MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Boston Coordinated Care Hub (BCCH)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Boston Coordinated Care Hub (BCCH)

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A Behavioral Health Community Partner

Organization Overview

BCCH combines expertise from nine community-based organizations to deliver primary care, behavioral health care, social services, housing, and shelter services. The member organizations, and the Massachusetts Housing and Shelter Alliance have worked together since 2013 and are legally bound through an Organized Health Care Agreement.

SERVICE AREA

POPULATIONS SERVED

- BCCH works with vulnerable, highly marginalized populations including those with serious mental illness, substance use disorders, chronic illnesses, and health related social needs, including a critical mass of homeless individuals in the Boston-Prime Service Area.
- Around half of the population served have cooccurring mental illness and substance use disorders, and greater than one-third had over six ED visits in the past year.

1,111

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- In the second half of 2019, BCCH established read only access to ACOs' electronic health records for Affiliated Partner care coordinators.
- BCCH formed a workgroup with a partner ACO to develop quality improvement plans for several measures, and to bridge their systems to improve these measures and share best practices.
- BCCH established the Hub which collects and stores enrollee consent, comprehensive assessments, and person-centered treatment plans. The CP also created a housing status dashboard with data at the enrollee level and at the ACO level to help track progress moving members along the housing continuum.

Statewide Investment Utilization:

- Student Loan Repayment Program, 4 Care Coordinators participating
- Special Projects Program
- Certified Peer Specialist Trainings
- Community Health Worker Trainings
- Technical Assistance
- CP Recruitment Incentive Program

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

[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 Coordinated Care Hub (BCCH) is a behavioral health (BH) CP.

BCCH combines expertise from nine long-standing, community-based organizations in Boston to deliver primary care, behavioral health care, social services, housing, and shelter services. The nine Affiliated Partners (APs) and the Massachusetts Housing and Shelter Alliance (MHSA), have worked together since 2013 and are legally bound through an Organized Health Care Agreement.[3] Data infrastructure and legal agreements allow for data sharing for integrated care coordination and performance feedback at all levels. In their capacity as a BH CP, the APs provide supports to high need individuals.

BCCH's primary service area is the greater Boston area. BCCH works with vulnerable, highly marginalized populations including those with serious mental illness (SMI), substance use disorders (SUD), chronic illnesses, health-related social needs, and individuals experiencing homelessness in the Boston primary service area. Around half of the population served have co-occurring mental illnesses and SUD, and greater than one-third had over six emergency department (ED) visits in the past year.

As of December 2019, 1,111 members were enrolled with BCCH[4].

SUMMARY OF FINDINGS

The IA finds that BCCH 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
Workforce Development	On track
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] 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.

[4] 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).
- ✓ **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 BCCH is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

BCCH and its APs have been convening since 2013. BCCH engages its partner organizations in monthly meetings to review the CP's assignment list and assign member outreach to specific APs. The IA did not receive sufficient documentation to identify the titles or number of CP leadership staff who attend these meetings.

Consumer Advisory Board

BCCH established a CAB in 2018 and continues to engage membership completing five meetings in 2019. Despite reported challenges related to CAB member turnover and the inability to locate certain CAB members, BCCH has had two to five CAB members attend each scheduled meeting. BCCH incentivizes members' CAB participation with a $20 travel stipend and a catered lunch at each meeting. BCCH has also changed the time of CAB meetings to earlier in the day so that attendance does not prevent members from queuing at homeless shelters in the mid-afternoon.

CP care coordinators and nurse care managers recruited potential CAB members. CP staff focused on recruiting a group representative of the CP's member population with regard to racial, ethnic, and linguistic diversity, composed of members who are engaged with the CP, and can inform BH CP policies.

Quality Management Committee

BCCH leverages Boston Health Care for the Homeless' Quality and Efficiency Committee which functions as its QMC that is led by the CP's Chief Medical Officer and has a membership comprised of clinicians, site leaders, CP management staff, and BCCH's Compliance Officer. BCCH developed a QI initiative focused on ACO quality measures and collaborates with Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan on QI plans. For a select number of quality measures, BCCH sets an annual goal and the QMC monitors progress towards that goal. BCCH's Quality Data Analyst tracks data associated with the quality measures, produces reports that demonstrate progress towards annual goals, and provides feedback on the CP's performance to clinicians and care coordinator teams.

