MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Southeast Community Partnership, LLC

(Southeast)

PUBLIC CONSULTING GROUP

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PUBLIC CONSULTING GROUP

A Behavioral Health Community Partner

Organization Overview

The Southeast Community Partnership, LLC (Southeast) is a newly formed company with two consortium partners, Aspire Health Alliance (Aspire) and Gosnold, Inc. and one Affiliated Partner, Family Continuity (FC). This partnership represents over 169 combined years of expertise serving people with substance use disorders and mental health conditions, especially individuals with serious and persistent mental illness, substance use disorders, and co-occurring disorders.

SERVICE AREA
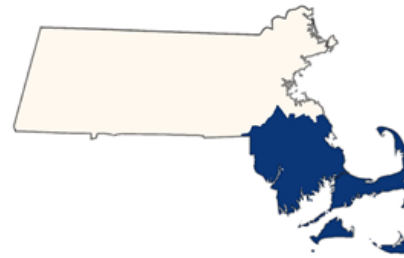
POPULATIONS SERVED

▶ Southeast serves the ethnically and culturally diverse Southeastern region. The four largest cities in Southeastern Massachusetts, Brockton, New Bedford, Taunton, and Fall River, also have the strongest Portuguese and Cape Verdean presence. There are also smaller, but significant presences of other Portuguese-speaking communities, such as other Azorean Islanders, Portuguese from mainland Portugal, Madeirans, Cape Verdeans, Brazilians, and Angolans in this region.

2,471
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

- Southeast established monthly high-risk rounds and case conferences with ACOs that share a critical number of mutual members.
- Southeast is the only BH CP program serving Nantucket and Martha's Vineyard and have built a close collaborative relationship with Partners' healthcare providers and the hospitals on the Islands.
- Southeast nurses serve as the primary liaison with primary care providers (PCPs) which expedites the exchange of care plans.
- When care coordinators accompany members to their PCP visits, members report that PCPs are taking longer with them during their visits and they are receiving more education from PCPs.

Statewide Investment Utilization:

o Student Loan Repayment Program, 4 Care Coordinators participating
o Community Mental Health Center Behavioral Health Recruitment Fund, 1 slot awarded
o Certified Peer Specialist 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]

Southeast Community Partnership, LLC (Southeast) is a behavioral health (BH) CP.

Southeast is a newly formed consortium between two entities, Aspire Health Alliance (Aspire)[3] and Gosnold, Inc. with Family Continuity (FC) as an Affiliated Partner (AP).[4] Combined, Aspire, Gosnold Inc. and FC have 169 years of expertise serving people with BH needs, especially individuals with serious and mental illness (SMI), substance use disorders (SUD), and co-occurring disorders. As a BH CP, Southeast's team provides integrated care and comprehensive care coordination for individuals who need medical and BH services and supports.

Southeast serves the Southeastern region, which includes the cities/towns of Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oak Bluffs, Orleans, Plymouth, Taunton, and Wareham. The Southeastern region is ethnically and culturally diverse. The four largest cities in Southeastern Massachusetts – Brockton, New Bedford, Taunton, and Fall River – have a large population of Portuguese and Cape Verdean residents. Fall River has a particularly high concentration of Portuguese residents. Other Portuguese-speaking communities comprising Azorean Islanders, Madeirans, Brazilians, and Angolans, have a significant presence throughout the region. Additionally, Southeast serves individuals who identify as African and American, Puerto Rican and Hispanic. Regardless of ethnicity or language spoken, Southeast serves all people with complex physical, mental, and social needs.

As of December 2019, 2,471 members were enrolled with Southeast[5].

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[2] Background information is summarized from the organizations Full Participation Plan.
[3] Aspire Health Alliance is part of two Behavioral Health Community Partnership programs in MassHealth's Delivery System Reform Incentive Payment program: South Shore Community Partnership and Southeast Community Partnership, LLC.
[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.
[5] Community Partner Enrollment Snapshot (12/13/2019).

SUMMARY OF FINDINGS

The IA finds that Southeast 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

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

Executive Board

The Southeast Board of Directors consists of senior-level executives from the CP's consortium entities (CEs), Aspire and Gosnold. The Leadership and Quality Management Team (LQMT) leads Southeast and is comprised of executives from both CEs and the CP's AP, FC. The LQMT began meeting weekly in November 2017 and is responsible for advancing the CP's overall strategy, overseeing program operations, and monitoring program progress and QI initiatives. The LQMT also led the development of organizational and operational structures and policies, outreach to ACO/MCO partners, and workforce development efforts.

