MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Community Care Partners, LLC.

(CCP)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Community Care Partners, LLC (CCP)

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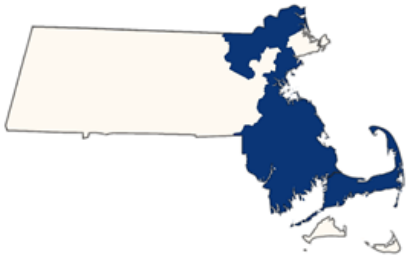
A Behavioral Health Community Partner

Organization Overview

CCP is a collaboration of three community-based providers that offer integrated care coordination services to MassHealth enrollees with complex medical and behavioral health needs. The organizations, Bay Cove, Vinfen and Bridgewell, provide a comprehensive set of community-based mental health, behavioral health and substance use treatment services.

SERVICE AREA



POPULATIONS SERVED

- CCP's primary service area includes the greater Boston area, and areas north and south of Boston. CCP serves a population of adults, age 21- 64, of diverse cultural, linguistic, racial, ethnic and religious backgrounds, many of whom are homeless and need help coordinating medical, mental health, substance use care; social services; and community resources.
- Over 50% of enrollees have co-occurring medical complexities, such as HIV and cardiovascular disease and nearly 40% have co-occurring serious mental illness and substance use disorders.

3,237

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- CCP hired bilingual care coordinators and care coordinators who specialize in partnering with LGBTQ enrollees.
- CCP established monthly administrative check-ins with several ACO/MCO partners.
- CCP care coordinators engage with hard-to-reach members in-person at emergency departments/hospitals.
- CCP transitioned a new care management platform that increases efficiency.

Statewide Investment Utilization:

- Student Loan Repayment Program, 2 Care Coordinators and 1RN/LPN participating
- Special Projects Program
- Certified Peer Specialist Trainings
- Community Health Worker Trainings
- Technical Assistance
- CP Recruitment Incentive Program

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1: Framework for Organizational Assessment of CPs

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

METHODOLOGY

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

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

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

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

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

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

CP BACKGROUND[2]

Community Care Partners, LLC (CCP) is a behavioral health (BH) CP.

CCP is a collaboration of three community-based providers – Bay Cove, Vinfen and Bridgewell – that offer integrated care coordination supports to MassHealth enrollees with complex medical and BH needs. These member organizations provide a comprehensive set of community-based mental health, BH and substance use treatment services.

CCP's primary service area includes the greater Boston area as well as areas north and south of Boston including the cities/towns of Revere, Somerville, Quincy, Haverhill, Lawrence, Lowell, Lynn, Malden, Salem, Attleboro, Barnstable, Brockton, Fall River, Falmouth, New Bedford, Orleans, Plymouth, Taunton, and Wareham. CCP serves a population of adults (ages 21- 64) of diverse cultural, linguistic, racial, ethnic and religious backgrounds. Members experiencing homelessness often need help coordinating medical care, behavioral healthcare including SUD treatment, social services and supports, and community-based resources. Over 50% of enrollees have co-occurring medical complexities, such as HIV and cardiovascular disease, and nearly 40% have co-occurring serious mental illness (SMI) or substance use disorder (SUD).

As of December 2019, 3,237 members were enrolled with CCP[3].

SUMMARY OF FINDINGS

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

[2] Background information is summarized from the organizations Full Participation Plan.
[3] 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).[4]
- ✓ **Consumer Advisory Board (CAB)**
  - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.
- ✓ **Quality Management Committee (QMC)**
  - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

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

Executive Board

CCP has an executive team consisting of leadership from CCP's founding member organizations. The executive team meets weekly with BH CP program leadership to review successes, barriers, mitigation strategies, and sustainability. One meeting each month is dedicated to reviewing financials for CPP.

CCP leadership meets with each member organization monthly to discuss staffing patterns, ACO relations, successes, and challenges. Program leadership additionally facilitates a weekly workgroup with Program Directors across member organizations to troubleshoot shared issues.

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

Consumer Advisory Board

CCP has had difficulties establishing and maintaining a consumer advisory board (CAB). CCP has been challenged to find members willing to make a continuous commitment. CCP held two CAB meetings in 2019; both had very low attendance. Due to low attendance, CCP decided to postpone CAB meetings until the fall of 2019. In the fall, CCP contracted with one of their LTSS member organizations, the Boston Center for Independent Living, to build out the CAB through targeted recruitment efforts. CCP continues to provide a stipend to CAB members.

