through transitions of care, accompanying them to visit members when necessary. Care coordinators are responsible for assisting members with following their after-care plans and updating a member's care plan as needed.

South Shore has established warm handoffs from local psychiatric hospitals and addictions programs and for members who are in crisis. With warm handoffs in place, South Shore can easily connect with these members and start coordinating care immediately after discharge.

Improving members' health and wellness

South Shore has policies in place to ensure that members are informed of their choices, including choices of LTSS programs and providers. South Shore reports having well-developed relationships with services and supports in the Quincy area. South Shore publishes a resource directory that care coordinators and members can reference to find service and support providers to help members achieve care plan goals. South Shore nurses have also made connections with PCPs who can help members meet their health and wellness goals.

South Shore also provides members with magnets that list important health-related information, such as hotline numbers, crisis team contact information, emergency contact information, and identifies where – PCP, urgent care, or ED – the member should go when they are experiencing a health issue.

CP Administrator Perspective: "*Despite the challenges, staff are finding the work incredibly rewarding. The team has already experienced many successes with helping members find stability, support, and direct services. Staff have helped members secure housing through rental assistance programs and Section 8 housing, obtain public benefits and community resources, return to school, and find employment. The most critical support care coordinators have provided to members is helping them get to their doctors' appointments, including attending the doctor's visit with them in order to support and advocate for them. This has had an added benefit of helping our teams build meaningful relationships with local PCP practices.*"

Continuous quality improvement

For each quality measure South Shore tracks, South Shore has a quality management plan that outlines the strategies staff should utilize to achieve quality performance in that domain of care. South Shore reports that these "blueprints" facilitate improvement in quality of care delivered to enrollees.

South Shore also implements a variety of QI process management principles to maintain a culture of continuous QI. South Shore's QI principles include engaging staff, key stakeholders, and providers to identify areas for improvement and growth, using data to establish and measure goals, communicating efforts and results of QI activities to all stakeholders, and using the science of Plan-Do-Study-Act (PDSA) cycles to operationalize and evaluate improvement projects.

Recommendations

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

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

- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

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

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);

- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;

- providing free transportation options for members to engage with services[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.

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

✓ **Person-centered care model**

- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;

- setting small initial goals that a member is likely to achieve to build member confidence in the engagement;

- developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and

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

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;

- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;

- meeting an enrollee in person once care coordinators receive alerts that they were admitted;

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

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

- 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 South Shore 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

- Workforce Development

The IA encourages SSCP 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.

- disseminating audit reports to each member organization or provide member organizations access to program documentation and performance metric dashboard

Health Information Technology and Exchange

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

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

Care Model

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

- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

SSCP should carefully self-assess the areas noted above, and consider the corresponding promising practices identified by the IA for each focus area. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL

DSRIP Implementation Logic Model

A. INPUTS

1. DSRIP funding for ACOs [$1065M]
2. DSRIP funding for BH CPs, LTSS CPs, and Community Service Agencies (CSAs) [$547M]
3. State Operations & Implementation funding (DSRIP and other sources)
4. DSRIP Statewide Investments (SWIs) funding [$115M]
5. Internal ACO & CP program planning and investments

State Context, e.g.
- Baseline performance, quality, cost trends
- Baseline medical/non-medical service integration
- Baseline levels of workforce capacity
- Transformation readiness
- Baseline status and experience with alternative payment models (e.g., MSSP, BPCI, AQC)
- Payment & regulatory policy
- Safety Net System
- Local, state, & national healthcare trends

B. OUTPUTS (Delivery System Changes at the Organization and State Level)

ACO, MCO, & CP/CSA ACTIONS SUPPORTING DELIVERY SYSTEM CHANGE
(INITIAL PLANNING AND ONGOING IMPLEMENTATION)

ACO UNIQUE ACTIONS
1. ACOs established with specific governance, scope, scale, & leadership
2. ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)
3. ACOs recruit, train, and/or re-train administrative and provider staff by leveraging SWIs and other supports, education includes better understanding and utilization of BH and LTSS services
4. ACOs develop HIT/HIE infrastructure and interoperability to support population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. CPs/CSAs; BH, LTSS, and specialty providers; social service delivery entities)
5. ACOs develop capabilities and strategies for non-CP-related population health management approaches, which includes risk stratification, needs screenings and assessments, and addressing the identified needs in the population via range of programs (e.g., disease management programs for chronic conditions, specific programs for co-occurring MH/SUD conditions)
6. ACOs 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., OMH)
7. ACOs develop structures and processes for integration of health-related social needs into their PHM strategy, including management of flex services
8. ACOs develop strategies to reduce total cost of care (TCOC) (e.g. utilization management, referral management, non-CP complex care management programs, administrative cost reduction)
9. MCOs in Partnership Plans (Model A's) increasingly transition care management responsibilities to their ACO Partners

CP/CSA UNIQUE ACTIONS
10. CPs established with specific governance, scope, scale, & leadership
11. CPs engage constituent entities in delivery system change through financial and non-financial levers
12. CPs/CSAs recruit, train, and/or re-train staff by leveraging SWIs and other supports
13. CPs/CSAs develop HIT/HIE infrastructure and interoperability to support provision of care coordination supports (e.g. reporting, data analytics) and data exchange within the CP (e.g. ACOs, MCOs; BH, LTSS; and specialty providers; social service delivery entities)
14. CPs/CSAs 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., OMH)

