MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

Family Service Association

(FSA)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Family Service Association (FSA)

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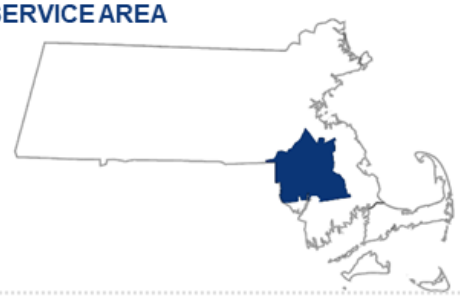
A Long-Term Services and Supports Community Partner

Organization Overview

FSA offers clinical, adult and elder, and children's services. Programs include adult day health and foster care, outpatient behavioral health, child-care and early education (ages 6 weeks to school-age) and after school care for youth up to age 13 years, or 16 for youth with special needs.

SERVICE AREA



POPULATIONS SERVED

- FSA's primary service area is the Southern region of the state: Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham.
- FSA works with children and adults with complex medical conditions and LTSS needs, aged 3 to 64. FSA serves individuals with physical disabilities, individuals with co-existing behavioral health needs, and individuals with and intellectual and/or developmental disabilities (I/DD), including autism.

972

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- FSA created monthly enrollment-disenrollment, member status and outreach reports for MasshHealth and on-demand individualized reports for ACOs/MCOs.
- FSA established a file management protocol to monitor the progression from member referral to termination/graduation.
- FSA formed a dedicated outreach team and improved their engagement rate in the first six months of 2019.
- FSA certifies all its care coordinators and CHWs through Boston University's School of Social Work Center for Aging and Disability Education and Research's (CADER) online Care Coordination Certification.

Statewide Investment Utilization:

- Special Projects Program
- Technical Assistance
- CP Recruitment Incentive Program

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1: Framework for Organizational Assessment of CPs

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

METHODOLOGY

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

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

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

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

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

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

CP BACKGROUND[2]

Family Service Association (FSA) is a Long-Term Services and Supports (LTSS) CP.

FSA was founded in 1888 as an organized social work agency and now offers clinical, adult, elder, and children's services. FSA is one of the largest providers of LTSS in Southern Massachusetts. FSA works with children and adults with complex medical conditions and LTSS needs, aged 3 to 64. FSA serves a population of individuals with chronic behavioral health (BH) needs, traumatic brain injury (TBI), physical disabilities, and intellectual and/or developmental disabilities (I/DD) including autism. Some of the programs FSA runs include: adult day health, adult foster care, group adult foster care, outpatient behavioral health, childcare and early education for children (ages 6 weeks to school-age) and after-school care for youth up to age 13 years or 16 for youth with special needs. As a LTSS CP, FSA provides care coordination supports to high need individuals.

FSA's primary service area is the southern region of the state which includes the cities/towns of Attleboro, Barnstable, Brockton, Fall River, Falmouth, Nantucket, New Bedford, Oaks Bluff, Orleans, Plymouth, Taunton, Wareham.

As of December 2019, 972 members were enrolled with FSA[3].

SUMMARY OF FINDINGS

The IA finds that FSA is On track or On track with limited recommendations in three of five focus areas. FSA has an Opportunity to improve with recommendations in two focus areas.

Focus Area	IA Findings
Organizational Structure and Engagement	On track with limited recommendations
Integration of Systems and Processes	Opportunity to improve with recommendations
Workforce Development	On track with limited recommendations
Health Information Technology and Exchange	On track with limited recommendations
Care Model	Opportunity to improve with recommendations

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

FOCUS AREA LEVEL PROGRESS

The following section outlines the CP's progress across the five focus areas. Each section begins with a description of the established CP actions associated with an On track assessment. This description is followed by a detailed summary of the CP's results across all indicators associated with the focus area. This discussion includes specific examples of progress against the CP's participation plan as well as achievements and or promising practices, and recommendations where applicable. The CP should carefully consider the recommendations provided by the IA, and MassHealth will encourage CPs to take steps to implement the recommendations, where appropriate. Any action taken in response to the recommendations must be taken in accordance with program guidance and contractual requirements.

