MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Boston Allied Partners

(BAP)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Boston Allied Partners (BAP)

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A Long-Term Services and Supports Community Partner

Organization Overview

Boston Allied Partners (BAP) is a partnership of Boston Medical Center (BMC) and the three Aging Services Access Points (ASAPs) that serve over 33,000 people across Boston annually: Boston Senior Home Care, Central Boston Elder Services, and Southwest Boston Senior Services (known as Ethos). BAP provides home-based care services and supports for children and adults that have long term services and supports (LTSS) needs. The ASAPs provide direct services to older adults, such as interdisciplinary case management and investigate abuse and neglect of elders.

SERVICE AREA

POPULATIONS SERVED

- BAP's team speaks over 20 languages and is focused on providing culturally sensitive engagement and care to meet the needs of individuals with complex LTSS needs, brain injury or cognitive impairments, physical disabilities, intellectual and developmental disabilities (I/DD) including autism, and older adults (up to age 64). BAP has expertise serving children, youth and adults with LTSS needs, addressing social determinants of health, and transitioning pediatric patients to adult services.

1,004

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- BAP integrated admission/discharge/transfer feeds, claims data, patient roster data, and patient eligibility data from the state into their electronic health record.
- BAP improved member engagement rates by hiring an outreach coordinator and instituting a schedule for a minimum of five outreach attempts per member.
- BAP built relationships with nurse care managers at Boston Medical Center HealthNet Plan practices and Tufts Health Public Plans practices.

Statewide Investment Utilization:

- 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]

Boston Allied Partners (BAP) is a Long-Term Services and Supports (LTSS) CP.

BAP is a partnership of Boston Medical Center (BMC) and the three Aging Services Access Points (ASAPs) that serve the Boston area: Boston Senior Home Care, Central Boston Elder Services, and Southwest Boston Senior Services (known as Ethos). Collectively, these ASAPs and BMC care for over 33,000 people across Boston annually. As a LTSS CP, BAP provides care coordination and navigation to members ages 3 to 64 who have complex LTSS needs.

BAP's primary service area is Greater Boston, which includes all neighborhoods in the city of Boston as well as the city of Brookline. BMC and BAP's ASAPs have the capacity to communicate with members in over 20 languages with the assistance of BMC's Interpreter Services Department. BAP is focused on providing culturally sensitive engagement and care to meet the needs of individuals with complex LTSS needs due to physical disabilities, and intellectual and developmental disabilities (I/DD) including autism. BAP has expertise addressing social determinants of health and transitioning pediatric patients to adult services.

As of December 2019, 1,004 members were enrolled with BAP[3].

SUMMARY OF FINDINGS

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

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track 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 BAP is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

BAP has a Joint Operating Committee (JOC) that includes representatives from all APs and serves as the governing body for its CP program. The committee meets bi-monthly to ensure APs stay engaged in programmatic decision making.

BMC employs a Program Manager and Program Director to provide leadership and oversight of the BAP program. The BAP Management Team holds weekly check-ins with frontline staff to identify barriers to and facilitators of BAP's success and reports this information to the JOC.

[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.

Consumer Advisory Board

In 2018, BAP sought the help of BMC's Community Engagement program to help them establish the framework, goals, and expectations for their CAB. BMC's CE program staff implemented multiple patient advisory boards and similar groups for research purposes at BMC. Community engagement staff recommended that BAP develop a CAB charter and establish ground rules for meetings as a way of increasing member involvement and maintaining a safe space for discussion. CE staff also recommended that BAP aim to recruit eight to ten CAB members who could commit to at least a year of service. The first CAB meeting was held in 2018, and BAP reports that in 2019 they had consistent membership with six to ten members present at every meeting, representing their adult and pediatric enrollee population. At the meetings, BAP staff explained the purpose of the CAB and collaboratively set expectations and goals with members.

Through CAB meetings, BAP aimed to elicit constructive feedback about their supports, staff, and communication methods; to learn more about the demographics of the member population; and to identify gaps in services. BAP reserves meeting time for member feedback and reported that all members provided constructive feedback about the program.

Quality Management Committee

BAP's QMC includes representatives from each AP. The QMC meets quarterly to conduct the following activities: audit case records; review Executive Office of Health and Human Services (EOHHS) quality data on prevention and wellness, member care experience, avoidable utilization, integration, and engagement; and identify new quality targets and action plans with the BAP Management Team. The QMC also determines baselines and conducts statistical analyses to examine changes in performance every six months. The QMC reports results to the Program Director, JOC, EOHHS, ACO/MCO partners, and BMC as warranted.