Quality Management Committee

CCP's Quality Management Committee (QMC) includes the Director of Quality and Analytics, the Executive Director, the Medical Director, and Directors of Quality Management and Care Coordination for each member organization.

CCP has a quality reporting structure based on data from its electronic health record (EHR). In 2019, CCP's Data Analyst created an audit report for care team leaders that also functions as a quality tool for CCP executive leadership. The report flags issues related to achieving engagement milestones, missing documentation, and coding errors that would result in a loss of billing. CCP's QMC analyzes trends and uses the information to develop quality improvement (QI) initiatives and interventions. The CCP leadership team shares performance reports with member organizations prior to monthly meetings to underscore accountability and promote best practices throughout the organizations.

Separate from the QMC, CCP formed a new Risk Management Committee (RMC) in 2019. The RMC reviews critical incident reports with a focus on developing new safety protocols for care coordinators and members. The RMC meets monthly.

Recommendations

The IA encourages CCP 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:

- developing a successful strategy for recruiting members to participate in the CAB.

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

✓ **Executive Board**

- holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
- conducting one-on-one quarterly site visits with APs and CEs;
- holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[5] Joint Operating Committee;
- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and

[5] For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan.

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

Joint approach to member engagement

CCP exchanges member care plans with ACO/MCO partners via secure file transfer protocols (SFTP) hosted by its care management platform or through secure email. Weekly audit reports show how many members have achieved specific engagement milestones, such as receiving PCP sign-off on their care plan.

CCP has a variety of strategies for engaging with PCPs. Firstly, CCP care teams make an effort to connect with members' PCPs within the first month of assignment. Many PCPs require members to attend an in-person appointment prior to providing their signature on a care plan. To address this challenge, CCP embedded a part-time care coordinator at PCP practices from two different ACOs and is exploring opportunities with additional ACO/MCO partners for a similar level of integration.

Additionally, CCP has found that PCPs within some ACOs are still unaware of the CP program. To engage these providers, CCP care teams take time to educate PCPs about the CP program by distributing a provider-specific brochure with information about CP supports.

CCP shares member contact information electronically, but some ACO/MCO partners only reciprocate this information by phone or through supplemental files, particularly as it relates to ADT

information for members who experienced psychiatric hospitalizations. Supplemental data files are often sent several weeks later.

CCP's intake team processes ACO/MCO member spreadsheets to track eligibility and manage member enrollment and disenrollment. In 2019, CCP implemented a new care management platform allowing the CP to perform automatic eligibility checks against the MassHealth EVS daily.

> CP Administrator Perspective: "*Given that eligibility verification is critical to the BH CP program, it is essential that CCP's EHR/care management platform has the automated functionality to ensure that eligibility checks can be performed against the MassHealth EVS [Eligibility Verification System] system daily. Fortunately, our vendor has honed this functionality in BP2 [Billing Period 2, which is 2019], and Care Teams rely heavily on it in their day to day work."*

Integration with ACOs and MCOs

Early in the program, CCP aligned each ACO/MCO partner with a lead member organization to promote relationship building and communications between clinical staff and care teams, respectively. This strategy helped CCP care teams build relationships with counterparts in Boston Medical Center HealthNet Plan, Steward Medicaid Care Network Inc., Partners Healthcare Accountable Care Organization, LLC, and Cambridge Health Alliance in partnership with Tufts Health Public Plans. Additionally, the team led by CCP's Lawrence care team became a member of Merrimack Valley ACO in partnership with Allways Health Plan's Multiple Visit Patient team which focuses on reducing Emergency Department (ED) visits. CCP is in the process of embedding care coordinators in PCP practices or EDs to further improve coordination between ACO/MCO practices and CCP staff.

CCP participates in monthly case reviews with five ACO/MCO partners—Atrius Health in partnership with Tufts Health Public Plans, Tufts Health Public Plans, Beth Israel Deaconess Care Organization in partnership with Tufts Public Plans, Cambridge Health Alliance in partnership with Tufts Public Plans and Wellforce in partnership with Fallon Community Health Plan--and initiated monthly administrative check-ins with several other partners.