Consumer Advisory Board

Southeast established a CAB that is comprised of four members. The CP reports that all members are representatives from the Southeast member community. Three CAB members are the parents of engaged CP members and the fourth CAB member is a former CP member who is in recovery. The CAB began meeting in February 2019 and continues to meet quarterly. The LMQT and frontline Southeast staff are responsible for recruiting CAB members who reflect the demographics of the Southeast population.

Quality Management Committee

Southeast created the Quality Improvement Workgroup to monitor CMS established BH CP quality metrics. The Divisional Director of Quality, Compliance, and Improvement leads this workgroup and its membership includes program directors, systems administrators, and the Director of Integrated Care.

In 2018, Southeast established its first QI initiative focused on increasing member engagement. The LQMT oversees this QI, with the assistance of the CP's Quality Assurance Analyst and Data Analyst. The LQMT assesses progress based on data from program operations, care plans, quality measures, and enrollees' health outcomes.

> CP Administrator Perspective*: "In order to manage changes in the BH CP program and monitor quality measures, Southeast has found it extremely helpful to build designated teams and workgroups. In addition to the monthly Leadership and Quality Management Team and the Hub Management Teams, Southeast has assembled a Billing Team and Quality Improvement Workgroup. Through the work of these teams, Southeast has been able to centralize procedures for managing denials and research for re-enrollment, monitor and improve documentation, and demonstrate achievement on key quality measures."*

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;

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

Joint approach to member engagement

Southeast implemented a centralized process to exchange care plans and other member files with ACO/MCO partners. Documented processes include the exchange of member files via Secure file transfer protocols (SFTP), secure email, and Mass HIway.[7] Southeast has also centralized the

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

exchange of monthly outreach status reports and enrollment/disenrollment files with ACOs/MCOs through their care management platform. Southeast staff review shared files on a regular basis. Southeast also receives member referrals from ACO/MCO partners on a monthly basis. Partner referrals contain more thorough member contact information and identify other providers on the member's care team, which promotes more effective member outreach and engagement.

Southeast program nurses are the primary liaisons with PCPs. To improve their ability to get PCP sign-off on care plans, Southeast's team adapts to the PCP's preferred method which might include consultations, phone calls, or electronic sharing of information. Southeast also works with ACO/MCO case managers, social workers, and community health workers to advance the delivery of integrated care and further engage with PCPs.

Integration with ACOs and MCOs

Southeast attends monthly meetings with three of its ACO partners in the Southeast region to discuss member cases and care integration strategies for shared members. These monthly meetings also promote relationship building between Southeast and ACO care teams. For its remaining ACO/MCO partners, Southeast attends quarterly meetings to assess the effectiveness of documented processes, share key contact personnel information, review the case management processes for shared members, address any issues in program implementation, and resolve problems in the workflows between the CP, ACOs, MCOs, or PCPs.

In addition to discussing cases during monthly meetings with their three ACO partners in the Southeast region, Southeast conducts care review conferences with individual PCPs who participate with Steward Medicaid Care Network, Inc., and Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan.

Southeast has care coordinators, registered nurses (RNs), and the Clinical Care Manager review ENS/ADT notifications daily. Southeast integrates ENS/ADT notifications into the care management platform which sends emails directly to program staff. Based on staff availability, one of the three individuals assigned to the review of ENS/ADT notifications reaches out to the in-patient facility the member presented at and begins to work with the clinical team on the member's behalf.

> CP Administrator Perspective: "*One example of a success story using ENS follows: A member with whom a care coordinator had been trying to find and engage showed up in a hospital and the care coordinator received the alert from CM [care management platform]. The care coordinator called the Emergency Department (ED), explained the situation, and they connected her to the social worker who was talking with the member. Between the social worker in the ED and the care coordinator, they developed a plan for the member to meet the care coordinator the next day. The member was happy to meet the care coordinator, signed the participation form, and began working on the assessment with the care coordinator.*"

Joint management of performance and quality

Southeast implemented a QI initiative to improve member engagement in 2018. Southeast's Quality Improvement Workgroup reviewed performance measures associated with the member engagement QI initiative while continuing to monitor other program quality measures defined by MassHealth and CMS to ensure that the care management platform captured all necessary data elements for accurate reporting. The Quality Improvement Workgroup shared quality measures results with all care coordinators. Care coordinators reviewed these results and created a visual aid to prioritize key measures for improvement. Care coordinators displayed this aid in care team offices so staff could visualize how the CP program sought to help members. Additionally, Southeast engaged care coordinators in a Care Coordinator Council to write the guidelines and standardized workflows that could improve these quality measures.

