MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Riverside Community Partners

(Riverside)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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A Behavioral Health Community Partner

Organization Overview
Riverside Community Partners are long-time providers of behavioral healthcare in their respective communities. Riverside and its Affiliated Partners (APs) have teams of care management staff to provide BH CP services and collaborate with ACOs and MCOs to provide coordinated care for enrollees.

SERVICE AREA
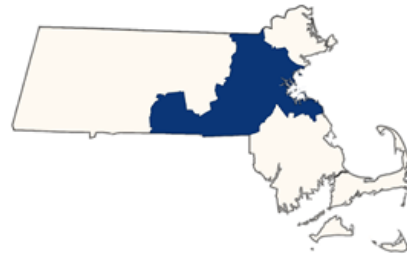
POPULATIONS SERVED

▶ Riverside serves a population of diverse adults with regard to ethnicity, LGBTQ identity, primary language spoken, urban and rural areas, and adults with serious mental illness and/or substance use disorders along with other comorbidities.

▶ North Suffolk serves a diverse population that includes Cambodian/Khmer, Chinese, Vietnamese families. Uphams Corner serves a particularly diverse and underserved population in Boston. Both Lynn Community Health Center and Riverside have significant expertise in serving individuals with behavioral health needs who have experienced significant trauma.

3,195
Members Enrolled as of December 2019

FOCUS AREA	IA FINDINGS	
Organizational Structure & Engagement	🟢 On Track	
Integration of Systems & Processes	🟢 On Track	🔵 Limited Recommendations
Workforce Development	🟢 On Track	
Health Information Technology & Exchange	🟢 On Track	🔵 Limited Recommendations
Care Model	🔴 Opportunity to Improve with Recommendations	

IMPLEMENTATION HIGHLIGHTS

• By the end of 2019, Riverside established consistent Consumer Advisory Board member attendance with a high level of engagement.

• Riverside developed an analytics system to monitor performance indicators. The CP meets with each AP monthly to review the data and opportunities for improvement.

• Riverside employs individuals who live locally and reflect the ethnic and cultural diversity of the service areas. When possible, the CP matches members with a care coordinator who speaks their language.

Statewide Investment Utilization:

o Student Loan Repayment Program, 2 Care Coordinators and 1 RN/LPN participating

o Special Projects Program

o Community Mental Health Center Behavioral Health Recruitment Fund, 2 slots awarded

o Certified Peer Specialist Trainings

o Community Health Worker Trainings

o Technical Assistance

o 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

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[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]

Riverside Community Partners (Riverside) is a behavioral health (BH) CP.

Riverside is an established provider of behavioral healthcare and has served MassHealth enrollees for many decades. Riverside and its Affiliated Partners (APs), have teams of care management staff to provide BH CP supports and collaborate with ACOs and MCOs to ensure better coordinated care for enrollees.[3]

Riverside's primary service area is Greater Boston, MetroWest, the North Shore, and South Central, specifically Boston, Revere, Somerville, Quincy, Lowell, Lynn, Malden, Woburn, Framingham, Southbridge, and Waltham. Riverside serves a population of diverse adults with regard to race, ethnicity, LGBTQ identity, primary language spoken, urban and rural areas, and other characteristics, and adults with serious mental illness (SMI) and/or substance use disorder (SUD) challenges with other comorbidities. Among Riverside's APs, North Suffolk Mental Health Association Inc., serves a diverse population that includes Cambodian/Khmer, Chinese, and Vietnamese families and the Uphams Corner Health Center serves a diverse and underserved population in Boston. Both Lynn Community Health Center and Riverside have expertise in serving individuals with BH needs who have experienced significant trauma.

As of December 2019, 3,195 members were enrolled with Riverside[4].

SUMMARY OF FINDINGS

The IA finds that Riverside is On track or On track with limited recommendations in four of five focus areas. Riverside has an Opportunity to improve with recommendations in one focus area.

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

[2] Background information is summarized from the organizations Full Participation Plan.

