MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Community HealthLink, Inc.

(CHL)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Community HealthLink Inc. (CHL)

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A Behavioral Health Community Partner

Organization Overview

CHL has been helping adults, children, and families to recover from the effects of mental illness, substance use, and homelessness since 1977. CHL's goal in being a Community Partner (CP) is to support and coordinate services across the continuum of care for adult MassHealth members in the Worcester and Fitchburg-Gardner service areas.

SERVICE AREA

POPULATIONS SERVED

- CHL's CP enrollees come from the city of Worcester and from the rural, isolated areas of North Central MA.
- Worcester, Leominster and Fitchburg, the three largest cities, have increasing populations of individuals with behavioral health (BH) needs who speak a language other than English (Spanish, Portuguese, Vietnamese are the top three).
- Approximately one in three of the population served have co-occurring mental health and substance use disorders (SUDs) and, of that population, one in four are at risk housing or are experiencing homelessness.

665

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- CHL used Lean process improvement to manage the performance of the CP program, capturing progress using a "True North" Metric Scorecard which tracks yearly quality improvement goals.
- CHL's leadership improved integration by participating in monthly meetings with emergency service providers, crisis services units, BH out-patient services, psychiatrists and primary care providers.
- CHL utilized statewide investments to improve staff skills and knowledge around outreach.
- CHL uses alerts to message providers at other practices sites about members who utilized emergency services.

Statewide Investment Utilization:

- Student Loan Repayment Program, 2 Care Coordinators, 1 LPN/RN participating
- Community Mental Health Center Behavioral Health Recruitment Fund, 2 slots awarded
- Certified Peer Specialist Trainings
- Community Health Worker Trainings
- Technical Assistance

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1: Framework for Organizational Assessment of CPs

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

METHODOLOGY

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

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

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

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

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

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

CP BACKGROUND[2]

Community Healthlink, Inc. (CHL) is a behavioral health (BH) CP.

CHL has over 50 years of experience providing primary care and behavioral health services to adults, children, and families. As a BH CP, CHL supports and coordinates services across the continuum of care for adult MassHealth members who suffer from serious mental illness (SMI) and/or substance use disorders (SUD).

CHL's primary service area includes Worcester, Gardner-Fitchburg, and Leominster. CHL's enrollees come from urban, suburban, and rural areas in Central Massachusetts. Worcester, Leominster, and Fitchburg, the three largest cities in CHL's service area, have an increasing number of individuals with BH needs who speak a language other than English, with Spanish, Portuguese, and Vietnamese being the most common. Approximately two-thirds of the population served have co-occurring mental health and SUD diagnoses, and, of that population, at least one-quarter are at risk of losing their housing or are experiencing homelessness. The population served by CHL also frequently uses the emergency department (ED) for primary medical care and many are not connected to a primary care provider (PCP).

As of December 2019, 665 members were enrolled with CHL[3].

SUMMARY OF FINDINGS

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

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

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

FOCUS AREA LEVEL PROGRESS

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

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

Results

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

Executive Board

CHL operates using a multidisciplinary team model in which three care teams are linked to specific BH and PCP practices and supported by a Medical Director and full-time director of integrated care management. CHL is affiliated with Clinical Support Options, Inc. (CSO). CHL did not provide a description of their governance structure in reports.

Consumer Advisory Board

CHL has a CAB that meets regularly. Although CHL initially struggled with low participation in their first year, they successfully recruited members to participate in 2019. At least four members were in

[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.

attendance for every meeting. CHL would like their CAB membership to be representative of their member population and has thus focused their efforts towards recruiting consumers from the North Central and Worcester areas, Adult Community Clinical Services (ACCS) programs, non-residential programs, and individuals from at least three different ACOs/MCOs. CHL provides a stipend, transportation assistance[5], and a meal to all members who attend their CAB meetings.

Quality Management Committee

CHL has an active QMC that meets monthly. The QMC monitors progress on quality metrics set forth by EOHHS[6] and on quality goals set internally by the BH CP team. CHL is also engaged in a Technical Assistance (TA) project through the Statewide Investment (SWI) 5a to analyze population health outcomes. CHL's QMC works with IT and Operations staff to track long-term objectives related to reducing total cost of care (TCOC) and improving quality of care.

