MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Community Counseling of Bristol County, Inc. (CCBC)

PUBLIC CONSULTING GROUP

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Community Counseling of Bristol County, Inc. (CCBC)

PUBLIC CONSULTING GROUP

A Behavioral Health Community Partner

Organization Overview

CCBC has provided behavioral health services for the greater Taunton and Attleboro communities over forty years. CCBC serves MassHealth members who present with serious mental illness, substance use disorders, have complex co-occurring medical conditions, and have been affected by or are at risk of losing access to health care due to a host of health-related social needs.

SERVICE AREA

POPULATIONS SERVED

▶ CCBC serves MassHealth Members who present with serious mental illness, substance use disorders, have complex co-occurring medical conditions, and have been affected by or are at risk of losing access to health care due to a host of health-related social needs.

▶ CCBC partners with ACOs and MCOs in Attleboro, Brockton, Taunton, and Southwestern Massachusetts.

2,420
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 2019, CCBC created an Events Supervisor role to support the growing demands of admissions, discharge, and transfer notifications and the subsequent care team response.
- In collaboration with some ACO partners, CCBC created an inter-operational care plan tracking system that helped CCBC obtain its one thousandth signed care plan in April 2019.
- CCBC strengthened their quality improvement process through the development of a dashboard driven by business intelligence software. CCBC uses the dashboard to analyze data on assigned members and the impact of care coordination services.

Statewide Investment Utilization:

- Student Loan Repayment Program, 4 Care Coordinators participating
- Certified Peer Specialist 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

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

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

Table 1: Framework for Organizational Assessment of CPs

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

METHODOLOGY

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

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

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

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

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

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

CP BACKGROUND[2]

Community Counseling of Bristol County, Inc. (CCBC) is a behavioral health (BH) CP.

CCBC has provided behavioral health services for the greater Taunton and Attleboro communities for over forty years. As a BH CP, CCBC serves MassHealth members who present with serious mental illness (SMI), substance use disorder (SUD), have complex co-occurring medical conditions, and have been affected by or are at risk of losing access to health care due to a host of health-related social needs (HRSNs).

CCBC's service area includes Brockton, Taunton, Attleboro and Southeastern MA. There is a large Cape Verdean population in Brockton and Taunton and a growing Asian population in Attleboro and Brockton. The unemployment rate in Brockton remains significantly higher than the state average.

As of December 2019, 2,420 members were enrolled with CCBC[3].

SUMMARY OF FINDINGS

The IA finds that CCBC 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
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track with limited recommendations

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

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

achievements and or promising practices, and recommendations where applicable. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage CPs to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must be taken in accordance with program guidance and contractual requirements.

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Executive Board**

    - has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and

    - is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).[4]

- ✓ **Consumer Advisory Board (CAB)**

    - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.

- ✓ **Quality Management Committee (QMC)**

    - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

The IA finds that CCBC is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

CCBC has a governing body consisting of CP leadership that meets regularly. CCBC program leadership, including the Chief Operating Officer and clinical lead Vice Presidents, meet weekly to ensure that barriers to CCBC's performance are addressed in an expedient manner.

Consumer Advisory Board

CCBC established and maintains a CAB that is representative of the members it serves. CCBC's CAB is comprised of 13 members and has diverse representation including members engaged in the CCBC CP program, professionals, and CP members' family members. The CAB met once over the first six months of 2019, has established a charter, and continues to meet quarterly. CAB members develop meeting agendas.

Quality Management Committee

CCBC has a QMC comprised of executive leadership with a clear reporting structure in place to review outcomes and monitor progress. CCBC's QMC meets quarterly and reviews weekly

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[4] Some CPs enter into agreements with Affiliated Partners: organizations or entities that operate jointly under a formal written management agreement with the CP to provide member supports.

cumulative CCBC operational data, develops plans for Technical Assistance (TA), reviews reporting on metrics derived from CCBC's business intelligence software, and monitors progress on MassHealth DSRIP quality measures. Additionally, CCBC maintains an excel workbook log of QMC activities with details on committee membership, meeting schedules, CCBC's quality measure slate, reporting and performance indicators, and a question and answer worksheet.

CCBC conducted QI initiatives focused on the implementation of the care management platform, data exchange with ACO/MCO and PCP partners, reporting on Qualifying Activities[5] (QAs), and tracking the conversion rate of assigned members to engaged members. CCBC's Program Director, Director of Quality, Care Management IT Manager, and data analyst review the results of these activities monthly.