Recommendations

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

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

- ✓ **Executive Board**
    - holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
    - conducting one-on-one quarterly site visits with APs and CEs;
    - holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
    - identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[5] 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;

[5] 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.

- 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 BCCH is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

BCCH exchanges care plans and other member files with ACO/MCO partners through Secure File Transfer Protocol (SFTP), secure email, a secure file-sharing application.

Despite early challenges to obtaining care plan sign off, ACOs/MCOs have become more familiar with the care plan approval process over time. These organizations are now able to assist the CP throughout the care plan approval process.

ACO/MCO partners share member contact data when BCCH requests it. Additionally, BCCH accesses member contact information through their access to ENS/ADT notifications, as this information is typically the most recent and accurate.

BCCH's Data Systems Project Manager reviews ACO/MCO member spreadsheets weekly, contacts ACOs for additional member information, triages ACO data requests, and makes referrals to ACOs. BCCH leverages BHCHP's electronic health record (EHRs) to identify when shared members have upcoming appointments which is helpful in identifying when members have upcoming appointments for outreach purposes and for supporting members during their appointments. All but one ACO partner allows BCCH staff to conduct outreach in their waiting rooms.

Integration with ACOs and MCOs

BCCH attends quarterly meetings with ACO/MCO partners to discuss operations and the engagement status of shared members. In 2019, BCCH began sharing housing data with ACO/MCO partners, generating ACO/MCO-specific reports of where their shared members were on the housing continuum.

BCCH conducts monthly case conferences with relevant clinicians and staff at a local hospital for members with high utilization. The CP's Program Director and Clinical Program Manager develop the agenda and materials for these meetings. BCCH's goal for each case conference is to develop an acute care plan for members with high utilization that will help guide ED and inpatient practices and

ensure that the outpatient team is involved in discharge planning. Additionally, BCCH conducts biweekly case conferences with Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan. These integrated case conferences bring staff from the CP, EDs, outpatient clinics, and the ACO together to discuss the complex care needs of members experiencing homelessness.

To facilitate clinical integration, BCCH nurse care managers and care coordinators receive ENS/ADT notifications through email or text message, which allows them to follow-up with the member upon admission or discharge in a timely manner.

Joint management of performance and quality

In addition to reviewing the outreach and engagement measures tracked by MassHealth, BCCH developed internal measures to understand the CP's performance on outreach and engagement and identify ways that it can improve its program. BCCH uses claims data and records from the CP's EHR and care management platform to calculate these measures. BCCH formed a workgroup with Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan to develop strategies to improve performance on these measures.

To support care coordinators in their efforts to engage PCPs in care plan review, BCCH worked with ACO partners to establish processes that help move the care plan through the approval process. At one ACO partner, a dedicated Medical Director expedites the approval of BCCH care plans. BCCH identified a contact person at the other ACO sites who helps escalate care approval requests with PCPs and helps obtain PCP signatures.

BCCH distributes audit reports to APs on a weekly basis. Audit reports explicate APs' performance on quality measures and identifies opportunities for improvement. BCCH maintains a dashboard that gives CP staff access to timely, informative, and actionable performance data.

> CP Administrator Perspective: "*Our data platform is hosted by the City of Boston's Department of Neighborhood Development which was originally designed to support efforts to reducing homelessness in Boston… We have added "Health" tabs that assist with outreach and communication for administrators, clinicians, and case managers to coordinate care. Since most of our enrollees have previous or current experience with homelessness and many are without phones, the Hub has been a valuable source of data in supporting face-to-face outreach by identifying where homeless individuals sleep."*

Recommendations

The IA has no recommendations for the Integration of Systems and Processes focus area.