CHL has undertaken at least one QI initiative based on collected data. CHL's model of QI is based on the lean process improvement method.[7] CHL's staff are trained in lean thinking, methodology, and tools. All BH CP managers have earned their yellow belts in lean training. CHL has a four-star idea board which generates ideas and inspires problem solving from the staff on a regular basis. CHL publishes a *True North Metric Score Card* listing two to four quality goals for each year. CHL's goals in 2019 included the following: (1) 90% of Medicaid eligible clients receiving an outreach attempt within the first 30 days and (2) 65% of referrals having a face-to-face contact within three months of assignment.

Recommendations

The IA encourages CHL to review its practices in the following aspects of the Organizational Structure and Engagement focus area, for which the IA did not identify sufficient documentation to assess progress:

- holding regular meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies.

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)[8] Joint Operating Committee;

[5] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[6] Executive Office of Health and Human Services for the state of Massachusetts
[7] Lean is a name for a set of tools, methodologies, and way of thinking with the goal of identifying and minimizing waste to improve process efficiency. CHL uses lean to enable improvements in patient-centered care, quality, safety, efficiency, and staff satisfaction. http://www.communityhealthlink.org/chl/give/2-uncategorised/130-lean
[8] For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

✓ **Consumer Advisory Board**

- seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;
- adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;
- hosting meetings in centrally located community spaces that are easy to get to and familiar to members;
- adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members;
- limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff;
- sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls;
- incentivizing participation by paying members for their time, most often through relevant and useful gift cards;
- incentivizing participation by providing food at meetings; and
- presenting performance data and updates to CAB members to show how their input is driving changes in the organization.

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
- integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
- ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential QI initiatives through the appropriate channels.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of CPs considered On track:

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

Results

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

Joint approach to member engagement

CHL securely exchanges member data files of assigned and engaged enrollees with ACO/MCO partners. CHL's Intake Coordinator monitors data exchange channels and routinely communicates with PCPs and ACOs to follow-up on care plans requiring sign-off, particularly those submitted electronically. Face-to-face meetings are the most efficient way CHL receives care plan sign-off with ACO/MCO PCPs.

Every month, CHL's registered nurse (RN) manager responds to the ACOs/MCOs' requests for information about the member population and meets in-person with each ACO/MCO to exchange member contact information, discover upcoming provider appointments, and collaborate on member outreach.

CHL's electronic health record (EHR) does not have the ability to accept MassHealth referral spreadsheets in their current format, so they hired a Data Entry Specialist in 2019 to load all member files into the EHR at the beginning of the year. CHL has since trained the Intake Coordinator and administrative staff to enter smaller files more frequently to keep up with new records. This adjustment allows CHL to conduct timely reviews of assignment files and enables outreach and engagement efforts.

> CP Administrator Perspective: "*Our relationships with a number of PCP practices are excellent. With releases, information flows back and forth, and members benefit from those relationships. Our Best Practice is with CHL's North Central Primary Care Practice in [Leominster] in which our staff join the weekly multidisciplinary team and share updates on Enrollees. We are working to replicate that in other practices.*
>
> *We developed more strategies for our Intake Coordinator to have contact and communication with PCP offices and ACOs regularly to help get [care] plans signed more quickly. We learned that those ACOs/MCOs that had good escalation processes increased the number of [person-centered treatment plans] signed [and returned] on time."*

Integration with ACOs and MCOs

CHL holds quarterly meetings with all of their ACO and MCO partners. During quarterly meetings, CHL reviews how many members are fully engaged and how many are still in the process of being engaged in care coordination supports. CHL uses these meetings to discuss best practices to engage members.

CHL conducts clinical case review meetings monthly with two MCOs and three ACO partners to review challenging cases identified by CHL care coordinators. In 2019, CHL began attending bi-monthly meetings with one ACO to review clinical cases and ensure sign-off on all CHL care plans. The clinical case review meetings enabled CHL to meet all engagement deadlines for members assigned to this ACO.

CHL's RN Manager and Program Director participate in monthly meetings with various service providers like Emergency Services, Crisis Stabilization Units, BH outpatient services, psychiatrists, and PCPs to further improve coordination.

CHL RNs receive real-time notifications through CHL's ENS system and distribute alerts to care coordinators to facilitate clinical integration after these events.