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Executive Board**
    - has a well-established executive board which regularly holds meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies; and
    - is led by governing bodies that interface with Affiliated Partners (APs) through regularly scheduled channels (at least quarterly).[4]
- ✓ **Consumer Advisory Board (CAB)**
    - has successfully recruited members for participation in the CAB, through outreach efforts which are informed by the community profile.
- ✓ **Quality Management Committee (QMC)**
    - has undertaken at least one Quality Improvement (QI) initiative based on collected data and maintains a quality management reporting structure to review outcomes and progress on their QI initiative.

Results

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

Executive Board

FSA's LTSS CP program is led by a director who reports to FSA's Chief Program Officer. The President, CEO, Director of Information Technology, and Care Coordination Supervisor support the director in leading the FSA's LTSS CP program. Additional members of FSA's leadership team include a registered nurse, a licensed social worker, and other administrative staff. The CP does not have any APs.

Consumer Advisory Board

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

FSA established a CAB and held three CAB meetings, one in March, July, and November of 2019. Attendees included representatives from area provider groups and two engaged members of FSA's LTSS CP program. FSA provides all CAB members with a $25 gift certificate to Stop & Shop for their participation and holds meetings at an LTSS service location in New Bedford.

FSA struggles with low participation and continues to recruit new CAB members to address this issue.

Quality Management Committee

FSA's QMC operates within the organizational Quality Council. Senior leadership appoints members to the Quality Council. The Quality Council meets at least bi-monthly and reports annually to FSA's governing body. In 2019, the Care Coordination Supervisor represented FSA's LTSS CP program on the Quality Council.

FSA's quality improvement (QI) plan includes performance improvement targets or QI initiatives with measurable goals, a rationale for goals, and timelines for achievement. All plans utilize the Plan-Do-Check-Act model. In 2019, FSA established thresholds for two separate QI initiatives. One QI initiative involved full integration of the LTSS CP program into FSA's quality management process, which includes case record reviews, consumer satisfaction measures, risk management practices, and QI reporting. The other QI initiative aimed to improve data integrity while transferring records from one electronic health record (EHR) to another. The Director of Healthcare Transformation, who serves as the Director of FSA's LTSS CP, is responsible for the QI and performance management interventions.

Recommendations

The IA encourages FSA to review its practices in the following aspects of the Organizational Structure and Engagement focus area, for which the IA did not identify sufficient documentation to assess progress:

- holding regular meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies.

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

✓ **Executive Board**

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

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

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

- ✓ **Consumer Advisory Board**
    - seeking proven best practices for member recruitment and meeting structure from experienced organizations in the service area(s) that have successfully run their own consumer/patient advisory groups;
    - adapting meeting schedules to accommodate the needs of members. For example, scheduling meetings at times feasible for members who are queuing at homeless shelters in the afternoon;
    - hosting meetings in centrally located community spaces that are easy to get to and familiar to members;
    - adapting in-person participation requirements to allow participation by phone and providing quiet space and phone access at locations convenient for members;
    - limiting CP staff presence at CAB meetings to a small number of consistent individuals, so that members are the majority in attendance and become familiar with the staff;
    - sending reminders to members in multiple formats prior to each meeting to increase attendance, including reminder letters and phone calls;
    - incentivizing participation by paying members for their time, most often through relevant and useful gift cards;
    - incentivizing participation by providing food at meetings; and
    - presenting performance data and updates to CAB members to show how their input is driving changes in the organization.
- ✓ **Quality Management Committee**
    - establishing robust reporting capabilities enabling the circulation of at least monthly performance reports on key quality measures;
    - scheduling regular presentations about best practices related to quality metrics;
    - adopting a purposeful organizational QI strategy such as Lean Six Sigma or PDSA cycles;
    - integrating data from multiple sources, such as care management platforms, claims data, and EHRs, into a dashboard that continuously monitors performance data; and
    - ensuring that management or executive level staff roles explicitly include oversight of performance data analysis, identification of performance gaps, and reporting gaps as potential QI initiatives through the appropriate channels.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of CPs considered On track:

- ✓ **Joint approach to member engagement**
    - has established centralized processes for the exchange of care plans;

- has a systematic approach to engaging Primary Care Providers (PCPs) to receive sign-off on care plans;
- exchanges and updates enrollee contact information among CP and ACO/MCO regularly; and
- dedicates staff resources to ensure timely (usually daily) reviews of ACO/MCO spreadsheets to assist with outreach and engagement efforts.