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

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

Care Model	Opportunity to improve with 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 followed by a detailed summary of the CP's results across all indicators associated with the focus area. This discussion includes specific examples of progress against the CP's participation plan as well as achievements and or promising practices, and recommendations where applicable. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage CPs to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must be taken in accordance with program guidance and contractual requirements.

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Executive Board**

    - has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and

    - is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).

- ✓ **Consumer Advisory Board (CAB)**

    - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.

- ✓ **Quality Management Committee (QMC)**

    - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

The IA finds that Riverside is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Executive Board

Riverside convenes a weekly work group for the managers from each of its six APs and the central CP administrative teams to discuss program operations and strategies for collaboration.

In addition, Riverside holds weekly conference calls for care coordinators, a nurses' forum, CP-wide quality meetings, and ad hoc meetings to address emergent topics. Riverside indicates that these meetings provide opportunities for staff from across the CP to work together.

CP Administrator Perspective: "*We have formed fabulous relationships with our affiliated partners and we have great teamwork, collaboration, sharing of best practices, mechanisms to toss out challenges any one of us are having, and that piece of it has really aided us in our success, and*

> *it's been so obvious that our team was recently awarded a recognition award for this collaborative process that we have done, which is new and innovative for Riverside as a team, and also for each one of these six independent organizations.*"

Consumer Advisory Board

Riverside established and maintains a CAB that meets quarterly. By the end of 2019, Riverside had six CP members regularly participating on the CAB. Riverside reports a desire to increase the number of members participating but is pleased with the level of continuity demonstrated by the current CAB members.

Riverside relies on care coordinators to connect with and invite engaged CP members to participate on the CAB during one-on-one sessions and BH CP open house events. Riverside care coordinators also distributed CAB recruitment materials at local Clubhouses[5] and day treatment centers as an additional method of recruiting potential CAB members.

Quality Management Committee

Riverside's QMC is comprised of representatives from each AP, Riverside's Quality Management department, and BH CP administrative staff. The QMC meets on a bimonthly basis. The QMC is chaired by Riverside's Vice President of Quality Management, who is responsible for reporting the QMC's activities and performance results to the CP Governance Committee. The QMC aims to disseminate best practices to improve performance and implement a QI plan to monitor the CP's efforts on the BH CP quality measures slate. During 2019, the QMC reviewed proposed CP policies, CP training needs, quality metrics, and implementation of Riverside's QI initiative.

Riverside developed a QI initiative to monitor and analyze hospital overutilization amongst engaged CP members. The CP began collecting member survey data to inform this initiative in December 2018. As of June 2019, Riverside had collected 113 completed surveys that would serve as baseline data. The QMC is using this data to understand how the care coordination model impacts the delivery of care for members and its overall efficacy.

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;

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

- identifying barriers to and facilitators of success during regular meetings between management and frontline staff and then reporting findings to the CP Executive Board and the Accountable Care Organization's (ACO's)[6] Joint Operating Committee;

- establishing subcommittees or workgroups in key areas such as IT and Outreach that meet more frequently than the Executive Board to advance the Board's objectives; and

- staffing central administrative positions that provide oversight of all CP partner organizations to ensure all organizations work as unified entities that provide consistent supports to members.

✓ **Consumer Advisory Board**

- seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;

- adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;

- hosting meetings in centrally located community spaces that are easy to get to and familiar to members;

- adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members;

- limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff;

- sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls;

- incentivizing participation by paying members for their time, most often through relevant and useful gift cards;

- incentivizing participation by providing food at meetings; and

- presenting performance data and updates to CAB members to show how their input is driving changes in the organization.

✓ **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

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[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.

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

Joint approach to member engagement

Riverside implemented a centralized process to exchange care plans and other member files with ACO and MCO partners. Documented Processes include the exchange of member files via Secure File Transfer protocols (SFTP), secure email, a secure file-sharing app, and via Mass HIway[7].

