MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Innovative Care Partners, LLC. - Behavioral Health (ICP-BH)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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A Behavioral Health Community Partner

Organization Overview

Innovative Care Partners, LLC (ICP-BH) is a consortium comprised of three organizations: Center for Human Development, Inc. (CHD), ServiceNet, Inc., and Gandara Mental Health Center, Inc. ICP-BH supports enrollees with complex BH needs and works with ACOs and MCOs to improve the care experience, continuity and quality of care through care coordination and care management activities.

SERVICE AREA

POPULATIONS SERVED

- ICP-BH's primary service area is Western Massachusetts, a predominantly rural area, surrounding the urban center of Springfield and smaller cities and towns. The target population is racially and ethnically diverse in the Springfield and Holyoke areas, including a significant number of non- or limited English-speaking enrollees. ICP-BH serves MassHealth members age 21 and older diagnosed with serious mental illness and/or substance use disorder (SUD) with high service utilization, and members aged 18-20 with primary SUD.

2,865

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- ICP developed engagement and quality metric dashboards to track and improve performance. ICP grants ACO/MCO partners rule-based access to dashboards.
- ICP implemented a care transition team to provide medication reconciliation and follow-up activities for members after emergency department visits and acute or post-acute stays.
- ICP established processes to audit member information in their electronic health record to improve the accuracy of care plans and facilitate more effective primary care provider review.
- ICP contracted with a vendor to receive integrated electronic notifications within their electronic health record

Statewide Investment Utilization:

- Student Loan Repayment Program, 2 Care Coordinators, 1 LPN/RN participating
- Special Projects Program
- Community Mental Health Center Behavioral Health Recruitment Fund, 1 slot awarded
- Certified Peer Specialist Trainings
- Community Health Worker Trainings
- Technical Assistance

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]

Innovative Care Partners, LLC (ICP-BH) is a behavioral health (BH) CP.

ICP is a consortium comprised of three organizations: Center for Human Development, Inc. (CHD), ServiceNet, Inc., and Gandara Mental Health Center, Inc. The consortium serves as a BH CP and a LTSS CP with separate staff for each member population. ICP-BH supports enrollees with complex BH needs and works with ACOs and MCOs to improve the care experience, continuity, and quality of care through care coordination and care management activities. ICP-BH serves MassHealth members age 21 and older who have serious mental illness and/or substance use disorder (SUDs) with high service utilization and members aged 18-20 with a primary SUD diagnosis.

ICP-BH's primary service area is Western Massachusetts, which includes the cities/towns of Adams, Greenfield, Holyoke, Northampton, Pittsfield, Springfield, and Westfield. Although Western Massachusetts is predominantly rural, Springfield has urban areas. ICP's member population is racially and ethnically diverse in the Springfield and Holyoke areas, including a significant number of enrollees who are best served in a language other than English. ICP works with members receiving BH services from any of the consortium entities (CEs) above, those enrolled in outpatient clinics, homeless outreach programs, and those who receive services from Adult Community Clinical Services (ACCS) within the Department of Mental Health (DMH).

As of December 2019, 2,865 members were enrolled with ICP-BH[3].

SUMMARY OF FINDINGS

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

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track
Health Information Technology and Exchange	On track with limited recommendations
Care Model	On track 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 ICP-BH is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

ICP-BH and ICP-LTSS share a Governing Board that includes the chief executive officers (CEOs) of the three CEs: Center for Human Development, Inc. (CHD), ServiceNet, Inc., and Gandara Mental Health Center, Inc. CHD's CEO serves as ICP President and Board Chair. CHD is the lead entity in the consortium, and it provides centralized administrative functions and care coordination services, pursuant to the ICP-BH CP Contract. The ICP Governing Board meets at least quarterly.

Consumer Advisory Board

[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.

ICP struggled to recruit CAB members. ICP held four CAB meetings in 2019, each with very low participation. At the March meeting, two members attended; at the June meeting, three members attended. To increase participation, ICP directed care coordinators to publicize the CAB to their members and increased compensation for attending from $10 gift cards to $25 gift cards. In addition, ICP began using structured agendas at CAB meetings in response to member feedback.