✓ **Integration with ACOs and MCOs**

- holds meeting with key contacts at ACOs/MCOs to identify effective workflows and communication methods;
- conducts routine case review calls with ACOs/MCOs about members; and
- dedicates staff resources for the timely review of real-time enrollee clinical event data (Event Notification Systems containing Admission, Discharge, and Transfer data (ENS/ADT)) to facilitate clinical integration).

✓ **Joint management of performance and quality**

- conducts data-driven quality initiatives to track and improve member engagement;
- has established comprehensive care plan review processes with ACOs/MCOs to support care coordinators in their effort to engage PCPs in comprehensive care plan review; and
- disseminates audit reports to each member organization, in some cases using an interactive dashboard to disseminate data on key quality metrics.

Results

The IA finds that FSA has an **Opportunity to Improve with recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

FSA faced challenges establishing a uniform and centralized process for care plan exchange. FSA shares care plans with most ACO/MCO partners via Secure File Transfer Protocol (SFTP), but uses fax, email, standard mail and hand delivery for the exchange of care plans directly with PCPs. Some ACOs request that FSA send them a copy of all care plans that were sent to the PCP, which creates an administrative burden for FSA staff. FSA addressed this administrative burden by centralizing the process for logging care plan completion. After receiving a completed care plan from ACO/MCO partners, FSA central administrative staff ensure that both members and PCP designees have signed the care plan and then upload the plans to the electronic health record (EHR).

FSA has a dedicated Outreach Team that regularly exchanges member contact information with ACO/MCO partners and PCPs. The Outreach Team collaborates with ACO/MCO staff who are also trying to contact members, relying on the power of shared information and combined efforts to produce greater member engagement. The Outreach Team also monitors comprehensive assessments and ACO/MCO data feeds for updated demographic information. FSA leadership works with partners to develop processes to rectify disenrollment and improve the accuracy of member contact information included in referral files. However, FSA reports that many PCPs are unaware of their CP program or are reluctant to share member contact information, which impedes outreach. When this occurs, FSA goes back to the ACO/MCO partner for support in communicating with PCPs.

Once received, FSA sorts member data files to improve staff's ability to coordinate, track, and appropriately code activities for new members. FSA uses an internal file management system that separates members in the "referral" phase from those who are assigned and engaged allowing better oversight and management of outreach activities. In 2019, FSA's retired Director of Healthcare Transformation provided consultation to streamline outreach processes so that every referral receives an outreach attempt.

> CP Administrator Perspective: "*The more streamlined approach to referral management and a dedicated outreach team has proven successful for our program. In the first six months of this budget period, our engagement rate has risen from 5.9% in January to 38.9% in June. Outreach billing has risen from 26% in January to a high of 86% in March. April, May and June showed a decline but remained above 60% with rates of 66%, 70%, and 65%, respectively."*

Integration with ACOs and MCOs

FSA's Program Director participates in quarterly check-in meetings with ACO/MCO partners either by phone or in-person. In particular, FSA created a strong working relationship with Steward Health Care Network (SHCN) while developing Documented Processes with the ACO at the beginning of the program. FSA subcontracts with SHCN to complete the comprehensive assessments for their members.

FSA receives ENS alerts that are integrated into the EHR and receives ADT notifications provided by ACO/MCO partners via SFTP, secure/encrypted email, or fax. The Outreach Coordinator ensures timely review of these alerts.

Joint management of performance and quality

FSA's EHR tracks key indicators such as care plan completion and transmission dates, comprehensive assessment uploads, and Qualifying Activities[6]. EHR alerts prompt care coordinators to take actions related to quality measure adherence and compliance with contractual obligations. In quarterly meetings with FSA's Program Director, ACO/MCO partners recommended that FSA improve reporting on rates of engagement, tracking time for PCP sign-off, and other performance metrics. In 2019, FSA developed a system to track members' progression from referral to outreach, outreach to engagement, and engagement to termination/graduation for better oversight of outreach and engagement activities.

FSA disseminates monthly Enrollment-Disenrollment, Member Status and Outreach reports and analytics on performance measures to ACO/MCO partners utilizing data from its EHR.