Riverside's relationships with key ACO contacts have improved workflows between the organizations and improved connections with PCPs. Riverside begins coordinating with members' PCPs during the outreach period, noting that members are more likely to engage with the CP when their provider has encouraged them to do so. As a result of these relationship building efforts, Riverside reports steady improvement in response time and care plan sign-off from PCPs.

Member information is regularly updated and exchanged with ACO/MCO partners. When a member is assigned to Riverside, they engage ACO contacts, behavioral health providers, and PCPs listed in the member's health record to collect all contact information available for that individual. Riverside staff documents all contact information in the electronic health record (EHR) and records whether staff collected the information directly from the member or from another provider on the member's care team.

Riverside's administrative staff review ACO/MCO member data files daily. Administrative staff receive ACO/MCO supplemental data files, daily hospitalization alerts, termination reports, member ACO/MCO affiliation changes, MassHealth eligibility updates, and Riverside enrollment data and then integrate these files into the member's record within the care management platform. Administrative staff flag any relevant updates for care coordinator review. Riverside and all APs review each partner ACO/MCO's member assignment file to identify if any of the member organizations have an established relationship with the potential members. The CP then assigns the member for outreach and engagement to one of the APs, prioritizing assigning potential members to an organization where they may have a preexisting relationship.

Integration with ACOs and MCOs

Riverside attends quarterly meetings with ACO/MCO partners. The CP uses this forum to establish mutual understanding, develop trust between the two entities, and work together to reconcile data and process discrepancies. Riverside reports that relationship building with partner ACO/MCOs is happening at all levels of the organization. CP staff formed working relationships with providers with whom they may not have previously interacted. On a monthly basis, Care Coordinators check in with other providers on the member's care team to get status reports on the member's progress and identify what work is being done for the member.

Riverside staff review ENS/ADT notifications to obtain updated member contact information on a daily basis. Riverside's ability to connect with members during outreach efforts improved with the timely updates from the ENS/ADT notifications. Riverside also credits its connection to ENS with increasing the CP's interactions with some medical providers and allowing CP staff to connect with members about their medical care.

Joint management of performance and quality

Riverside developed a QI initiative that monitors the member engagement rate. The results of this initiative will inform Riverside's care coordination model, specifically the usefulness and impact of the model.

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

To support care coordinators in their effort to engage PCPs in care plan review, the CP implemented a feature in the care management platform that tracks care plan approvals from PCPs and generates follow-up reminders for CP staff when the care plan is approaching its approval due date. Riverside improved their care plan transmission process as a result of mutual learning between their care coordinators and ACO clinical care management staff. Riverside indicates that response time in care plan sign off improved significantly during 2019.

Riverside engaged a vendor to evaluate its operations and make improvements to internal processes. The vendor recommended that Riverside's administrative team increase its oversight and support of APs to ensure that APs are providing high-quality supports to members. In response, Riverside implemented standing one-on-one meetings with AP's Program Director to ensure that the partner reviews available data and takes steps to improve performance. During the one-on-one meetings, Riverside reviews AP engagement rates, transitions of care efforts, per member per month billings, and other performance indicators. Riverside partnered with their care management platform vendor to develop a dashboard that allows staff to visualize CP performance on utilization and outcomes measures.

> CP Administrator Perspective: "*The experiences of [2019] and the productive relationships we formed with all our ACO partners position us well to move towards more meaningful integration efforts throughout [2020]. The data warehouse and dashboards provided through [IT Vendor] will allow us to share critical information on utilization and outcomes with our ACO partners so that we can work together to support our shared members.*"

Recommendations

The IA encourages Riverside 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:

- initiating routine case review calls with ACO/MCO partners about shared members.