Quality Management Committee

At the beginning of the program, the ICP Governing Board developed a Performance and Quality Improvement (PQI) plan and hired a full-time Quality Director to lead QI efforts for the CP program through a QMC. The QMC meets quarterly with the following members: ICP Quality Director and VP, representatives from ICP CEs, the CHD Medical Director, an ACO representative, and a member. The PQI plan guides QMC activities with directives about the structure, tools, and timelines for measuring and monitoring progress towards goals, performance metrics, and contract requirements. The PQI plan addresses quality measures included in the contract, as well as other program processes and outcome measures specific to ICP. The QMC reviews data from the CP's electronic health record (EHR), event notification system (ENS) alerts, member experience surveys, and ACO/MCO surveys. At the beginning of the contract period, ICP contracted with a data analytics vendor to develop dashboards for reporting operational and quality metric activities. ICP's comprehensive dashboards allow the QMC and program leadership to summarize engagement and quality metrics and analyze trends related to per member per month claims. ICP's data analytics vendor provides performance data to CEs monthly and to the QMC and Governing Board on a quarterly basis.

ICP conducted at least two QI initiatives per year. In 2019, ICP's QMC implemented several Technical Assistance (TA) projects through the Statewide Investments program (SWI) with approved vendors and oversaw staff hiring, training on quality metrics, program audits to ensure Qualifying Activities[5] were completed in a timely manner, and the streamlining of staff workflows to improve the accuracy of member information sent to ACO/MCO partners.

Recommendations

The IA has no recommendations for the Organizational Structure and Engagement focus area.

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

✓ **Executive Board**

- holding monthly meetings between CP leadership and all Affiliated Partners (APs) and Consortium Entities (CEs);
- conducting one-on-one quarterly site visits with APs and CEs;
- holding weekly conferences with frontline staff to encourage interdisciplinary collaboration;
- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[6] Joint Operating Committee;

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

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

✓ **Consumer Advisory Board**

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

✓ **Quality Management Committee**

- establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
- scheduling regular presentations about best practices related to quality metrics;
- adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
- integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
- ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential QI initiatives through the appropriate channels.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of CPs considered On track:

- ✓ **Joint approach to member engagement**
    - has established centralized processes for the exchange of care plans;
    - has a systematic approach to engaging Primary Care Providers (PCPs) to receive sign-off on care plans;
    - exchanges and updates enrollee contact information among CP and ACO/MCO regularly; and
    - dedicates staff resources to ensure timely (usually daily) reviews of ACO/MCO spreadsheets to assist with outreach and engagement efforts.
- ✓ **Integration with ACOs and MCOs**
    - holds meeting with key contacts at ACOs/MCOs to identify effective workflows and communication methods;
    - conducts routine case review calls with ACOs/MCOs about members; and
    - dedicates staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).
- ✓ **Joint management of performance and quality**
    - conducts data-driven quality initiatives to track and improve member engagement;
    - has established comprehensive care plan review processes with ACOs/MCOs to support care coordinators in their effort to engage PCPs in comprehensive care plan review; and
    - disseminates audit reports to each member organization, in some cases using an interactive dashboard to disseminate data on key quality metrics.

Results

The IA finds that ICP-BH is **On track with limited recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

ICP's ACO/MCO partners all use different Documented Processes to exchange member information. To address this administrative challenge and centralize the process to exchange data, ICP supervisory staff assumed the responsibility of transferring files on behalf of care coordinators, allowing care coordinators to focus their work on completing comprehensive assessments and care plans.

For Berkshire Fallon ACO, ICP administers all comprehensive assessments jointly with ACO staff which improved the flow of information.

ICP adjusted their internal process to improve management of care plan sign-off by assigning the responsibility to clinical care managers, reducing the burden on care coordinators. ACO partners

reliably return signed care plans but PCP partners do not. Clinical care managers attempt to schedule care plan conferences with PCP partners to obtain sign-off, but many PCPs will not schedule these meetings citing time constraints. ICP reported that some PCPs expressed a willingness to begin scheduling care plan conferences.

ICP increased their rate of signed member participation forms by expanding their Enrollment team. Signed participation forms provide the CP with up to date member contact information. Enrollment specialists review ACO/MCO assignment files, make first contact with each assigned member, collect basic demographic, and contact information, and assist with eligibility issues. ICP's combined EHR and care management platform is capable of querying Executive Office of Health and Human Services (EOHHS) eligibility data and producing standards based Consolidated Clinical Document Architecture files to exchange information with MassHealth and the ACOs.