To confirm receipt of sent care plans, Southeast identified key contacts within each PCP office who would receive each new care plan. The CP's RN is responsible for the transmittal of the care plan to the specified PCP key contact. This RN position helps Southeast bridge the gap between PCP offices and develop productive relationships with those providers. Productive relationships with PCPs, ACOs, and MCOs facilitate more effective care plan transmission and care coordination for Southeast.

In 2019, Southeast developed a dashboard to oversee program documentation and performance on key quality metrics. Southeast also conducts internal audits on member records to monitor performance on quality measures and ensure accurate record keeping.

Recommendations

The IA encourages Southeast 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:

- disseminating audit reports to each member organization or provide member organizations access to program documentation and performance metric dashboard; and

- 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;

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

Recruitment and retention

Southeast filled all CP program positions with qualified staff, including positions added more recently in response to increased member engagement.

To recruit staff, Southeast posts opportunities on job boards and attends job fairs. Southeast also implemented signing bonuses for key positions, including clinical care managers and RNs. Additionally, Southeast offered four care coordinators loan repayment through the DSRIP Statewide Investment (SWI) Care Coordinator and Registered Nurse/Licensed Practical Nurse Recruitment Incentive program. To retain CP staff, Southeast creates a rewarding work environment where staff have access to trainings and professional development opportunities and receive recognition for their achievements. For example, Southeast holds an annual celebration for the CP staff to build morale and team cohesion.

Southeast successfully hired a Spanish-speaking care coordinator. The CP also employs staff who can communicate with enrollees in Mandarin, Cantonese, Portuguese, French Creole, and Cape Verdean Creole in their effort to ensure linguistic accessibility in the workplace.

Training

Southeast developed a standardized training program comprised of 12 hours of live training complemented by 15 hours of online training in the CP's learning management system. In-person trainings focus on program requirements and workflows, the population served, integrating primary

care, BH, social determinants of health, motivational interviewing, and trauma-informed care. The online trainings cover physical health management for individuals with mental illness, enhancing communication with medical providers, integrated treatment/care planning, and care management.

Southeast provides ongoing monthly trainings to CP staff to refresh existing knowledge and ensure that they are kept up to date on best practices and advancements in the field.

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

Implementation of EHR and care management platform

Southeast implemented a care management platform across all member organizations. To ensure that staff are able to work in the field and maintain communication with the Southeast team, the CP implemented the care management platform's mobile application, patient and provider web portal, and electronic signature functionality. Southeast has contracted with an ENS/ADT provider, and notifications are integrated into the care management platform. Southeast also receives ADT reports and direct messages related to member admission and discharge on a daily basis from ACO/MCO partners.

Interoperability and data exchange

Southeast exchanges member files via SFTP, secure email, care management platform mobile application, and Mass HIway.[9] The CP reports that the method of data exchange varies based upon the established documented processes with the specific ACO or MCO partner. Southeast initially faced challenges accommodating the various partner organization's preferred data exchange methods however, the CP's care management platform vendor has been able to adapt its platform over time to accommodate the negotiated documented process the CP has in place with ACO and MCO partners.

In their most recent progress report, Southeast reported they are able to share and/or receive member contact information, comprehensive needs assessments, and member care plans electronically from all or nearly all ACO and MCO partners. However, Southeast is only able to share member contact information, comprehensive needs assessments, and member care plans electronically from very few (or no) PCP offices.

Data analytics

In April 2019 Southeast's Quality Improvement Workgroup developed a dashboard to monitor performance on BH CP quality metrics and oversee program documentation. This workgroup is led by the Divisional Director of Quality, Compliance, and Improvement and its membership includes program directors, systems administrators, and the Director of Integrated Care.

The LQMT is responsible for overseeing QI for the CP and uses program outcomes and quality metrics data to set yearly goals. The LQMT uses the data sets established for quality measures and

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

claims data provided by MassHealth to identify areas in need of improvement and develop strategies to address them.

Recommendations

The IA encourages Southeast 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 Southeast has an **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

Southeast ensures that staff are providing supports that are tailored to and reflective of the member population. The CP has hired a Spanish-language speaking care coordinator and employs staff who can communicate with enrollees in Mandarin, Cantonese, Portuguese, French Creole, and Cape Verdean Creole. Southeast has also contracted with an interpretation service to support enrollees with language accessibility needs not met by CP or agency staff.