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

Recruitment and retention

Riverside leverages existing connections with local organizations and within communities the CP serves to identify and hire employees. In addition, Riverside recruits potential staff from diversity-driven student organizations at local colleges such as the Latino Leadership Initiative at Boston College; the Gay Straight Alliance; Black Student Unions; ALANA, the African American, Latina, Asian, and Native American Nursing Group; and other multicultural community organizations such as the Haitian American Society Club, Mass Alliance for Portuguese Speakers, the Puerto Rican Cultural Center, Casa Latina, and the Bilingual Veteran's Outreach Centers of Massachusetts. Riverside also implemented a targeted media strategy focused on recruiting diverse staff, using multicultural media platforms to advertise CP positions. Using these strategies, Riverside has recruited a cohort of CP staff who know and understand the local community, reflect the cultures of the service area, and speak the languages spoken by the member population.

The CP's main barrier to retention is the staff's challenging member outreach experience. To mitigate this challenge and redirect more staff effort to care coordination, Riverside shifted the responsibility for outreach to hard-to-reach members to a Dedicated Outreach and Engagement (DOE) team in fall 2019. Riverside recognizes that an engaged workforce leads to increased employee longevity. To engage staff, Riverside hosts regular events that promote staff cohesion and boost employee morale such as weekly conference calls for care coordinators, bi-monthly cookouts, community service events, and staff meetings where the CP recognizes staff achievements. Riverside has also allocated DSRIP funds for CP staff retention bonuses.

Training

Riverside developed an initial training program that addresses all elements required by the CP program contract. All CP staff receive a minimum of 24 hours of mandatory clinical training during their orientation period, ensuring that all staff understand the BH CP model of care coordination and the state-sponsored and community-based resources available to enrolled members, e.g., resources offered through the Massachusetts Rehabilitation Commission, the Department of Mental Health, and the Community Support Program.

Riverside's APs provide ongoing trainings for staff during their staff meetings, and Riverside schedules additional ad hoc training as needed. Riverside CP managers also invite guest presenters to educate staff about the variety of resources available to CP members.

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[8] 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 Riverside is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

Riverside implemented a new care management platform in 2019. The new care management platform is utilized by all APs. The CP has contracted with a vendor to receive ENS/ADT notifications. Riverside has integrated these notifications into the care management platform.

Interoperability and data exchange

Riverside has the capability to exchange member files via SFTP, secure email, a secure file-sharing app, and Mass HIway. The CP reports that the method of data exchange varies based upon the established Documented Processes with the specific ACO or MCO partner. Riverside has established its connection to Mass HIway through its care management platform.

In its most recent progress report Riverside reported that it is able to share and/or receive member contact information, comprehensive assessments, and care plans electronically from most ACOs and MCOs. Riverside is able to share and/or receive care plans from most PCPs and is able to share and/or receive comprehensive needs assessments and member contact information with some PCPs.

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

Data analytics

To oversee documentation and performance on key quality metrics, Riverside engaged a vendor to assist with the development of an integrated data warehouse that combines claims data with data from the CP's care management platform and the EHRs of BH CP members who also receive care at other Riverside programs. The vendor also built dashboards that allows CP staff to visualize member engagement rates and progress towards quality and Healthcare Effectiveness Data and Information Set (HEDIS) metrics.

Riverside reports that its ability to document and generate reports on care coordination activities has improved with the implementation of its new care management platform. The CP can query the complete care management platform dataset to generate reports on key performance metrics. Through the creation of these reports, Riverside also monitors care team performance and identifies potential opportunities to implement QI efforts. These reports and CP performance on quality metrics are monitored by the QMC to assure that progress is being made towards established goals, that quality measures are being accurately programmed in the system, and that Riverside's internal data aligns with the calculations completed by MassHealth.

Recommendations

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

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

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 Riverside has an **Opportunity to improve with recommendations** in the Care Model focus area.

Outreach and engagement strategies

Riverside ensures that staff are providing supports that are tailored to and reflective of their member population. Riverside hires care coordination staff from the local community who reflect the diversity of the CP's service area. When possible, Riverside matches members with care coordinators who speak the member's preferred language, including American Sign Language (ASL). Riverside has contracted with a translation services vendor to support members with language accessibility needs not met by care coordination staff.

