MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Clinical and Support Options Inc.

(CSO)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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A Behavioral Health Community Partner

Organization Overview

CSO is a nonprofit community behavioral health agency providing therapy, counseling, and supports in Western MA. CSO began as the Franklin County Mental Health Association, incorporated in 1955. Today, CSO employs nearly 700 multi-disciplinary staff, who serve thousands of families throughout Western Massachusetts and the North Quabbin region.

SERVICE AREA

POPULATIONS SERVED

- CSO's primary service area includes Adams, Athol, Greenfield, Northampton and Pittsfield. These cities and rural towns are located in Western Massachusetts and are generally under-resourced. The population is majority white and speaks primarily English.
- CSO serves persons 18 and older for behavioral health needs. Substance use disorders are a large driver of hospital admissions in the CP member population with alcohol being the most common cause of admissions followed by heroin.

583

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	Limited Recommendations
Health Information Technology & Exchange	On Track	Limited Recommendations
Care Model	On Track	Limited Recommendations

IMPLEMENTATION HIGHLIGHTS

- CSO improved member response rates by reducing nurse care coordinator caseloads to give them more time to follow-up with all members after an emergency department visit or inpatient stay.
- CSO enhanced its electronic health record to automatically download data files from MassHealth and ACO/MCO partners.
- CSO developed individualized dashboards for staff to facilitate team goal setting. The dashboards contributed to an improvement in their member care plan completion rate.
- CSO designed a workflow to transmit assignee files to their event notification system (ENS) vendor to improve the accuracy of ENS alerts.

Statewide Investment Utilization:

- Student Loan Repayment Program, 3 Care Coordinators participating
- Community Mental Health Center Behavioral Health Recruitment Fund, 1 slot 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[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]

Clinical and Support Options, Inc. is a behavioral health (BH) CP.

Clinical and Support Options, Inc. (CSO) is a nonprofit community behavioral health agency providing mental health therapy and addiction counseling, family support programs, crisis and emergency services, housing supports, and community-based programs in Western Massachusetts and the North Quabbin region. As a BH CP, CSO provides care management to MassHealth members ages, 21 to 64, who have complex BH needs, such as those who experience serious mental illness (SMI) and substance use disorders (SUD).

CSO's primary service area is Western Massachusetts and includes Adams, Athol, Greenfield, Northampton and Pittsfield. These cities and rural towns are generally under-resourced. The population is majority white and English is the primary language. SUD is a large driver of hospital admissions in CSO's CP member population with alcohol being the most common cause of admissions followed by opioids.

As of December 2019, 583 members were enrolled with CSO[3].

SUMMARY OF FINDINGS

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

FOCUS AREA LEVEL PROGRESS

The following section outlines the CP's progress across the five focus areas. Each section begins with a description of the established CP actions associated with an On track assessment. This description is

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

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 CSO is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

CSO's existing Board of Directors serves as the governing body for the CP program, with focused oversight of the CP executive team by the Executive Committee. The executive team for the CP program includes the Vice President of Community Services, the CP Director, the Vice President of Strategic Development, the Medical Director, and others. The executive team meets weekly, and reports progress to the Board of Directors monthly. CSO does not have any Affiliated Partners.

Consumer Advisory Board

CSO continues to recruit members for the CAB, with the goal of having at least eight CAB members attend every meeting. CSO's CAB roster currently has eight members, but attendance has not been consistent. The board meets quarterly in March, June, September and December to review and provide input on member outreach and engagement, comprehensive care plan assessment and development, consumer survey questions, and member incentives. In the first half of 2019, CSO held

[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.

two CAB meetings. Members provided input on the CSO consumer survey, reviewed the new care plan and advised the CP on the best ways to use member incentives.

Quality Management Committee

CSO's Continuous Quality Improvement (CQI) Committee is responsible for evaluation of the CP program's progress towards established benchmarks. Members of the CP CQI Committee include the Vice President of Community Based Services, the Director of Quality Improvement, and CP staff. The CQI Committee develops at least one QI initiative annually based on data collected from the EHR and consumer satisfaction surveys. Progress towards QI goals is assessed and communicated during bi-monthly executive team meetings, staff meetings, and in quarterly reports to the Board of Directors. Chart audits are periodically conducted by clinical teams for quality control purposes.