ICP's Enrollment Specialists ensure the timely review of ACO/MCO spreadsheets. ICP's EHR imports eligibility reports and enrollment rosters from EOHHS and ACOs.

Integration with ACOs and MCOs

ICP holds regular meetings with health centers, ACO/MCO contacts, and state agencies to identify barriers to high-quality member care. ICP service area directors hold ongoing meetings with five Baystate Health Care Alliance in partnership with Health New England affiliated health centers.

ICP has routine meetings with some ACO care teams in which staff discuss members at high-risk of utilizing inpatient or Emergency Department (ED) services. For example, ICP currently attends monthly interdisciplinary care team meetings with Health Collaborative of the Berkshires in partnership with Fallon Community Health Plan.

ICP receives ENS/ADT notifications that integrate into the EHR and care management platform. Staff also have access to this information in real-time through the vendor's designated web portal. Members of ICP's enrollment team and care coordinators with certain high-risk members on their panel also receive ENS notifications by text. In western Massachusetts, ICP notes some area hospitals are not signed up with an ENS which inhibits full integration for members admitted to these practices.

Joint management of performance and quality

ICP developed a dashboard to track and improve performance on activities related to member engagement including completing participation forms, comprehensive assessments, and member care plans. ICP managers review performance on the engagement dashboard weekly and individual care coordinators review performance daily. ICP offers rules-based access[7] to all ACO/MCO partners at no cost so that the dashboard functions as an integration platform. ICP uses data analytics to monitor achievement in member engagement activities.

ICP established processes to audit member information in their EHR to improve the accuracy of care plans and ensure a more effective PCP review. In 2019, ICP discovered that Enrollment Specialists and care coordinators sent care plans with inaccurate member ACO assignments to ACO and PCP offices. ICP's leadership also determined that available member data was often incorrect. In response, ICP made supervisory staff responsible for data exchange with partners and instituted frequent eligibility and ACO checks on all members records. ICP also had their EHR vendor develop a report to compare ACO information in the MassHealth Eligibility Verification System to information contained in their EHR. Supervisory staff review this report to identify ACO assignment changes and make the corresponding updates in the EHR. Additionally, an ICP registered nurse (RN) in the Quality

[7] Under Rules Based Access Control, access is allowed or denied to resource objects based on a set of rules defined by a system administrator.

Department conducts quarterly audits of a random sample of member records to ensure that care coordinators are completing the appropriate Qualifying Activities[8] within designated time frames.

As stated above, ICP's EHR generates eligibility reports and feeds data to ICP's dashboard for analysis of claims and performance. All of ICP's member organizations have access to this dashboard.

Recommendations

The IA encourages ICP-BH 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, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts.

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;

[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.

- 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 ICP-BH is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

ICP had no persistent vacancies in planned staffing roles but had difficulty hiring a Data Specialist in 2019. The CP utilized TA from SWI 5a to formulate a workforce development plan at the beginning of the contract period. ICP held three job fairs in 2017 and advertised positions on well-known professional networking sites. The CP also engaged a full-time recruiter from one of its member organizations to recruit multicultural and bilingual/multilingual staff. The recruiter assisted with outreach, screening, and interviewing a diverse set of candidates. The recruiter attended local job fairs and traveled to Puerto Rico on behalf of ICP to recruit Spanish-speakers for key staff roles. ICP also advertised positions with the local chapters of the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and Hispanic Social Workers, Vietnamese American Civic Association and Russian Community Association. ICP hired sixty staff members through these efforts.

ICP offers a variety of incentives to recruit and retain staff including recruitment bonuses for certain positions, referral bonuses, and performance bonuses using additional infrastructure funds. ICP's approved TA vendor gave ICP the tools to implement additional strategies to retain staff such as: creating career ladders, generous time off policies, employee health and wellness programs, and ongoing opportunities for training and professional development. In 2019, ICP introduced a pathway for obtaining the Massachusetts Certified Community Health Worker (CHW) credential to all interested staff who qualify.