In 2019, BAP reports their main challenge in developing QI initiatives was the lack of baseline or benchmark data for their quality measures slate. Program leadership monitors Qualifying Activities[5] (QA) traffic to track their billing but reports not having access to verified MassHealth claims data, making it difficult to initiate programmatic improvements. BAP received comparative data from EOHHS site visits and uses this data to compare their performance against the CP program averages. Despite these challenges, BAP set goals of submitting QAs for <65% of its members each quarter and engaging all members within 3-6 months of assignment.

Recommendations

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

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

✓ **Executive Board**

- holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
- conducting one-on-one quarterly site visits with APs and CEs;
- holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;

[5] Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow up after discharge, and health and wellness coaching.

- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[6] Joint Operating Committee;
- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

✓ **Consumer Advisory Board**

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

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
- integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and

[6] For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

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

Joint approach to member engagement

BAP's care coordinators send member information to ACO/MCO partners via secure file transfer protocol (SFTP) and receive electronic health record (EHR) alerts when partners return data through an SFTP upload. BAP has a centralized administrative assistant to help care coordinators transmit files, but individual care coordinators are responsible for communicating with the ACO care management team and the PCP care team to obtain sign-off on care plans.

BAP reports that, on average, it takes three to four weeks for PCPs to sign care plans. One challenge preventing BAP from obtaining timely sign-off is discerning whether the ACO care team or the individual PCP is the main point of contact for the ACO. At times, both entities request that the CP copy them on care plan transmissions. In addition, some PCPs refuse BAP's request to share contact information for hard-to-reach members prior to care plan development and require in-person visits before signing off on a care plan. In 2019, BAP employed a systematic approach to engage PCPs in care plan sign-off by implementing a single point of contact and PCP Designee method with some ACO partners.

In 2019, BAP hired an Outreach Coordinator to complete all outreach activities for new referrals as well as schedule care coordination appointments for interested members. BAP redesigned their workflows in their EHR so that receipt of a comprehensive assessment generates a new outreach attempt. These changes improved member engagement and allows BAP to share more accurate member contact information with their ACO/MCO partners.

BAP staff process an enrollment/disenrollment report manually at the end of each month and review the refresh file against their own active member panel in the middle of each month.

Integration with ACOs and MCOs

BAP attends quarterly meetings with ACOs/MCOs in which they discuss ways to improve current processes and workflows.

BAP has monthly check-in calls with ACO central teams to discuss members who are hard to reach, ready to graduate from the CP program, disengaged, and disenrolled. BAP care coordinators achieved care team integration with ACO central teams by forming working partnerships with nurse care managers at Boston Medical Center HealthNet Plan (BMCHP) and Tufts Health Public Plans (THPP). BAP saw an increase in ACO/MCO requests for planned integrated care team meetings to discuss successes and challenges for members on the panels. BAP also has internal bi-monthly case review meetings with all four of its APs.

BAP utilized DSRIP funds to add ADT integration to their care management platform. This integration pushes ENS notifications into the EHR, notifying care coordinators of ADT data as soon as BAP receives them. In-app notifications facilitate timely review.

> CP Administrator Perspective: "*[There is a] bi-monthly Case Review meeting that is mandatory for all program staff to attend. Case Review has proven to be an effective method for cross-site communication about program updates and a forum for staff to discuss cases that are going well and cases that they could use advice or help on."*

Joint management of performance and quality

In 2019, BAP implemented a data-driven QI initiative with its APs to reduce the time to engage new members within six months of assignment.

To facilitate comprehensive care plan review by PCPs, BAP maintains a policy of sending weekly updates to all ACO partners that list members who recently signed a participation form, members who have an outstanding comprehensive assessment, and members who have unsigned care plans that are due or overdue.

BAP's EHR creates custom reports that track a variety of metrics including QAs[7] comprehensive assessments, signed participation plans, member care plans, and demographic information on their

[7] Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow-up after discharge, and health and wellness coaching.

member population. In 2019, BAP developed the ability to export these EHR reports in a format that is both readable and measurable, providing on-demand information to their ACO/MCO partners and their four AP organizations. BAP's ACO/MCO partners indicated that these monthly reports are useful.

