MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Brien Center Community Partner Program

(Brien)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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A Behavioral Health Community Partner

Organization Overview

Brien is a community-based, non-profit agency providing a continuum of care for children, adolescents, adults and families living with serious and persistent behavioral health (BH) disorders. Each year, the Brien Center serves approximately 10,000 Berkshire County residents, including 4,000 children, and is Berkshire County's largest provider of behavioral health and addiction services.

SERVICE AREA

POPULATIONS SERVED

- Brien's primary service areas are Berkshire County, Adams and Pittsfield. The Brien Center has programs at 26 locations throughout Berkshire County to provide comprehensive health services.
- The populations served include ACO and MCO-enrolled members ages 21 and older with serious mental illnesses and/or substance use disorders and high service utilization. Berkshire County is a rural area and approximately one in ten of the population live at or below the federal poverty level.

675

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- Brien's Consumer Advisory Board filled all its seats in 2018. Those members continue to attend board meetings bi-monthly.
- Brien developed a system to coordinate co-management of patients who require medical and BH CP services from ACO and Brien staff. Brien hired a Transitions of Care Manager located on-site at Berkshire Medical Center to implement this process.
- Brien care coordinators send appointment reminders and exemplify positive behaviors for members.

Statewide Investment Utilization:

- Community Mental Health Center Behavioral Health Recruitment Fund, 1 slot awarded
- 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]

Brien Center Community Partner Program (Brien) is a behavioral health (BH) CP.

Brien is a community-based, non-profit agency providing a continuum of care for children, adolescents, adults, and families living with serious and persistent BH disorders. Each year, Brien serves approximately 10,000 Berkshire County residents, including 4,000 children, and is Berkshire County's largest provider of BH and addiction services. Brien has programs at 26 locations throughout Berkshire County to provide comprehensive health services. As a BH CP, Brien organizes care and facilitates communication across medical, behavioral health and long-term services, including agencies and social supports.

Brien's primary service area is Western Massachusetts and includes all of Berkshire County. The populations served include ACO and MCO-enrolled members ages 21 and older with serious mental illness (SMI) and/or substance use disorder (SUD) and high service utilization. Berkshire County is a rural area and approximately one in ten of the population live at or below the federal poverty level.[3]

As of December 2019, 675 members were enrolled with Brien[4].

SUMMARY OF FINDINGS

The IA finds that Brien 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 with limited recommendations
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track

[2] Background information is summarized from the organizations Full Participation Plan.
[3] The Federal Poverty level is defined annually by the Department of Health and Human Services and used to calculate eligibility for Medicaid. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/
[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).[5]
- ✓ **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 Brien is **On track with limited recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

The governing board serves as the decision-making authority for Brien, providing strategic direction and programmatic oversight. The governing board determines the rules, practices, and policies for the CP.

Brien is a single entity CP; it does not have consortium entities or Affiliated Partners.

[5] 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

Brien's CAB began meeting in December 2018 and continues to meet on a bimonthly basis. Brien staff have a limited presence during CAB meetings, with no more than two CP staff members in attendance at each meeting. To incentivize participation, Brien provides enrollees with a catered lunch at meetings.

In 2018, Brien had filled all CAB membership spots. However, in early 2019 two enrollees stopped participating. In response, Brien sent a mailing out to all enrollees to gauge interest in participating and identified two new CAB members.

Brien's CAB is responsible for ensuring that the CP delivers services consistent with the CP's mission and values, identifying service gaps and suggesting solutions to address them, and gathering direct feedback regarding service delivery from enrollees and direct care workers. Information gathered from the CAB is used to inform changes in policy and practice.

Quality Management Committee

Brien's QMC meets monthly and is chaired by the Director of Compliance, Quality Improvement, and Nursing. The QMC reviews CP performance data, compares results against established program goals, and develops performance improvement initiatives. The QMC reviews medical records, member and provider complaints, utilization review, and survey data to inform their activities. The QMC reports directly to the governing board.

The QMC also monitors the CP's QI initiatives. In 2019, Brien implemented a QI initiative focused on member connections. The QMC reviews progress on three process measures that monitor staff's ability to connect members to services and coordinate care. Additionally, the QMC monitors the CP's ongoing QI initiatives focused on obesity and other chronic diseases. The CP is focused on increasing the percentage of CP members with a Body Mass Index (BMI) that is within normal limits.[6] A Brien nurse care manager tracks the weight of members choosing to participate in the project.