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)[6] Joint Operating Committee;

- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and

- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

✓ **Consumer Advisory Board**

- seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;

- adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;

- hosting meetings in centrally located community spaces that are easy to get to and familiar to members;

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[5] Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow-up after discharge, and health and wellness coaching.
[6] For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

- 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 CCBC is **On track** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

CCBC implemented a centralized process to exchange care plans and other member files with ACO and MCO partners. These Documented Processes include the exchange of member files via Secure File Transfer Protocol (SFTP), secure email, a secure file-sharing application, and Mass HIway.[7] CCBC assigned staff to review shared files, including ACO/MCO spreadsheets, and developed internal processes to determine the validity and completeness of member data files so that they can be utilized to inform outreach and engagement efforts.

To engage PCPs in care plan review and approval, CCBC leadership met with and engaged several of the large PCP practices throughout their service area with whom CCBC has shared members. As a result of this engagement, CCBC care coordinators have developed close working relationships with PCPs and have reported success at receiving care plan sign-off within 30 days of initial transmission.

CCBC reports that it has the capability to share and receive member contact information electronically from all or nearly all its ACO and MCO partners.

Integration with ACOs and MCOs

CCBC attends quarterly meetings with all of its ACO/MCO partners and schedules monthly meetings with ACOs/MCOs with whom it shares a large volume of members. At the beginning of the program, CCBC set up "meet and greet" meetings with ACOs and MCOs to identify key contacts at each entity and develop Documented Processes that meet the needs of each partner.

In 2019, CCBC began conducting case review conferences with ACO care team providers. CCBC staff use this forum to discuss shared members with complex needs.

To facilitate clinical integration, CCBC contracted with a vendor to receive ENS/ADT notifications. CCBC care coordinators and direct supervisors receive these notifications via real-time email alerts. In late 2019, CCBC hired an events supervisor to triage ENS/ADT notifications and facilitate the timely review of the growing number of notifications CCBC receives.

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

CP Administrator Perspective: "*By continuing to leverage our existing relationships with area primary care practices and by working* together *with our ACO partners to support relationships with previously lesser known primary care practices we have made substantial progress in advancing healthcare integration with our shared members."*

Joint management of performance and quality

CCBC utilizes a business intelligence platform to develop dashboards to monitor program performance. CCBC created a custom dashboard that combines claims data from MassHealth, ACOs, and MCOs with CCBC's electronic health record (EHR) data to identify members who could benefit from CP supports. The dashboard allows CCBC to track members' ACO affiliations and CP program enrollment status. CCBC also monitors member engagement through the dashboard; CP leadership can review care coordinators' engagement rates on an ongoing basis and identify engagement best practices. The Program Director and nursing staff utilize several dashboard reporting options in an operational capacity and care team leaders can review member progress daily. CCBC also has a comprehensive process for analyzing claims data to better understand at-risk members' medical histories and current enrollment status, so as to design care coordination strategies to meet their unique needs with ACO partners.

To support care coordinators in their efforts to have care plans approved by PCPs, CCBC developed relationships with key ACO staff who assist with care plan follow-up efforts. CCBC reports that personal relationships have been a helpful facilitator of care plan sign-off, especially with difficult to reach PCP offices. In the case of one of CCBC's ACO partners, CCBC staff generate an unsigned care plan reminder list for the ACO contact who then assumes responsibility for following up on the care plan with the specific provider and educating the PCP about why signing off on and returning care plans in a timely fashion is important. With its larger ACO partners, CCBC created an inter-operational care plan tracking system.

To monitor performance, CCBC's QMC uses internal and external data sources to evaluate contractual compliance and guide workforce training. Each week CCBC's QMC reviews member enrollment, member disenrollment, completed participation forms, member screenings, and completed, sent, and returned care plans to identify any workflow revisions, staff training needs, opportunities for stakeholder relationship development, and areas requiring targeted supervision efforts.

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 CCBC is **On track** in the Workforce Development focus area.

Recruitment and retention

CCBC reports that it has been able to maintain sufficient staffing levels that are necessary to provide support for assigned members. For positions not filled through internal recruitment, CCBC uses staff referrals and job boards to recruit additional candidates.

