

MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Central Community Health Partnership BH (CCHP BH)

Report prepared by The Public Consulting Group: December 2020



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DSRIP Midpoint Assessment Highlights & Key Findings

Central Community Health Partnership BH
(CCHP BH)

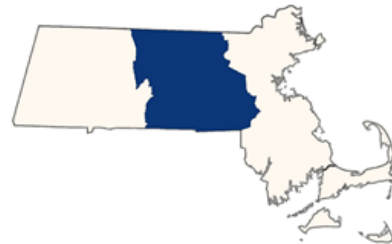


A Behavioral Health Community Partner

Organization Overview

CCHP BH is a collaboration of four agencies, Open Sky Community Services, LUK Crisis Center, Inc, Venture Community Partners, and AdCare Hospital. CCHP is also a long-term services and supports CP.

SERVICE AREA



POPULATIONS SERVED

- ▶ Central Community Health Partnership's primary service area includes Athol, Framingham, Gardner-Fitchburg, Southbridge, Worcester.
- ▶ Central Community Health Partnership BH currently serves vulnerable populations – the elderly, low-income residents, non-English speaking residents, and those with disabilities and/or serious mental illness or substance use disorders. Over the 5-year contract, they plan to expand to be able to serve 3,000 members or more.

890

**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	
Workforce Development	● On Track	● Limited Recommendations
Health Information Technology and Exchange	● On Track	● Limited Recommendations
Care Model	● On Track	

IMPLEMENTATION HIGHLIGHTS

- CCHP worked with their electronic health record vendor to produce customized reports for performance management.
- CCHP BH utilized statewide investments to provide loan assistance to two staff members who have pledged to remain with the CP for four years of service.
- CCHP BH care teams established a collaborate relationship with Department of Mental Health's care teams and ACO hospital staff during care transitions.

Statewide Investment Utilization:

- 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 Evaluator¹ (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	<ul style="list-style-type: none"> • CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 BACKGROUND²

The Central Community Health Partnership (CCHP BH) is a behavioral health (BH) CP.

CCHP is a collaboration of four Affiliated Partner (AP)³ agencies, LUK Crisis Center, Inc, Venture Community Partners, Open Sky Community Services, and AdCare Hospital. CCHP employs evidence-based practices to deliver fully integrated behavioral health (BH) and long term services and supports (LTSS) care management to individuals with serious mental illness (SMI), substance use disorders (SUD) and those who present with a variety of medical, physical, and developmental disabilities.

CCHP BH's primary service area includes Athol, Framingham, Gardener-Fitchburg, Southbridge, and Worcester. CCHP BH serves vulnerable populations – including the elderly, low-income residents, non-English speaking populations, and those with disabilities. The members served by CCHP BH typically face challenges such as long wait times to schedule appointments, limited transportation to and from health care appointments, linguistic and cultural barriers, difficulty navigating the complex health care system, and in some instances, lack of culturally competent care.

As of December 2019, 890 members were enrolled with CCHP BH⁴.

SUMMARY OF FINDINGS

The IA finds that CCHP BH 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
Workforce Development	On track with limited recommendations
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 Some CPs enter into agreements with Affiliated Partners: organizations or entities that operate jointly under a formal written management agreement with the CP to provide member supports.

⁴ Community Partner Enrollment Snapshot (12/13/2019).

FOCUS AREA LEVEL PROGRESS

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

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

Results

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

Executive Board

CCHP has a single centralized governing board for the BH and LTSS CP entities. Membership for the BH governing board includes two representatives from CCHP BH, the CCHP BH Director, and leadership from all APs, all of whom have voting rights. The board serves as the decision-making authority for CCHP BH and provides strategic direction and programmatic oversight. The CCHP BH governing board is chaired by the CEO of the lead agency, the BH side of Open Sky Community Services. AdCare Hospital has one non-voting member.

