COMMUNICATIONS WORKGROUP

RECOMMENDATION #2: Develop and implement a communications strategy to promote the value of CCP and the CP program

ALL TACTICS

1	Include materials/campaigns to educate **leadership** and **providers** about the CP program and about CCP to include: information about services provided, information on CCP and its member organizations, value of the program/impact on member outcomes, not only processes.
2	Develop reports that include success stories that focus on specific subpopulations being served, and impact, e.g. individuals with housing needs, high or moderate risk patients ("specialization")
3	Provide updates with aggregated and quantitative data on services provided and populations served. Consistent, frequent, and regular reports sent to **program managers;** reports with compiled information sent by CCP on the same day each week was cited as a best practice. Program managers also reported that Central Intake is a best practice.
4	Materials for **provider practices** should brief and targeted with information/data on impact on ACO goals, performance and clinical quality outcomes. Focus on PCP goals and developing provider buy-in.
5	Develop materials for **patients** that assist with coordination across multiple care managers and program staff, as necessary, and to increase patient satisfaction. Work collaboratively with ACO care management teams.
6	Work closely with Data and Analytics team to obtain relevant data needed for materials as noted above, to include aggregated data on services, outcomes data, clinical data and analysis by subpopulations.

RECOMMENDATION #3: Provide value-add services for priority ACOs through specialized, tailored and enhanced CP services

TACTIC 2 – Develop menu of enhanced integration options

2.1	Assist ACOs with education of providers about the CP program and services using tangible marketing materials developed as part of Communications strategy (See also Recommendation #2 and Tactic 3). ACOs acknowledged challenge of educating providers about the program due to issues with provider turnover and the number of different care management programs, CPs, and organizations within CPs.
2.2	Facilitate ability of members to engage with PCPs via telehealth recognizing challenges such as availability and use of technology, location of visit and privacy concerns, reaching out to members to ensure comfort with process (3 ACOs).
2.3	Embed care managers in the ED or meet patients in the ED, use a real-time alert system (i.e. secure texting) with hospitals by engaging ED or inpatient care managers and crisis teams. Several ACO respondents reported that ED boarding is a significant concern.
2.4	Develop processes for real-time communications and responses for provider practices to capture opportunities for engaging hard-to-reach members.
2.5	Develop innovative ways to address transportation barriers to PCP visits (particularly first visit) and reduce no-shows, e.g. coordinating transportation for members, partnering with third-party vendor to provide car service to appointments (4 ACOs)

RECOMMENDATION #3: Provide value-add services for priority ACOs through specialized, tailored and enhanced CP services

TACTIC 2 – Develop menu of enhanced integration options, continued

2.6	Include integration options cited as helpful or best practices by ACOs, such as: embedding a care manager in a practice, accompanying patients to visits, EHR read-only access, case conferences more frequent than monthly, separate meetings for administrative vs case reviews.
2.7	Frequent, proactive, and regular updates for program managers with data on the services provided, including flagging members who are difficult to reach; work collaboratively with ACO staff on outreach efforts (see also Recommendation #2).

RECOMMENDATION #3: Provide value-add services for priority ACOs through specialized, tailored and enhanced CP services

TACTIC 3 – Pilot communications and data sharing strategies with provider practices

3.1	Develop standard communications processes, workflows and tools for transmitting member information to PCPs with particular attention to provider burden, a concern for ACOs, and limited knowledge of the CP program. Noting that EHR access may not be possible, explore transmitting information through practice contacts, social workers and care managers (see also Tactic 4). Most ACOs acknowledged the need for greater engagement with provider practices.
3.2	Initial communications to include information that demonstrate the value and services of the CP program, such as brief and specific information about member outcomes or needs, to develop trust and increase provider buy-in to the program.
3.3	Use clear, brief messages (one-page or less) with actionable data or outcomes of interest to PCPs and timed around PCP visits, with particular attention to clinical quality goals. Reading long reports is time-consuming for PCPs.
3.4	Collaborate with provider practices on developing interventions around clinical quality metrics of interest to the practice, and specifically develop capacity to ingest and analyze clinical data (see also Tactic 5)
3.5	Suggestion from one ACO is to put a cover page on care plans that highlight need for PCP signature; not all PCPs understand the requirements of the CP program, which may lead to delays in signed care plans.