To engage members who are not easily reached telephonically, Riverside hired a the DOE team in Fall 2019. This team is tasked with contacting members who have been unreachable during the initial member outreach period. The DOE team is responsible for validating member contact information and conducting community-based outreach. Riverside has also partnered with staff at ACO and provider practices to identify and conduct outreach for difficult to reach members.

CP Administrator Perspective: *"As mentioned earlier, some of the [APs] have designated specific staff members to take on all outreach work. Allowing care coordinators to work with members rather than spend a significant amount of their time on outreach activities supports their ability to develop relationships with members and deliver person-centered care and has improved staff morale."*

Person-centered care model

Riverside reports that care coordination staff receive training on person-centered treatment planning during staff orientation. The CP employs a person-centered approach to developing the care plan, ensuring it represents the member's needs and preferences, recognizing that members often have differing types and intensity of needs, natural supports, and personal goals. During the initial care planning, care coordinators meet with each member to discuss the member's short- and long-term goals related to health, recovery, employment, housing, and education. The care plan is populated with the member's goals and sent for approval from the member's PCP.

After the care plan is approved, Riverside care coordinators meet with members monthly to discuss tasks and progress towards goals. The CP ensures that these meetings are facilitated in a person-centered way, being mindful of the member's needs related to scheduling and accessibility accommodations. Care coordinators facilitate members' progress towards goals by assisting with the completion of applications and other paperwork for social services and supports, referring the members to community-based services or providers that will help the member achieve their goals. In addition, Care coordinators encourage members to achieve their goals and help them identify obstacles to meeting their identified objectives.

To ensure that the member's care team is engaged in supporting the individual's achievement of care plan goals, the care coordinator speaks with individuals on the member's care team to ensure they are completing their assigned tasks in support of the member's plan.

Managing transitions of care

Riverside is building relationships with ACO partners and implementing systematic changes and formalized workflows to better facilitate transitions of care. Nursing staff on each CP care team take the lead on transitions of care efforts, working with ACO transitions of care committees to coordinate efforts and eliminate duplication of care. When the CP receives an Admission or Discharge or Transfer notification for a member, Riverside staff share that notification with all individuals who are identified in the member's care plan with the member's consent. Riverside has made it a practice to share member information, as appropriate and with necessary consent, to ensure that all members of the individual's team are informed of the member's condition and engaged in supporting the individual through any transitions of care. The CP also engaged some of its ACO partners in high-risk rounds to enhance support for members at a high risk for frequent admissions and to develop strategies to prevent admissions and coordinate discharges, as needed.

Improving members' health and wellness

Riverside works with members to identify the services and supports needed to achieve their health and wellness goals as well as where the member can receive those services and supports. Care coordination staff provide a wide range of assistance to members including health coaching, assistance making and keeping appointments, help accessing new providers who meet their needs, management through transitions of care, and triage of acute needs. Care coordinators also connect members to social supports and services, as part of the person-centered treatment planning process. Care coordinators assist members with paperwork, make referrals to community-based services and supports, and identify other social supports and services that may help the member achieve their health and wellness goals. Riverside care coordinators also have pamphlets and other materials on

hand, including a full list of health and wellness supports that are available at Riverside locations, to assist members with health and wellness goals.

Continuous quality improvement

To improve quality of care for CP members, Riverside's central administrative team implemented standing one-on-one meetings with each AP's Program Director to ensure staff are using available data to enhance their team's performance. In addition, Riverside's QMC leads QI initiatives focused on member utilization and the efficacy of Riverside's care model.

Riverside has a functioning CAB. CAB members have reviewed, and edited marketing materials and have provided feedback on translation needs for member-facing materials. CAB members have also proposed recruitment strategies including open houses, member incentives, and contingency management programs. It is not clear from documentation that Riverside's CAB enables QI in member experience beyond initial engagement, however.