To recruit and retain staff, CCBC utilized the DSRIP Statewide Investment (SWI) Behavioral Health Workforce Development Program and Student Loan Repayment programs. Additionally, CCBC retains staff with bonuses and a supportive work environment. CCBC promotes a culture that acknowledges staff accomplishments, offers staff professional development opportunities, and hosts morale boosting events all of which have helped staff retention.

CCBC has a strong record of hiring individuals from the communities they serve in Taunton, Attleboro, and Brockton. CCBC leverages their working relationships with community-based organizations such as the YMCA and local cultural associations, such as the Cape Verdean Association in Brockton and the Haitian Center in Brockton, to recruit professionals for staff roles. Additionally, CCBC developed materials in multiple languages to advertise open positions and uses its position on local taskforces to informally recruit new staff.

Training

CCBC staff attend initial trainings and semi-annual and annual refresher trainings that cover all components of the CP program. Additionally, all CCBC staff complete a Community Health Worker (CHW) certification training. CCBC partnered with an outside training resource to conduct the CHW training. In 2019, CCBC expanded staff access to trainings and certifications, adding staff training programs and certificate opportunities for peer/recovery support, housing specialists, and certified applications counseling.

Recommendations

The IA encourages has no recommendations in 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[8] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.

- ✓ **Data analytics**

  - develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and

  - reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Results

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

Implementation of EHR and care management platform

CCBC has an EHR and care management platform in place to assist with the operation of the CP program. CCBC also contracted with two vendors to receive ENS/ADT notifications. CCBC integrated ENS notifications into the care management platform. CCBC worked with its care management platform vendor to design a platform that complies with MassHealth's specifications, supports the Documented Processes established with ACOs/MCOs, and meets the needs of CP care coordinators and their supervisors.

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

Interoperability and data exchange

CCBC has the capability to exchange member files via SFTP, secure email, a secure file-sharing application, and Mass HIway.[9] CCBC is looking for ways to increase interoperability with partners and is leveraging TA funds through SWI 5a to advance these efforts.

CCBC shares and/or receives member contact information, comprehensive assessments, and care plans electronically from all or nearly all ACOs and MCOs. However, CCBC can only share and/or receive member contact information, comprehensive assessments, and care plans with very few PCPs.

To further interoperability and data exchange efforts, CCBC hired consultants to improve integration and collaboration with ACOs. This project included improving software integration, reporting capabilities, and connectivity with ACO EHRs.

Data analytics

CCBC utilizes a business intelligence platform to produce analytic dashboards that are useful to all levels of CCBC staff. The Program Director and nursing staff utilize a number of the dashboard's reporting options in an operational capacity and care team leaders review member progress on a daily basis. CCBC leadership use the dashboard to sort and review members' engagement status by care coordinator and ACO affiliation. The dashboard also allows CCBC staff to identify how many members are engaged in the CP program at any given time. Additionally, CCBC reports that the dashboard helps CP leadership identify best practices for member engagement that can be applied to future QI initiatives.

Recommendations

The IA encourages CCBC to review its practices in the following aspects of the Health Information Technology and Exchange focus area, for which the IA did not identify sufficient documentation to assess progress:

- developing a plan to increase active utilization of Mass HIway; and

- 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).

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

- ✓ **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 CCBC has an **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

In 2019, all CCBC care coordination staff who had been hired in the first six months of the year participated in CHW Certification training. In late 2019, CCBC expanded staff training opportunities to include peer/recovery support, housing specialist training, and certified application counselor training programs.

Additionally, CCBC assigns recovery coach care coordinators to support members with SUD at the initial stage of engagement and applies the principles of "Seeking Safety," a trauma-informed treatment approach that focuses on the development of safe coping behaviors for those who have SUD and have experienced trauma.

To reach members who are not easily reached telephonically, CCBC implemented a new staff role, the intake care coordinator (ICC), that performs activities related to both intake and care coordination. The ICC completes initial outreach attempts through calls, text messages, letters, follow-up event notifications, and coordination with known providers. The ICC is also responsible for screening potential members and assigning these individuals to the CCBC care coordinator who best meets the member's language, gender preference, demographic, and recovery needs.