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

Recruitment and retention

Initially, BCCH struggled to recruit and hire staff due to competition with ACOs and other CPs that were also hiring complex care staff. However, BCCH met its established hiring targets. BCCH used a combination of professional development opportunities, staff development funds, tuition reimbursement, and internal trainings to incentivize CP staff recruitment. Additionally, BCCH leveraged four DSRIP Statewide Investment (SWI) Student Loan Repayment program slots to facilitate the recruitment and retention of care coordinators.

BCCH designed a multifaceted strategy to attempt to hire diverse staff who are reflective of the communities served by the CP and meet the language needs of the member population. BCCH attended Latino-focused job fairs, started an employee referral program to increase the CP's reach among diverse communities, and worked with the CP's internal Diversity and Inclusion Committee to identify potential candidates. BCCH compensates staff fluent in Spanish, Haitian Creole, and Portuguese at a higher rate.

In addition to tuition reimbursement, BCCH utilizes a variety of mechanisms to retain CP staff. BCCH maintains staff development funds so that the CP can offer staff the opportunity to attend internal trainings and participate in professional development opportunities. To prevent burnout, BCCH reduced care coordinator and nurse care manager caseloads in response to the intense needs of the CP's member population and the strain that imposes on CP staff. In 2019, BCCH reduced staff caseloads by five members.

> CP Administrator Perspective: *"At the end of [2019], we stabilized our numbers of assigned members and had modest success reducing care coordinator and nurse care manager caseloads to better match the intense needs our BH CP population that have a high burden of substance use disorder accompanied with homelessness and housing instability. Improved staff workload will help reduce staff turnover and burnout."*

Training

BCCH established a training program for all CP staff that ensures compliance with MassHealth contractual requirements. All new staff participate in an orientation program that includes an introduction to the care management landscape at BCCH and training on the EHR system, protected health information, ACOs and health care reform, cultural competency in healthcare, quality reporting, and population health management. BCCH is responsible for delivering the orientation training for all newly hired CP staff, including staff hired at each of the APs. BCCH staff participate in ongoing trainings facilitated by both BH CP leadership and external partners. BCCH staff can attend trainings hosted by Boston Medical Center and Boston Healthcare for the Homeless.

Recommendations

The IA has no recommendations for the Workforce Development focus area.

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

- ✓ **Promoting diversity in the workplace**
  - compensating staff with bilingual capabilities at a higher rate.
  - establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
  - advertising in publications tailored to non-English speaking populations;
  - attending minority focused career fairs;

- recruiting from diversity-driven college career organizations;
- tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
- implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
- advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers; and
- recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.

✓ **Recruitment and retention**

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

✓ **Training**

- providing staff with paid time to attend outside trainings that support operational and performance goals;

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

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

- ✓ **Implementation of EHR and care management platform**
  - uses ENS/ADT alerts and integrates ENS notifications into the care management platform.
- ✓ **Interoperability and data exchange**
  - uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
  - uses Mass HIway[6] 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 BCCH is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

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

Implementation of EHR and care management platform

BCCH has implemented a care management platform and EHR across all APs and is contracted with a vendor to receive ENS/ADT notifications. ENS/ADT notifications are sent directly to BCCH nurse care managers and care coordinators. Care coordinators and nurse care managers receive ENS/ADT notifications via emails and/or text message in real-time and collaborate on discharge planning with care team members including embedded CP staff via BCCH's EHR.

Interoperability and data exchange

BCCH has the capability to exchange member files via SFTP, secure email, a secure file-sharing application, and Mass HIway. The CP reports that the method of data exchange varies based upon the established Documented Processes with the specific ACO or MCO partner. BCCH has established its connection to Mass HIway through its EHR vendor.

In its most recent progress report, BCCH noted its ability to send and/or receive member contact information, comprehensive assessments, and care plans electronically from all or nearly all ACOs, MCOs, and PCPs.

To further interoperability and data exchange efforts, BCCH's EHR is connected to other institutions that are using the same EHR software via Mass HIway. BCCH and all its APs have established read-only access to the EHR vendor's system and have been provided training on using the EHR. BCCH reports that this interoperability feature expands information sharing capacity, streamlines the outreach and care coordination processes for shared members, and allows for real-time management of referrals, transitions of care, and medication reconciliation across the system of care.