Joint management of performance and quality

CHL developed data-driven QI initiatives to improve the engagement rate they report to ACOs/MCOs. CHL documented these QI goals in their *2020 True North Metric Scorecard* and display progress on these goals on idea boards in a designated space within practice sites. CHL care team staff meet weekly to execute a lean process, known as an idea system.[9] Staff gather around boards and brainstorm ideas to improve current performance metrics. CHL established multidisciplinary team meetings every other week with two ACOs to receive sign-off on member care plans. However, CHL also supports their care coordinators in their effort to engage PCPs in comprehensive care plan review through an audit system that tracks the quality of documentation sent to PCPs. Audits of member records ensure the results of the member's assessment drove the design of the care plan and all critical information is documented in the member's progress note.

[9] An Idea System is a process and environment for empowering people allowing for continuous improvement. Idea Systems emphasize the importance of having the people who are doing the direct work generate ideas. http://www.communityhealthlink.org/chl/images/Files/Lean%20and%20Idea%20System.pdf

CHL's shared EHR system effectively tags BH CP members so that other CHL providers can view activities conducted with that individual. All CHL care teams can access member information on the shared EHR. CHL is a single entity CP with no member organizations, therefore it does not generate audit reports for any other organization.

Recommendations

The IA encourages CHL 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.

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

Recruitment and retention

CHL reports that they have been able to maintain sufficient staffing levels. Despite losing a significant number of staff in 2019, CHL was able to promote existing staff and recruit externally to fill most of these openings within the year. CHL employs a workforce recruiter and maintains a CLAS (Culturally and Linguistically Appropriate Services) taskforce to recruit and support personnel with diverse and multilingual backgrounds. CHL works with local colleges and universities to attract students to its large internship program and recruits heavily from their intern pool to fill key staff positions.

According to CHL, the Program Director, three clinical staff, an administrative assistant, and seven care coordinators left the agency within a short period of time. CHL administers staff surveys focused on staff engagement efforts and conducts exit interviews to learn more from staff about decisions to leave CHL. CHL developed an Idea System within their quality management framework to work on goals related to staff satisfaction and the implementation of staff ideas. While it is clear CHL has taken steps to address barriers to staff retention, the IA did not receive documentation indicating that they offer monetary incentives, such as performance bonuses or educational assistance, to retain staff. CHL did, however, take advantage of the Community Health Worker Training Capacity Expansion Grant (4a); The Community Health Worker Supervisor Training Incentive Fund(4c) and the Competency-Based Training Program for ACOs and CPs (4e) enabling staff to become certified CHWs in Massachusetts. Additionally, CHL offers credit hours to clinical staff to maintain licensure and stay informed of evidence-based practices.

Training

New staff at CHL attend one month of initial trainings that cover the CP program, program goals, health care reform, SMI, SUD, chronic medical conditions, social determinants of health, the social services system, motivational interviewing, safety policies and procedures, boundaries, and self-care

and the use of supervision. Staff develop skills in person-centered treatment planning, safety planning, implementing the wraparound model, managing transitions of care, and properly documenting activities in the EHR. CHL conducts training in a variety of educational settings such as traditional classroom-based learning, webinars, e-learning modules, and experiential learning. CHL reports offering monthly trainings on key topics such as motivational interviewing, Substance Abuse and Mental Health Services Administration's (SAMHSA) principles of recovery for individuals with SUD and Mental Health First Aid. CHL engaged the Center for Health Impact to train staff in the core competencies of community health. CHL managers monitor staff progress on required training elements.

Recommendations

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

- implementing additional strategies such as staff incentive programs to retain staff.

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

Implementation of EHR and care management platform

CHL has demonstrated policies and procedures for information sharing, and their EHR allows CHL care coordinators to communicate with all CHL programs through a single client record. CHL reports using an ENS system through an established vendor and has devoted significant staff resources to ensure daily reviews of ADT notifications to assist with outreach and engagement efforts. CHL care managers receive alerts by phone and by email and notify care coordinators of their members' admissions, discharges, or transfers so coordinators are able to perform follow-up activities. CHL reports ENS has been incorporated into their care management model, but this is different than having ENS alerts integrated into a care management platform or EHR. This functionality would allow care coordinators to automatically receive alerts for members that are attached to the member record.

Interoperability and data exchange

CHL has the capacity for securely sharing information with ACOs, MCOs, and other providers. CHL exchanges member files via SFTP, secure email, a secure file sharing app, Mass HIway[11], and via secure e-faxing through a virtual private network.

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

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

CHL reports that despite their capacity to exchange data, the number of different processes for the exchange of EHR information required by ACO/MCO partners created challenges. Initially managers led most communication with the ACO/MCO partners through these channels.