Consumer Advisory Board

CCHP BH established a BH CAB in February of 2019. The CP hosted an open house for potential board members to come and learn about the experience of participating in a CAB prior to the first meeting. Currently the CAB includes seven members engaged in the BH CP, three caregivers of

engaged members, one caregiver who does not work with engaged members, and two BH advocacy support specialists. Managers from AP agencies, such as AdCare Hospital, LUK, and Venture, are also allowed to participate in meetings to bring process-improvement strategies back to their agencies.

CCHP BH reports that recruitment for the BH CAB is an ongoing process. CCHP BH care coordinators distribute recruitment flyers for the CAB with participation forms and continually advertise the CAB to their engaged members to assist with recruiting individuals who are diverse in age, gender, sexual orientation, language, etc., to be representative of the broader member population.

The BH CAB focuses on the stigma experienced by members in their day-to-day lives. Engaged members and their caregivers or family members shape the agenda for BH CAB meetings and have discussed ways CCHP can be more visible in the community to reduce stigma around substance use disorder (SUD) and mental illness. CCHP staff also use the CAB as a forum to share ACO initiatives designed to address known barriers to navigating the healthcare delivery system. After the CAB highlighted the need for greater transportation services to allow members to get to their appointments and meetings, CCHP BH created a fund to provide transportation to all BH CP members.⁵

Quality Management Committee

The CCHP QMC reports to the CCHP governing board and is responsible for the QI plans for both CCHP LTSS and CCHP BH. The QMC began holding meetings in 2019 and is comprised of the Director of Administration and Quality, the Director of Clinical Services for CCHP, and representatives from CCHP LTSS and CCHP BH CPs. The QMC meets on a quarterly basis. QMC members created a Quality Improvement Plan for FY20 which established clear QI initiatives around outreach and engagement, proper follow-up after discharge, completion of home visits, and implementation of referrals to other providers or community resources.

The CCHP QMC has a clear reporting structure to analyze progress on quality and performance management goals. The information used for quality monitoring derives from several sources including but not limited to medical record review, stakeholder input, utilization review, and survey data. Annually, CCHP conducts a comprehensive program assessment that examines QI program effectiveness, service utilization, cost, quality data, and the prior year's outcomes. The newly hired Director of Administration and Quality is responsible for analyzing data and summarizing progress on goals to the QMC, which then determines opportunities for improvement, designs interventions, and tracks the effectiveness of interventions.

Recommendations

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

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

⁵ CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

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;
- 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.

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.

✓ **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 CCHP BH is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

CCHP utilizes their integrated electronic health record (EHR) and care management platform to exchange member information with ACO/MCO partners. The EHR hosts CCHP's Secure File Transfer Protocols (SFTP) server allowing BH care coordinators to submit member care plans, assessments, and other releases to ACO/MCO partners. An administrative assistant also helps care coordinators communicate with ACO/MCO partners about member data.

The CCHP referral coordinator is the primary point of contact for ACOs/MCOs and is responsible for reviewing ACO/MCO spreadsheets containing referred members' contact information. The referral coordinator distributes contact information to the BH care teams and supports the care teams in communicating contact information and member status outreach reports back to the ACOs/MCOs. The coordinator also follows up on outreach activities for high priority members prior to them showing up on enrollment files from ACOs/MCOs to meet immediate member needs. CCHP BH receives various other files (i.e., assessment tracker spreadsheets, PCP information, weekly member update files, weekly approved/denied authorization files) from at least one ACO. They receive ADT feeds from three ACOs/MCOs.

CCHP BH is unable to share member contact information with some PCP partners and faces delays in getting some PCPs to sign-off on care plans. However, CCHP BH has made inroads in engaging PCPs through strategic integration with the Department of Mental Health (DMH) and Adult Community Clinical Services (ACCS) staff. CCHP BH RNs and clinical care managers hold monthly meetings with all DMH offices to discuss complex cases and in return, DMH and ACCS staff teams have also supported CP integration with PCP practices.