BAP's Management Team also holds weekly check-ins with frontline staff to identify barriers and facilitators to providing care coordination supports for BAP's member population. Check-ins allow the Management Team to focus on challenges that require timely solutions, such as the need to build new collaborations with specific providers.

Recommendations

The IA encourages BAP 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 BAP is **On track with limited recommendations** in the Workforce Development focus area.

Recruitment and retention

BAP experienced persistent vacancies in staffing due to difficulty hiring qualified care coordinators and high turnover in the first year of the program. BAP reports that competition from ACOs/MCOs in their geographic area hiring for similar positions contributed to the vacancies. BAP also struggled to find bilingual care coordinators with experience in the healthcare or social services fields.

BAP's recruitment strategies include posting on job and social media sites, advertising in local newspapers, sending targeted postcard mailings, and reaching out to college career centers to introduce human services professions. Each of BAP's APs must recruit and hire their own care coordinators, but BAP assisted APs by setting standardized salary rates and job expectations for care coordination staff across all partners, regardless of whether they are part-time or full-time.

BAP had significant staff turnover early in the program. Three of the ten original care coordinators in the program left the organization in 2018. BAP remained understaffed until June of 2019 when they rehired to full capacity. One reason for high turnover were the large patient panels that had to be maintained by care coordinators while BAP was understaffed.

BAP utilized Statewide Investment (SWI) 1a to offer loan assistance to three of its staff and has built year-end retention bonuses into its budget. BAP pays competitive salaries and ensures that all full-time and part-time employees make a living wage. In addition, all BAP staff have access to generous benefits through the BMC Select plan.

Training

BAP offers in-person and web-based programs to train new staff on all contractually required elements of the CP program. BAP completed the following in-person trainings in 2019: motivational

interviewing; Medicaid fraud, waste, and abuse; conflict of interest; health and wellness principles; and an overview of BAP and the LTSS CP program. BAP's care coordination staff receive online training on cultural competency and person-centered planning. Additionally, BAP is using direct Technical Assistance SWI funding to cross-train all care coordinators to provide CP supports to enrolled members representing multiple generations from the same family. To track participation, the BAP Management Team gives staff a list of required trainings, a schedule for in-person trainings, and the due dates for completion of each module.

BAP holds a mandatory bi-monthly case review meeting for all program staff which provides an opportunity for effective cross-site communication about best practices and advancements in the field.

Recommendations

The IA encourages BAP 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:

- exploring additional recruitment and retention strategies to avoid persistent vacancies in planned positions;
- creating a plan to increase diversity in the workplace; and
- designing incentives that support CP priorities.

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

✓ **Promoting diversity in the workplace**

- compensating staff with bilingual capabilities at a higher rate.
- establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
- advertising in publications tailored to non-English speaking populations;
- attending minority focused career fairs;
- recruiting from diversity-driven college career organizations;
- tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
- implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
- advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers; and
- recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.

✓ **Recruitment and retention**

- implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;

- assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;
- conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention;
- making staff retention a priority initiative of the QMC to leverage existing quality improvement structures and engage leadership to monitor progress towards retention goals;
- implementing opportunities for peer mentoring and other supports; For example, scheduling office hours that allow care coordinators to network and receive support from experienced staff and/or have direct communication with CP leadership;
- reducing staff training burden by allowing experienced staff to test of out of basic training exercises and instead participate in more advanced training modules;
- instituting a management training program to provide lower level staff a path to promotion;
- allowing flexible work hours and work from home options for care coordination staff;
- striving to maintain a balanced ratio of care coordinators to members served, to avoid unmanageable workloads and staff burnout;
- offering retention bonuses to staff that are separate from performance-based bonuses; and
- participating in SWI loan assistance for qualified professional staff.