Data analytics

To oversee documentation and performance on key quality metrics, BCCH has developed "The Hub." The Hub is a centralized data warehouse that compiles data from MassHealth process metrics, CP accountability metrics, partner ACO quality metrics, the City of Boston, housing assessments, social determinants of health screenings, and CP Qualifying Activities[7]. The Hub also stores BCCH member consent forms, comprehensive assessments, and care plans. A data dashboard is embedded within The Hub and is used by BCCH staff to track progress on QI efforts. BCCH has engaged a vendor to refine the dashboard, ensuring that staff have access to timely, informative, actionable data.

BCCH has hired a full time data systems Project Manager and two part-time data analysts to build reports from data in the Hub and the CP's EHR. CP care team coordinators rely on the data dashboard within The Hub and reports generated from the CP's EHR to monitor their team's performance. Reports are also shared with the CP's QMC, a multidisciplinary team led by BCCH's Chief Medical Officer, to track progress on quality measures and established QI initiatives.

Recommendations

The IA encourages BCCH 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.

[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.

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

Outreach and engagement strategies

To contact assigned members who cannot be easily reached telephonically, BCCH has implemented several practices that prioritize face-to-face, community-based outreach with potential members. BCCH leverages Boston Health Care for the Homeless Registered Nurses (RNs) embedded within local hospital and respite facilities who help identify potential members through review of daily inpatient censuses. Additionally, in 2019, BCCH hired two outreach team coordinators to help care coordinators locate hard-to-reach members.

To ensure that BCCH is providing services that are tailored to and reflective of the member population, BCCH has implemented strategies targeted at outreaching and maintaining communication with its homeless population. To reach the CP's homeless population, BCCH utilizes homeless management information system (HMIS) data through a data sharing agreement with the City of Boston, to locate where homeless individuals are sleeping in shelters and accessing services. This information allows BCCH care coordinators to conduct face-to-face outreach with homeless members. Additionally, when HMIS data indicates that a member is frequenting a shelter operated by a BCCH AP, BCCH asks that an alert be entered in the AP's system and that shelter staff relay a message to the member that the CP is trying to make contact with them. To further meet the needs of its homeless members, BCCH distributed free cell phones[8] to enrolled members who had a signed care plan and who committed to maintaining regular communication with the CP. BCCH reports that this strategy has encouraged members' continued engagement and communication with the CP program.

To further ensure CP services are tailored to meet a member's needs, BCCH adopted BCHCP's mantra "meet the person where they are at." This includes accommodating members' disabilities and language needs. BCCH has contracted with interpretation services to support members with language needs not met by CP staff and train staff on making accommodations for members. BCCH also utilizes peer supports to assist members throughout the provision of BH CP services and activities.

> CP Administrator Perspective: "*Our decentralized BH CP Care Coordination Teams coupled with the combined footprint of our Affiliated Partners offers many advantages: 1) It gives us a leg up finding, outreaching, and enrolling the assigned BH CP enrollees face-to-face. 2) The BH Care Coordination Teams conducts a vast majority of the outreach face-to-face where they can make a personal connection and discuss the benefits of enrolling in the BH CP. This has resulted in a high rate of enrollment into the program."*

[8] CPs should first utilize Lifeline program for members as appropriate.

Person-centered care model

BCCH care coordinators engage members in all steps of the person-centered care planning process. BCCH staff make efforts to meet with members face-to-face to understand the member's needs and preferences and engage the member in care plan decision making. BCCH staff ensure that each member's decisions, goals, and specific action steps to achieve goals are documented in their care plan.

BCCH has had varying success including members' health and wellness goals in their care plan. BCCH reports that the content of care plan varies based on number of care team members involved in the development of the care plan and whether those individuals have access to the member's medical record. BCCH has reported challenges identifying the right number of medically based goals to include in the person-centered care plan and has received varying feedback from ACOs on this question. To mitigate this challenge, BCCH has retrained all staff on care plan writing and implemented a two-tiered internal review process for all BH CP care plans.