In their most recent progress report, CHL reported they can share and/or receive member contact information, comprehensive needs assessments, and member care plans electronically from all or nearly all MCOs, ACOs, and PCPs.

Data analytics

CHL has made updates in their EHR to help capture data and measure progress more efficiently as part of its overall QI initiatives. For performance management, CHL utilizes an Idea System. As stated above, Idea Systems utilize a visual system to track progress on each goal and capture progress in the form of a scorecard which is used by managers and submitted to CHL's QMC for performance improvement. CHL's previous EHR had significant reporting capabilities, but the IA did not identify documentation describing CHL's current reporting capabilities.

Additionally, CHL RNs collect data on the success of coordination activities in response to ENS notifications in a stand-alone spreadsheet. The spreadsheet is used to pull monthly data and is presented to the QMC at meetings.

In 2019, CHL took steps to significantly expand their analytic capacity. CHL is working with a population health management TA vendor. CHL set up a server to house and integrate claims data with activity data extracted from its EHR to help continuous improvement initiatives around quality outcomes and TCOC.

Recommendations

The IA encourages CHL 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;
- using ENS/ADT alerts and integrating ENS notifications into the care management platform; and
- developing a data dashboard that displays performance on key quality metrics in real time.

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

Outreach and engagement strategies

CHL assesses individual language and access needs at intake and provides care coordination supports in the language and location that best meets members' needs. CHL has multilingual staff, medical interpreters, and a service providing video and telephonic translation. Additionally, all CHL materials, including brochures describing CHL's program, participation forms, and releases, are translated into at least three major languages.

CHL utilized the CHW Training Capacity Expansion Grant, the CHW Supervisor Training Incentive Fund, and the Competency-Based Training Program for ACOs and CPs to provide their care coordinators with advanced skills and a greater knowledge base around outreach. Although the IA did not identify documentation that CHL uses peer supports, all CHL staff receive extensive training in SUD and in motivational interviewing and use the SAMHSA guiding principles of recovery when working with individuals experiencing SUD and mental illness.

CHL does not describe direct outreach strategies at community locations in reports. CHL did hire temporary outreach specialists in 2019 to reach hard-to-reach members, but these staff members are primarily responsible for tracking down members using ENS notifications, claims data, and PCP records.

Person-centered care model

CHL care plans include statements by individual members about their goals in their own words. CHL care coordinators encourage members to identify personal needs in five areas – medical, behavioral, social, wellness, and substance use, if applicable – in order to form personal health and wellness goals. CHL reports using shared decision-making during the care planning process and trains all staff in motivational interviewing techniques to help members identify skills they already possess that will help them achieve their goals.

CHL has developed strategies to complete the comprehensive assessment and communicate the results to the assigned enrollee's Care Team, ACO/MCO, and other providers who serve the assigned enrollee including state agencies or other case managers, as appropriate.

Managing transitions of care

CHL is alerted to member transitions in a variety of ways. In 2019 CHL incorporated ENS/ADT notifications into their care management model so that care coordinators are immediately notified if a member has been admitted or discharged from a provider subscribed to the ENS. Care coordinators perform follow-up using contact information available in the ENS.

Additionally, one of CHL's ACO partners has a direct transitions of care team that reaches out to CHL staff to support members transitioning from detox, a crisis stabilization unit (CSU), inpatient stays, or nursing facilities.

Within CHL's own network of providers, the BH CP program is alerted if a member comes into one of CHL's Urgent Care, Open Access, or Emergency Services Programs. CHL RNs check detox and CSU inpatient lists weekly to monitor for recent discharges of BH CP members. In response to all internal alerts, a CHL care coordinator is dispatched to meet with the enrollee face-to-face.

To support individuals with SUD, CHL care coordinators are able to refer to a range of services including: Acute Treatment Service ("detox"), Clinical Stabilization Services, Transitional Support Services, Medication for Addiction Treatment (MAT), and SUD outpatient and residential services.

> CP Administrator Perspective: "*CHL BHCP program sets alerts on an enrollee's face sheet in the agency's shared electronic health record stating an enrollee is active in the BHCP program with their assigned care coordinator and contact information. CHL's Emergency Services, ACCS,*

CSU, and BH outpatient services use this alert regularly to notify care coordinators when an enrollee needs support or there has been changes in the community status."