Recommendations

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

- ensuring the governing board meets at least quarterly.

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;

[6] BMI is a measure used to screen for weight categories that may lead to health problems. https://www.cdc.gov/healthyweight/assessing/bmi/index.html

- 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)[7] 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

[7] 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 Brien is **On track with limited recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

Brien implemented a centralized process to exchange care plans and other member files with ACO/MCO partners. These Documented Processes include the exchange of member files via Secure File Transfer Protocols (SFTP), secure email, the care management platform, and Mass HIway.[8]

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

Brien enrollment coordinators make connections with local PCPs and educate these providers about the BH CP program and member eligibility. This relationship-oriented system promotes the Brien's connection with providers and helps achieve PCP sign-off on care plans.

Brien worked with ACO/MCO partners to streamline the collection of member information and improve information accuracy. Brien leverages information that the member has previously shared with their ACO/MCO or PCP, with their consent, to eliminate duplication of efforts and decrease the demands imposed on the member. Brien also developed an urgent referral form for ACO/MCO partners to complete that includes member information such as diagnosis, last inpatient admission, and other pertinent information that helps guide the member's assessment and care planning process upon enrollment. Additionally, Brien enrollment coordinators have access to the Brien Center's outpatient electronic health record (EHR) and billing software, which houses additional member contact information that helps locate members and identify other service providers.

Brien reported that staff review enrollment file reports and MassHealth roster data on a regular basis to improve their member outreach and engagement efforts.

Integration with ACOs and MCOs

ACO/MCO and CP leadership, management, and staff meet monthly to ensure that their organizations integrate services at all levels. At these monthly meetings Brien and ACO/MCO partners discuss strategies to meet the requirements of Documented Processes, initiate process improvements, and address challenges in serving shared members.

Brien also participates in monthly clinical case review meetings with Health Collaborative of the Berkshires in partnership with Fallon Community Health Plan (FLN Berkshire) care management staff. Brien care coordinators and the Program Director meet with their ACO/MCO counterparts to present and review shared high-risk member cases. Brien and the ACO/MCO engaged a multidisciplinary team including psychiatrists, therapists, and other support providers to participate in the case review meetings. Additionally, Brien and FLN Berkshire care coordinators conduct member meetings together to lessen the member's burden of appointments and confusion about each entity's role in the provision of services. For members who are not part of FLN Berkshire, Brien schedules case review meetings with other ACO/MCO care teams as needed.

Brien augments integration with one ACO partner and two other CPs through shared trainings. Brien's direct care staff build relationships with other ACO and CP direct care staff and learn valuable information related to care delivery at these collaborative trainings. Additionally, Brien's Transitions of Care Manager increased collaboration with ACO community health workers (CHWs) to improve co-management of mutual members who have co-morbid medical and behavioral health conditions both in the in-patient setting and in the community.

Brien receives ENS/ADT notifications through its care management platform vendor. The care management platform integrates ENS/ADT notifications for regular review by CP staff. Receipt of ENS/ADT notifications does not increase clinical integration with Brien's partner ACOs/MCOs who do not participate in these services. To mitigate this challenge, Brien worked with one ACO partner to improve timely data exchange about shared members who have been hospitalized through alternate secure channels.

Joint management of performance and quality

Brien implemented a QI initiative to improve the number of consistent and thorough connections between members and staff in 2019. The QI initiative had three process level measures including an

assessment of the number of Qualifying Activity[9] notes logged per week per care coordinator, the number of enrollees with documented face-to-face visits for the previous week per care coordinator, and the number of enrollees with documented face-to-face visits that occurred in the community for the previous month per care coordinator. Brien used Qualifying Activity notes within their care management platform to track progress on these measures.

To support care coordinators' efforts to have care plans approved by PCPs, Brien uses their care management platform to send care plans to PCPs and accept approved care plans returned from PCPs. The care management platform streamlines the transmittal of PCP signatures on care plans either electronically within the system or through the upload of a signed document. Brien also worked with ACO/MCO partners to employ a single comprehensive assessment and person-centered care plan template to increase the efficiency of the approval process.

> CP Administrator Perspective: "*We really want staff out engaging members in the community; there are so many benefits to being able to see members in their own environment compared to coming into the office. So just coming up with those quality initiatives [is] part of that. Coming up with timelines for staff to reach out to all of their members within the first two weeks of the month, and then that allows them that follow-up time for the remainder of the month if they were not able to connect with a member initially.*"

Recommendations

The IA encourages Brien 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;

[9] 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.