Training

ICP trains new hires in all contractually required training elements during on-boarding including motivational interviewing, care coordination basics, de-escalation, person-centered care planning, CPR and First Aid, trauma informed care, cultural diversity, and wellness coaching. New staff also receive instruction on how to perform key functions in the CP's joint EHR and care management system. In 2019, ICP's program launched a performance management system that allows human resources staff to track staff progress on required training elements for all CEs.

All ICP CP staff are currently completing training on best practices for writing a care plan to stay up to date on advancements in the field. ICP hosts several in-house trainings on topics such as vicarious trauma, medication reconciliation, managing compassion fatigue for direct care staff, and management strategies for performance improvement for supervisory staff. To further advance their skills, some ICP staff take advantage of the Integrated Care Management Certification Program through University of Massachusetts Medical School.

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[9] 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 ICP-BH is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

ICP contracts with an ENS vendor to receive ADT data and has integrated ADT notifications into the CP program's EHR/care management platform. ICP's EHR uploads data from the ENS daily, so that care coordinators are made aware of an admission, discharge, or transfer within the day. ICP has purchased additional functionality from the EHR vendor to allow CP staff to access notifications in real-time via the ENS providers' web portal.

Interoperability and data exchange

At the beginning of the contract period, ICP discussed multiple methods of data exchange with ACO/MCO partners, but due to the different technologies, file types, file formats and file naming conventions employed by each provider, the CP chose to rely primarily on secure email, secure fax, and hand delivery to transmit member care plans. ICP does exchange some information over HIEs through their EHR/care management platform. ICP is connected to Mass HIway and PVIX (the Baystate Medical Center's HIE) through their EHR/care management platform. The EHR is able to complete standards-based transactions[10] including Continuity of Care Document (CCD) based on HL7 Clinical Document Architecture over Mass HIway and PVIX.

[9] Mass HIway is the state-sponsored, statewide, health information exchange.
[10] Clinical Document Architecture (CDA) is a document standard, governed by the HL7 organization. HL7 is a leader in healthcare IT standards with its v2 and v3 standards. The HL7 standards include messaging and document standards. The document standards for HL7 v3 is CDA and CCD is one of the documents within CDA.

The CP is able to share and/or receive member contact information electronically from most MCOs, but only some ACOs and PCPs. The CP is able to share and/or receive comprehensive needs assessments electronically from most ACOs and MCOs but very few PCPs. Finally, the CP is able to share and/or receive care plans electronically from all or nearly all ACOs and MCOs and most PCPs.

Data analytics

ICP utilized TA provided by SWI 5a from an approved data vendor to build separate performance management analytics dashboards for the BH and LTSS CP program. ICP's pre-existing data warehouse was expanded to include medical claims data and data from ICP's EHR. Dashboards are displayed using visualization software and track all key activities conducted by CP staff. ICP has an engagement dashboard and a quality metric dashboard to display performance on pay-for-performance measures. In 2019, ICP added Healthcare Effectiveness Data and Information Set (HEDIS) metrics and claims analysis to its suite of dashboards to support integration with ACO/MCO partners.

Engagement dashboards inform daily operations down to the level of care coordination for individual members; managers review engagement dashboards weekly. Quality metric dashboards are reviewed by the QMC during every meeting and are utilized by the Director of Quality and Training to implement QI training programs.

> CP Administrator Perspective: "*ICP has been building, and in this period continued to build, analytics dashboards. The dashboards are designed to serve multiple purposes. A key purpose is to facilitate integration with ACOs and MCOs. During BP2 Q1 and Q2 additional dashboards were added to the suite of dashboards: Claims Analytics and HEDIS Analytics. These additional dashboards were additive to the already developed Engagement dashboards and Quality Metric (pay-for-performance measures) dashboards. These dashboards were shown to the MassHealth reviewers at ICPs June 4th site visit. In June we began to show these dashboards to ACO/MCOs. Paraphrasing three comments summarizes the themes of their assessment for the dashboards: You are aligned with us; You are thinking the way we are thinking; If CPs don't have these types of analytics by Year 6, we won't contract with them.*"

Recommendations

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

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

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

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

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

✓ **Interoperability and data exchange**

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

- ✓ **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 ICP-BH is **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

ICP has endeavored to hire a racially, ethnically, and linguistically diverse staff who can provide services that are tailored to members. All staff are trained in cultural diversity and have access to a suite of online trainings on cultural competence for healthcare professionals. ICP care coordinators inform members of their rights to receive CP information in their preferred language. If a need is identified, ICP offers members interpretation and translation services, recorded versions of program materials for members with visual impairments, and resources from the Massachusetts Commission for the Deaf and Hard of Hearing and the Massachusetts Rehabilitation Commission to assist members with disabilities.