Improving members' health and wellness

As previously noted, CHL care coordinators incorporate wellness goals into member care plans and strive to match members with an intervention that matches their goals. CHL members can participate in PCP wellness coaching via CHL's well-established referral networks or the BH CP's wellness classes and walking groups. Additionally, CHL staff are knowledgeable about community-based wellness opportunities that members can take advantage of such as YMCA memberships, local recreation programs, nutrition consultation, and stress management seminars. CHL staff stay up to date on these programs and on programs within the ACO/MCO (e.g., weight management services) through regularly scheduled resource updates during staff meetings.

Continuous quality improvement

CHL's Idea System, which is a facet of the Lean process improvement method, allows for staff ideas to come forward and focuses staff on organizational goals related to client access and quality of care. CHL's TA project, by combining claims data with data from their EHR, will advance this effort with interventions specifically designed to address health outcomes.

To measure member experience, CHL administers a client survey. One of the ways in which CHL promotes a positive member experience is by rewarding members with gift cards for attending primary care appointments and completing their care plan goals. CHL also maintains a CAB as a method to promote continuous quality and member experience improvement.

Recommendations

The IA encourages CHL 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:

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

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[12];
- 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.

[12] 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[13];
    - 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;

[13] 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 CHL is On track with limited recommendations across all five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration.

The IA encourages CHL to review its practices in the following aspects of the focus areas, for which the IA did not identify sufficient documentation to assess or confirm progress:

Organizational Structure and Engagement

- holding regular meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies.

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.

Workforce Development

- implementing additional strategies such as staff incentive programs to retain staff.

Health Information Technology and Exchange

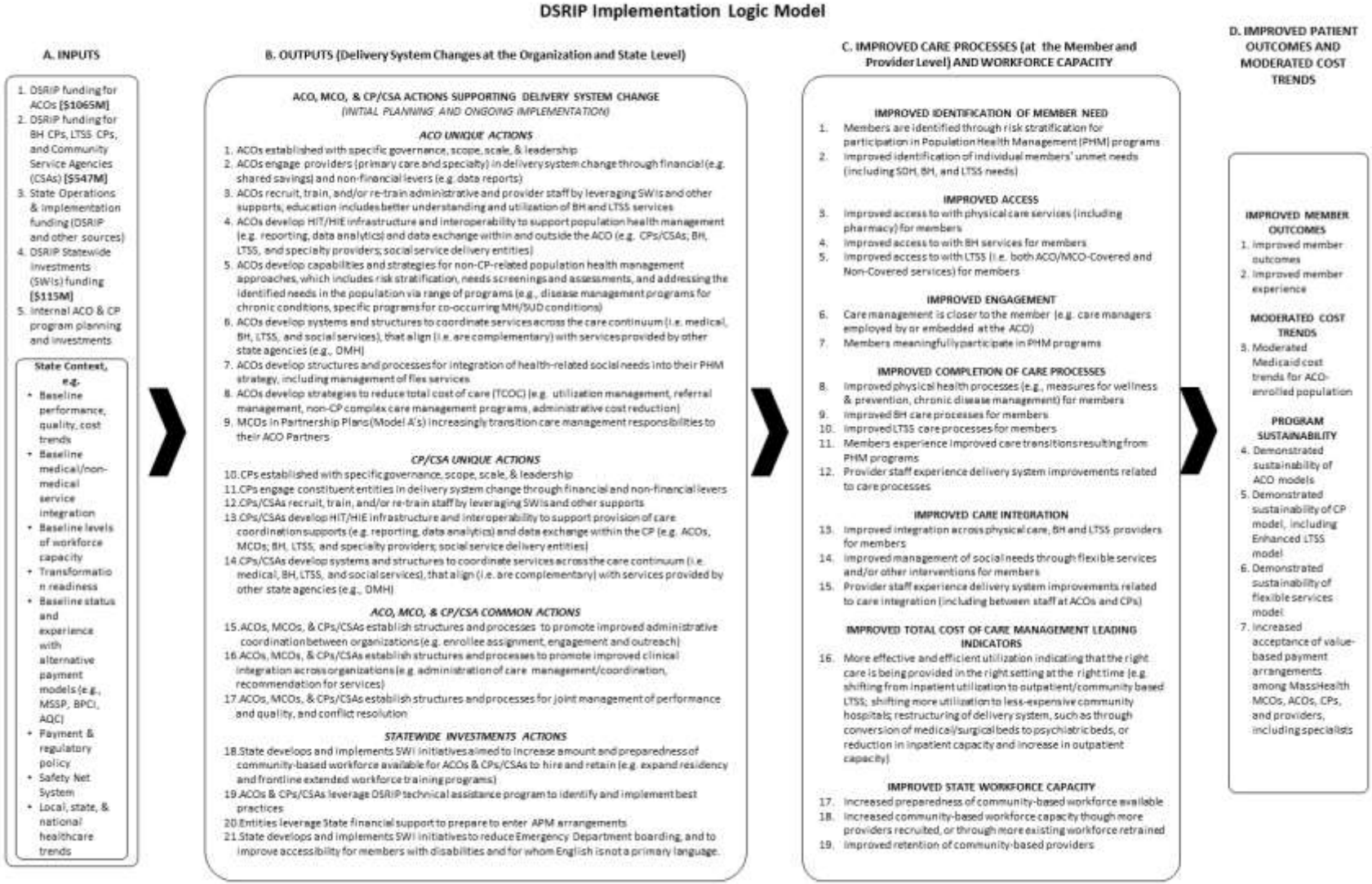
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;
- using ENS/ADT alerts and integrating ENS notifications into the care management platform; and
- developing a data dashboard that displays performance on key quality metrics in real time.