Integration with ACOs and MCOs

CCHP BH has agreements and established Documented Processes with the nine ACOs/MCOs in their service area. CCHP BH holds quarterly meetings with their ACO/MCO partners in which they discuss member journeys and highlight the ways they have been successful connecting members to the appropriate services.

The CCHP has had success in setting up separate monthly case review meetings for the BH CP with many of its ACO/MCO partners, including Community Care Cooperative, BMCHP BACO, FLN Reliant, and Tufts MCO. Notably, CCHP BH has an in-person meeting every other week with FLN Reliant staff to obtain sign-off on member care plans and discuss complex cases. Tufts MCO has implemented integrated care team meetings with CCHP BH that occur at the time a care plan is signed for an individual member.

CCHP BH recognized the importance of collaborating with agencies, such as ACCS and DMH, for mutual members early in the program. CCHP BH created an FAQ reference document for ACCS to demonstrate ways in which the two organizations may effectively work together to provide the best care for members. Additionally, CCHP BH staff meet monthly with all DMH offices to discuss complex cases and outreach efforts for members that have been difficult to engage. In return, DMH and ACCS staff teams collaborate with CCHP care coordinators to achieve integration with PCP practices.

CCHP BH facilitates collaboration with ACO/MCO partners on member care transitions through timely review of clinical event data. CCHP BH's staff have access to ENS notifications through the CP's EHR, and care coordinators review alerts in their workflow daily to ensure appropriate follow-up.

CP Administrator Perspective: “*Staff members and Enrollees participating in ACCS have shared that the CCHP Team has been valuable to them, specifically around providing support for medical needs (since they have been more focused on attending to member's behavioral health needs). More specifically, we have connected individuals with needed medical equipment (Durable medical equipment like wheelchairs, Lifeline, CPAP supplies, etc.) or referrals to specialty providers (VNA, Nutritionist, AFC, etc.).*”

Joint management of performance and quality

CCHP BH has data-driven QI initiatives related to member engagement outlined in CCHP’s Quality Plan and uses reports from their EHR to track progress on key performance indicators. The CP shares these reports with ACO/MCO partners and with all APs during QMC and Governing Board meetings. One example is CCHP’s Care Coordination Touchpoints Report, which is produced in CCHP’s EHR and provides insights on the number and type of interactions staff have had with members and how many interactions are required for a member to become engaged.

In 2019, CCHP enhanced their reporting to demonstrate their value to ACOs and MCOs. CCHP collaborated with the University of Massachusetts (UMass) to combine claims data and Qualifying Activities⁷ data recorded in their EHR into an online reporting solution that can show total cost of care (TCOC) and pre and post engagement in care coordination supports.

CCHP has established case conferences with one ACO to engage PCPs in a comprehensive review of outstanding member care plans. Case conferences have allowed the CP to receive sign-off on care plans in a timely manner. CCHP exchanges assessment tracker spreadsheets with one MCO as well as assignment files that contain ACO and PCP contact information. To further ensure care plan review, CCHP produces a weekly member update file that it distributes to all ACO/MCO partners.

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;

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

- 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 CCHP BH is **On track with limited recommendations** in the Workforce Development focus area.

Recruitment and retention

CCHP BH reports challenges in hiring independently licensed staff and registered nurses (RNs) and bilingual care coordinators to serve their Arabic and Vietnamese speaking member populations. CCHP BH was able to hire a Spanish-speaking care coordinator and other licensed staff. The CP struggled to hire a billing specialist in 2019, and this position remains vacant. Despite these challenges, CCHP BH recently reported that they filled all core staff positions and are no longer actively hiring care coordinators or care managers.

CCHP BH employs a variety of mechanisms to recruit qualified candidates for the BH CP program, including college career resource centers, internet sources, career fairs, Recovery Learning Communities, and referrals through current employees. To share costs and hire more efficiently, all CCHP APs use a centralized recruitment platform to triage candidates. The CP also holds internal career fairs to give current staff the opportunity to learn more about BH CP program opportunities.

