e-Flash

Anniversary Issue

COMMUNITY + LTSS CARE PARTNERS

July 20, 2022

A Message from Executive Director, Julie Battisti

July 2022 marks the fourth-year anniversary of MassHealth's Community Partners program. Four truly impactful years are now behind us as we round the corner into the fifth and final year of the pilot. Fortunately for those we serve, MassHealth will be extending the Community Partners program in 2023. And while the core of the program will remain the same, there are a few notable changes we will see in CP 2.0 that should make for an even stronger program for those we serve. First, the LTSS Program model will now align with the BH Program model, which will streamline the LTSS CP program and minimize some of the cumbersome workflows we have been navigating in the initial LTSS program model. Secondly, PCP sign off will no longer be required on Enrollee care plans! With the evolution of CP 2.0, MassHealth aims to minimize administrative burdens so as to promote more time and attention to those we serve.

We have endured our share of challenges this year as we continue to face the ebb and flow of the public health crisis and the staffing challenges that come with it. Still, CCP/LTSS Care Partners continues to persevere. And as with past years, we continue to focus on strengthening internal workflows/systems as well as external partnerships with both ACOs and PCP practices as we aim to deliver a quality service. It bears repeating, as a startup enterprise partnered with 14 different ACOs, we exist in the midst of great complexity and constant change. We recognize that constant change, whether big or small, requires an agility and flexibility, and extend our gratitude to all for your ongoing commitment to pivoting as workflows are updated, tools are enhanced, and we engage in new initiatives such as the Tufts AIC pilot, the MVP program, and our work with MLPB. Thank you!

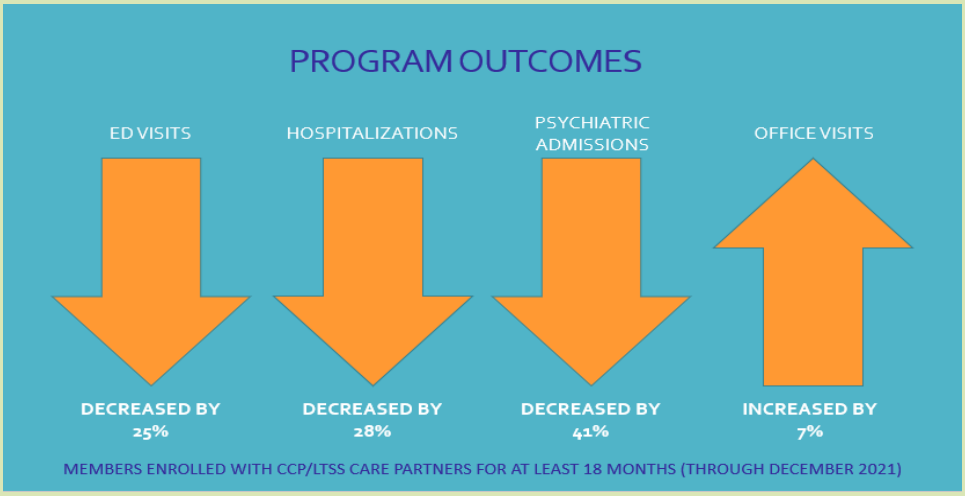
As is tradition, we highlight our collective accomplishments and extend recognition in this Annual Newsletter. We look at our progress through metrics and success stories, and well as through gains we've made with ACO integration initiatives and collaborations with PCP practices. We take this opportunity to extend our appreciation for the ongoing dedication and determination of our Care Teams, and for the difference each and every one of you makes in the lives of those we serve.

We hope you enjoy this Anniversary Newsletter.

YEAR FOUR: METRICS AT A GLANCE

Outreach can be tricky for a variety of reasons we all know too well, though lessons learned have allowed us to hone our outreach skills over time. As of June 2022, of the 15,581 BH members assigned to us over the life of the program and enrolled with us for at least 122 days, we have engaged 47%. On the LTSS side, of the 6,548 members assigned to us over the life of the program and enrolled with us for at least 122 days, we have engaged 31%.

As we've noted in previous years, the work our BH and LTSS Care Coordinators are accomplishing in partnership with our Members is yielding encouraging outcomes. We're making strides in diverting ED visits and inpatient stays, and likewise are increasing visits to the PCP office, sometimes for members who haven't seen a PCP in years.



