

# MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

## Community Partner Report: Coordinated Care Network (CCN)

Report prepared by The Public Consulting Group: December 2020

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# DSRIP Midpoint Assessment Highlights & Key Findings Coordinated Care Network (CCN)



A Behavioral Health Community Partner

## Organization Overview

CCN is a consortium of providers dedicated to connecting individuals with local services and resources to support wellness, independence, and recovery. CCN provides inclusive case management to adults with serious mental illness (SMI) and/or substance use disorders (SUD), working together with ACOs and health plans.

## SERVICE AREA



## POPULATIONS SERVED

- ▶ CCN's primary service area includes Quincy, Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, and Wareham and all surrounding towns.
- ▶ CCN serves a population with diverse cultural and linguistic needs, those diagnosed with SMI and SUD, persons experiencing homelessness, enrollees with life skills needs, and enrollees with development disabilities. CCN also serves enrollees' family members, if applicable to the enrollee's care plan.

**2,321**

**Members Enrolled  
as of December 2019**

## FOCUS AREA

## IA FINDINGS

Organizational Structure & Engagement	● On Track	
Integration of Systems & Processes	● On Track	● Limited Recommendations
Workforce Development	● On Track	
Health Information Technology & Exchange	● On Track	● Limited Recommendations
Care Model	● On Track	

## IMPLEMENTATION HIGHLIGHTS

- CCN developed an internal event notification capability to locate members and contracted with three event notification services to receive notifications from all emergency departments in their service area.
- CCN's outreach workers engaged persons experiencing homelessness in care coordination services by visiting locations in the community where these individuals live.
- CCN initiated clinical rounds with several partner ACOs to discuss high risk members.
- CCN partnered with a health plan on a quality initiative project which focuses on improving rates of follow-up after hospitalization.

## Statewide Investment Utilization:

- Student Loan Repayment Program, 4 Care Coordinators participating
- Community Mental Health Center Behavioral Health Recruitment Fund, 2 slots awarded
- 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<sup>1</sup> (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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<sup>1</sup> 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
<b>Organizational Structure and Governance</b>	<ul style="list-style-type: none"> <li>CPs established with specific governance, scope, scale, &amp; leadership</li> <li>CPs engage constituent entities in delivery system change</li> </ul>
<b>Integration of Systems and Processes</b>	<ul style="list-style-type: none"> <li>CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)</li> <li>CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)</li> <li>CPs establish structures and processes for joint management of performance and quality, and problem solving</li> </ul>
<b>Workforce Development</b>	<ul style="list-style-type: none"> <li>CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports</li> </ul>
<b>Health Information Technology and Exchange</b>	<ul style="list-style-type: none"> <li>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)</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>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))</li> </ul>

## 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<sup>2</sup>

Coordinated Care Network (CCN) is a behavioral health (BH) CP.

Coordinated Care Network (CCN) is a consortium of providers dedicated to connecting individuals with local services and resources to support wellness, independence, and recovery. CCN is comprised of six Affiliated Partner (AP) agencies, Bay State Community Services, Brockton Area Multi Services, Child & Family Services, Duffy Health Center, High Point, and Steppingstone, and two material subcontractors, Brockton Neighborhood Health Center and Community Health Center of Cape Cod.<sup>3</sup> CCN provides inclusive case management to adults with serious mental illness (SMI) and/or substance use disorders (SUD), working together with ACOs and MCOs.

CCN's primary service area is Southeastern Massachusetts and includes the communities of Quincy, Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, and Wareham and all surrounding towns. CCN serves a member population with diverse cultural and linguistic needs and life skills needs. CCN enrollees may experience housing instability or homelessness and/or have developmental disabilities. CCN serves enrollees' family members, if applicable to the enrollee's care plan.

As of December 2019, 2,321 members were enrolled with CCN<sup>4</sup>.

## SUMMARY OF FINDINGS

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

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track

<sup>2</sup> Background information is summarized from the organizations Full Participation Plan.

<sup>3</sup> 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.