RECOMMENDATION #3: Provide value-add services for priority ACOs through specialized, tailored and enhanced CP services

TACTIC 4 – Tailor processes with ACO care management teams

4.1	Use templates and tools to develop standard and consistent workflows and reduce duplication with ACO care management teams, such as a roles and responsibilities grid or workflow diagrams. ACOs valued consistent, predictable CP processes and workflows, and greater/shared understanding of care management activities.
4.2	Include processes for warm hand-offs, educating members about different care manager roles, and updating new ACO or CP staff when there is staff turnover.
4.3	Develop processes for sharing data (include in above workflows) with ACO care managers, which could include interfacing with eHana and/or creating shared dashboards. Reducing duplication and streamlined workflows demonstrate how CPs can extend and expand capacity of ACO care management teams.
4.4	Develop capacity for analyzing internal data to help ACO care management teams identify members for targeted care management (see also Tactic 5).
4.5	Work with ACO care management teams to increase patient satisfaction, which was reported as an ACO goal (4 ACOs)

RECOMMENDATION #3: Provide value-add services for priority ACOs through specialized, tailored and enhanced CP services

TACTIC 4 – Tailor processes with ACO care management teams, continued

4.6	One ACO valued having nurses on BH CP teams to assist with integration with medical teams
4.7	One ACO was interested in CPs assisting with outreach to members for LTSS comprehensive assessments. This would also reduce fragmentation of the LTSS CP program.

RECOMMENDATION #3: Provide value-add services for priority ACOs through specialized, tailored and enhanced CP services

TACTIC 5 – Analyze data to target services and interventions

5.1	Create capability for analyzing internal data for targeting services and interventions, which includes the identification of data collected through assessments, care plans, screening, social determinants of health, and care management data.
5.2	Create capability for ingesting external data from MassHealth or clinical data from provider practices and ACOs for clinical quality improvement activities around ACO goals.
5.3	Analyze data to demonstrate "specialization" or improved outcomes for subpopulations of members, e.g. individuals experiencing housing instability, individuals with special needs, individuals with addiction, and to determine who is best served by the program
5.4	Implement process for sharing data with ACOs and provider practices for clinical quality improvement activities and for educational purposes (see also Recommendation #2 and Tactic 3)
5.5	Consider examining metrics in addition to engagement, such as: quality of life (3 ACOs), community tenure (5 ACOs), also patient satisfaction (4 ACOs); meeting care plan goals, whole person care planning, and SDOH and social services coordination was cited as important to ACOs (6 ACOs) (see also Recommendation #4)
5.6	Consider tracking and analyzing referral outcomes using closed loop referral systems, such as Aunt Bertha and Unite Us, cited as an innovation by ACOs; can use data in communications materials;

RECOMMENDATION #4: Provide value-add services to ACOs by leveraging member organizations and initiatives that can wrap around the CP program

TACTIC 1 – Identify other non-CP services of value to ACOs

1.1	Pilot evidence-based practices for prevention of readmissions and ED use targeted to specific subgroups
1.2	Connections to recovery coaches (3 ACOs)
1.3	Connections to BH services providers, including prescribing providers (4 ACOs)
1.4	Programs around addiction and OBAT (2 ACOs)
1.5	Medication management (1 ACO), medication compliance (2 ACOs)
1.6	Data analytics to help identify members that are "impactable" (3 ACOs)
1.7	MVP program cited as a best practice

RECOMMENDATION #4: Provide value-add services to ACOs by leveraging member organizations and initiatives that can wrap around the CP program

TACTIC 3 – Contract for new services, e.g. Flex Services

3.1	Interventions around housing, such as flex services for housing support services, potentially embedding care manager in a shelter. Housing cited as member need (4 ACOs)
3.2	Nutrition supports to address food insecurity, including flex services, mobile markets and addressing food insecurity in response to COVID-19 pandemic (3 ACOs)
3.3	Transportation coordination and services (see also Recommendation #3), including emergency transportation (4 ACOs)
3.4	BH CP services for children (2 ACOs)
3.5	Other innovations: providing cell phones for members