CCBC has found success in engaging members with assertive outreach tactics. CCBC staff are trained to use statements such as, "When we meet, what do you want to discuss about your needs and goals?" Or, "At your meeting next week, we will discuss how the program works and ask you about your dreams, preferences, and cultural affiliations." Additionally, CCBC care coordination staff ensure that members have their assigned care coordinator's phone number programed into their cell phones. CCBC reports that this engagement strategy ensures that members know who is calling them and encourages them to answer the phone and check-in with their care coordinator.

> CP Administrator Perspective: "*I think that we've developed really good relationships with the complex care managers and I think probably even more so than any of the other BH CPs we're far more boots on the ground with people face to face. I think we have a much higher touch ratio. We're seeing people probably on average three times a month*."

Person-centered care model

Once CCBC staff complete the comprehensive assessments, they promptly communicate the results of the assessment with the member's care team, including their ACO, MCO, and other providers who serve the member including state agencies or other case managers. CCBC developed a care plan guide as a resource to help staff become more specific and intentional when working with members to develop short and long-term goals. This tool guides staff in identifying and developing person-centered goals and interventions that will meet the medical, BH, recovery, and social needs of CCBC's members.

CCBC recognizes that care planning includes not only the creation of the care plan, but the application of the action steps included in the care plan. Care coordinators are required to reach out to members directly at least twice per month to discuss their care plan goals. Care coordinators use the intervention/follow-up section of member's activity notes to guide members towards completion of identified goals and help them reflect on their progress and accomplishments.

CCBC provides "small win" goals for their members that are easily achievable at the outset, especially for those who are homeless. These successes act as a bridge to larger goals, such as permanent housing, meeting with their assigned PCP, and making appointments for BH treatment.

Managing transitions of care

To support members experiencing transitions of care, CCBC care coordinators make every effort to be involved in members' discharge planning. When a CCBC member is admitted to an inpatient

facility, their care coordinator contacts clinical staff at the facility to start coordinating care. CCBC care coordinators will also attempt to meet with the member while they are admitted. The care coordinator ensures the member's care team is made aware of the discharge plan. When the member is discharged, the care coordinator, in collaboration with a CCBC nurse and the member's care team, works to address the member's unique aftercare needs. Care coordinators ensure that medication reconciliation is completed and that an optimal level of care coordination is being delivered to members after discharge.

Additionally, CCBC is piloting an enhanced approach to transitions of care. CCBC developed the high utilization intervention team project. The high utilization team includes assigned care coordinators and CP nurses. CCBC identified 30 members with high utilization rates to participate in the pilot program and implemented enhanced transitions of care interventions for these members. CCBC had high utilization intervention team staff meet with members upon presentation at the inpatient facility or ED, to improve management of members' transitions of care.

Improving members' health and wellness

CCBC reports maintaining strong collaborative referral relationships with numerous agencies across their service area, as well as with facilities providing Medication for Addiction Treatment (MAT), detoxification, residential SUD treatment programs, hospital-based and free-standing inpatient mental health programs, and primary care. CCBC also continues to work with social service providers, such as food pantries, housing authorities, the Department of Transitional Assistance, and Social Security Administration to help meet members' needs. CCBC tries to complete the initial member health needs assessment at the first meeting with new members. This allows CCBC to gauge the member's immediate and long-term needs and immediately make the necessary referrals to outside services such as Outpatient Therapy, Visiting Nurse Association (VNA), Community Support Program, Day Treatment, and MAT.

In addition, CCBC staff help members locate and attend 12 step meetings, access appropriate benefit and entitlement programs, and utilize transportation services[10] to attend preventive healthcare appointments.

CCBC also provides members with health and wellness coaching on topics such as the prevention and management of chronic medical conditions and education on how to reduce high-risk behaviors and health risk factors, such as smoking, inadequate nutrition, and infrequent exercise. CCBC also helps members establish connections to health promotion activities such as smoking cessation and weight loss programs.

CCBC utilizes an evidence-based illness management and recovery program that uses a stress vulnerability model[11] to educate enrollees about the impact of exercise, nutrition, and sleep on both the intensity and frequency of their symptoms. Through motivational interviewing techniques and psychoeducation, members are provided with support, information, and tools to develop and implement wellness plans and make incremental changes to allow for improved physical and mental health.