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

Recruitment and retention

Brien recruited and retained a qualified workforce to serve CP members using a comprehensive recruitment and retention strategy. Brien posts job opportunities on online job boards, in local newspapers, on the CP's internal job board, and with local employment agencies. Brien established an internship program with a local community college's CHW program to aid recruitment.

Brien offers employees a robust benefits package and promotes a positive work culture with opportunities for career growth, supportive supervision, integrative teams, and the opportunity to have an influential role in supporting individuals and families who are affected by behavioral, mental, medial and substance use disorders. Brien leveraged the CP Recruitment Incentive Program and the CMHC BH Recruitment fund, which are both part of DSRIP Statewide Investments (SWI) to fill four staff positions within the CP program.

Brien recruited a diverse workforce who reflects the language and cultural needs of the member population.

Training

Brien designed their training program to increase staff understanding and awareness of member needs. The CP trains care team staff on SMI, SUD, BH CP supports, social services, community supports, and strategies for delivering culturally competent care. Brien staff attend annual refresher trainings that are updated annually to reflect best practices in the field. In addition to this required training, Brien offers staff trainings from Berkshire Community College and the Northern Berkshire Community Coalition. Brien also participates in shared trainings with FLN Berkshire and tries to develop and deliver trainings in conjunction with ACOs/MCOs on topics of mutual interest whenever possible.

The CP tracks staff participation in trainings through an online learning management system. Brien encourages staff participation in trainings by hosting sessions during work hours. Brien provides CP staff with resource guides and training materials that reinforce learning after trainings are complete.

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[10] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.
- ✓ **Data analytics**
  - develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and
  - reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Results

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

Implementation of EHR and care management platform

Brien has implemented a care management platform across the CP. Brien connected to ENS/ADT notifications through its care management platform and integrated notifications into the care management platform. ENS/ADT service is not available for all of the CP's ACO/MCO partners. To mitigate this challenge, Brien has worked with one ACO partner to enhance the timeliness of data provided to CP staff for shared members who are hospitalized through other means of secure communication.

Interoperability and data exchange

Brien has the capability to exchange member files via SFTP, Mass HIway, secure email, and its care management platform.

In their most recent progress report, Brien reported they can share and/or receive member contact information, assessments, and care plans electronically from all or nearly all ACOs, MCOs, and PCPs. To further interoperability and data exchange efforts, Brien has worked with its care management platform vendor to share member assessment data and person-centered care plans with the CP, PCPs, Model A ACOs, MCOs, and other care integration stakeholders. Brien care coordinators have also gained access to Berkshire Health System's EHR system. Berkshire Health

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

System staff have trained CP staff on how to use their EHR to find medical information about shared members and identify when these individuals are admitted to any of the providers' facilities. Brien's enrollment coordinators also have access to the Brien Center's outpatient EHR and billing software, which has assisted in locating members and identifying other service providers they have visited.

Data analytics

To oversee documentation and performance of key quality metrics, Brien leverages its care management platform to track data from Brien's EHR and generate reports that describe CP performance. In 2019, Brien's care management platform vendor implemented a customized report, that includes statistics that allows Brien leadership to track program performance more accurately. Brien has also made modifications to other standard reports to track CP performance data more easily within the EHR. Dashboards are generated within the EHR and demonstrate performance at both the individual care coordinator level and team level. Brien reports that QI indicators, trends, and opportunities for improvement derived from these reports and dashboards are reviewed during governing board and CAB meetings.

Recommendations

The IA encourages Brien 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.

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 Brien has an **On track with no recommendations** in the Care Model focus area.

Outreach and engagement strategies

Brien ensures that services provided by staff are tailored to and reflective of the member population. Brien utilizes a combination of bilingual CP staff and community-based contract staff to provide in-person interpretation. With Brien's access to in-person interpretation, digital interpretation is not typically needed. Brien also meets the needs of the member population by providing staff with evidence-based trainings and tools that help them appropriately engage with members who have a history of high service utilization and/or complex BH needs, beyond cultural and linguistic needs. Brien staff are responsible for ensuring that visits with members are conducted in a manner that accommodates any disability and accessibility needs. Brien staff ensure that they meet members in a location that is safe and allows the member to actively engage in the visit free of all barriers.

Brien care coordinators are trained as CHWs and recovery coaches and assist members through the provision of CP services and supports. Care coordinators provide members with appointment

reminders, assist with transportation to and from appointments[11], and model positive behaviors that will help the member attend necessary appoints and receive necessary services.