✓ **Training**

- providing staff with paid time to attend outside trainings that support operational and performance goals;
- assessing the effectiveness of training modules at least annually to ensure that staff felt the module's objectives were met and that staff are getting what they need to fill knowledge or skill gaps;
- updating training modules on an annual basis to ensure they reflect the latest best practices;
- developing a learning management system that tracks staff's completion of required trainings and provides online access to additional on-demand training modules;
- including role-playing exercises in trainings to reinforce best practices of key skills;
- partnering with local educational institutions to provide staff access to professional certification training programs;
- providing new staff with opportunities to shadow experienced care coordinators in the field prior to taking on their own caseload to build tangible skills and foster relationships between team members; and
- making use of online trainings designed and offered by MassHealth.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

- ✓ **Implementation of EHR and care management platform**
    - uses ENS/ADT alerts and integrates ENS notifications into the care management platform.
- ✓ **Interoperability and data exchange**
    - uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
    - uses Mass HIway[8] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.
- ✓ **Data analytics**
    - develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and
    - reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Results

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

Implementation of EHR and care management platform

BAP uses BMC's cloud based EHR, which connects to their care management platform. In 2019, BAP utilized DSRIP funds to add ADT integration to their care management platform. This integration pushes ENS notifications directly into member records within the EHR, notifying care coordinators of ADT data.

Interoperability and data exchange

BAP primarily uses SFTP to send and receive files from ACO/MCO partners. BAP's care management platform digests data, uploads it to the SFTP site, and notifies care coordinators of transmission or receipt automatically. When information is uploaded by BAP, a notification can be sent to the ACO/MCO partner if the partner is interactive on BAP's specific care management platform. BAP does not note any specific difficulties in getting ACO/MCO partners to use their SFTP site.

BAP's Management Team has access to Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plans EHR, facilitating communication and integration with this partner.

BAP reports the LTSS CP program is able to share and/or receive member contact information electronically from all ACOs and MCOs and most PCPs and is able to share and/or receive

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

comprehensive needs assessments electronically with all ACOs and MCOs but very few PCPs. BAP is able to share and/or receive member care plans electronically with all ACOs, MCOs, and PCPs.

Data analytics

BAP began developing custom reports within their care management platform in 2018 to measure their progress against the quality measures. The BAP Management Team is responsible for generating QI targets and the QMC reviews progress at least quarterly. BAP has the capacity to generate reports on demographics of their member population, billing activity, completed comprehensive assessment counts, signed participation form counts, and historic caseloads. This data allows BAP to predict revenue and potential shortfalls.

Recommendations

The IA encourages BAP 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:

- developing a plan to increase active utilization of Mass HIway; and
- developing a continuously refreshed dashboard, overseen by a multidisciplinary team, to monitor performance on key quality metrics.

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

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

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

✓ **Interoperability and data exchange**

- developing electronic information exchange capabilities that enable a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email; and
- connecting with regional Health Information Exchanges (HIEs).

✓ **Data analytics**

- designing a data warehouse to store documentation and performance data from multiple sources in a central location that can underwrite a performance dashboard;
- incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress;
- updating dashboards daily for use by supervisors, management, and the QMC; and
- incorporating Healthcare Effectiveness Data and Information Set metrics into dashboards to support integration with ACO/MCO partners.

5. CARE MODEL

On Track Description

Characteristics of CPs considered On track:

- ✓ **Outreach and engagement strategies**
    - ensures staff are providing supports that are tailored to and reflective of the population racially, ethnically and linguistically;
    - 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 BAP is **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

BAP accommodates members with limited English proficiency through extensive language assistance services. The BMC Interpreter Services Department provides face-to-face interpreters in 21 spoken languages, American Sign Language, and Certified Deaf Interpreting and utilizes telephonic and video interpreting. BAP also reports using a vendor for interpretation and requests interpretation services from the ACO partners in some cases. For those with mobility challenges or cultural preferences that prevent staff from entering a member's home, BAP has engaged a platform that allows members to join care meetings by HIPAA[9]-compliant video chat.

Some of BAP's staff have participated in the Comprehensive Outreach Education Certificate program, an 80-hour training program that covers the core competencies needed by CHWs to provide effective

[9] Health Insurance Portability and Accountability Act

community outreach in community-based settings. BAP care coordinators and the Outreach Coordinator obtain information from shelters and day programs about the homeless and precariously housed population.

Person-centered care model

BAP incorporates member goals into the LTSS care plan. BAP care coordinators guide members through a conversation about their goals by identifying their needs. Questions BAP staff may ask members include: Would you like to have additional help with homemaking, laundry, or transportation? Would a Personal Care Attendant improve your quality of life and ability to remain at home? Could a family member assist with household duties or Activities of Daily Living (ADL)? Would you like to stop smoking, or improve exercise habits? Would you like to become stronger and more able to handle activities of daily living? Would you like to reduce the number of medications you must depend upon? What personal strengths can you build upon in service to these goals?