ICP actively recruits peer supports from the New North Citizens Council, the Recovery Learning Center, and the Transformation Center. ICP recently unveiled a path for staff to obtain the Massachusetts CHW certification, and currently employs five care coordinators who are certified as CHWs.

ICP Enrollment Specialists conduct visits to member homes as well as to community locations to contact members who cannot be reached telephonically.

Person-centered care model

ICP ensures members' goals are incorporated into person-centered care plans. ICP care coordinators encourage members to identify strengths and barriers to health and wellness and pay careful attention to their desired level of involvement with care coordination, recommending resources that will meet members' goals. CP staff will involve members' caregivers in care planning as appropriate and at a minimum have an in-person meeting with members once per quarter. In between visits, ICP gives members contact information for local crisis services in the community should they need immediate assistance. To assist members with memory or cognition issues, ICP has a practice of posting a sign-in sheet on a member's refrigerator when conducting a home visit; this allows all in-home providers to sign their name, title, agency, and contact information.

For BH engaged members, ICP staff assist members with developing a recovery plan that includes a contract to maintain sobriety and reduce harmful use.

All ICP staff are trained in person-centered modalities such as motivational interviewing, de-escalation, trauma informed care, and wellness coaching and utilize these skills when providing CP supports.

Managing transitions of care

In 2019, ICP implemented a Care Transitions Team that is made up of two RNs and a care coordinator and is managed by the Quality Director. The RNs focus on medication reconciliation and follow-up with BH engaged members discharged from an ED or inpatient facility. The care coordinator focuses on in-person follow-up activities within three days of discharge for members who have had an acute or post-acute stay to ensure they attend a mental health visit. ICP closely monitors Care Transitions Team activities for impact on quality measures.

With the consent of members in recovery, ICP-BH care coordinators maintain communication with area detox and rehabilitation centers, so they are notified of inpatient admissions and discharges. If notified, ICP care coordinators partner with the Care Transitions Team to participate in discharge planning for members with SUD.

ICP reports success in working with ACCS and the Department of Mental Health. ICP staff have worked with PCP care managers and ACCS teams on specific cases where members have had multiple admissions. Joint care teams which include CP staff help perform medication reconciliation, obtain Visiting Nurse Association (VNA) supports, and accompany members to appointments. This

suggests the CP has established processes that include routine warm handoffs between ACO/MCO care teams and CP care team.

Improving members' health and wellness

ICP incorporates health and wellness goals into member care plans and all staff receive training on health and wellness coaching.

For BH engaged members, ICP staff report leveraging the self-help community to identify temporary sponsors, arrange transportation to meetings[11], and otherwise help support the enrollee's ongoing recovery journey.

Continuous quality improvement

ICP's QMC and program leadership ensure continuous QI in quality of care. ICP's comprehensive dashboards allow the QMC and program leadership to summarize engagement and quality metrics. Through medical claims data, ICP tracks readmission rate and psychiatric versus medical admissions and identifies members with high utilization who may need more support.

To improve member experience, ICP's QMC administers member experience surveys. In addition, ICP-BH invested in a mobile application that allows BH CP members to track their own care coordination activities.

Recommendations

The IA encourages ICP-BH 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:

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

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

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
- providing free transportation options for members to engage with services[12];
- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and
- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

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

- ✓ **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[13];
- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and
- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

- ✓ **Improving members' health and wellness**
    - allowing PCPs or other providers to access referrals through a centralized hub powered by the care management platform;
    - negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and
    - contracting with national databases for community resources to develop a library of available supports.
- ✓ **Continuous quality improvement**
    - providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;
    - administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;

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

- 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 ICP-BH is On track or On track with limited recommendations across all five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Organizational Structure and Engagement
- Workforce Development

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

Integration of Systems and Processes

- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts.