CCP accesses statewide Electronic Notification Systems (ENS) to notify care coordinators of changes in a member's status. This helps CCP locate hard to reach members.

Joint management of performance and quality

CCP studies outreach and engagement strategies used by BH CP care teams across the member organizations to identify best practices for outreach and engagement. In 2019, CCP began promoting the best practice of contacting PCPs within the first month of member assignment to ask for the date of the member's last visit. If it has been over a year since the member's last visit, the CCP care team will proactively schedule an appointment on behalf of the member. CCP tracks changes to member organization quality metrics such as days to first member contact, days to member participation form completion, and days to member engagement.

To support care coordinators in engaging PCPs in a comprehensive care plan review, CCP maintains a dedicated intranet system to share promising practices with BH care teams from different member organizations. Shared information includes PCP contact information, contact information for LTSS providers and local social services providers, MassHealth updates, updates to ACO/MCO workflows, and updates to internal workflows.

To further monitoring efforts, CCP developed a comprehensive audit report in their EHR that serves as a one stop supervision tool for managers. The report flags upcoming deadlines for member milestones, reviews enrollment and disenrollment actions, and identifies missing documentation for members who are not fully engaged. It also flags errors in coding for activities giving care teams the

ability to make corrections in advance of billing. CCP leadership use the audit report to ensure processes are being implemented consistently across member organizations.

Additionally, CCP shares monthly performance reports with member organizations derived from the audit tool in advance of leadership meetings. Performance reports contain key performance metrics and are reviewed with member organizations to ensure program compliance and underscore accountability, particularly in relation to member engagement.

Recommendations

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

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

✓ **Joint approach to member engagement**

- adopting systems, preferably automated, that process new ACO member files instantaneously, inputting member information in the applicable platform and reconciling those members with existing eligibility lists, enabling the CP to engage with the new member list without delay;
- redesigning workflows and automated notifications so that receipt of a comprehensive assessment from an ACO/MCO partner generates a new outreach attempt;
- establishing on-demand access to full member records through partners' EHRs;
- tracking members' upcoming appointments through partners' EHRs to enable staff to connect with members in the waiting room prior to their appointment;
- negotiating fast track primary care appointments with practice sites to ensure that members receive timely care and to enable PCPs to engage with and sign off on the member's care plan;
- collaborating with interdisciplinary staff, such as CE and AP program managers, clinical care managers, nurses, and care coordinators to develop a promising practices toolkit for PCP engagement and care plan sign-off;
- hiring a dedicated community liaison to build relationships with PCPs and educate them about the benefits provided by the CP program;
- embedding care coordination staff at PCP practices, particularly those that require an in-person visit as a prerequisite for care plan sign off;
- determining the date of the member's last PCP visit within a month of that member's assignment, and proactively scheduling an appointment on behalf of any member who has not had a PCP visit in the prior 12 months;
- developing a single point of contact for ACO/MCO partner referrals to review prospective members, research previous treatment history, and to strategize on how to accommodate new members with current CP care team capacity;
- identifying a lead member organization or CP care team to align with each ACO/MCO partner to promote and facilitate relationship building between CP care teams and ACO/MCO clinical staff; and
- implementing a real-time communication tool such as secure texting to communicate with ACO practices about shared members.

- ✓ **Integration with ACOs and MCOs**
    - attending regularly occurring case conferences with PCPs to review member cases and obtain PCP sign-off on care plans;
    - collaborating with state agencies to improve management of mutual members. For example, creating an FAQ document to explain how the two organizations may effectively work together to provide the best care for members or conducting complex case conferences;
    - scheduling joint visits with the PCP, ACO/MCO clinical care team representative, and the CP care coordinator to present a unified team to the member and establish distinct support roles and who the member can contact in to address various needs; and
    - collaborating with PCP practice sites so that CP care coordinators are invited to meet with members onsite prior to their clinical appointments.
- ✓ **Joint management of performance and quality**
    - monitoring process metrics associated with member outreach and engagement such as the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff;
    - sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding, and members who have unsigned care plans that are due or overdue;
    - having clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of those plans prior to submission to PCPs for sign-off;
    - developing dashboards that combine data from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement;
    - generating a reminder list of unsigned care plans for ACO and MCO key contacts;
    - maintaining a dedicated web portal to share information with CP care teams across member organizations. Shared information includes contact information of primary care practices; the LTSS/BH provider network and local social services providers; training materials; and policies and procedures;
    - developing a daily report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to identify members' ACO assignment changes and keep the members' records in the EHR up to date; and
    - embedding staff at local Emergency Departments (EDs) to improve outreach to members not engaged in regular care, particularly members experiencing homelessness, and connect them to care coordination supports.