<sup>4</sup> 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 CCN is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

#### **Executive Board**

CCN has an Executive Committee made up of leadership from all six of its Affiliated Partners (APs). AP senior management staff have proportional voting powers based on the number of members served by each entity. The Executive Committee meets monthly and holds regular meetings with the QMC and Operational Committee.

#### **Consumer Advisory Board**

CCN's CAB meets quarterly at a minimum. CCN has a CAB handbook and an ongoing agenda of topics to discuss during meetings. CCN continues to face low participation in CAB meetings but reports that increasing the frequency of meetings has helped attract more members. CCN provides mileage reimbursement, offers catered meals, introduced teleconferencing capability, and held chair

and co-chair elections to increase interest and attendance. In 2019, CCN hosted a Halloween party and holiday social to promote awareness of the CAB.

*CP Administrator Perspective: "With a consistent membership, the CAB was able to complete some goals they had set for the year including, the development of the CAB handbook and an ongoing agenda identifying several topics of relevance to current and prospective members. Some topics discussed during the CAB meetings included, overview of CCN and the ultimate goals of developing a CAB, clinical discussions of varying behavioral health related matters, health and wellness, community based resources, dietary matters and financial matters including budgeting and saving."*

### **Quality Management Committee**

The CCN Director chairs the QMC along with CCN APs' senior management staff who serve on the committee. The QMC meets monthly to review CCN's quality metrics slate and develop policies and procedures related to quality monitoring and improvement. CCN also has an Operations Committee which reviews CCN's day to day operations.

The QMC selects CCN's QI initiatives using data from their care management platform, staff meetings, patient meetings, surveys, grievances, critical incident reporting, and other data. The QMC then reports QI initiatives to the Executive Committee along with the Plan-Do-Check-Act plans implemented by performance teams. The QMC collects data from APs quarterly to report to the executive committee.

In 2019, CCN improved reporting capacity within their care management platform to show productivity and insights about their member population. At present, the QMC is monitoring metrics on Care Transitions, the Follow-up After Hospitalization for Mental Illness (FUH) Healthcare Effectiveness Data and Information Set (HEDIS) measure with Boston Medical Center HealthNet Plan, monthly chart audit reviews of CCN enrollees and follow-up after emergency department (ED) visits and inpatient admissions.

### **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)<sup>5</sup> Joint Operating Committee;

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<sup>5</sup> 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.

- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and
- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

✓ **Consumer Advisory Board**

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

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
- integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
- 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 CCN is **On track with limited recommendations** in the Integration of Systems and Processes focus area.

#### **Joint approach to member engagement**

CCN contracts with 11 ACO/MCO partners. CCN's electronic health record (EHR) and care management platform hosts the Secure File Transfer Protocol (SFTP) site for the exchange of care plans and updated member contact information. CCN also uses secure file sharing applications for file transfer allowing staff at all AP organizations to access secure file transfer platforms. Individual care coordinators are responsible for transmitting care plans and tracking receipt of PCP signatures for their members.

CCN hired a dedicated community liaison to build relationships with PCPs and educate them about CCN's program. CP leadership is working with ACO partners to build more established partnerships between the CP and individual PCPs.

CCN staff begin member outreach within days of receiving and documenting ACO/MCO spreadsheets in their EHR. During outreach, CCN staff collect all necessary data from the member. CCN developed task lists to assist care coordinators with filling in missing contact information from ACO/MCO member lists. Task lists direct coordinators to reach out to the PCP on file, reach out to the ACO listed, check the internal EHR for other contacts and send mailings to the member to collect the correct member information that the coordinator can document in the EHR.

### **Integration with ACOs and MCOs**

CCN conducts monthly meetings with representatives from several ACOs/MCOs, and quarterly meetings with others, to discuss program implementation. CCN uses these meetings to align their current processes with ACO/MCO priorities. CCN also had individual meetings with ACO leadership at the outset of the program to prevent duplication of effort during member care transitions and to discuss best practices for initiating contact with potential members.