ACO, MCO, & CP/CSA COMMON ACTIONS
15. ACOs, MCOs, & CPs/CSAs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)
16. ACOs, MCOs, & CPs/CSAs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)
17. ACOs, MCOs, & CPs/CSAs establish structures and processes for joint management of performance and quality, and conflict resolution

STATEWIDE INVESTMENTS ACTIONS
18. State develops and implements SWI initiatives aimed to increase amount and preparedness of community-based workforce available for ACOs & CPs/CSAs to hire and retain (e.g. expand residency and frontline extended workforce training programs)
19. ACOs & CPs/CSAs leverage DSRIP technical assistance program to identify and implement best practices
20. Entities leverage State financial support to prepare to enter APM arrangements
21. State develops and implements SWI initiatives to reduce Emergency Department boarding, and to improve accessibility for members with disabilities and for whom English is not a primary language.

C. IMPROVED CARE PROCESSES (at the Member and Provider Level) AND WORKFORCE CAPACITY

IMPROVED IDENTIFICATION OF MEMBER NEED
1. Members are identified through risk stratification for participation in Population Health Management (PHM) programs
2. Improved identification of individual members' unmet needs (including SDH, BH, and LTSS needs)

IMPROVED ACCESS
3. Improved access to with physical care services (including pharmacy) for members
4. Improved access to with BH services for members
5. Improved access to with LTSS (i.e. both ACO/MCO-Covered and Non-Covered services) for members

IMPROVED ENGAGEMENT
6. Care management is closer to the member (e.g. care managers employed by or embedded at the ACO)
7. Members meaningfully participate in PHM programs

IMPROVED COMPLETION OF CARE PROCESSES
8. Improved physical health processes (e.g., measures for wellness & prevention, chronic disease management) for members
9. Improved BH care processes for members
10. Improved LTSS care processes for members
11. Members experience improved care transitions resulting from PHM programs
12. Provider staff experience delivery system improvements related to care processes

IMPROVED CARE INTEGRATION
13. Improved integration across physical care, BH and LTSS providers for members
14. Improved management of social needs through flexible services and/or other interventions for members
15. Provider staff experience delivery system improvements related to care integration (including between staff at ACOs and CPs)

IMPROVED TOTAL COST OF CARE MANAGEMENT LEADING INDICATORS
16. More effective and efficient utilization indicating that the right care is being provided in the right setting at the right time (e.g. shifting from inpatient utilization to outpatient/community based LTSS; shifting more care utilization to less-expensive community hospitals; restructuring of delivery system, such as through conversion of medical/surgical beds to psychiatric beds, or reduction in inpatient capacity and increase in outpatient capacity)

IMPROVED STATE WORKFORCE CAPACITY
17. Increased preparedness of community-based workforce available
18. Increased community-based workforce capacity though more providers recruited, or through more existing workforce retrained
19. Improved retention of community-based providers

D. IMPROVED PATIENT OUTCOMES AND MODERATED COST TRENDS

IMPROVED MEMBER OUTCOMES
1. Improved member outcomes
2. Improved member experience

MODERATED COST TRENDS
3. Moderated Medicaid cost trends for ACO-enrolled population

PROGRAM SUSTAINABILITY
4. Demonstrated sustainability of ACO models
5. Demonstrated sustainability of CP model, including Enhanced LTSS model
6. Demonstrated sustainability of flexible services model
7. Increased acceptance of value-based payment arrangements among MassHealth MCOs, ACOs, CPs, and providers, including specialists

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

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[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.

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[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 Request for Change

In reference to Section 2 Page 14, *"dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts."*

> We do have staff resources for timely, daily, review of ACO/MCO referral files to assist with outreach and engagement efforts. We have a senior systems admin and a systems administrator who both check daily to see if we have any new referrals, once we have those files, they are checked for errors, assigned to the particular hubs based on where the client lives, and are imported into eHana (our EHR) in less than a week, we have always met the deadline of getting the files to eHana. The moment these files are imported into eHana they are assigned to our care coordinator who serves as an engagement specialist and calls clients right away. The care coordinator always reaches out to the PCP offices and to the SPOC contacts in order to let them know client is assigned to our CP and to ask for any updated contact information they may have for the clients. Also it is important to note the eHana our EHR uses automated systems 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.

In reference to Section 2 Page 14, "*disseminating audit reports to each member organization or provide member organizations access to program documentation and performance metric dashboard."*

> We audit our files on a regular basis, in order to make sure we are meeting our quality metrics. We can send an excel spreadsheet in order to show you how and what we look for when auditing. Both agencies in this CP are shown all of this information right away.

In reference to Section 5 Page 23, *"creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB."*

> The South Shore CP does have a high-functioning CAB with members who are very involved. The CAB members updated our CP Member Flyer and helped lead and coordinate our Holiday party last year. Our CAB prior to COVId-19 were meeting every other month.