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Recruitment and retention**
  - does not have persistent vacancies in planned staffing roles;
  - offers a variety of incentives to attract candidates and retain staff, and uses a variety of mechanisms to recruit and retain staff; and
  - employs tactics to ensure diversity in the workplace and design staff incentives and performance bonuses around CP priorities such as enrollee engagement, signed care plans and intensive care coordination.
- ✓ **Training**
  - develops policies and procedures to ensure staff meet the contractual training requirements and offer training to all new staff based on program requirements; and
  - holds ongoing (often monthly) training to ensure staff are up to date on best practices and advancements in the field.

Results

The IA finds that CCP is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

CCP maintains sufficient staffing levels and adapts their staffing model to reflect changes in enrollment and engagement projections.

As of January 2019, CCP hired nearly 79 employees across their member organizations. Recruitment challenges are contained to hiring for specific positions such as Registered Nurses (RNs), Recovery Support Navigators (RSNs), and Community Health Workers (CHWs) in the Boston area. To attract a skilled workforce, CCP is using Statewide Investments Loan Repayment funds for Licensed Social Workers, Licensed Practitioner of the Healing Arts, RNs, CHWs, and RSNs who would not ordinarily accept lower compensation compared to hospital-based salaries. CCP also offers recruitment bonuses.

To retain staff, CCP offers employee recognition activities, professional development opportunities, and learning collaboratives to share best practices and receive ongoing training. CCP gives staff the opportunity to participate in Suffolk University's Graduate Certificate Program in Non-Profit Leadership tuition-free. CCP began a performance-based incentive program to reward teams that have the highest engagement rates or highest Qualifying Activity[6] rates in a given month.

Although CCP did not provide detail on its tactics to ensure diversity in the workplace, CCP was able to hire both bilingual care coordinators and care coordinators who specialize in partnering with enrollees identifying as LGBTQ.

[6] 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.

CP Administrator Perspective: "*CCP has had success in hiring Care Coordinators who are most often bilingual in English and either Spanish, Mandarin, Cantonese, Vietnamese, Khmer, Haitian Creole, and Portuguese. Recruitment bonuses had a positive impact on CCP's recruitment efforts in this regard in the earlier half of this budget period."*

Training

In 2019, CCP's new-hire training program included training on EHR documentation, care management plans, and all contractually required program topics. New hire training is held every other month to serve the onboarding needs of all member organizations. CCP collects training evaluations and established tracking mechanisms to record attendance and performance.

In 2019, CCP sponsored a professional development session with Phillipe Copeland, Clinical Assistant Professor of Boston University's School of Social Work, and launched several learning collaboratives for staff to support shared learning around care planning processes.

Recommendations

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

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

- ✓ **Promoting diversity in the workplace**
    - compensating staff with bilingual capabilities at a higher rate.
    - establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
    - advertising in publications tailored to non-English speaking populations;
    - attending minority focused career fairs;
    - recruiting from diversity-driven college career organizations;
    - tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
    - implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
    - advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers; and
    - recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.
- ✓ **Recruitment and retention**
    - implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;
    - assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;

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

✓ **Training**

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

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

- ✓ **Implementation of EHR and care management platform**
    - uses ENS/ADT alerts and integrates ENS notifications into the care management platform.
- ✓ **Interoperability and data exchange**
    - uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
    - uses Mass HIway[7] 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 CCP is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

CCP integrated ENS/ADT alerts into its EHR/care management tool. CCP contracts with two separate ENS vendors and receives ENS alerts in real-time from one and ENS alerts the next day from the other. CCP still receives direct ADT feeds from some ACO/MCO partners, and these are not in real-time or integrated in their EHR/care management platform. CCP launched a steering committee for CPs which focuses on prioritizing enhancements of the care management platform.