To retain qualified staff, CCHP BH provided student loan repayment to one staff nurse and one care coordinator through Statewide Investment 1a; the staff nurse has pledged to remain with CCHP BH for four years of service. CCHP pays tuition for care coordination staff to attend community health worker training. Other incentives include salary enhancements offered at year end to care managers, RNs, administrative personnel, and care coordinators, although these were not disbursed in 2019. CCHP BH allocates funds for staff celebrations to build morale and recognize employees. In April of 2018, CCHP BH offered a raffle prize to care coordination staff that completed the most care plans.

CCHP BH pays a group of care managers a stipend to serve as mentors for new care coordinators and allows remote work as additional retention measures. CCHP BH also holds weekly staff meetings that allow care coordinators to network, discuss program changes, pose questions, and collaborate in a team setting.

Training

At the start of the contract period, the CCHP Core Team developed and facilitated a set of training sessions aimed to meet the MassHealth contract requirement as well as increase each Care Coordinator's core competencies. CCHP BH now provides in-person training during the first two weeks of employment and provides ongoing monthly training on established and emerging best practices for care coordination for all staff. Notably, in 2019, the BH team participated in a Hearing Voices training to gain insight into the experience of members who hear voices. Managers regularly observe all BH staff performing care coordination activities and staff participate in weekly meetings that provide training and consultation.

The CCHP adopted their AP's Human Resources Workgroup training approach to track participation, gather evaluations, develop training guides, and monitor ongoing training needs.

CP Administrator Perspective: "We have used our monthly meetings to provide refresher trainings as well as bring in guest speakers to discuss needs the team may have identified. Most notably were recent training sessions focused on vicarious trauma and motivational interviewing. CCHP staff also participated in a Tobacco Education and Treatment ... presentation in May. The BH team participated in a Hearing Voices training for staff which was extremely helpful for us to gain insight into what it is really like for someone who is hearing voices. In addition, regular clinical consultation to the team is provided."

Recommendations

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

- developing strategies to promote diversity in the workplace.

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 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 Hlway⁸ 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.

⁸ Mass Hlway is the state-sponsored, statewide, health information exchange.

Results

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

Implementation of EHR and care management platform

CCHP BH has access to ADT notifications from most of its ACO/MCO partners via its care management platform. The CP has integrated notifications from two separate ENS platforms and manually enters data from ADT feeds as events in the platform. CCHP BH maintains four ADT feeds with Beacon Health Options, Inc. (a managed BH Organization) and with multiple ACOs/MCOs including, Partners HealthCare Accountable Care Organization, LLC; Steward Medicaid Care Network, Inc.; Tufts Health Public Plans (MCO); and Wellforce in partnership with Fallon Community Health Plan. Regardless of the source, care coordinators have access to the relevant information for the member event via CCHP's care management platform.

In addition to integration of ENS, CCHP BH reports other improvements to their care management platform since the program began. The CP's care management vendor updated the activity notes, so care coordinators are able document activities beyond Qualifying Activities⁹ that do not qualify for PMPM¹⁰ payment, such as unanswered follow-up attempts.

Interoperability and data exchange

As previously discussed, CCHP's integrated EHR and care management platform solution hosts CCHP's SFTP server for document exchange with ACO/MCO partners. Reports indicate the platform is equipped to alert care coordinators of receipt of member information.

CCHP BH has advanced towards greater interoperability with one ACO, FLN Reliant, by obtaining read-only access to their EHR.

In their most recent progress report, CCHP BH reported they can share and/or receive member contact information, comprehensive needs assessments, and member care plans electronically from all or nearly all MCOs and from most ACOs. CCHP BH can share and/or receive member care plans from most PCPs but not member contact information or comprehensive needs assessments. CCHP BH is only able to share and/or receive member contact information electronically from some PCPs and comprehensive needs assessments from none or very few PCPs.