Recommendations

The IA encourages Riverside 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:

- using Peer Support and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities;

- increasing standardization of processes for connecting members to community resources and social services where applicable; and

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

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

✓ **Outreach and engagement strategies**

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

- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;

- providing free transportation options for members to engage with services[9];

- assigning dedicated care coordinators for special populations such as pediatric, LGBTQ, members experiencing homelessness, so that they can become skilled at addressing the needs of and tailoring supports for those populations; and

- expanding staff coverage outside of normal business hours to better serve the needs of the service population and increase outreach and engagement opportunities.

✓ **Person-centered care model**

- addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;

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

- setting small initial goals that a member is likely to achieve to build member confidence in the engagement;

- developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and

- allowing members to attend care planning meetings by phone or teleconference.

✓ **Managing transitions of care**

- assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;

- establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;

- meeting an enrollee in person once care coordinators receive alerts that they were admitted;

- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[10];

- establishing a multidisciplinary Care Transitions team to review discharge summaries, develop transitional plans and form and manage relationships with local hospitals, PCP sites, ACO/MCO complex care management teams and other relevant organizations; and

- having care coordinators flag for an inpatient facility a member's need for additional home support to ensure the need is addressed in the member's discharge plan.

✓ **Improving members' health and wellness**

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

- 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

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

- 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 Riverside is On track across four of 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 Riverside 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

- initiating routine case review calls with ACO/MCO partners about shared members.

Health Information Technology and Exchange

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

Care Model

- using Peer Support and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities;

- increasing standardization of processes for connecting members to community resources and social services where applicable; and

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

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL

DSRIP Implementation Logic Model
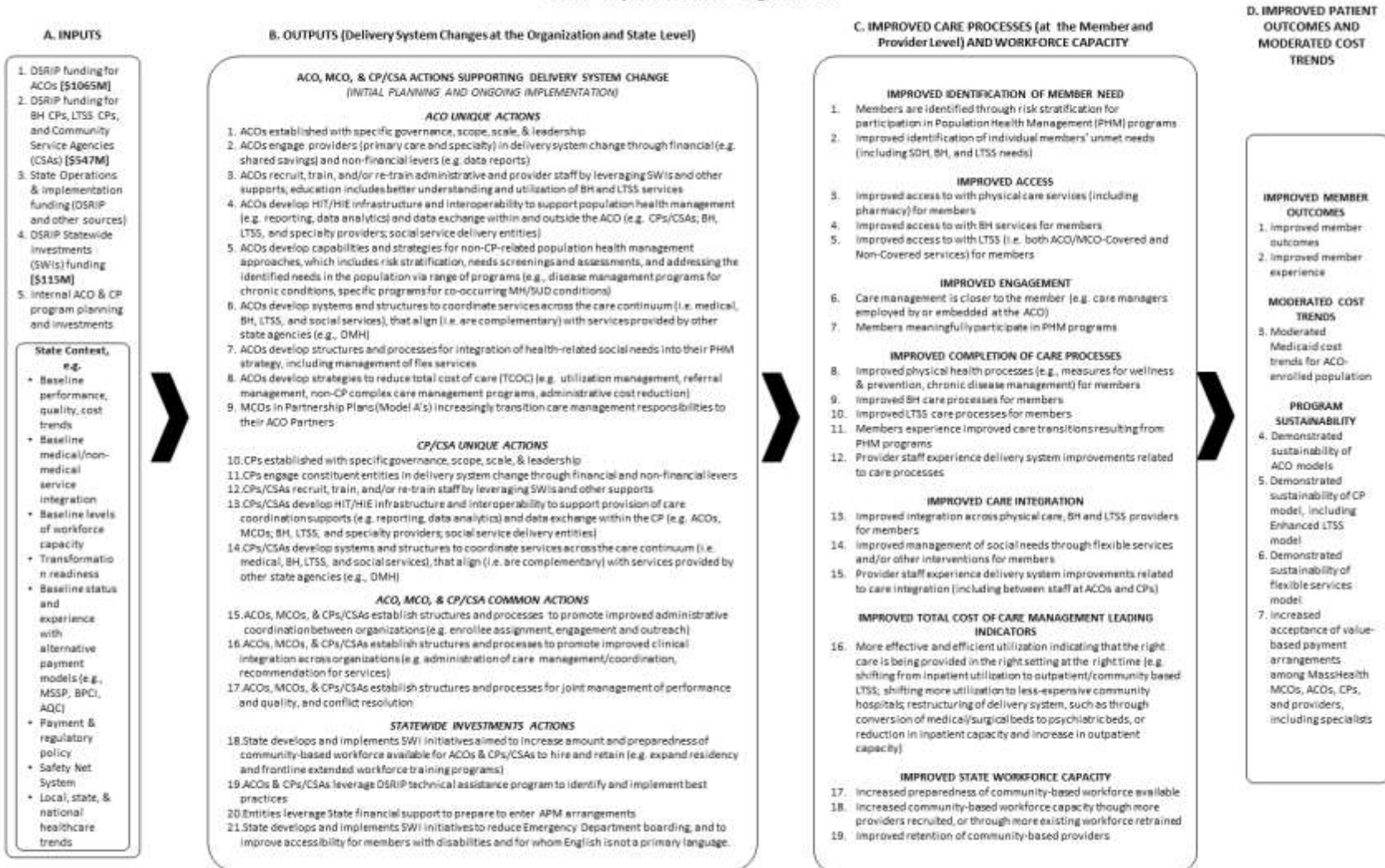
APPENDIX II: METHODOLOGY