Managing transitions of care

To manage members' transitions of care, BCCH has leveraged Boston Health Care for the Homeless RNs embedded at three local hospitals and at medical respite sites and a licensed clinical social worker is embedded at a local psychiatric facility. BCCH embedded staff are responsible for monitoring BCCH member admissions, communicating about member statuses with the care coordination team via The Hub, and coordinating a warm handoff with the member's assigned care coordination team during the member's discharge from the inpatient facility.

For inpatient facilities where BCCH does not have embedded staff, the CP has focused on developing relationships with the facility's staff. BCCH works closely with the Homeless Discharge RN at Boston Medical Center. BCCH reports that open communication with the Homeless Discharge RN has led to CP staff being more aware of when the member is being discharged and where they are being discharged to, allowing the CP to more efficiently and effectively follow-up with the member and perform any necessary assessments and medication reconciliation.

Within BCCH, CP leadership is improving communication and buy-in across the care teams around care transitions. BCCH designed and implemented a care transitions training that is taught to every new employee. This training goes through what "transitions of care" entails, the importance of a supported care transition, and how CP staff can work together to promote a healthy and successful transition for the member.

Improving members' health and wellness

BCCH is comprised of nine community-based organizations that provide breadth of services to members. The CP's APs include medical, behavioral health, housing, and social services agencies. BCCH reports that these partnerships are strategic, offering members linkages to services that go beyond homeless service coordination. As an agency with a long history in its service area, BCCH has developed relationships with other community service providers that provide mental health, substance use services, LTSS, social services, and housing support. BCCH members can also access these providers to help meet their health and wellness goals.

Additionally, BCCH's AP BHCHP has expanded the CP's capacity to provide medications for opioid use disorder (MOUD) at many of its sites. BCCH accomplished this by increasing the number of providers who are waivered to prescribe MOUD and expanding its formal Office Based Addictions Treatment programs. BCCH intends for this expanded capacity to help members initiate and maintain participation in addiction treatment. BCCH has also leveraged access to BHCHP health fairs and "HER Saturdays" (Health, Empowerment, Resources), a women's health community event that

engages volunteer community partners and volunteer practitioners from local organizations, as another means of promoting member's health and wellness.

BCCH used the second half of 2019 to plan a series of trainings for CHWs focused on chronic disease management. Trainings will include information on managing diabetes, chronic obstructive pulmonary disease (COPD), and cirrhosis within the homeless population.

Continuous quality improvement

To ensure continuous QI in quality of care, BCCH's QMC meets monthly with a multidisciplinary team composed of clinicians, site leaders, and BCCH management to review progress on the slate of CP quality measures. BCCH selects key measures and goals at the beginning of each year and has chosen to focus on ACO quality measures in the first two years of the program. As a result, BCCH has improved its process for transitions of care from hospitals to shelters. BCCH helped inform Boston Medical Center's process for discharging people experiencing homelessness, including providing 'meds to bed' for those individuals being discharged to shelter and providing suggestions on how to better ensure that discharged members attend appointments with their providers after leaving the hospital.

Additionally, BCCH invested in modifications to its data dashboard so that the CP can track members' housing status and monitor progress towards moving members along the housing continuum.

BCCH monitors QI in member experience through its CAB. CAB members have focused on ways to improve transitions of care and engage more members in the BH CP.

Recommendations

The IA encourages BCCH 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:

- increasing standardization of processes for connecting members to community resources and social services where applicable.

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

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
- providing free transportation options for members to engage with services[9];
- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

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

- ✓ **Person-centered care model**
    - addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
    - setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
    - developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and
    - allowing members to attend care planning meetings by phone or teleconference.
- ✓ **Managing transitions of care**
    - assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
    - establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
    - meeting an enrollee in person once care coordinators receive alerts that they were admitted;
    - visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[10];
    - establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
    - having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.
- ✓ **Improving members' health and wellness**
    - allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;
    - negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and
    - contracting with national databases for community resources to develop a library of available supports.
- ✓ **Continuous quality improvement**
    - providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;