Prior to initial engagement, CCN care coordination staff contact ACO care management teams to assist with outreach and participate in a member's care team. In 2019, CCN began hosting clinical rounds with two ACOs. During rounds, CP staff discuss high-risk cases with key ACO contacts.

In 2019, CCN gained access to ENS notifications from multiple vendors. These notifications appear in their EHR and provide up-to-date contact information for members to facilitate timely outreach.

### **Joint management of performance and quality**

CCN partnered with an ACO on a QI initiative to improve the percent of members who had a follow-up visit with a mental health practitioner within seven days of a psychiatric hospitalization. CCN's QMC collects and reports data on this measure for the QI initiative.

To support care coordinators in their effort to engage PCPs in a comprehensive care plan review CCN shares monthly outreach status reports with ACO/MCO partners. CCN has reports to track the date they sent each care plan and the date the partner received it. These status reports encourage partners to review and sign-off on care plans in a timely manner. One of CCN's ACO/MCO partners regularly reviews the status reports and reaches out to their own PCPs to proactively help complete sign-off on care plans.

CCN established internal review processes to collect and disseminate data on key quality metrics. CCN program directors and clinical care managers review charts of their engaged members against a rubric of quality metrics and contract requirements every month. CCN reports this data to staff through the centralized care management platform and compares performance between APs.

Similarly, all APs have access to CCN's billing reports through the centralized care management platform.

### **Recommendations**

The IA encourages CCN to review its practices in the following aspects of the Integration of Systems and Processes focus area, for which the IA did not identify sufficient documentation to assess progress:

- dedicating staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).

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

### Recruitment and retention

CCN does not report any persistent vacancies but had difficulty finding qualified candidates to meet the needs of high-risk members and in projecting staffing based on member volume. CCN overcame these challenges and was fully staffed a month before program go-live in 2018. CCN adopted an aggressive initial hiring strategy, hosting three open house hiring fairs, presenting at career centers, and targeting more than seven local colleges. CCN currently has a human resource (HR) committee comprised of the HR staff of all APs. The HR committee advertises open positions using a data-based platform that allows them to access all job boards where positions are posted through one interface as well as trend and analyze applicant data over time. CCN posts opportunities on college/university job boards, social media, agency websites, and their own organizational website. Several CCN partners provide referral bonuses to aid the recruitment process.

To ensure diversity in the workplace, CCN advertises in local bilingual newspapers and on social media with messaging that emphasizes their desire to hire diverse staff. Additionally, some AP organizations reimburse bilingual staff at a higher rate. CCN recruiters work closely with the local recovery centers, recovery learning communities, peer training programs, and the University of Massachusetts' Addictions Certificate programs to reach individuals with lived experience that reflect the populations they serve.

CCN retains staff in part through yearly retention bonuses, leadership's commitment to a collaborative team-based culture, the opportunity for staff to maintain licensure, become a recovery coach or be certified in trauma-informed care, and a commitment to hiring individuals full-time with health, dental, and paid-time off benefits. CCN implemented performance incentives on key quality metrics such as having a member complete their annual primary care visit or performing medication reconciliation within three days of a care transition. As an additional incentive, CCN is participating in the following statewide investment opportunities: the Student Loan Repayment Program (SWI 1a, 1b, and 1c), Primary Care/Behavioral Health Special Projects Program, Investments in Community-based Training and Recruitment, Competency-based Training/Background and CHW Core Competency and CHW Supervisor investments to provide student loan assistance and training for eligible care coordination staff.

### Training

CCN has a comprehensive training program on all program requirements including modules on motivational interviewing, effective outreach and active engagement techniques, and documentation requirements. CCN hosts an in-person training event annually for all BH CP staff. A similar event is held for new hires. CCN's HR committee develops policies and procedures for training, staff curriculum, processing systems, and implementation requirements.



CCN staff can attend additional trainings that are held on a rotating basis at various CCN partner sites to keep up to date on best practices in the field. These additional trainings cover the SHARE curriculum<sup>6</sup>, cultural competency, and trauma-informed care.