Data analytics

CCHP leadership and the quality management staff have access to a variety of sample reports via CCHP's EHR/care management platform. CCHP leadership have worked with the vendor to create and update reports as needed to assist staff with tracking Qualifying Activities¹¹, status, and where in the engagement process the member is, as well as to reflect changes and extensions to the CP Program guidelines and timeline. In 2019, CCHP created the Care Coordination Touchpoints Report as described above and the ACO Spend Report, which will be used to identify members with the highest need by ACO/MCO. This was achieved through a Technical Assistance (TA) project, funded by DSRIP Statewide Investment program (SWI), with the University of Massachusetts Medical School on data integration. CCHP is working with University of Massachusetts Medical School to develop a cohesive online environment (fulfilling the functions of an interactive dashboard) fed by a data

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.

¹⁰ PMPM stands for per Member per month. CPs are reimbursed as a set PMPM rate.

¹¹ 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.

warehouse to oversee documentation on key quality metrics. All performance data for the LTSS and BH entities is reported to the QMC. CCHP is actively working with their care management vendor on new reports as well as more frequent reporting mechanisms.

Recommendations

The IA encourages CCHP BH 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 Hlway.

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

Outreach and engagement strategies

CCHP BH prioritizes hiring highly qualified, culturally competent individuals who are trained in evidence-based practices such as motivational interviewing, wraparound care models, and psychiatric rehabilitation service models. CCHP BH employs staff who have lived experience (peer supports) and has trained several care coordinators as CHWs. Additionally, CCHP BH utilizes Recovery Support Navigators to provide specialized care to individuals with SUD through their material subcontractor, AdCare Hospital.

CCHP BH conducts direct community outreach in shelters, food pantries and parks to engage the homeless population. CCHP contracted with a vendor to provide telephonic and in-person language interpretation services, which has assisted in connecting with members.

CCHP BH notes challenges with member engagement. There have been many instances in which a member is no longer interested in CCHP BH's supports after the member's immediate needs were met. Another barrier to successful engagement is lack of member transportation. As previously noted, CCHP BH has worked to mitigate this barrier by providing members with free app-hailed rides through a dedicated account.¹²

Person-centered care model

CCHP BH's person-centered treatment plans include enrollee goals and objectives, specific action steps to achieve goals, a method for tracking goal progress, referral needs to obtain care and services, educational needs, and any other necessary information. The plans may also include a crisis plan, especially for individuals with BH needs with a history of crisis service utilization.

CCHP care coordinators employ motivational interviewing techniques and other person-centered modalities that specifically assess the enrollee's immediate care needs and existing relationship with

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

a PCP. For the BH CP comprehensive assessment, CCHP BH utilizes a standardized community health assessment tool to minimize duplication and avoid strain on the enrollee.

CP Administrator Perspective: “The [proprietary community health assessment tool] and [person-centered care plan] ensure that work with [the] enrollee is person-centered by asking specifically about an enrollee’s self-identified strengths, challenges, interests, choices, preferences, and personal goals. In monthly contact with enrollees, care coordinators, care managers, and RNs encourage enrollees to discuss care plan goals.”

Managing transitions of care

CCHP BH has processes in place with the majority of its ACO/MCO partners that enable CCHP BH to pull reports of admissions and discharges and manage transitions of care. Care coordinators are first alerted of an ED or inpatient admission/discharge for one of their members in their daily workflow within CCHP’s care management platform. CCHP BH’s care coordinators perform follow-up by calling the hospital and ensuring members make their subsequent appointments. BH care managers, who are the supervisors of care coordinators, also receive notifications when a member in their caseload is admitted or discharged from a provider hospital. BH care managers support care coordinators if they are unable to follow-up with members during a transition. CCHP BH’s Senior RN Manager meets monthly with ACO/MCO care teams to discuss high priority members, and CCHP BH’s nursing team collaborates with ACCS, DMH, and ACO hospital staff during care transitions for members with complex medical and BH needs.