Continuous quality improvement

CCBC enables continuous QI in quality of care through its rigorous analysis of claims data. CCBC analyzes claims for utilization patterns and tracks this data in a business intelligence platform

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

[11] The stress vulnerability model helps understand the causes of psychiatric disorders, how psychiatric disorders and addiction can influence each other, and how co-occurring disorders can be managed and treated together. The two main factors involved are vulnerability, which refers to our basic susceptibility to mental health disorders, and stress, which refers to the challenges faced in our lives.

dashboard to inform QI efforts. Results of analyses are reviewed on a weekly basis and examined for opportunities to improve CCBC workflows and better serve members.

Additionally, the CCBC leadership team plays an active role in defining strategies to improve quality of care. In 2019, CCBC leadership set new standards for CCBC staff pertaining to the number of outreach activities per month, frequency of face-to-face meetings with members, and expectations for care plan goals. CCBC care coordinators are now required to reach out to engaged members directly two times a month at a minimum to address care plan goals.

CCBC maintains a high functioning CAB that meets quarterly to provide feedback on the provision of CP supports with the goal of improving member experience.

Recommendations

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

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

- 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[12];

- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and

- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

✓ **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

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

- allowing members to attend care planning meetings by phone or teleconference.

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;

- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;

- meeting an enrollee in person once care coordinators receive alerts that they were admitted;

- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[13];

- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and

- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

✓ **Improving members' health and wellness**

- allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;

- negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and

- contracting with national databases for community resources to develop a library of available supports.

✓ **Continuous quality improvement**

- providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;

- 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.

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

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that CCBC 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 CCBC 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

- developing a plan to increase active utilization of Mass HIway; and

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

Care Model

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

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

CCBC 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

DSRIP Implementation Logic Model
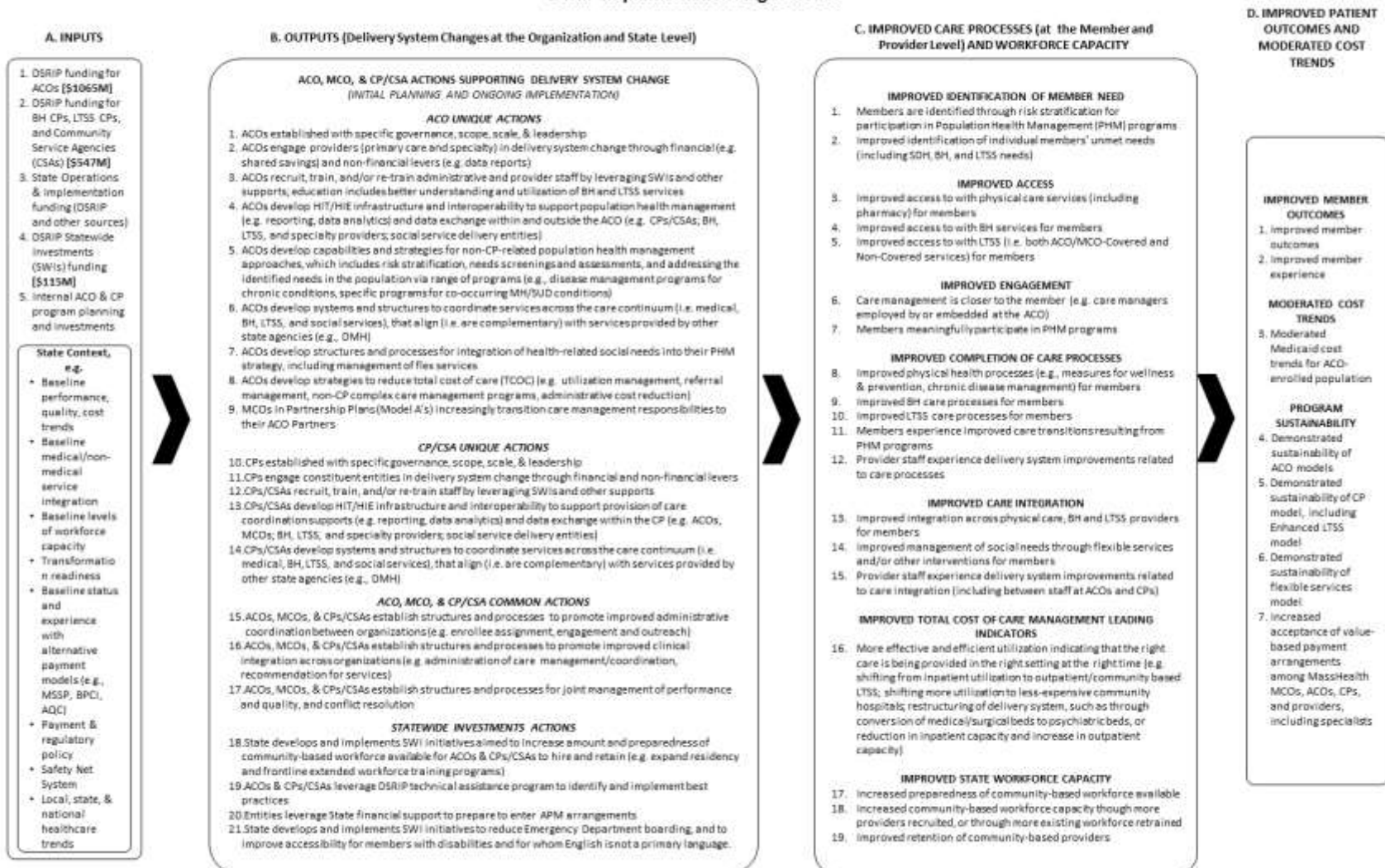
APPENDIX II: METHODOLOGY