OUR NEW INTRANET PLATFORM - JIVE

In Year 3, CCP/LTSS Care Partners took a big leap into the world of social media. You can now find us on **Facebook**, **LinkedIn** and **Twitter**. Most importantly, we leveraged our social media platforms to give voice to those we serve by spotlighting Member Testimonials. If you haven't had a chance to view some of the Member Testimonials just yet, check them out on our **You Tube Channel** as well as our new and improved **CCP website**.

In Year four, in an effort to further streamline the delivery of information and resources between our Central Management Team and our six Member Organizations, we launched a new Intranet Platform. Care Teams now access Jive to: engage in CCP informational updates via the newsfeeds, explore new workflow tools, review quality and performance reports, find out the latest training opportunities, and collaborate on cross organizational projects. Jive even has a space for our Consumer Advisory Board to share information and ideas. Jive gives each staff member the chance to respond to items that CCP shares in real time and ask questions. Jive has also allowed us to cut down on specific emails sent from CCP (when preferred). It also serves as a great landing spot for new employees to access training materials, policies, programmatic guides, and get a sense of what life looks like in a MassHealth CP program. This platform serves as a one-stop shop for all things CP, and promotes timely and effective communication with our Member Organizations.

HEALTH EQUITY FOCUS

Health Equity is fundamental to the mission of the ACO-CP Initiative, and with the data we can now access in Year 5, our aim is to target our efforts accordingly. CCP / LTSS Care Partners engaged a TA vendor, Health Management Associates (HMA), in early 2022 to support us in analyzing our data through a Health Equity lens. The following data points from the

project will in turn inform our development of a Health Equity Initiative. Ideally, one (or more) of our ACO partners will be interested in launching a Health Equity pilot with us in the coming months.

- Rates of ED/IP utilization are higher for people of color
- DMH members' rates for diabetes and asthma are higher than for non DMH members
- Rates of Diabetes are higher for persons of color
- Housing instability/homelessness rates are higher for non DMH members than for DMH members

QUALITY UPDATES

While marketing the CP Program, honing our outreach skills, and streamlining referral workflows were priorities in the first few years of the pilot, our current "steady state" gives us pause to dedicate ourselves more so to both Quality Improvement and Quality Assurance. As such, we have launched several initiatives in the past twelve months which support our efforts in this essential area.

Quality Improvement

Follow Up after Discharge (FUD) tool – this tool offers a standardization of what an ideal follow up after discharge entails and has been integrated into eHana for easy use by Care Coordinators

Practice Pathways tools

- **Preparing for a Provider Visit -**This tool assists a member in preparing for a provider visit. It prompts questions such as "do you have any questions you want to ask your provider?" and "how will you be getting to your appointment?"
- **Provider Relationship Assessment (for use at new member's Intake) -**This tool, which has also been integrated in eHana, helps staff to assess provider relationships and identify barriers members may be encountering to connecting to the healthcare system

Quality Assurance

Quality Assurance Checks - A quality assurance check form was developed and takes a three-prong approach, with guided checks for: completed chart components, aligned notes/QAs, and quality member contact

Member Survey - The survey, circulated via email to 1,000 Enrollees, had a 10% return rate, with 87% of the respondents including feedback in text fields in addition to completing checkboxes

Consumer Advisory Board

CCP/LTSS Care Partners has had success in further developing and sustaining the Consumer Advisory Board. In the past year, CAB members contributed instrumental feedback to a variety of workflow tools including new Practice Pathways tools - the Assessment Tool of a new Enrollee's relationship to their PCP, and the Appointment Prep tool, as noted above. CAB Members contributed recommendations on the Follow Up After Discharge Tool for Care Coordinators as well. And they contributed invaluable feedback on the initial Member Survey launched in Q4 of 2021.

ACO Integration Initiatives

Despite a few pandemic setbacks, CCP/LTSS Care Partners has forged the way to enhanced integration with many of our ACO partners in a variety of ways this past year. We have had success in establishing collaborative meetings inclusive of high utilization reviews, are exploring ED/IP Pathways, are establishing new Referral pathways, and have gained read only EHR access with four of our 14 ACO partners.

Successes

- **High Utilization Reviews / Case Reviews:** High Utilization and/or regular Case Reviews have gained traction with six Hospitals, six Health Centers and three Primary Care Practices, with more in the works!