BAP care coordinators discuss member goals with the PCP care team and create a care plan based on both sets of priorities. Once the member approves of the care plan, BAP staff send it to the PCP for final approval. Care coordinators communicate monthly with members and providers to track progress on care plan goals.

Care coordinators receive intensive training and ongoing supervision on the use of motivational interviewing, a person-centered modality used to motivate and empower enrollees to remain active and engaged in achieving their goals.

Managing transitions of care

As previously noted, BAP receives ADT data through its care management platform from an ENS vendor. BAP states these mobile notifications increase care coordinators' ability to conduct outreach to members and trigger BAP's protocol for managing transitions of care. The protocol is as follows: When an ADT notification is received, BAP staff first reach out to the member by phone and then, if this is unsuccessful, make an unannounced home visit to the member. If the care coordinator cannot reach the member by phone or in-person, they will contact the member's PCP and ACO transitions of care team to discuss next steps in supporting the member's care.

BAP has a dedicated Transition Coordinator located at BMC to manage transitions from pediatric to adult care.

Improving members' health and wellness

The content of BAP's health and wellness coaching is driven by the recommendations from the ACO, and BAP staff will use motivational interviewing to move members forward on the stages of change continuum[10] (Precontemplation, Contemplation, Preparation, Action, Maintenance) with respect to healthy habits and behaviors.

BAP's three ASAPs offer evidence-based programs and workshops to CP members to promote health, prevent disease, and support independent living. Among the topics covered are fall prevention (e.g., A Matter of Balance; Tai Chi for Healthy Aging), chronic disease self-management (e.g., My Life, My Health, Diabetes Self-Management), family caregiving (e.g., Powerful Tools for Caregivers), depression management (e.g., Healthy Ideas), brain health (e.g., Stay Sharp) and nutrition (e.g., Healthy Eating for Success).

[10] The Transtheoretical Model (also called the Stages of Change Model) was developed by Prochaska and DiClemente in the late 1970s. The Transtheoretical Model posits that individuals move through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. For each stage of change, different intervention strategies are most effective at moving the person to the next stage of change and subsequently through the model to maintenance, the ideal stage of behavior.

BAP care coordinators are trained to identify and access key LTSS resources. BAP contracted with a national database of community resources to develop a library of preferred social service agencies and LTSS providers for each ACO/MCO. BAP care coordinators also have access to BMC's searchable database of over 150 community resource providers. BMC's database contains contact information for providers of income supports, housing, education, employment, legal services, and personal safety. BAP staff also have monthly case review meetings with the Medical Legal Partnership of Boston staff to assist with member issues pertaining to housing that are of a legal nature.

> CP Administrator's Perspective: "*[According to feedback from the CAB,] BAP care coordinators helped members the most with DME [durable medical equipment] requests, transportation needs[11], and navigating their health insurance benefits. Some members have been assigned social workers in the past but did not feel that there was enough follow through compared to the LTSS CP Program. Members like that their care coordinator is checking in to make sure they were able to get to their appointments, connect to the resources they need, and if they have made progress on established goals."*

Continuous quality improvement

BAP's CAB is one vehicle for enabling continuous QI in member experience for the CP program. BAP is unique in that its CAB members serve on the CAB for at least a year. BAP reports that members have provided constructive feedback on their experience working with BAP CP care coordinators.

BAP's annual program evaluation enables continuous QI in member experience and quality of care. The annual program evaluation is reviewed by the BAP Management Team and QMC. The annual evaluation is focused on identifying the most effective LTSS supports and services as well as the CP members at the highest risk for hospital admissions.

Recommendations

The IA encourages BAP 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; and
- establishing processes that make warm handoffs between transitions of care teams and CP care team routine.

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];

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

- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

✓ **Person-centered care model**

- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
- setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
- developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and
- 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.

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

- ✓ **Continuous quality improvement**
    - providing a “Passport to Health” to members that contains health and emergency contact information and serves as the member’s advance directive in healthcare emergencies and transitions of care;
    - administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;
    - scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and
    - creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

OVERALL FINDINGS AND RECOMMENDATIONS

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

- Organizational Structure and Engagement

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

Integration of Systems and Processes

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

Workforce Development

- exploring additional recruitment and retention strategies to avoid persistent vacancies in planned positions;
- creating a plan to increase diversity in the workplace; and
- designing incentives that support CP priorities.