CSO Administrator Perspective: "*CSO has a four-year accreditation from the Council on Accreditation (COA). The CP program has been integrated into the accreditation renewal process. We submitted documentation to COA in April 2019 and will be part of COA's accreditation site visit in December. COA Accreditation ensures the highest of standards and quality management for all programs within the agency."*

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)[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
    - 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;

[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.

- 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 CSO is **On track with limited recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

CSO has demonstrated the capacity to send and receive member care plans and member contact information for assigned and engaged enrollees via Secure File Transfer Protocol (SFTP) sites, secure email, or other secure communication sites. CSO has hired two program assistants to streamline the process for care plan exchange and timely review of ACO/MCO assignment files. Program Assistants help resolve enrollment issues, manage member lists, process care plan PCP signatures, and schedule care plan meetings for new members with care coordinators located in their geographic location.

CSO's systematic approach to engaging with PCPs involves constant contact and begins with the CP serving as a resource to PCPs. CSO reports routinely reaching out to PCPs to obtain updated member contact information and shares medication reports with PCPs to document medications that an enrollee is taking at the time of an inpatient follow-up.

CSO had to adjust their processes for obtaining PCP signatures on care plans based on the practices of the ACO/MCO partners. Some of CSO's ACO/MCO partners rigorously screen care plans prior to sending the plans to PCPs. Other partners have a more disperse governing model in which central leadership does not intervene in their PCP practices on behalf of the CP. This has required CSO to build rapport with ACO/MCO key contacts as well as develop local contacts with individual PCPs to receive care plan sign-off. In addition, CSO utilizes a log to track care plan signatures overall, and leadership use this tool in meetings with ACO/MCO leadership to ensure CP staff receive signatures on their care plans.

Integration with ACOs and MCOs

At the start of the DSRIP program, CSO facilitated meetings with nine ACOs and MCOs to identify key contacts at each entity and develop Documented Processes that meet the needs of each of partner. The CP Director serves as the primary point of contact for all ACO/MCO leadership.

At the care team level, CSO participates in routine case consultation meetings with several ACOs and one MCO. These meetings have allowed CSO staff to build on the ACOs/MCO's relationship with individuals members by discussing both their medical and social needs; this facilitates a coordinated response. CSO care coordinators have also developed direct lines of communication with ACO/MCO complex care management teams touching base with them monthly to identify shared members that the CP team is struggling to reach.

CSO receives ADT notifications from a statewide vendor. CP nurse care coordinators and program assistants receive real-time email alerts when one of their members is admitted to an ED or inpatient unit. Program assistants ensure timely review by nurse care coordinators who are responsible for follow-up activities. The primary hospital and ED in Berkshire County, Berkshire Medical Center, does not participate in any ENS or ADT feed. For this institution, CSO receives daily updates via the hospital's management team which are also reviewed by CP program assistants and nurse care coordinators.

> CSO Administrator Perspective: "*We've also set up meetings with various local practice groups. Sometimes they're the intensive care management offshoot of an ACO, and sometimes they're more administrative than that. But it really helps if we can be in the same room together, meet each other, get a sense of each other, and then things go more smoothly moving forward."*

Joint management of performance and quality

CSO utilizes individualized dashboards in their electronic health record (EHR) to track and improve member engagement. This enhanced reporting platform enables care coordinators to visualize where members are in the engagement process by placing a green check next to activities that have been completed and a red "x" next to activities that still need to be completed. CSO program assistants and leadership staff can use dashboards to report directly to ACO/MCO partners to show them how many shared members are engaged with the CP. In addition, CSO shares demographic data with ACO/MCO partners on shared members to facilitate a coordinated response.