Care Model

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

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, and key informant interviews (KIIs) to assess progress of Community Partners (CPs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019. Note that the CP program was implemented July 18, 2018.

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[14] (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

[14] 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.[15] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[15] KII were developed by the IE and conducted jointly by the IE and the IA. The IA utilized the KII transcripts as a secondary data source; the IA did not perform a full qualitative analysis of the KII.

APPENDIX III: ACRONYM GLOSSARY

ACPP	Accountable Care Partnership Plan
CP	Accountable Care Organization
ADT	Admission, Discharge, Transfer
AP	Affiliated Partner
APR	Annual Progress Report
BH CP	Behavioral Health Community Partner
CAB	Consumer Advisory Board
CCCM	Care Coordination & Care Management
CCM	Complex Care Management
CE	Consortium Entity
CHA	Community Health Advocate
CHEC	Community Health Education Center
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CSA	Community Service Agency
CWA	Community Wellness Advocate
DMH	Department of Mental Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
ENS	Event Notification Service
EOHHS	Executive Office of Health and Human Services
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HLHC	Hospital-Licensed Health Centers
HRSN	Health-Related Social Need
HSIMS	Health Systems and Integration Manager Survey
IA	Independent Assessor
IE	Independent Evaluator
JOC	Joint Operating Committee
KII	Key Informant Interview
LGBTQ	lesbian, gay, bisexual, transgender, queer, questioning
LCSW	Licensed Independent Clinical Social Worker
LPN	Licensed Practical Nurse
LTSS CP	Long Term Services and Supports Community Partner
MAeHC	Massachusetts eHealth Collaborative
MAT	Medication for Addiction Treatment
MCO	Managed Care Organization

MPA	Midpoint Assessment
NCQA	National Committee for Quality Assurance
OBAT	Office-Based Addiction Treatment
PCP	Primary Care Provider
PFAC	Patient and Family Advisory Committee
PHM	Population Health Management
PT-1	MassHealth Transportation Program
QI	Quality Improvement
QMC	Quality Management Committee
RN	Registered Nurse
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SVP	Senior Vice President
SWI	Statewide Investments
TCOC	Total Cost of Care
VNA	Visiting Nurse Association

APPENDIX IV: CP COMMENT

Each CP was provided with the opportunity to review their individual MPA report. The CP had a two week comment period, during which it had the option of making a statement about the report. CPs were provided with a form and instructions for submitting requests for correction (e.g., typos) and a comment of 1,000 word or less. CPs were instructed that the comment may be attached as an appendix to the public-facing report, at the discretion of MassHealth and the IA.

Comments and requests for correction were reviewed by the IA and by MassHealth. If the CP submitted a comment, it is provided below. If the CP requested a minor clarification in the narrative that added useful detail or context but had no bearing on the findings, the IA made the requested change. If a request for correction or change had the potential to impact the findings, the IA reviewed the MPA data sources again and attempted to identify documentation in support of the requested change. If documentation was identified, the change was made. If documentation was not identified, no change was made to the report but the information provided by the CP in the request for correction is shown below.

CP Comment

None submitted.