- **ED / IP Pathways**: CCP/LTSS Care Partners has seized the opportunity to pave ED and/or IP pathways with Hospitals to promote enhanced collaboration with ED / IP staff, coordinate warm hand offs to our care teams and ensure we're involved in discharge planning. While this opportunity tends to be more complicated that we might hope, we've gaining traction this year with eight of our 14 ACO partners. We have three partners who alert us directly when a shared member is in the ED, and six of our partners have provided ED and IP POCs for our Care Teams. Three of our ACO partners have also added alerts within their EHRs that flag for ED and IP staff that a patient is a shared member, provide our contact information and request that we be contacted.
- **Referral Pathways:** CCP/LTSS Care Partners has had some success in establishing new referrals pathways with ACO partners. To date, five ACO partners have established pathways through an ED, Urgent Care, or PCP practices.

Maximizing on TA Funding

MassHealth has made Technical Assistance (TA) Funding available to Community Partners and ACO's alike throughout the five-year pilot. TA funding has been dedicated to Staff Development and Training Initiatives including CHW Certification course Fall 2021 and Spring 2022; and a Culturally Responsive Care training series Spring 2022, with a session on the Muslim community and another on the Latinx community. We also have two TA projects that have strengthened our Care Teams' abilities to address systemic barriers as well as invisible drivers of (ED and IP) utilization, and in turn promote life changing advocacy and support for our members.

Medical Legal Partnership of Boston (MLPB)

Our partnership with MLPB serves to strengthen our Care Teams' ability to meet members' HRSN (health-related social needs) and improve population-level SDOH (social determinants of health) through human-centered, strengths-based legal problem-solving strategies. Our shared goal is to increase health equity for people served.

Pediatric Member and family received a Notice to Quit – Tenancy was at risk. In consultation with MLPB, our Pediatrics team was able to accomplish the following, and tenancy was preserved:

- Provide a link to the court docket and instructions for navigating, including checking for court dates to ensure attendance.
- Offer a template letter for the family to submit to their housing authority regarding missing documentation and missed appointments.
- Provide the link to create a "my Social Security" account through which the family was able to obtain an SSI verification letter needed to demonstrate termination of benefits.
- Share instructions to request and review complete housing authority file upon submission of paperwork.

Collaborative Health Strategies (CHS) Multi Visit Patient (MVP)

Partnering with CHS is a unique opportunity for Care Teams to hone their skills in identifying the driver of utilization (DOU) for members with multi-ED visits and / or multi IP stays (MVPs) and implement a collaborative and integrated approach to care across the healthcare system. Our shared goal is to measurably and meaningfully improve care for MVPs.

Member with 29 ED visits over past 12 months:

- Driver of Utilization → Substance Use Disorder (SUD) leading to housing instability, and unmanaged anxiety related to Lymphoma diagnosis.

BH CP Care Coordinator

- ✓ Collaborated with Lawrence General via care alert in ADT system and weekly MVP meetings
- ✓ Supported Member in resuming substance use treatment - providing early morning Ubers while awaiting PT1 transportation approval from MassHealth
- ✓ Coordinated with Dana Farber for Member's cancer treatment

Impact of Interventions

- ✓ Member able to move back home with spouse once SUD was better managed
- ✓ Received ongoing support from team and increased family stability reduced anxiety

No ED visits since March 27, 2022

Member with 103 ED visits and 150+ EMS calls over past 12 months:

- Driver of Utilization → Lack of diabetes support and care, resulting in frequent hypoglycemia. Member would leave ED once stabilized and before comprehensive plans and supports could be established.

BH CP Care Coordinator

- ✓ Collaborated on plan wherein Care Coordinator would be contacted when Member in ED.
- ✓ Met Member at ED bedside to support Member's decision to be medically admitted.
- ✓ Attended in-person appointments with Member re: kidney transplant approval process.

Impact of Interventions

- ✓ Member engaged in receiving necessary care for more effective diabetes management.

Only 2 ED visits since April 13, 2022

YEAR FOUR: SUCCESS AT A GLANCE

Success looks different for each member served by our BH and LTSS Care Coordinators. There are big successes, and there are small successes that add up over time. Here is a sampling of successes from over the past year.

Submitted by Jeffrey Vizarreta - Bay Cove

Member: Spanish-speaking homeless member who is HIV and Hep-C positive and in need of assistance coordinating medical appointments, treatments and behavioral health supports. Struggling with anxiety and depression, requesting help obtaining safe, stable, and independent housing.