CSO's internal care plan review process ensures compliance with clinical quality standards. CSO's clinical teams review member care plans regularly and conduct chart audits in weekly multidisciplinary team meetings. CSO has developed systems to trigger a case review for high risk members, in which care coordinators review and update the member's care plan.

Recommendations

The IA encourages CSO 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 CSO is **On track with limited recommendations** in the Workforce Development focus area.

Recruitment and retention

CSO reports ongoing hiring challenges, especially in attracting masters-level applicants and competing with higher salaries in the labor marketplace. CSO has adapted to these challenges by identifying applicants with particular skill sets rather than trying to attain applicants with specific degrees or credentials. CSO has also learned to emphasize their benefit packages in interviews.

CSO hired a recruitment specialist in 2018 to pre-screen applicants and develop strategies for advertising and hiring; this has resulted in a larger candidate pool. CSO entered 2019 understaffed but has since been able to hire and now has the capacity to have one nurse cover each of its service areas.

Examples of CSO's more traditional recruitment strategies include web-based advertising, posting vacancies online and on-site at local colleges and universities, tuition and training reimbursement offerings, attending job fairs and college recruitment events, and the use of specialized recruitment firms for targeted positions. In addition to internal promotion and career advancement opportunities, CSO has a successful internship program, which historically has retained nearly 70% of its participants as full-time CSO staff.

CSO has identified retention as a challenge for their organization, especially in certain geographic areas such as Berkshire County. CSO cites a high turnover rate in the first four months of service delivery. However, CSO has taken steps to mitigate this risk by offering a variety of incentives to retain staff such as a year-long management training program, generous benefits compared to other agencies in the region, incentives and financial support for further professional education, and an employee recognition program. Additionally, CSO has strong team-based culture in which supervisors meet with small groups of staff regularly and quality goals become shared goals of care teams. Staff have reported that the team-based culture is one of the most satisfying elements in working for CSO's CP program.

Training

CSO staff attend initial trainings that cover all MassHealth-required training elements and refresher trainings on an annual basis including training on their EHR. CSO incorporates shadowing into their training curriculum for all new care coordinators build tangible skills and foster relationships between team members. All staff receive individual supervision from their peers at least weekly. CSO encourages staff to attend internal trainings, on a wide variety of topics, such as motivational interviewing, trauma informed care, nonviolent crisis intervention, the ARC Model (Attention, Regulation and Competency)[6], Seeking Safety, SBIRT (Screening, Brief Intervention and Referral to Treatment), and others as offered. CSO budgets for staff to attend up to two days of external training every year to promote professional development. The CP Director monitors progress on training requirements to ensure staff are up to date on program requirements and best practices in the field.

Recommendations

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

- employing strategies to promote diversity in the workplace.

[6] The Attachment, Regulation and Competency (ARC) Framework is a flexible, components-based intervention developed for children and adolescents who have experienced complex trauma, along with their caregiving systems.

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 member files; and
- uses Mass HIway[7] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.

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

- ✓ **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 CSO is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

CSO's CP care coordinators document care coordination activities in the CP's daily encounter system in their EHR, which operates as their care management platform. CSO is connected to statewide ENS, and the ENS pushes real-time email alerts to CSO staff when one of their members is admitted to an ED or inpatient unit. In addition, CSO staff have access to the ENS vendor's secure website at all times to track ADT data for their members. In 2019, CSO's Business Systems Analyst developed and implemented a workflow to transmit member files to their ENS vendor so that the alerts they receive are accurate.

Interoperability and data exchange

CSO has connected with all its ACO and MCO partners via SFTP or through other secure communication sites. CSO reports that the variety of protocols for naming and sharing files remains a challenge that creates an administrative burden for the CP, but staff have adapted to these differences.

In 2019, CSO contracted with its EHR vendor to support Mass HIway connectivity, which suggests the CP program plans to use Mass HIway to further improve its information sharing strategy.

CSO reports that it is currently able to share and/or receive member contact information, comprehensive needs assessments, and care plans electronically with all ACOs, MCOs, and PCPs.