## **Recommendations**

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

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

### ✓ **Promoting diversity in the workplace**

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

### ✓ **Recruitment and retention**

- implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;
- assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;
- conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention;
- making staff retention a priority initiative of the QMC to leverage existing quality improvement structures and engage leadership to monitor progress towards retention goals;

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<sup>6</sup> Developed by The Agency for Health Care Research and Quality (AHRQ) SHARE curriculum. This curriculum offers the best practices of providing care management.

- 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 Hlway<sup>7</sup> 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 CCN is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

### Implementation of EHR and care management platform

CCN went live with a new EHR at the start of 2019. CCN utilizes a variety of ENS solutions that are integrated into their EHR and care management platform. The proprietary systems that CCN contracts with send admission notifications for all EDs and inpatient units in their catchment area, as well as admission notifications to skilled nursing and rehabilitation facilities in some cases. CCN notes these alerts are not received in real time but are still helpful in connecting with individuals who have presented in medical settings. In addition, CCN continues to use their own internally developed ENS which is also integrated into their care management platform. CCN's internal ENS tracks when a member is admitted into any level of care provided by High Point Treatment Center and other APs.

Integration of ADT data into their care management tool has assisted CCN in tracking admissions and discharges, which the CP cross references with the activities conducted by CCN care coordinators during care transitions.

*CP Administrator Perspective: "We also continue to use our own internally developed ENS. This system was developed last year by our IT department. When an BH CP Enrollee is admitted into any High Point Treatment Center level of care, including Substance Use levels of care, the care team receives an alert. This system has significantly increased the [number] of Enrollees we have been able to locate. The first month the system went live, October 2018, we located over 200 Enrollees. The system continues to be utilized and has shown great success."*

### Interoperability and data exchange

CCN's EHR hosts their SFTP server and they have been successful in sharing information with ACO/MCO partners through this method of data exchange as well as through secure file sharing applications. CCN recently gained read-only access to Boston Medical Center HealthNet Plan's PCPs' EHR to assist in gathering outcomes data for a shared QI initiative on the Follow-up After Hospitalization HEDIS measure and to promote the Boston Medical Center HealthNet Plan's text messaging reminders program for upcoming appointments. CCN shares and/or receives member

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<sup>7</sup> Mass Hlway is the state-sponsored, statewide, health information exchange.

contact information, comprehensive needs assessments, and care plans electronically with all ACOs and MCOs and some PCPs.

### Data analytics

CCN closely tracks their key quality metrics and uses this information for performance management of the BH CP program. CCN's EHR and care management platform houses all CCN's Qualifying Activities<sup>8</sup>, documentation, member information, comprehensive assessments, person-centered treatment plans, member medications and much more. CCN AP program directors and clinical care managers conduct monthly chart audits to monitor performance on key quality metrics and contract requirements. At present, program directors capture metrics manually, aggregate the results and send reports to the QMC and Executive Committees for review. Along with chart audits, CCN is also monitoring progress on their care transitions by aggregating monthly data on activities conducted in response to ENS notifications. CCN's Quality and Compliance Director oversees this data collection process and helps program directors generate reports. The CP Operations and Quality Committees implement corrective actions if necessary.

*CP Administrator Perspective: "Our change to a new [EHR] system at the very beginning of the budget period year significantly improved our workflows and procedures, making us recognize that we made the right decision. The efficiencies brought to us by standardized reports offered in our new [EHR] helped lessen the administrative burdens."*

### Recommendations

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

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;
- developing a plan to increase active utilization of Mass HIway; and
- developing a continuously refreshed dashboard, overseen by a multidisciplinary team, to monitor performance on key quality metrics.

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

- ✓ **Implementation of EHR and care management platform**
  - adopting enterprise exchange software that automatically retrieves files from partner SFTPs and moves them into the CP's EHR.
- ✓ **Interoperability and data exchange**
  - developing electronic information exchange capabilities that enable a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email; and
  - connecting with regional Health Information Exchanges (HIEs).

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<sup>8</sup> 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.