> CP Administrator Perspective: *"Maximizing on ADT feeds has proven to be a highly successful outreach strategy for Care Teams. Care Coordinators not only have access to real-time admissions alerts, they also have access to other pertinent Enrollee detail, including contact information of any medical providers recently seen by an Enrollee."*

Interoperability and data exchange

CCP exchanges member data files with ACO/MCO partners via SFTP hosted by its care management platform, secure file sharing applications, and secure email. When glitches arise with an ACO's SFTP system, secure email is used as a reliable backup method of data exchange. CCP has read-only access to the EHR system of two ACO partners, Wellforce in partnership with Fallon Health and Cambridge Health Alliance (CHA) in partnership with Tufts Health Public Plans (THPP). CCP

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

continues to maintain shared business applications in the cloud for all member organizations to enable email capability document storage, and information sharing.

CCP is able to share and/or receive member contact information and comprehensive health assessments electronically with all ACOs, MCOs, and some PCPs. CCP is able to share and/or receive member care plans electronically with all ACO, MCOs, and most PCPs.

Data analytics

CCP reports that they are engaged in a technical assistance (TA) project with an approved vendor to build a data warehouse and data dashboard that allows the CP to access performance data which will be used to inform program strategy.

CCP uses EHR data to create audit reports, which are distributed to CCP's QMC on a weekly basis. The report flags issues related to progress towards engagement milestones, missing documentation, and coding errors that would result in a loss of billing. CCP team leaders use the audit report as a tool to drive improvements and efficiencies on the care team level.

Recommendations

The IA encourages CCP 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 dashboard or a set of standard frequent reports to oversee documentation and performance on key quality metrics in real time.

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

Outreach and engagement strategies

CCP is committed to employing teams that reflect the cultural and linguistic preferences and needs of those they serve. CCP employs care coordinators who speak Spanish, Mandarin, Cantonese, Vietnamese, Khmer, Haitian Creole, and Portuguese and uses a language line to provide translation support by phone. To meet the growing needs for language accessibility support, CCP has recently entered into an agreement with the local Catholic Charities organization to provide in-person translation when a care coordinator is completing a comprehensive assessment with a new member.

CCP also employs two care coordinators who specialize in supporting members of the LGBTQ community, and CCP care coordinators receive ongoing support to tailor engagement practices to meet needs in relation to gender identity, LGBTQ identity, and homelessness.

CCP utilizes RSNs who specialize in understanding the individual impact of SUD and CHWs for the provision of CP supports and activities.

CCP convened a workshop specific to direct outreach for care teams. One member organization launched an Outreach Team of care coordinators designated as Engagement Specialists who conduct outreach in shelters, parks and clubhouses. Another member organization has implemented mini teams that share outreach efforts. CCP care teams developed a list of outreach techniques and practices that are sensitive to members' needs and designed to engage members in an efficient manner.

Person-centered care model

CCP care coordinators complete the comprehensive assessment with members and then survey care team participants for recommended care plan goals. CCP allows members to designate specific family, friends, caregivers, and healthcare providers to participate in their care team. CCP care coordinators review all recommended goals with the member and then personalize goals to align with the member's needs and interests.

When members have LTSS needs, CCP care coordinators provide their members with a list of LTSS and other available providers in the appropriate geographic region so that members can make an informed choice. All efforts to promote informed choice are documented in the care management system.

CCP's campaign of outreach and engagement tactics demonstrates CCP's commitment to the use of person-centered modalities in care planning. Some of these tactics include: addressing member concerns in a hopeful and non-judgmental manner, forgoing the assumption that the CP will be able to predict which members will engage in supports based on care history and instead providing all members with the ability to engage with the CP at their own pace, customizing engagement strategies to address interests and needs that are distinct based on gender differences or LGBTQ status, and learning to identify and manage people who pose a challenge to a members' willingness to embrace the use of supports.

Managing transitions of care

CCP care teams utilize real-time ENS notifications to engage directly with hard-to-reach enrollees at the ED or inpatient hospital unit. Care coordinators verify the scope and intensity of services in a member's care plan, make introductions to new and current healthcare providers, and obtain updated member contact information from the ENS. CCP maintains a policy of following up with members in-person within the first three business days of discharge from an ED or inpatient unit to ensure members have started their medications, Visiting Nurses Association services have been arranged if necessary, and all durable medical equipment is working properly. CCP reports this transition of care process functions effectively, with the exception of one ACO that does not allow CP teams to perform direct follow-up in hospital ED or inpatient units.