CCHP BH’s AP, AdCare Hospital, plays a large role in administering their transitions of care. CCHP BH reports AdCare Hospital offers immediate enrollment into outpatient treatment, post-inpatient admission, suggesting the presence of warm handoffs. AdCare Hospital also provides expertise in transitions from intensive outpatient treatment to less intensive services.

Improving members’ health and wellness

CCHP BH reports they use a variety of smartphone applications to assist enrollees in improving their health and wellness, including applications to track condition-related information such as mood and anxiety levels, and applications that support recovery by providing support and information. The CP has taken a variety of other actions to support member health and wellness such as developing a Health and Wellness Committee, training staff in Executive Order 509 nutrition standards, and offering programs related to nutrition, tobacco cessation, and self-management of chronic medical conditions. CCHP provides in-house trainings by external agencies for care coordinators to enhance their knowledge of community resources. The CP reports that their care management platform provides a centralized hub for outside providers to receive referrals.

Continuous quality improvement

CCHP BH fully utilizes their CAB as a structure to gauge and improve member experience. The CAB advised BH staff to become more visible in the community to reduce stigma surrounding SUD and mental illness, and this prompted the CCHP team to participate in a local suicide prevention walk to raise money and awareness. As previously discussed, the CAB has also drawn CCHP leadership’s attention to the importance of transportation in accessing healthcare system resources.

CCHP BH is engaged in a TA project funded through SWI to assess quality of care in relation to TCOC in order to improve their provision of CP supports and maximize value.

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 services¹³;
- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

✓ **Person-centered care model**

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

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
- meeting an enrollee in person once care coordinators receive alerts that they were admitted;
- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges¹⁴;
- 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**

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

¹⁴ Where members have authorized sharing of SUD treatment records.

- 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.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that CCHP BH 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:

- Integration of Systems and Processes
- Care Model

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

Organizational Structure and Engagement

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

Workforce Development

- employing tactics to increase diversity in the workplace

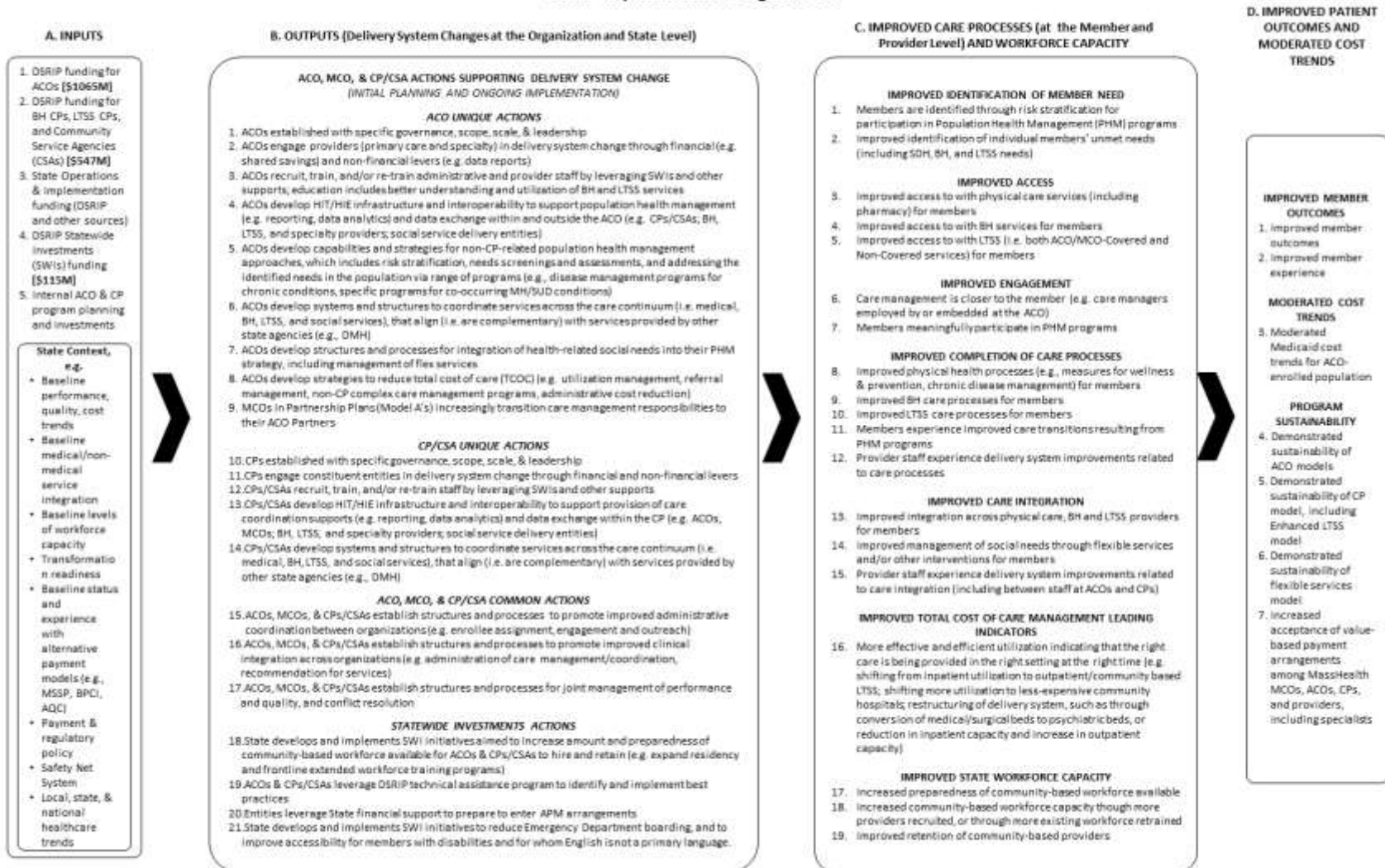
Health Information Technology and Exchange

- developing a plan to increase active utilization of Mass HIway

CCHP BH 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 Evaluator¹⁵ (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	<ul style="list-style-type: none"> • CPs established with specific governance, scope, scale, & leadership • CPs engage constituent entities in delivery system change
Integration of Systems and Processes	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports
Health Information Technology and Exchange	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 Request for Change

In reference to Recruitment and Retention Results, pg. 16: CCHP pays 2 senior BH care coordinators a monthly stipend to serve as mentors for the BH Care Coordination team.

CP Comment

- Per the recommendation for Organizational Structure, since 2018 CCHP instituted weekly meetings with administrative and clinical leadership, identified as the “Core Team,” to discuss operations and strategies to improve efficiencies. In the weekly Core Team meetings, CP productivity stats are reviewed, an update on operations is provided for each area of the CP (enrollment, quality and administration, LTSS CP, BH CP, and nursing), and plans are made to ensure follow through with improvement efforts to address identified needs or challenges. The CCHP Governing Board meets monthly. Via this meeting structure all Affiliated Partners are informed about CCHP operations participate in strategic planning and high level problem solving..
- Per the recommendation for Workforce Development,
 - CCHP created an “HR Work Group” where leadership from each Affiliated Partner meets quarterly to make ensure staff compensation and benefit packages are equitable and fair.
 - CCHP has attempted to recruit bicultural staff since the inception of the program. There have been challenges recruiting diverse candidates. We have been successful in hiring bilingual staff (Spanish-Speaking); however, have struggled to hire Arabic staff to serve high Arabic population.
 - The lead Affiliated Partner (Open Sky Community Services) is dedicated to advancing race equity and inclusion. Our hope is that these efforts will attract diverse candidates..
- Per the recommendation for Health Information Technology and Exchange, CCHP has been working with representatives from the Mass Hlway and Fallon 365 in an effort to utilize the Mass Hlway for exchange of shared Member information relating to visits with providers.