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

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[14] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

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

DATA SOURCES

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

List of MPA data sources:

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

- Full Participation Plans

- Semi-annual and Annual Progress Reports

- Budgets and Budget Narratives

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

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

1. Organizational Structure and Engagement

2. Integration of Systems and Processes

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

3. Workforce Development

4. Health Information Technology and Exchange

5. Care Model

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

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

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

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

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

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

DATA COLLECTION

Key Informant Interviews

Key Informant Interviews (KII) of CP Administrators were conducted in order to understand the degree to which participating entities are adopting core CP competencies, the barriers to transformation, and the organization's experience with state support for transformation.[15] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Request for Change

Community Counseling of Bristol County takes great pride in the delivery of behavioral health services to clients in Southeastern Mass with a special focus in Brockton, Taunton and Attleboro. We have assembled a committed team for our Behavioral Health Community Partner program and have worked to engage over 2,000 members of our nearly 3,000 assigned as of November, 2020. We take these findings very seriously and seek to correct the record before this document is made public. We appreciate the recommendations of Best Practices and will review them as they apply to our ongoing quality improvement processes throughout all of our programs.

CCBC wants to clarify the following findings from the report that do not reflect accurately on our robust BH CP program.

Health Information Technology and Exchange

In reference to the recommendation on page 18, *"using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files."*: this recommendation does not acknowledge the finding on page 11 under "Joint approach to member engagement" in the first paragraph which states the CCBC has implemented the exchange of member files via SFTP.

In reference to the recommendation for *"developing a plan to increase active utilization of Mass HIway."*: Per CP contract requirements, CCBC established a secure email address for the HIway and has been ready willing and able to work with ACO partners in accessing the HIway as a means of data exchange. It is not clear what other steps CCBC can take to increase "active utilization" without a willing partner.

Care Model

The first recommendation for which the IA did not identify sufficient documentation relates to *"developing a strategy to contact assigned members who cannot be easily reached…"*

> CCBC believes that this recommendation does not apply, based on the finding on page 20 under Outreach and engagement strategies. Specifically, the third paragraph states the dedicated role of the intake care coordinator to address the findings in the first Recommendation and includes additional "assertive outreach tactics" described in the fourth paragraph.

CCBC wishes to comment on the second Recommendation in this section regarding "increasing standardization of processes for connecting members to community resources . . . ." CCBC believes that every member has their own unique circumstances and that, while "standardization" may save time for some interventions, other types of follow up require a nuanced knowledge of community resources that the Care Coordinator may have direct knowledge of, or, if uncertain, can seek guidance from their

supervisor. Moreover, in CCBC's experience resources are constantly changing; often once a process or contact is "standardized, it can be out of date in short order.

CCBC continues to work on enhancing access to community resources for its members and to make the process more efficient and effective for clients and staff.

CP Comment

CCBC is concerned that the report does not reflect the unique features of the organization and the establishment of the BH CP program. For example, in the narrative describing CCBC's management there are several references under "promising practices for the Executive Board" (on page 9) to meeting and working with Consortium Entities and Affiliated Partners. Similarly, under "promising practices for Joint Approach to Member Engagement" on page 13, there is reference to working with CEs and APs. CCBC is a single entity and does not have CEs or APs.