CCP has established partnerships with LTSS providers such as VNAs, home health agencies and Department of Mental Health (DMH) Adult Community Clinical Services (ACCS) teams to coordinate member transitions. Care teams assist in ensuring that a member is transitioned to the most appropriate care setting. Potential care settings include: medical and psychiatric hospitals; detoxification units; crisis stabilization units; respite programs; EDs; sub-acute and post-acute nursing facilities; rehabilitation facilities; hospice and long-term care facilities, including end-of-life care facilities. CCP is working on embedding a social worker within a PCP or hospital system to facilitate interdisciplinary transition of care teams.

Improving members' health and wellness

CCP employs a number of health and wellness coaching strategies throughout the provision of CP-based supports. CCP care coordinators utilize the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Eight Dimensions of Wellness model[8] as a starting point for treatment planning and wellness coaching activities. Care coordinators address lifelong patterns of unhealthy behaviors by identifying member barriers or misconceptions, providing education and skills training, addressing lack of resources and using motivational interviewing to promote behavioral change. Care coordinators emphasize healthy behaviors such as smoking cessation, nutrition programs, exercise, safe sexual health practices, sleep hygiene and weight loss. CCP care coordinators encourage members to attend workshops in local community settings and find groups to connect with in their area of interest, such as community sports teams, local reading groups, and walking/running groups that reduce isolation and enhance the member's sense of purpose. CCP reports that any services coordinated within the community are monitored on a regular basis to evaluate ongoing necessity, member satisfaction, and effectiveness.

To keep care coordinators informed of the variety of community-based supports available in their geographic area, CCP maintains a dedicated web portal for sharing information with BH Care Teams across Member Organizations, which includes information on local social services providers.

Continuous quality improvement

CCP has established a variety of forums to enable continuous QI in quality of care. One of the most immediate ways CCP consistently identifies opportunities to improve member care is through monthly meetings with CCP's Medical Director. Care teams from across both member organizations review high-risk clinical cases with CCP's Medical Director who them recommends how CP staff might improve members' care. The CCP leadership team also meets with each member organization during a weekly CP workgroup to review staffing patterns and promote problem solving.

Additionally, CCP's audit report serves as a quality tool to assist the QMC in identifying areas for improvement.

Frontline staff are kept abreast of continuous QI in quality of care through CCP's dedicated intranet web portal and weekly eFlash Newsletter. Here, CCP care teams share best practices and success stories to encourage peer learning.

CCP has faced challenges in maintaining a CAB during the assessment period and did not report on any alternative structure to facilitate continuous QI in member experience.

Recommendations

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

- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

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);

[8] http://www.ncdsv.org/images/SAMHSA_EightDimensionsOfWellness_revised2012.pdf

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

✓ **Person-centered care model**

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

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
- meeting an enrollee in person once care coordinators receive alerts that they were admitted;
- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[10];
- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

✓ **Improving members' health and wellness**

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

[9] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[10] 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 CCP is On track 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
- Workforce Development

The IA encourages CCP 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

- developing a successful strategy for recruiting members to participate in the CAB.