Data analytics

CSO's business systems analyst developed and implemented a data collection system in CSO's EHR and designed individualized dashboard for managers and staff to enhance reporting for the CP program. CSO care coordinators use these dashboards to track their own progress on billable activities for their member panel each month. Managers set team goals for staff in care team meetings based on real-time progress. CSO reports data has helped care teams rally together and complete outstanding care plans as a team to meet the deadline for PCP signatures. As a result, CSO reported a high completion rate of care plans for their engaged members.

> CSO Administrator Perspective: "*We have developed very specific dashboards in our electronic health records system, so people get a green check or a red X, and it's easy for them to see which [activities for members] have been done and which haven't…So that's our best tool. In addition, I compile data for the staff because I want us to be a strong team, I don't put any individual goals up on the board, I only put team goals. For things like getting a unique member count of Qualifying Activities[8] every month, in the middle of the month, I'll say, "OK, here's where*

[8] 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.

we're at, look at your dashboards, reach the people you haven't talked to yet this month" -- that sort of thing -- and remind them. Then closer to the end of the month, people actually help each other. We tell all of our clients that we work as a team and that they may be hearing from someone else as an extra support, and that goes over pretty well."

Recommendations

The IA encourages CSO 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 member files.

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

✓ **Implementation of EHR and care management platform**

- adopting enterprise exchange software that automatically retrieves files from partner SFTPs and moves them into the CP's EHR.

✓ **Interoperability and data exchange**

- developing electronic information exchange capabilities that enable a CP to exchange information with community organizations that do not have EHRs and ACO/MCO partners and PCPs whose method of data sharing is fax or secure email; and
- connecting with regional Health Information Exchanges (HIEs).

✓ **Data analytics**

- designing a data warehouse to store documentation and performance data from multiple sources in a central location that can underwrite a performance dashboard;
- incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress;
- updating dashboards daily for use by supervisors, management, and the QMC; and
- incorporating Healthcare Effectiveness Data and Information Set metrics into dashboards to support integration with ACO/MCO partners.

5. CARE MODEL

On Track Description

Characteristics of CPs considered On track:

✓ **Outreach and engagement strategies**

- ensures staff are providing supports that are tailored to and reflective of the population racially, ethnically and linguistically;
- uses peer supports and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities; and
- has a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations.

- ✓ **Person-centered care model**
    - ensures goals are documented in the care plan so that the team is engaged in supporting the enrollee towards achieving goals; and
    - uses person-centered modalities so that care coordinators can assist enrollees in setting health and wellness goals.
- ✓ **Managing transitions of care**
    - manages transitions of care with established processes including routine warm handoffs between transitions of care teams and CP care team.
- ✓ **Improving members' health and wellness**
    - standardizes processes for connecting members with community resources and social services.
- ✓ **Continuous quality improvement (QI)**
    - has a structure for enabling continuous QI in quality of care and member experience.

Results

The IA finds that CSO is **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

CSO has two program assistants that connect with members telephonically. When they reach a member, they attempt to schedule an appointment with a care coordinator in the member's geographic location. For members who cannot be easily reached by phone, CSO approaches and communicates directly with members at EDs and as a result has seen increased rates of success engaging difficult to reach members. CSO has also taken steps to reduce the caseload of each nurse so that they have the time to be the primary responders to every ENS/ADT alert and provide medication reconciliation whenever is feasible for members. CSO also provides training in negotiation and strategies for locating difficult-to-reach individuals to provide community-based care and encourage an individual to return for other clinic-based care.

Person-centered care model

CSO staff complete comprehensive assessments and promptly communicate the results of the comprehensive assessment to the assigned enrollee's care team, which may include ACO/MCO partners, and other providers who serve the member including state agencies and other care managers. CSO utilizes a shared-decision strategy to develop care plans which considers the preferences of the member and the care team, including desired caregivers. Needs, strengths, abilities, preferences, and goals are documented in the person-centered care plan by capturing the member's words or ideas and, when appropriate, those of the family/caregiver. The care team reviews the member's care plan every six months, or more frequently if obstacles or barriers arise, to monitor progress on the member's stated goals. CSO has additional systems in place to identify when high-risk member need to have their care plan re-reviewed and updated.