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

## Outreach and engagement strategies

CCN strives to employ individuals with lived experience as part of their outreach strategy. CCN works closely with the local recovery centers, recovery learning communities, the state Department of Public Health Bureau of Substance Addiction Services Recovery Coach Training program, the state Department of Mental Health Peer Training program, and the University of Massachusetts' Addictions Certificate programs to recruit staff with lived experience as well as provide funding for current staff to become certified as recovery coaches. CCN recovery coach care coordinators support members with SUD. CCN also employs direct outreach workers who have significant experience with community outreach and visit locations the homeless population tend to frequent, such as homeless shelters and tent communities. Outreach workers distribute CCN brochures, which are written in multiple languages, provide a program description, delineate the care coordination process, and provide responses to commonly asked questions.

CCN's outreach strategy is multifaceted. Care coordinators conduct direct outreach in locations where the enrollee may be getting support services (e.g. recovery learning centers and clubhouses<sup>9</sup>, food pantries, soup kitchens, day programs). To further keep in contact with members who may not be easily reached telephonically, CCN has used additional infrastructure funds to provide members with cell phones<sup>10</sup> in 2019.

## Person-centered care model

CCN reports that whenever possible, care team meetings are held at a convenient time in easily accessible locations to accommodate member needs. CCN also gives members the option to attend care planning meetings by phone or electronically. CCN team members are responsible for assisting in the development of goals, supports, and interventions that are both clinically appropriate and acceptable to the enrollee. Care coordinators collaboratively identify and document personal wellness goals as well as the means of achieving overall goals in member care plans. CCN care coordinators assign action steps to help members meet their goals to specific members of the care team. To promote person-centered care planning, CCN care teams are trained in motivational interviewing and the Five Stages of Change Model<sup>11</sup> to understand the process each member moves through when making changes in their life.

CCN provides supports to all assigned members, even if they are not yet engaged, to encourage future participation in CP supports. CCN care teams often provide supports to members prior to signing the participation plan due to the health-related social needs identified in member assessments. CCN care coordinators assist members with accessing housing, food, transportation<sup>12</sup>, and financial assistance first to build trust and provide person-centered care.

## Managing transitions of care

CCN focused its first QI initiative on transitions of care at the program's inception. Their initiative focused on timely and complete information exchange, participation in the transition planning process from the outset, follow-up with the member according to quality goals, and deployment of recovery coaches to support members with SUD.

<sup>9</sup> The Massachusetts Clubhouse Coalition is a non-profit organization dedicated to assisting adults with major mental illness to live full, productive, stable lives in the community. Their membership includes more than 15,000 Massachusetts residents who have a major mental illness and belong to at least one of the 32 community-based vocational and social rehabilitation centers, called "Clubhouses".

<sup>10</sup> CPs should first utilize Lifeline program for members as appropriate.

<sup>11</sup> Prochaska, J. O., & Velicer, W. F. (1997). The Transtheoretical Model of Health Behavioral Change. *American Journal of Health Promotion*. <https://doi.org/10.4278/0890-1171-12.1.38>

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

CCN's processes for routine warm handoffs during transitions of care involve the member's assigned care coordinator and a CCN nurse care manager. Once informed of an admission, the assigned care coordinator and a CCN nurse care manager contact the facility where the member was admitted, coordinate with provider staff, and begin discharge planning. The nurse care manager also assists the care coordinator with follow-up and care planning post-discharge. CCN meticulously tracks transition activities for the CP using the ADT record integrated into their care management platform.

Another way in which CCN provides warm handoffs is through open access hours at some of their AP sites. At these sites, members are offered a walk-in appointment immediately following discharge to discuss plans for how they will manage their care at home. During these appointments, CCN care coordinators ensure members are connected to the services they need: an outpatient provider, psychiatrist, referral to day-treatment, or a crisis team evaluation, if necessary.

### **Improving members' health and wellness**

CCN models their approach to health and wellness after the state Department of Mental Health's "Healthy Changes Initiative." The framework emphasizes improved health and wellness through screening, assessment, and evidence-based treatment planning for multiple needs, including nicotine addiction, obesity, and physical inactivity throughout the system of care. CCN care coordinators document personal wellness goals in member care plans and provide ongoing health education on methods to reduce high-risk behaviors.