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

- administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;
- scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and
- creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that BCCH 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
- Integration of Systems and Processes
- Workforce Development

The IA encourages BCCH 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:

Health Information Technology and Exchange

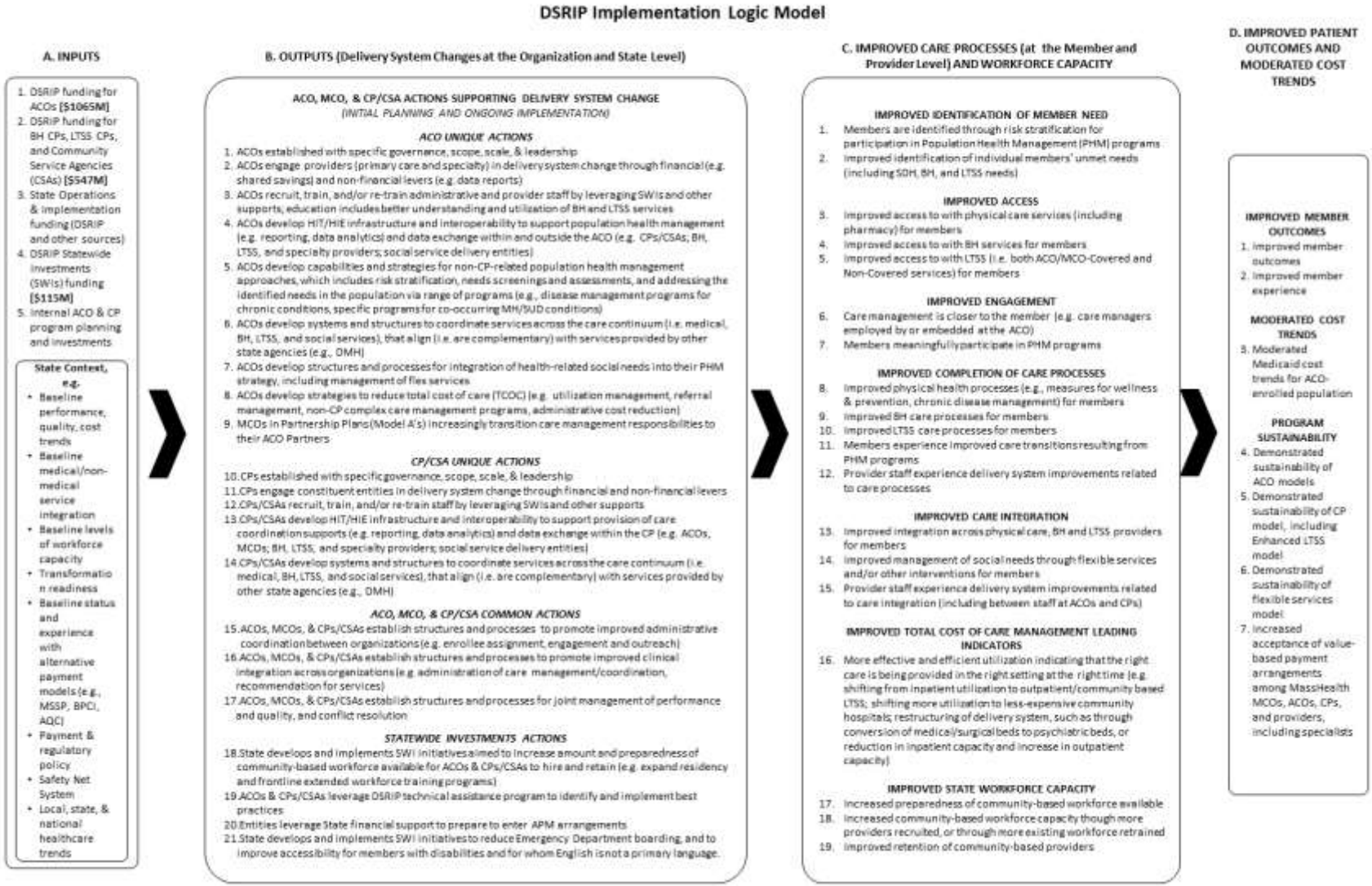
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;

Care Model

- increasing standardization of processes for connecting members to community resources and social services where applicable.