To connect with members who are not easily reached telephonically, care coordinators send letters to members, contact PCPs for updated member information, and go to members' homes to attempt to engage with individuals in person. Southeast reports that its outreach and engagement process is rooted in persistence, patience, and persuasion. The CP makes multiple attempts to connect with members and relay the value of the program's scope of services and supports. Southeast care coordinators try to meet members face-to-face whenever necessary and possible. Southeast offers members gift cards for achieving specific milestones for engagement, such as signing the participation form or completing the care plan.

> CP Administrator Perspective: *"We will bring the member to their PCP appointment...another focus of the model is to ensure that under population health that members are seeing their PCP, but also it builds engagement too, and it helps to connect the member to the CP as a resource when they need something....we have magnets now on their refrigerator...don't forget -- before you go to the emergency department, call your CP!"*

Person-centered care model

Southeast views care planning as a collaborative process directed by enrollees in partnership with clinical providers, friends and family members key stakeholders, and community partners. Southeast care plans incorporate members' physical health, BH and health-related social needs into one integrated plan. Care coordinators document member goals and progress in the care plan. Southeast care coordinators review enrollees' care plans, progress towards goals, and care plan areas that

require additional assistance from the CP during weekly meetings with their supervisions. Southeast RNs are also engaged in the care planning process, with their roles being guided by enrollees' goals and defined action steps.

To facilitate the care planning process, Southeast care coordinators are trained in motivational interviewing and trauma-informed care. Southeast views the member as the center of the care team and teach care plan is updated and adjusted as the member's needs change. At minimum, the care plan is revised and updated after six months and then again annually. Southeast care coordinators update the care plan more frequently if the member experiences a significant event or goes through a transition of care.

Managing transitions of care

Southeast reviews ENS/ADT notifications to track when enrollees present to inpatient facilities and EDs. Southeast staff reach out to the hospital or ED as soon as they are aware that a member has presented there. The Southeast nurse is the main liaison between the clinical staff at the hospital and the CP staff. The Southeast nurse mobilizes and meets with clinical staff in person to develop enrollees' discharge plans and after-care plans. The nurse also attempts to meet with the member while they are admitted to the facility.

The nurse also supports care coordinators in managing their assigned enrollees through transitions of care, accompanying them to visit enrollees when necessary. Care coordinators are responsible for assisting enrollees with following their after-care plans and updating the member's care plan as needed.

Improving members' health and wellness

Southeast has policies in place to ensure that enrollees are informed of their choices, including choices of LTSS programs and providers. Southeast reports that it has well-developed relationships with community-based services and supports providers in the Southern region. The CP publishes a resource directory that care coordinators and enrollees can reference to find services and supports providers who will help enrollees achieve care plan goals. Southeast nurses have also made connections with PCPs who can help enrollees meet their health and wellness goals.

Southeast also provides enrollees with magnets that list important health-related information, such as hotline numbers, crisis team contact information, emergency contact information, and identifies where – PCP, urgent care, or, ED – the member should go when they are experiencing a health issue.

Continuous quality improvement

For each quality measure the CP is tracking progress on, Southeast has a quality management plan that outlines the strategies CP staff should utilize to achieve quality performance in that domain of care. The CP reports that these "blueprints" facilitate QI in quality of care delivered to enrollees.

Southeast also implements a variety of QI process management principles to maintain a culture of continuous QI. Southeast's QI principles include engaging staff, key stakeholders, and providers in identifying areas for improvement and growth, using data to establish and measure goals, communicating efforts and results of QI activities to all stakeholders, and using the science of Plan-Do-Study-Act cycles to operationalize and evaluate improvement projects.

Recommendations

The IA encourages Southeast 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; 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[10];

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

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

✓ **Person-centered care model**

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

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

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

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

✓ **Managing transitions of care**

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

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

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

- visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[11];

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[10] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[11] Where members have authorized sharing of SUD treatment records.

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

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

✓ **Improving members' health and wellness**

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

- negotiating reduced or no-cost arrangements with community-based resources such as farmers markets and gyms; and

- contracting with national databases for community resources to develop a library of available supports.

✓ **Continuous quality improvement**

- providing a "Passport to Health" to members that contains health and emergency contact information and serves as the member's advance directive in healthcare emergencies and transitions of care;

- administering standardized surveys at least annually to assess member satisfaction such as the Mental Health Statistics Improvement Program Survey;

- scheduling regular meetings to disseminate best practices related to key quality measures to all CP staff; and

- creating materials such as posters and checklists that define best practices and providing implementation guidance to staff.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that Southeast is On track across all five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Organizational Structure and Engagement

- Workforce Development

The IA encourages Southeast 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

- disseminating audit reports to each member organization or provide member organizations access to program documentation and performance metric dashboard; and

- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts. Does not change focus area status.