CCN has had success in connecting members to social services and community resources to further improve health and wellness. CCN care coordinators have helped members obtain housing, enroll in educational programs, and obtain financial assistance (e.g., state Department of Transitional Assistance benefits, SNAP program, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)). CCN care coordination staff access community resource documents via a shared site.

### **Continuous quality improvement**

CCN's CAB and QMC are the primary mechanisms for identifying opportunities for continuous QI in quality of care and member experience. CCN's CAB discusses member health and wellness, the availability of community-based resources, and financial matters that are important to members in the provision of CP supports. CCN's CAB meets frequently and the structured agenda of discussion topics allows the CAB to touch upon both CP and member priorities. CCN's QMC reviews member grievances and critical incident reporting in addition to data related to CCN's quality metric slate to ensure adverse member experiences are appropriately addressed by CCN's quality management plan.

One way in which CCN has worked to improve quality of care and member experience is by forming relationships with two ACO-driven health centers – Brockton Neighborhood Health Center and Community Health Center of Cape Cod—in order to provide care coordination supports to members in the same location where they receive primary care and behavioral healthcare.

## ***Recommendations***

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

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

- ✓ **Outreach and engagement strategies**
  - acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);

- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
  - providing free transportation options for members to engage with services<sup>13</sup>;
  - assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
  - expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.
- ✓ **Person-centered care model**
- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
  - setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
  - developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and
  - allowing members to attend care planning meetings by phone or teleconference.
- ✓ **Managing transitions of care**
- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
  - establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
  - meeting an enrollee in person once care coordinators receive alerts that they were admitted;
  - visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges<sup>14</sup>;
  - 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;

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

<sup>14</sup> Where members have authorized sharing of SUD treatment records.



- 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 CCN 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
- Workforce Development
- Care Model

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

### ***Integration of Systems and Processes***

- dedicating staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).

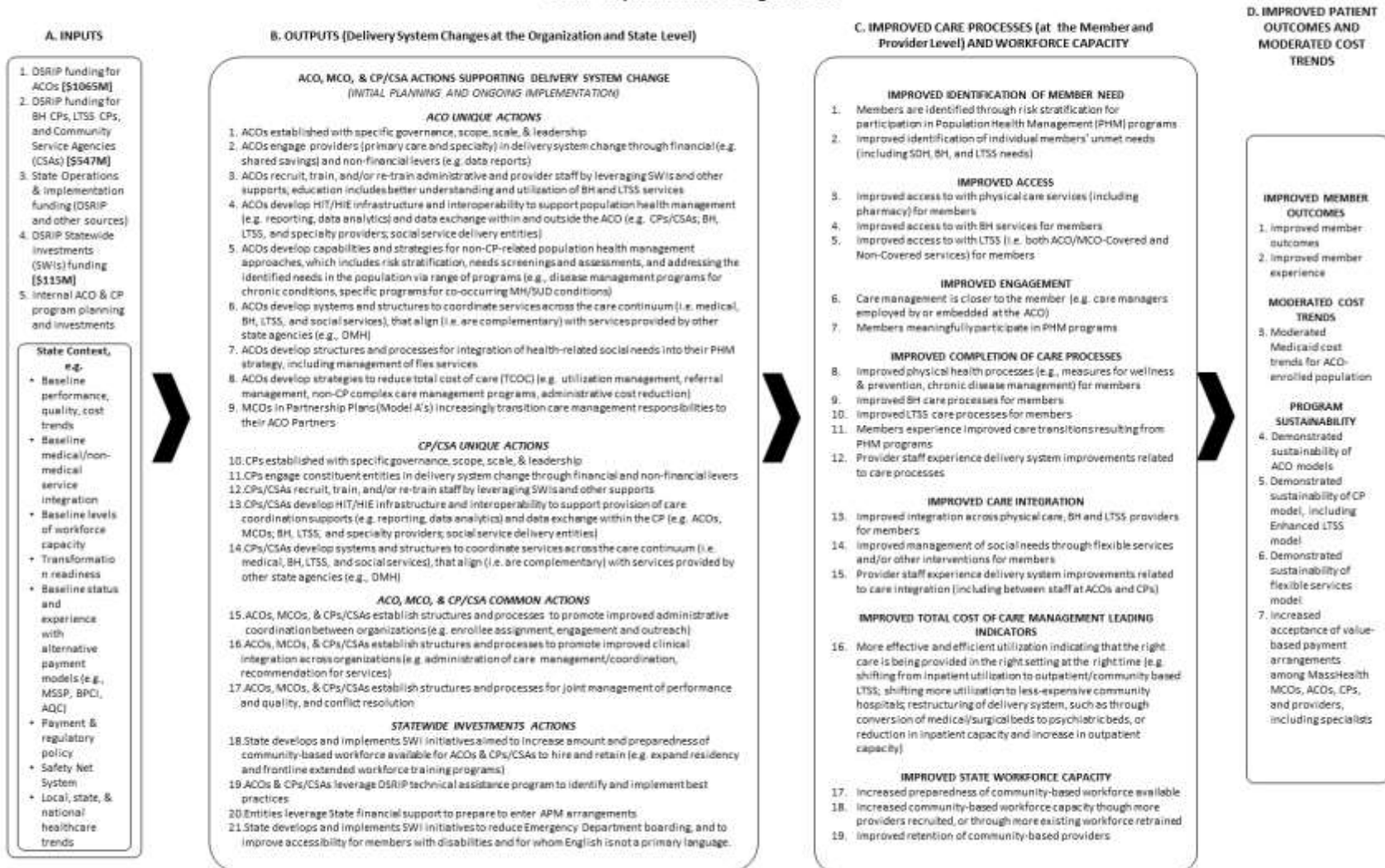
### ***Health Information Technology and Exchange***

- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;
- developing a plan to increase active utilization of Mass HIway; and
- developing a continuously refreshed dashboard, overseen by a multidisciplinary team, to monitor performance on key quality metrics.

CCN 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<sup>15</sup> (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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<sup>15</sup> 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
<b>Organizational Structure and Governance</b>	<ul style="list-style-type: none"> <li>• CPs established with specific governance, scope, scale, &amp; leadership</li> <li>• CPs engage constituent entities in delivery system change</li> </ul>
<b>Integration of Systems and Processes</b>	<ul style="list-style-type: none"> <li>• CPs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)</li> <li>• CPs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)</li> <li>• CPs establish structures and processes for joint management of performance and quality, and problem solving</li> </ul>
<b>Workforce Development</b>	<ul style="list-style-type: none"> <li>• CPs recruit, train, and/or re-train staff by leveraging Statewide Investments (SWIs) and other supports</li> </ul>
<b>Health Information Technology and Exchange</b>	<ul style="list-style-type: none"> <li>• 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)</li> </ul>
<b>Care Model</b>	<ul style="list-style-type: none"> <li>• 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))</li> </ul>

## 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.<sup>16</sup> Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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<sup>16</sup> KII were developed by the IE and conducted jointly by the IE and the IA. The IA utilized the KII transcripts as a secondary data source; the IA did not perform a full qualitative analysis of the KII.

## APPENDIX III: ACRONYM GLOSSARY

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

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

## APPENDIX IV: CP COMMENT

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

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

### CP Comment

CCN appreciates the thorough detail of the report. We are looking forward to implementing new strategies based on the recommendations, in addition to the continued use of our current strategies. For health information technology and exchange, current strategies include the daily use of SFTP with dedicated staff monitoring the alerts and daily receipt of client files. As a TA DSRIP project, CCN is in the process of developing a refreshed dashboard to monitor performance on key quality metrics. In regards to Integration of systems and processes, CCN is currently contracted with two Event Notification Systems and has developed our own internal system which notifies us to members entering our substance use levels of care. These systems are monitored daily by program staff and we are reviewing internal processes to improve our review and response time to these notifications.