Recommendations

The IA encourages FSA 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:

- developing a systematic approach to engage PCPs to obtain sign-off on care plans;
- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts;
- initiating routine case review calls with ACO/MCO partners about shared members;

[6] Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow up after discharge, and health and wellness coaching.

- implementing a data-driven quality initiative to track and improve member engagement; and
- establishing processes to support care coordinators in their effort to engage PCPs in comprehensive care plan review.

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 FSA is **On track with limited recommendations** in the Workforce Development focus area.

Recruitment and retention

FSA experienced one persistent vacancy for a community health worker (CHW) position but successfully retained all original staff hired at the outset of the CP program. Prior to program go-live, FSA anticipated challenges in hiring bilingual care coordinators to support Spanish-speaking populations and care coordinators in remote geographic areas like Cape Cod. To address these challenges, FSA hired a Recruitment Specialist with DSRIP funding in 2018 and uses online job-hunting sites to target specific cities and towns for recruitment. FSA also implemented an employee referral program which offers incentives to current staff for referring peers. Other recruitment strategies employed by FSA include recruiting from area colleges, local career centers, and word-of-mouth referrals. FSA's applicant tracking system provides an efficient and cost-effective way to increase their online presence.

FSA reached out to cultural organizations to identify historically underrepresented candidates and promoted the employee referral program among their bilingual staff to attract individuals with varied linguistic capabilities.

FSA offers a variety of incentives to hire and retain staff, including signing bonuses, performance incentives, flexible work hours through their web accessible EHR, and opportunities for advancement. FSA provides care coordination certification to every LTSS CP employee and notes that they intend to promote all CHWs to full-time care coordinators.

Additionally, FSA's leadership implemented workplace wellness initiatives and maintains an open dialogue with staff about ways to improve the CP program. The President and CEO host office hours, maintain a public comment email inbox, and sponsor a monthly event called "Talk To Me Tuesday" to invite employees throughout the organization to express thoughts, ideas, and challenges.

Training

FSA provides internal training on all contractually required training elements and invests in online care coordination certification for its staff through Boston University's School of Social Work Center for Aging and Disability Education and Research (CADER). CADER's program helps training participants understand the core functions and responsibilities of care coordination, explores person-centered planning, introduces care transitions, and reviews resources available to support community-based care. FSA mandates that all their CP care coordinators and CHWs complete this program.

FSA publishes and distributes a monthly training calendar that details the date, time, location, and topic of training offerings to keep staff up to date on advancements in the field. FSA's Department of

Continuous Quality Improvement has a training coordinator that helps staff find targeted training resources and tracks training attendance at the employee level and at the CP program level. Program leadership assess the need for additional training needs during the annual performance appraisal cycle. For example, FSA LTSS CP leadership identified a training gap when the program moved to a different EHR in 2019. The reporting mechanisms in the new EHR used Microsoft Excel but most of FSA's direct care staff did not know how to manage data in Excel. FSA program leadership scheduled a ten-hour Excel training to close this gap in staff skills.

Recommendations

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

- exploring additional recruitment and retention strategies to avoid persistent vacancies in planned positions.

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

✓ **Promoting diversity in the workplace**

- compensating staff with bilingual capabilities at a higher rate.
- establishing a Diversity and Inclusion Committee to assist Human Resources (HR) with recruiting diverse candidates;
- advertising in publications tailored to non-English speaking populations;
- attending minority focused career fairs;
- recruiting from diversity-driven college career organizations;
- tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives;
- implementing an employee referral incentive program to leverage existing bilingual and POC CP staff's professional networks for recruiting;
- advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers; and
- recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.

✓ **Recruitment and retention**

- implementing an internship program in partnership with higher education institutions to create a pool of eligible applicants whom the CP can hire after graduation;
- assessing applicants based on skill sets rather than credentials, then offering onsite training to close any gaps;
- conducting staff satisfaction surveys to assess the CP's strengths and opportunities for improvement related to CP workforce development and retention;

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

✓ **Training**

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

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of CPs considered On track:

- ✓ **Implementation of EHR and care management platform**
    - uses ENS/ADT alerts and integrates ENS notifications into the care management platform.
- ✓ **Interoperability and data exchange**
    - uses SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
    - uses Mass HIway[7] to improve coordination and delivery of care, avoid readmissions and enhance communication among partners.
- ✓ **Data analytics**
    - develops a dashboard, overseen by a multidisciplinary team, to monitor documentation and performance on key quality metrics and uses the dashboard to create sample reports for performance management; and
    - reports progress toward goals to the QMC, which determines opportunities for improvement, design interventions, and track the effectiveness of interventions.