Health Information Technology and Exchange

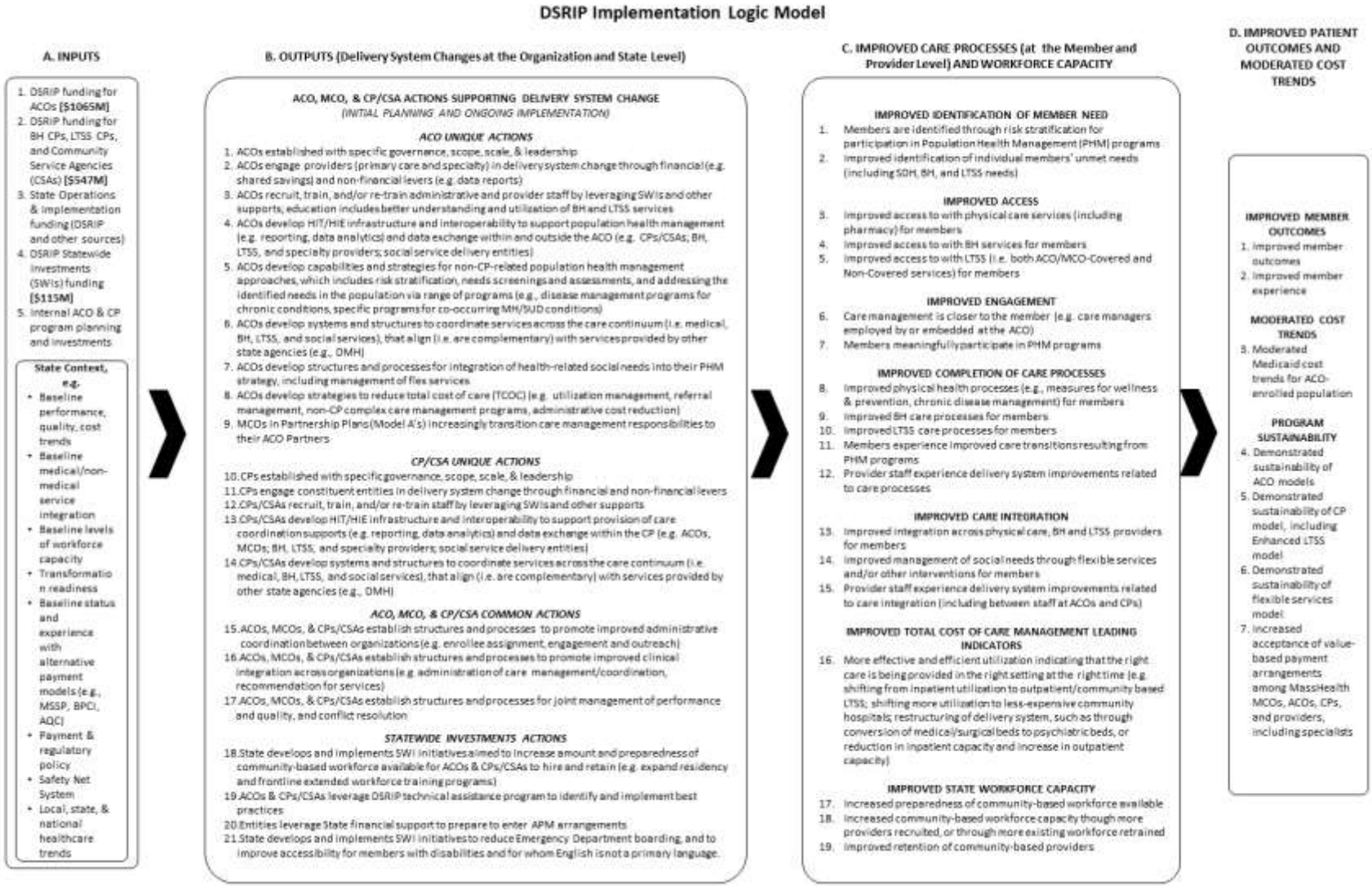
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files;
- developing a plan to increase active utilization of Mass HIway; and
- developing a dashboard or a set of standard frequent reports to oversee documentation and performance on key quality metrics in real time.

Care Model

- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

CCP should carefully self-assess the areas noted above, and consider the corresponding promising practices identified by the IA for each focus area. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

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

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[11] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

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

DATA SOURCES

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

List of MPA data sources:

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

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

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

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

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

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

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

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

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

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

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

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

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

DATA COLLECTION

Key Informant Interviews

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

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Comment

CCP appreciates the recognition this report represents and confirmation that CCP is on track, meeting program requirements and implementing innovative practices. Likewise, CCP appreciates the recommendations made specific to CCP within the report as well as the breadth of information shared in relation to best practices across all CPs statewide. This is no doubt invaluable information as we continually seek to improve our services. CCP acknowledges it's initial struggle with successfully launching a Consumer Advisory Board (CAB), and are pleased to report that we have since had a very successful launch of the CAB which has been meeting monthly since September 2020. And while alerts are not set within while CCP's SFTP, a manual cycle of checking for files multiple times per day has been in place since the inception of the program. We are glad to report that as of Fall 2020 we are now utilizing the Mass HIway in partnership with two of our ACO partners, and will continue to explore other active uses of the MassHIway.