BCCH 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[11] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

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

DATA SOURCES

The MPA drew on multiple data sources to assess organizational performance in each focus area, including both historical data contained in the documents that CPs were required to submit to MassHealth, and newly collected data gathered by the IA and/or IE. The IA performed a desk review of documents that CPs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. The IE developed a protocol for CP Administrator KIIs, which were conducted jointly by the IA and the IE.

List of MPA data sources:

Documents submitted by CPs to MassHealth covering the reporting period of July 1, 2017 through December 31, 2019:

- Full Participation Plans
- Semi-annual and Annual Progress Reports
- Budgets and Budget Narratives

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

The CP MPA assessment findings cover five “focus areas” or aspects of health system transformation. These were derived from the DSRIP logic model, by grouping organizational level actions referenced in the logic model into the following domains:

1. Organizational Structure and Engagement
2. Integration of Systems and Processes

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

3. Workforce Development
4. Health Information Technology and Exchange
5. Care Model

Table 1 shows the CP actions that correspond to each focus area. This framework was used to assess each CP's progress. A rating of On track indicates that the CP has made appropriate progress in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the CP was rated "On track with limited recommendations" or, in the case of more substantial gaps, "Opportunity for improvement."

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

The CP actions are broad enough to be accomplished in a variety of ways by different CPs, and the scope of the IA is to assess progress, not to prescribe the best approach for an CP. Moreover, no pre-established benchmark is available to determine what represents adequate progress at the midpoint. The need for a realistic threshold of expected progress led the IA to use a semi-empirical approach to define the state that should be considered On track. Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans, which identified a broad range of activities and capabilities that fell within the logic model actions. This provided specific operational examples of how CPs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item, and relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality

of CPs. Items that had been accomplished by only a small number of CPs were considered to be emerging practices, and were not included in the expectations for On track performance. This calibrated the threshold for expected progress to the actual performance of the cohort as a whole.

Qualitative coding of documents to focus areas, and analysis of survey results relevant to each focus area, were used to assess whether and how each CP had accomplished the actions for each focus area. The assessment was holistic, and as such did not require that CPs meet every item on a list. A finding of On track was made where the available evidence demonstrated that the entity had accomplished all or nearly all of the expected items, and there are no recommendations for improvement. Where evidence was lacking in the results of desk review and survey, keyword searches of KII interview transcripts were used to seek additional information. Prior to finalizing the findings for an entity, the multiple reviewers convened to confirm that thresholds were applied consistently, and that the reasoning was clearly articulated and documented.

A rating of On track indicates that the CP has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated On track with limited recommendations or, in the case of more substantial gaps, Opportunity for improvement.

DATA COLLECTION

Key Informant Interviews

Key Informant Interviews (KII) of CP Administrators were conducted in order to understand the degree to which participating entities are adopting core CP competencies, the barriers to transformation, and the organization's experience with state support for transformation.[12] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Request for Change

In reference to the first paragraph of page 21:

- To mitigate this challenge, BCCH has retrained all staff on care plan writing and implemented a new section, “Issues to Consider later” as a way to mitigate these situations.

In reference to page 23:

- BCCH has a process for connecting members to community resources and social services using their collective intimate knowledge of resources in the Boston area. One way in which BCCH standardized this process is by creating a “Case management wiki” page which is updated by care coordination staff and has pages for all known resources, including directions on how to access these resources. The value in using this resource versus a national database is that it includes our working knowledge which is vital in navigating these systems to best serve members.
- BCCH also brings in organizations to help train staff on different social services such as: social security to enhance staff knowledge and keep up to date with changes. Other ways that BCCH standardizes processes for connecting members to social services is by creating relationships with organizations- example- relationship with local donor fund in which staff can apply on behalf of members for funds such as grocery cards for food insecurity or to pay for utilities owed. Another example would be leveraging relationships with city initiatives to improve transportation by taking part in a grant which allows us to utilize free cab rides for members.