Health Information Technology and Exchange

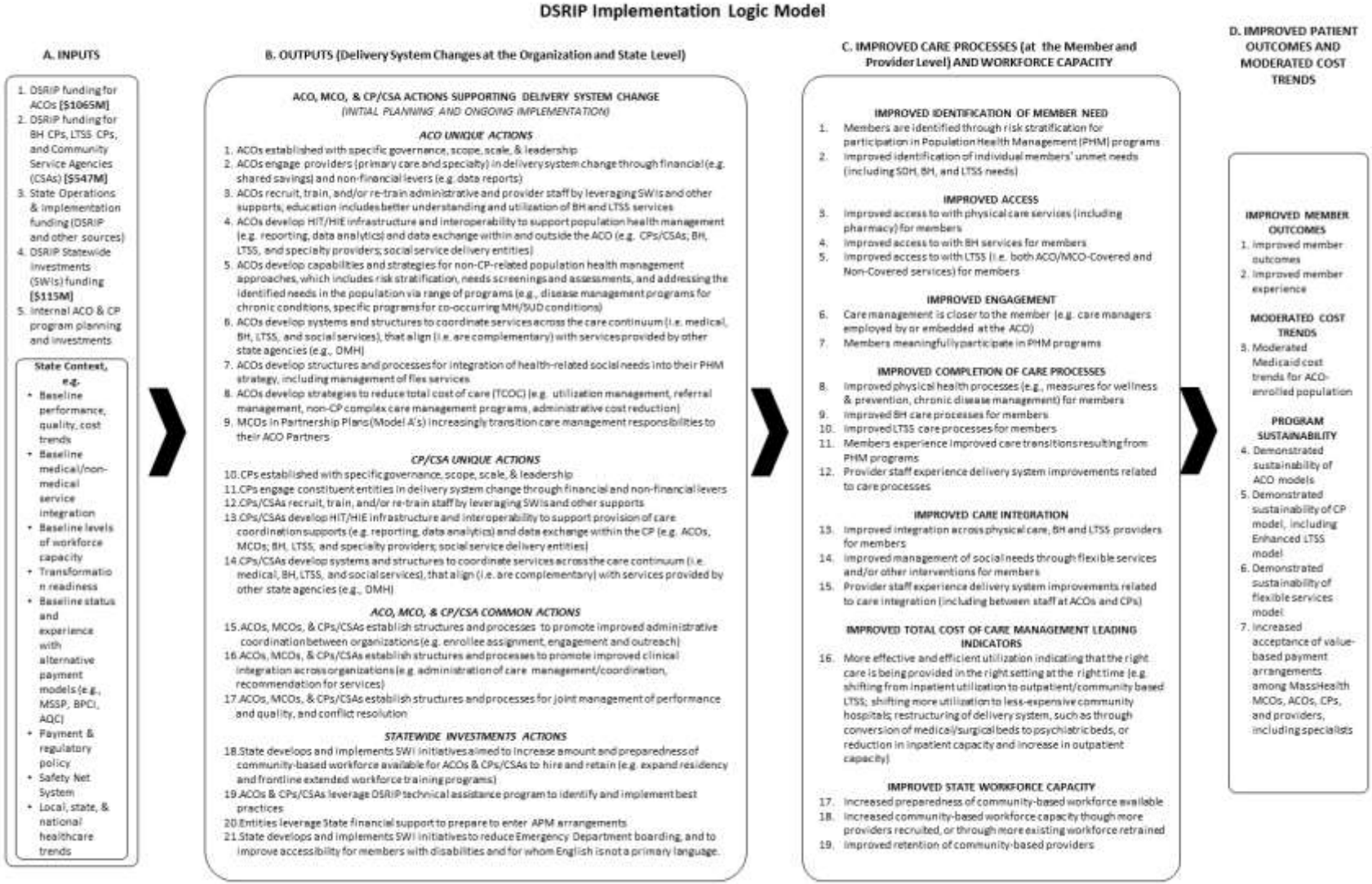
- developing a plan to increase active utilization of Mass HIway; and
- developing a continuously refreshed dashboard, overseen by a multidisciplinary team, to monitor performance on key quality metrics.

Care Model

- developing a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations; and
- establishing processes that make warm handoffs between transitions of care teams and CP care team routine.

BAP 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.