Results

The IA finds that FSA is **On track with limited recommendations** in the Health Information Technology and Exchange focus area.

Implementation of EHR and care management platform

In August of 2019, FSA migrated to a new EHR platform which has helped automate key tasks that were previously completed manually, such as incorporating data from the refresh files[8] and daily enrollment files. FSA contracts with an ENS vendor that integrates ENS notifications into FSA's EHR. FSA care coordinators receive notifications on their home screen dashboards within the EHR. However, FSA notes that half of their ACO/MCO partners use a different ENS system, which prevents FSA from receiving alerts from all ACO/MCO partners at this point in time.

Interoperability and data exchange

FSA used DSRIP funds to create an in-house SFTP server. The FSA-hosted SFTP allows the CP to control the timing of exporting files, retrieving files, and ingesting incoming files. The server was completed in January 2019. FSA additionally uses external SFTP servers hosted by their ACO/MCO partners for data exchange. For ACOs and MCOs that continue to use fax as a method of transmission for some data elements, FSA set up a secure fax to email protocol. Faxed documents go to an email account dedicated to these communications that is only accessible by the Program Director and Care Coordination Supervisor.

[7] Mass HIway is the state-sponsored, statewide, health information exchange.
[8] Refresh files reflect changes in enrollment status for members referred to the CP.

FSA shares and/or receives member contact information and comprehensive needs assessments electronically with/from all ACOs and MCOs and none or very few PCPs. FSA shares and/or receives care plans electronically with/from all ACOs and MCOs and some PCPs.

Data analytics

FSA tracks and evaluates CP performance on quality metrics through their EHR. FSA tracks participation forms, dates care plans were sent to the PCP/PCP designee and when they were approved, comprehensive assessment uploads, Qualifying and non-Qualifying Activities[9], ACO/MCO attribution, and time from assignment to engagement. FSA can analyze trends for specific cohorts or for isolated points in time. Care coordination staff can run operational reports for themselves in the EHR to manage their own caseloads and track their progress in meeting certain benchmarks during the month. Managers communicate benchmark expectations and then run bi-monthly reports to track their team's performance. A limitation to FSA staff's use of the EHR for tracking quality and performance is that currently all reports export to Microsoft Excel.

FSA has a structure in place to report progress to FSA's Quality Council through their EHR, although part of this reporting is manual. FSA programs hold quarterly QI meetings that engage all stakeholders in activities in support of the performance improvement target.

> CP Administrator Perspective: "*We try to clearly communicate benchmark expectations. We set the fifteenth of the month and the last day of the month for measurement. The fifteenth of the month we provide notice to staff as to where they're at with achieving certain benchmarks so that they can know where they stand with things. We have since built it into our EHR -- so our staff can run a report for themselves out of the EHR and the report that they run for themselves, they can run it every day if they want, twice a day, once a week, whatever works best for them. We allow them flexibility in how best to use the tools that are available to them. But the reports will automatically tell them. It will run their roster and it will highlight the name in green if they've reached certain benchmarks for them within the month. It will highlight the name in red if there's unmet tasks. So, we put those tools at their disposal so that they can manage the caseloads themselves.*"

Recommendations

The IA encourages FSA 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:

- developing a plan to increase active utilization of Mass HIway.

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

[9] Qualifying Activities are activities performed by the Contractor on behalf of or with an Assigned or Engaged Enrollee. Examples include outreach, care coordination, follow up after discharge, and health and wellness coaching.

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

Outreach and engagement strategies

FSA is committed to hiring staff residing in their service region in order to build stronger ties between the CP program and the communities they serve. FSA cites difficulties in providing language accessible services due to the lack of bilingual care coordinators. However, FSA adapted to this challenge by actively employing CHWs to fill gaps and reach their member population.