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; and

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

Southeast 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
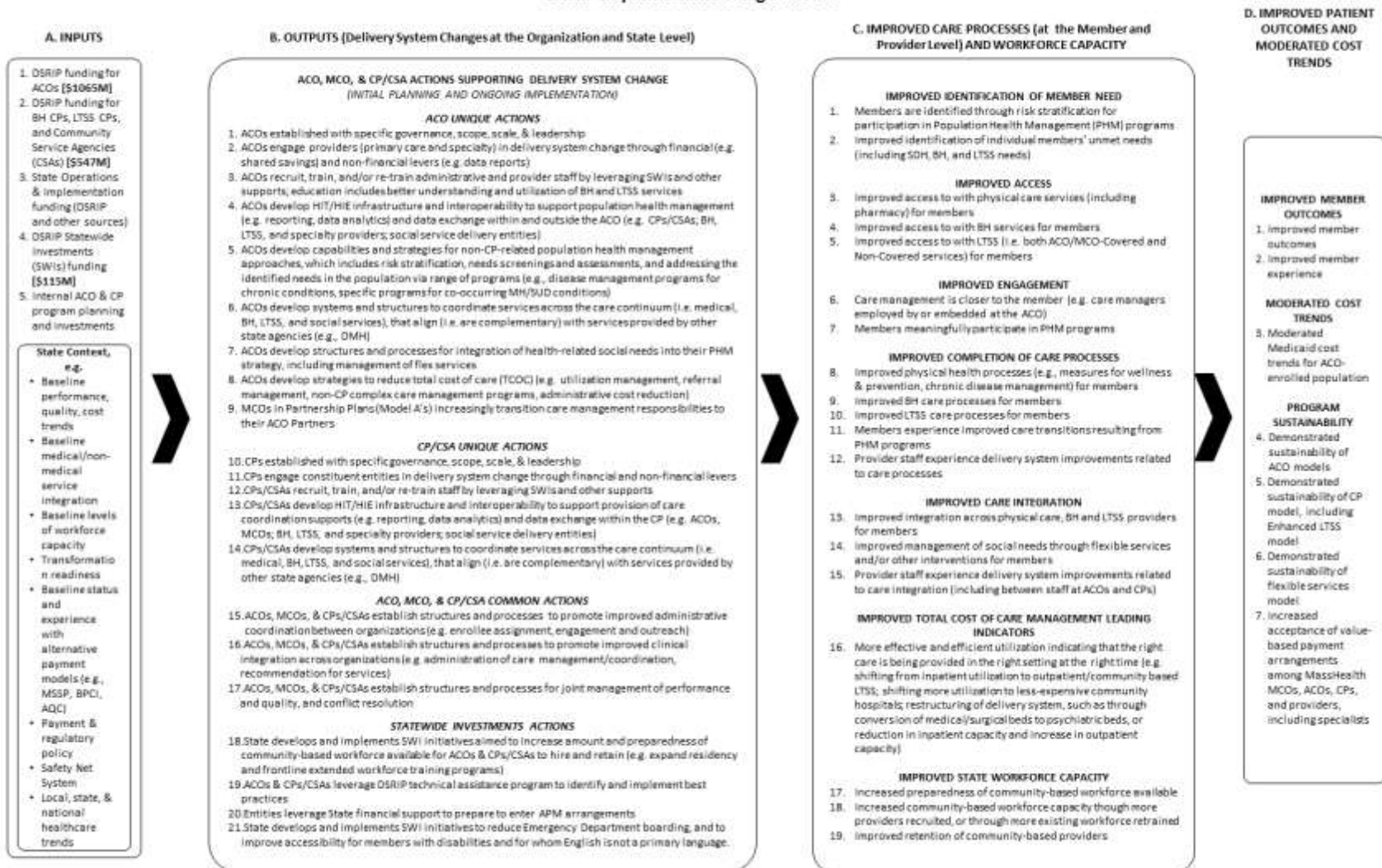
APPENDIX II: METHODOLOGY

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[12] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

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

DATA SOURCES

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

List of MPA data sources:

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

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

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

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

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

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

3. Workforce Development

4. Health Information Technology and Exchange

5. Care Model

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

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

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

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

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

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

DATA COLLECTION

Key Informant Interviews

Key Informant Interviews (KII) of CP Administrators were conducted in order to understand the degree to which participating entities are adopting core CP competencies, the barriers to transformation, and the organization's experience with state support for transformation.[13] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Comment

None submitted.