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

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

The question addressed by this assessment is:

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

DATA SOURCES

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

List of MPA data sources:

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

- Full Participation Plans

- Semi-annual and Annual Progress Reports

- Budgets and Budget Narratives

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

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

1. Organizational Structure and Engagement

2. Integration of Systems and Processes

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

3. Workforce Development

4. Health Information Technology and Exchange

5. Care Model

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

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

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

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

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

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

DATA COLLECTION

Key Informant Interviews

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

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Comment

Riverside Community Partners appreciates the helpful feedback provided by the Independent Assessor and is pleased to note that we have already initiated the recommendations provided in the report throughout Budget Period 3, as follows:

- *Initiating routine case review calls with ACO/MCO partners about shared members.*

  Throughout 2020 we have continually enhanced our collaborative efforts with our ACO/MCO and provider partners. We are now holding monthly meetings with almost all of our partners, both at the administrative level and at the practice-level. These meetings provide an opportunity to collaborate on supporting high- or rising-risk members, engaging hard-to-reach members, and ongoing QI efforts to improve shared workflows.

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

  From the beginning of the program Riverside has had SFTP technology set up to receive client files from several of our partners, including care plans as well as supplemental data from ACOs that support our care coordinators in their outreach and member care efforts.

- *using Peer Support and/or Community Health Workers (CHWs) throughout the provision of CP supports and activities*

  During 2020 Riverside Community Care stood up its Connect2Recovery program, which provides Recovery Coaching and Recovery Support Navigation to people with SUD needs. The Riverside Community Partners program is integrating with the Connect2Recovery program by providing Recovery Coaching trainings to CP Care Coordinators, engaging in ongoing mutual referrals, and collaborating on shared members.

  Also of note is that multiple care coordinators on our different teams serve in functions that are similar to CHW roles, which provides our program with access to those types of supports for our members.
  Further, as noted in the findings, Riverside makes extensive efforts to ensure that its care coordinators represent the communities they serve, and lived experience is considered a benefit in the hiring process.

- *Increasing standardization of processes for connecting members to community resources and social services where applicable*

In March 2020 Riverside purchased a subscription to a cloud-based platform that serves as a comprehensive search engine for community resources, which allows care coordinators to connect to various supports for members' SDOH needs, process and track referrals, and gather data on the types of services to which we are connecting our members in order to inform program development.

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

As noted in the report, Riverside's CAB has had strong and committed and ongoing membership. We appreciate the suggestions for how to enhance CAB involvement in QI efforts and will implement accordingly.