FSA created a stratified plan to connect with difficult to engage members. FSA's dedicated Outreach Team completes tasks according to this protocol. After referral, the outreach worker determines if the member was ever affiliated with FSA. The outreach worker, assigned CHW, or care coordinator complete two attempts by phone to reach the member. If there is no response, or contact information is not correct, the outreach coordinator makes contact with the ACO/MCO or PCP to verify member information, to determine if the ACO/MCO/PCP partner made contact with the member to complete the comprehensive assessment, and finally, to notify the partner that the member was not reached.

Person-centered care model

Once a member is engaged, FSA care coordinators meet with the member to ascertain their preferences and interests that are integral to developing a care plan. As part of the care planning process, members are encouraged to create care goals and personal goals. Early goals are set small so that the member can see progress. Once the care plan has been drafted, it is endorsed by the member and the PCP. FSA care coordinators ensure members are aware of their right to have their information secure and confidential and leave the member with a copy of the FSA privacy notice.

FSA care coordinators conduct face-to-face meetings with engaged members at least quarterly to advance care plan objectives. FSA's training modules indicate that care coordinators use person-centered modalities such as motivational interviewing, cultural competence, and trauma-informed care when engaging with members. FSA explores the role of the ACO/MCO as the care plan is developed.

Managing transitions of care

FSA care coordinators and CHWs receive ENS notifications from some providers and conduct follow-up for these members. FSA CP staff now receive more accurate information on member discharges and transfers because of the integrated ENS which pushes notifications to the home dashboards of individual care coordinators.

Improving members' health and wellness

FSA writes in their participation plan that CP members can receive both coaching to reach wellness goals as well as referral to services available within the health plan, ACO/ MCO. FSA reports that if a need is identified for group coaching or education, wellness groups will be formed to support learning and to build connections with other members who have similar needs and interests.

For member needs that require a referral to an external provider, FSA's LTSS CP program maintains a list of covered service options and Medicaid State Plan providers organized by sub-region, which FSA care coordinators and CHWs use to contact providers in the region to determine availability. FSA encourages members to choose their preferred provider and then document the member's choice.

Continuous quality improvement

FSA's QI plan enables continuous QI in quality of care. The plan includes performance management targets with measurable goals, a rationale for goals and timelines for achievement. FSA utilizes Plan-Do-Check-Act (PDSA) cycles to implement performance management plans and has integrated the LTSS CP program's QI plan into FSA's broad organizational quality management process.

FSA's CAB is a venue to improve member experience and demonstrate program value, however FSA has struggled with low CAB participation.

Recommendations

The IA encourages FSA 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:

- designing a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations;
- developing relationships between ACO/MCO transitions of care teams and CP care teams to facilitate routine warm handoffs for members experiencing a care transition;
- increasing standardization of processes for connecting members to 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[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.

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

- ✓ **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];
    - 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 FSA is On track or On track with limited recommendations across three of five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration.

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

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

Organizational Structure and Engagement

- holding regular meetings with administrative and clinical leadership to discuss operations and strategies to improve efficiencies.

Integration of Systems and Processes

- developing a systematic approach to engage PCPs to obtain sign-off on care plans;
- dedicating staff resources for the timely, usually daily, review of ACO/MCO referral files to assist with outreach and engagement efforts;
- initiating routine case review calls with ACO/MCO partners about shared members;
- implementing a data-driven quality initiative to track and improve member engagement; and
- establishing processes to support care coordinators in their effort to engage PCPs in comprehensive care plan review.

Workforce Development

- exploring additional recruitment and retention strategies to avoid persistent vacancies in planned positions.