Health Information Technology and Exchange

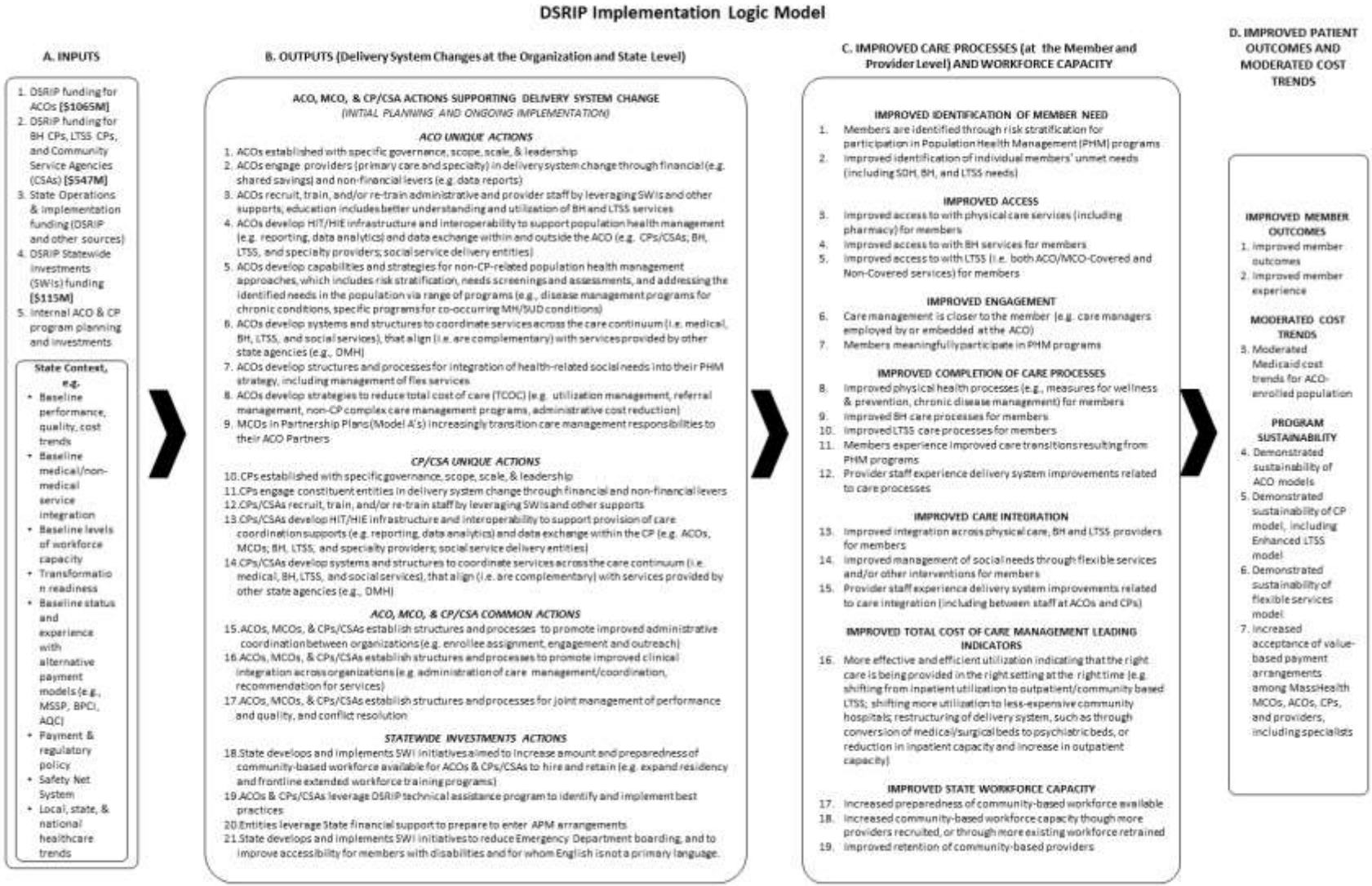
- implementing SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files.

Care Model

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

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

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

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

The question addressed by this assessment is:

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

DATA SOURCES

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

List of MPA data sources:

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

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

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

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

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

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

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

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

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

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

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

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

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

DATA COLLECTION

Key Informant Interviews

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

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Comment

None submitted.