Managing transitions of care

CSO's care transitions are managed by program assistants and nurse care coordinators. Program assistants receive and track all ENS/ADT alerts via email, while nurse care coordinators conduct all initial follow-up activities. After changing their transitions of care model to have nurse care coordinators follow-up in all cases, CSO reported notable improvements in members' response rate

and agreement to have a face-to-face follow-up. CSO reports that nurse care coordinators have developed relationships with inpatient/ED care managers, and social workers, at each of the hospitals in their service area which has in some cases, helped CSO receive discharge notifications.

The transitions team incorporates strategies to reduce and prevent future hospitalization and ED utilization. CSO has designated an outreach nurse to review all discharge summaries, conduct member assessments, and develop short-term transitional plans to address immediate housing, transportation[9], pharmacy, family needs, and to support members' ability to manage their care in their home environment. CSO has also developed a medication report in which nurse care coordinators document members' current medication usage which the team provides to PCPs and psychiatric providers to check for any discrepancies.

Improving members' health and wellness

CSO has a standardized process for connecting members with community resources and social services that support their health and wellness. Staff review community resources and contacts in regularly scheduled staff meetings. CSO has made available resource guides and encourages staff to use web-based search libraries when referring members. CSO supervisors are responsible for reviewing the profile of their member panels to identify relevant social service providers. CSO reports that staff often provide immediate interventions such as helping members apply to DTA and/or SNAP benefits or other resources. Target caseloads have been slightly reduced to accommodate the need for immediate interventions.

Additionally, CSO has developed a wellness initiative and hired a CP Wellness Coach to provide strategies for members to incorporate healthy behaviors and refer members to a variety of wellness resources. The CSO wellness initiative focuses on good nutrition, regular exercise, stress reduction techniques, and symptom management support. The CP Wellness Coach conducts health and wellness coaching that is responsive to the member's care plan goals. Health and wellness goals are integrated into the care plan and regularly reviewed with the member.

> CSO Administrator Perspective: "*We sometimes have representatives from various organizations come and meet with our team and explain how things work, so that we have the context and so that our referrals are more likely to be successful … what we find is, the majority of the people who we're working with want to focus, at least initially, on social determinants of health. And so that often boils down to housing and food access and help with employment…We want to make sure that they're accessing all of the public benefits they might be eligible for. So, we interact with the Community Action agencies a lot."*

Continuous quality improvement

One of CSO's quality management goals is to solicit and evaluate CP member feedback. The CP collects data annually via consumer satisfaction surveys to help identify issues that impact consumer experience. CSO engaged with members of the CAB to review the existing consumer feedback survey and to determine if any revisions to the survey were necessary to better assess member experience for the CP program.

As an agency, CSO also maintains a Patient Care Assessment Committee (PCAC) as part of its qualified patient care assessment program. The PCAC reviews all incidents involving members on a quarterly basis to monitor quality of direct care services, including supports provided under the CP program. Each incident is analyzed for level of risk, root cause and appropriateness of preventive or corrective action with the intention of making recommendations for QI.

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

Recommendations

The IA encourages CSO 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:

- implementing strategies to provide supports that are tailored to and reflective of the population racially, ethnically, and linguistically; and
- using Peer Support and/or CHWs in the provision of CP supports and activities.

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[10];
- 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;

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

- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[11];
- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

✓ **Improving members' health and wellness**

- allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;
- negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and
- contracting with national databases for community resources to develop a library of available supports.

✓ **Continuous quality improvement**

- providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;
- administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;
- scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and
- creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that CSO 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

The IA encourages CSO 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).

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

Workforce Development

- employing strategies to promote diversity in the workplace.