Interventions: Support and reminders around meeting consistently with psychiatrist and therapist, sustaining engagement in MAT and maintaining continued abstinence. Support in completing intake with Commonwealth Land Trust. Member is now attending all appointments with BH providers and has been approved for an SRO with a targeted move in date of September 1st, 2022.

Submitted by Naomi Weiner - Vinfen

Member: Member with Schizophrenia, SUD, COPD and obesity struggling with managing medications effectively resulting in auditory hallucinations, heavy daily alcohol use prompting falls.

Interventions: Secured a BH provider, advocated for continued treatment with other providers. Obtain a new AC, advocated for DME and in-home services, coached around the impact of alcohol use on independent living. Member has decreased drinking to the point that it no longer interferes with functioning. Shower chair and grab bars have been installed. COPD is under much better control. No additional falls reported, and no hospitalizations.

Submitted by Thaina Vilson - JRI

Member: Haitian Creole-speaking pediatric with speech impairment, elevated lead blood levels and obesity, living with her mother. Mother lacked financial benefits leading to housing and financial instability. Member also in need of dental care and social supports.

Interventions: Provided options for income-based housing and facilitated connection with ABCD for housing support services. Assisted with application for unemployment benefits and with process for locating a dentist covered by member's insurance. Shared resources for summer recreational programming and supported mother with sign-up. Mother is now receiving unemployment and is actively working with ABCD to find affordable housing. Member completed summer program.

Submitted by Linda Guerrero-Ohiri - Bay Cove

Member: Member with asthma, depression, anxiety, endometriosis, benign and unspecified neoplasms and adjustment disorder, residing in a family shelter with 2 children after fleeing domestic violence. In need of safe, stable housing, financial and transportation supports.

Interventions: Provided list of real estate agents and affordable housing resources. Coaching and modelling to enhance communication of needs in shelter setting. Supported understanding of notices received from Social Security and steps to appeal SSDI denial. Offered instructions around the process to request PT-1 referral for appointments. Member is now renting her own apartment for her and her children and can independently manage PT1 services now that she has a consistent home address.

We're so grateful for the big steps and little steps our Care Coordinators support our members' in achieving every day!

YEAR FOUR: *MEMBER APPRECIATION*

Who better to express how our partnerships with Members impact the quality of their lives than our Members themselves, who often site appreciation in the following three areas. These recognitions speak volumes!

 **Key link to PCP/specialists/other community resources**	 **Advocate for self-care and independence**	 **Good listener/non-judgmental support**
"Our son has obtained through [his care coordinator] advice on resources that we did not even know existed."	*"[My care coordinator] has acted as an advocate on my behalf for quite some time and I am a better person for making her acquaintance. [She] has brought a sense of calm and relief to my life. She is a true humanitarian."*	*"I never really had anyone that really understood me or cared to understand me not only do you understand you don't judge me and the advice that you give me I know that it's good because it's got me very far your advice helped me to stay clean."*
"[My care coordinator] is a great worker that listens, understands, and tries to help us as much as she can. [The most helpful thing is] having found a person with the warmth of [my care coordinator] who knows how to listen to us, understand us, guide us and help us find resources to help our son."	*"She helps me advocate for myself when needed, and she helps me in departments I struggle in. She has helped me be able to be more independent and proactive. She has helped me a lot with self-care and self-esteem."*	*"I was communicated to very coherently by the coordinators that I was a top priority and they proved it in so many ways and counting."*
"They show knowledge of my medical conditions and suggest prompt solutions. They are the key link (central connector) with my PCP, specialists, [and] insurance. I feel well understood at a linguistic, emotional, and cultural plane."	*"She is helping me be more independent by having me do the outreach to new care providers."*	*"My CP Care Coordinator is dependable, efficient, and communicates well."*
"[My care coordinator] has delivered tangible results both in medical equipment and housing accommodation. I suffer from two serious and disabling chronic diseases, and through his professional efforts my life quality has dramatically improved."		*"[My care coordinator] works very hard to make sure we are always on the same page and working together towards the same goals. I am so thankful for him and all that he does"*
		"[My care coordinator] is probably one of the most dedicated workers I've come across and seems to go above and beyond in her work. She has helped me a lot with my health and housing and really puts the time and effort into anything she does."