Health Information Technology and Exchange

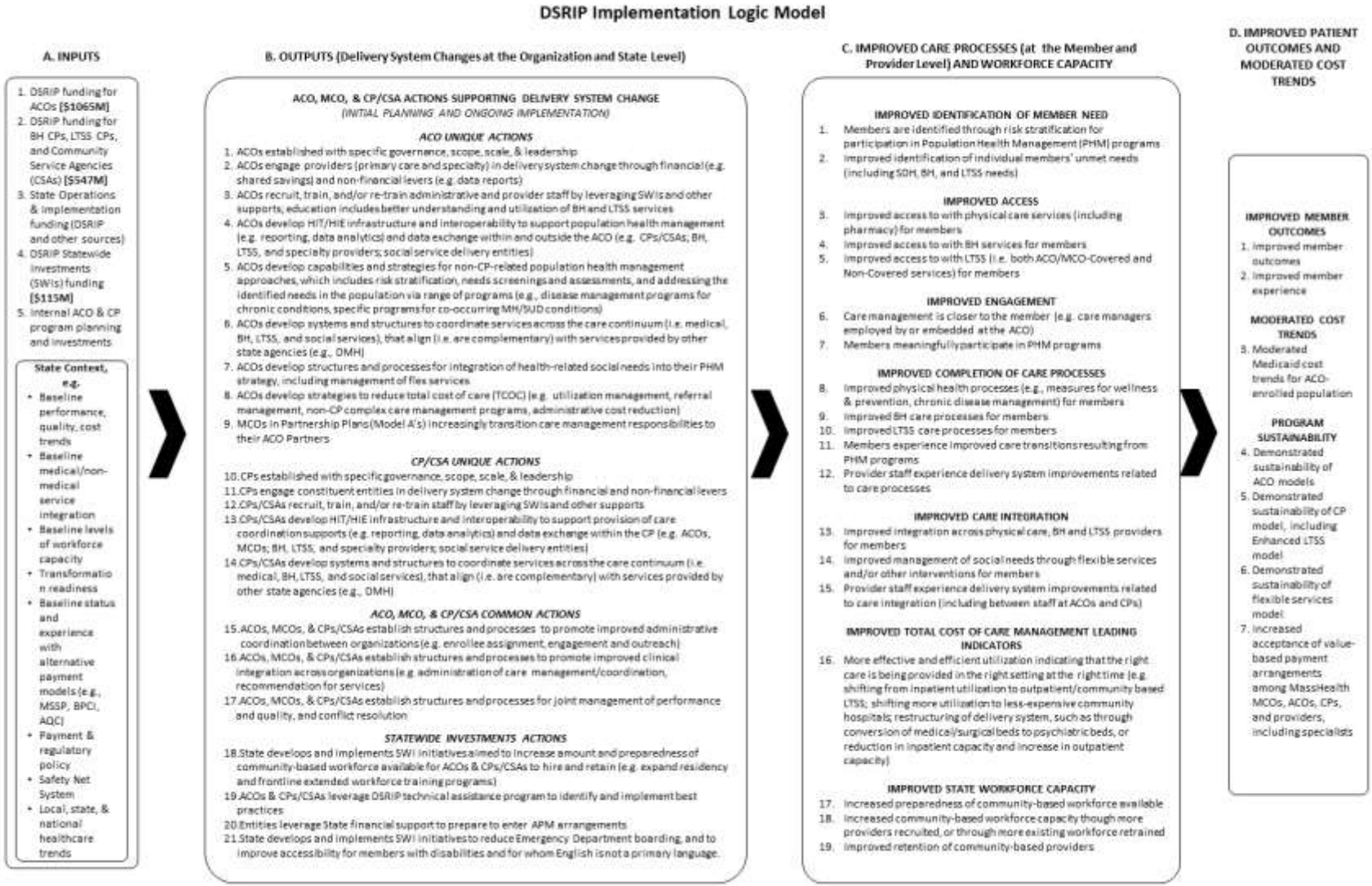
- developing a plan to increase active utilization of Mass HIway.

Care Model

- designing a strategy to contact assigned members who cannot be easily reached telephonically by going to community locations;
- developing relationships between ACO/MCO transitions of care teams and CP care teams to facilitate routine warm handoffs for members experiencing a care transition;
- increasing standardization of processes for connecting members to social services where applicable; and
- creating a structure for enabling continuous quality improvement in member experience, such as a high-functioning CAB.

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

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

Progress was defined by the CP actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[12] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

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

DATA SOURCES

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

List of MPA data sources:

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

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

Newly Collected Data

- CP Administrator KIIs

FOCUS AREA FRAMEWORK

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

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

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

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

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

Table 1. Framework for Organizational Assessment of CPs

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

ANALYTIC APPROACH

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

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

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

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

DATA COLLECTION

Key Informant Interviews

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

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

APPENDIX III: ACRONYM GLOSSARY

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

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

APPENDIX IV: CP COMMENT

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

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

CP Comment

None submitted.