Health Information Technology and Exchange

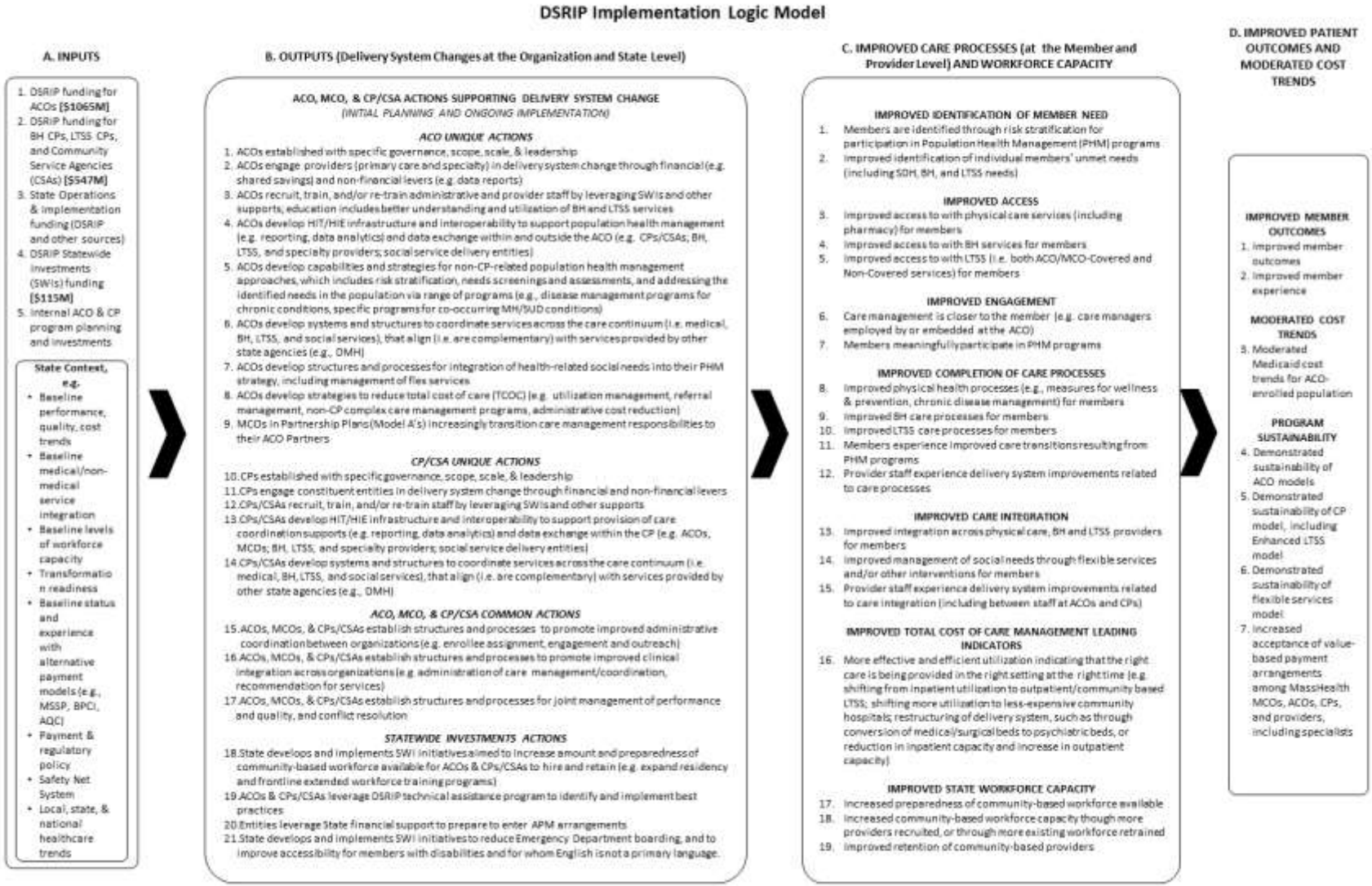
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of member files.

Care Model

- implementing strategies to provide supports that are tailored to and reflective of the population racially, ethnically, and linguistically; and
- using Peer Support and/or CHWs in the provision of CP supports and activities.

The CP 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[12] (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

[12] 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.[13] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Comment

None submitted.