To reach members who are not easily reached telephonically, Brien staff make efforts to contact assigned members by going to community locations where the individual may be, such as their home or a congregate meal site. Additionally, when Brien is made aware of an assigned member's hospitalization, Brien staff attempt to connect the member while they are in the hospital. Once a member is engaged with the CP, Brien staff continue to meet with them in the setting they are most comfortable in, which is often a community location.

> CP Administrator Perspective: "*we had a member who has...severe anxiety and other behavioral health diagnoses, and he had asthma and couldn't get into his primary care doctor -- he was somebody who was utilizing the emergency room a lot because of that…. So, the care coordinator met with the member and brought him to the doctor's office, modeling that …. [the member can be] the head of their own healthcare team. And they were able to get an appointment with the primary care doctor within the same week, compared to six months out."*

Person-centered care model

Brien staff engage with individuals to identify their needs, priorities, and preferences in a person-centered assessment and care planning process. During the member's comprehensive assessment, CP staff work to truly understand the member's needs and preferences including their preferred language and cultural beliefs. Brien staff utilize motivational interviewing and strength-based language to understand members' aspirations and identify perceived barriers to care delivery. Brien also engages the member's family and informal caregiver, the enrollee's PCP, specialist and other providers or key stakeholders the member would like to be involved in the care planning process. As part of the comprehensive assessment, Brien evaluates members' health and wellness needs and ensures that this information is incorporated into the care plan. Brien care coordinators use all available information to collaborate with the member and develop their person-centered care plan.

Brien staff include goals and objectives, specific action steps to achieve goals, a method of tracking goal progress, referral needs to obtain care and services, and educational needs in the member's care plan. For individuals with BH needs and a history of crisis service utilization CP staff also may include a crisis plan in the member's care plan.

Managing transitions of care

To manage members' transitions of care, Brien hired a Transitions of Care Manager and Transitions of Care Program Coordinator to oversee transitions of care for Brien members. The Transitions of Care Manager and Transitions of Care Program Coordinator began seeing members in the inpatient setting in August 2019. The Transitions of Care staff members actively collaborate with ACO/MCO staff to deliver integrated care to individuals in the inpatient setting. Additionally, the Transitions of Care Manager schedules members' three-day post-discharge follow-up appointments with their CP care coordinator and assists with medication reconciliation following the member's hospitalization.

Brien observed a significant increase in collaboration between the ACO CHWs and the CP's Transitions of Care Manager that has led to better management of members with comorbid medical and BH conditions. Such co-management now begins in the inpatient setting and continues after discharge in the community setting. Brien and ACO partner leadership continue to work collaboratively to identify and address opportunities to improve transitions of care and other integrated care processes.

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

Improving members' health and wellness

Brien has processes in place to refer members to and coordinate with community service providers and social services agencies. Brien appointed CP Liaisons who are responsible for fostering relationships and facilitating communication with community agencies. Brien also developed a comprehensive referral and community resource guide for engaged members.

Brien also provides members access to health and wellness information, coaching, and interventions within the CP program. Brien maintains a Health and Wellness Committee, provides staff training on Executive Order 509 nutrition standards,[12] offers member programs related to nutrition, connects members to tobacco cessation programs, and educates members on self-management of chronic medical conditions.

Brien ensures that CP members with co-occurring LTSS needs have access to these services. To facilitate connection to LTSS services, CP staff provides enrollees with a list of available LTSS providers in their geographic region and helps enrollees gain access to LTSS supports.

Continuous quality improvement

Brien maintains a QI initiative focused on obesity and chronic disease management. The CP reports that it works with members to lower their BMI through a series of deliberate improvement cycles. Data from this QI initiative is frequently reviewed by the Program Director and CP Nursing Supervisor to guide further development of the initiative. Member health outcomes and effectiveness of this QI initiative are continuously monitored by the QMC.

Brien has also prepared a Language Access Plan (LAP), which defines the actions to be taken by the CP to ensure meaningful access to services, programs and activities for individuals who have limited English proficiency. Brien will review and update the LAP on a biannual basis to ensure continued responsiveness to community needs.

Recommendations

The IA has no recommendations for the Care Model focus area.

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[13];
- 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

[12]EO 509 requires certain MA state agencies within the Executive Department to follow nutrition standards developed by the Department of Public Health when purchasing and providing food and beverages, whether directly or through contract, to agency clients/patients. https://www.mass.gov/files/documents/2016/09/ts/eo509-fact-sheet.pdf

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

- 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[14];
- 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.

[14] 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 Brien 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:

- Workforce Development
- Care Model

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

Organizational Structure and Engagement

- ensuring the governing board meets at least quarterly.

Integration of Systems and Processes

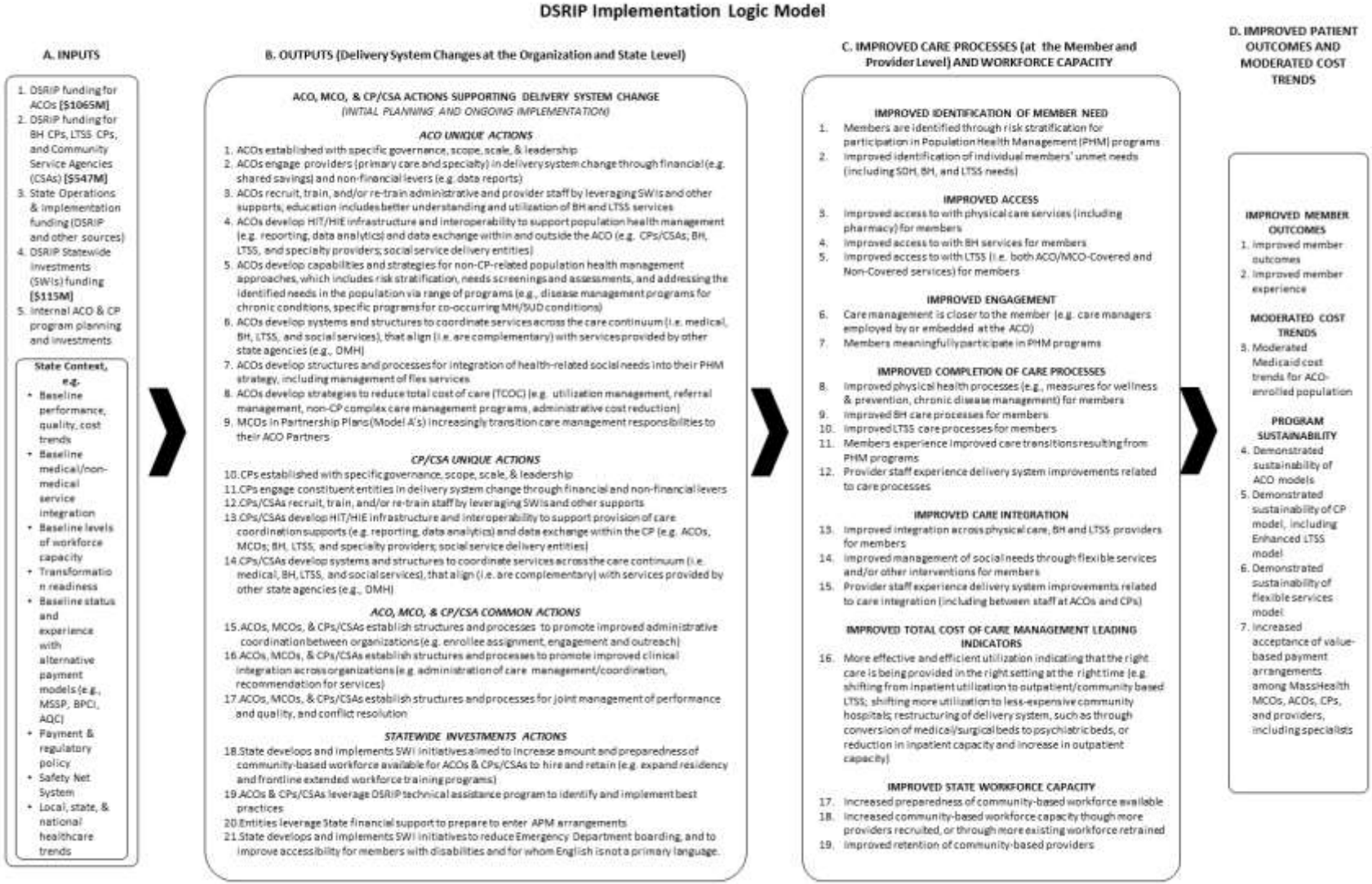
- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts.

Health Information Technology and Exchange

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

Brien 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[15] (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

[15] 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.[16] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[16] 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.