MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

Community Partner Report:

SSTAR Care Community Partners (SSTAR)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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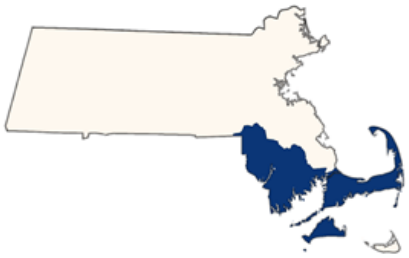
A Behavioral Health Community Partner

Organization Overview

SSTAR Care Community Partners provide primary care, substance use treatment and behavioral health resources. SSTAR and its Affiliated Partners provide outreach, care management and care coordination to marginalized communities. All affiliates are Federally Qualified Health Centers (FQHCs), providing primary care and a full range of mental health and substance use disorder treatment.

SERVICE AREA



POPULATIONS SERVED

- SSTAR and its partners serve some of the region's hardest hit by the opioid crisis, with some of the highest rates of overdose and general use in Massachusetts.
- A majority of the population served identify themselves as White and after English, the two most widely spoken languages are Spanish and Portuguese. Approximately 40% of the population are Portuguese, approximately 15% Latino, and 8% Black.

1,762

Members Enrolled as of December 2019

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

IMPLEMENTATION HIGHLIGHTS

- SSTAR established a system to import member appointments across their partners so care coordinators can work with members to prepare for upcoming appointments.
- SSTAR provides incentives when members complete outreach and engagement activities. Small incentives increased member engagement with their care team and encouraged members to complete necessary paperwork.
- SSTAR developed a cell phone program that provides cell phones to about 600 active CP members. *(CPs should first utilize Lifeline program for members as appropriate)*

Statewide Investment Utilization:

- Student Loan Repayment Program, 4 Care Coordinators participating
- Special Projects Program
- Community Health Worker Trainings
- Technical Assistance
- CP Recruitment Incentive Program

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

LIST OF SOURCES FOR INFOGRAPHIC

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1: Framework for Organizational Assessment of CPs

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

METHODOLOGY

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

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

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

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

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

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

CP BACKGROUND[2]

Stanley Street Treatment and Resources Care Community Partners (SSTAR) is a behavioral health (BH) CP.

SSTAR is a partnership between Health First Family Care Center Inc., Greater New Bedford Community Health Center, Inc., Fellowship Health Resources, Inc., Martha's Community Services, and Stanley Street Treatment and Resources (SSTAR). Health First Family Care Center Inc., Greater New Bedford Community Health Center, Inc. are Federally Qualified Health Centers that provide primary care to over 30,000 patients annually; in addition to primary care, SSTAR offers a full range of substance use and behavioral health (BH) treatment options. As a BH CP, SSTAR and its Affiliated Partners (APs) provide outreach, care management and care coordination to marginalized communities.[3]

SSTAR's service areas are in Southeastern Massachusetts and include Fall River, Attleboro, New Bedford, Oak Bluffs, Taunton, Barnstable, Falmouth, Orleans, and Wareham. SSTAR and its partners serve some of the regions hardest hit by the opioid crisis, with some of the highest rates of overdose and general use in the state.

SSTAR's member population is relatively diverse. The population is approximately 40% Portuguese, 15% Latino, and 8% Black/African American. Many enrollees are best served in a language other than English, with Spanish and Portuguese being the most commonly spoken languages after English.

As of December 2019, 1,762 members were enrolled with SSTAR[4].

SUMMARY OF FINDINGS

The IA finds that SSTAR 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
Workforce Development	On track
Health Information Technology and Exchange	On track with limited recommendations

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

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

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

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

Executive Board

SSTAR has a governing body that is comprised of leadership representatives and key operations personnel, including SSTAR's Chief Executive Officer and Chief Financial Officer. SSTAR designed its governance structure to promote consistent program implementation across its APs. SSTAR achieved this end this by having central administrative positions serve all partner organizations. SSTAR employs a Medical Director, Program Director, Intake Coordinator, and Quality Manager who serve all APs and ensure that the partner organization works as a unified entity and provides services in a consistent manner. Additionally, SSTAR engages APs in monthly meetings and maintains ongoing communication via email and phone calls between meetings.

Consumer Advisory Board

SSTAR struggles to maintain consistent membership and recruit new membership to their CAB. CAB membership was not consistent in 2019, with different members attending meetings throughout the year. To address this participation challenge SSTAR provides CAB members the option to participate in meetings telephonically and offers members space and phones at CP office locations to call into CAB meetings. CAB members also report that uncertainty about membership responsibilities is a barrier to participation.

Despite these challenges, the members who did participate provided SSTAR with feedback on a variety of initiatives. The CAB developed a member cell phone policy, related to SSTAR's outreach pilot program, that gives CP members more responsibility and ownership for their CP issued cell phone[5]. The CAB also identified a series of helpful classes that SSTAR could offer members; suggested topics include art, basic finance, and college and financial aid application processes. The CAB also advocated to improve the member incentive program to better suit the population's needs and interests.

Quality Management Committee

SSTAR implemented a QI initiative focused on care coordination and care management. SSTAR tracks completed comprehensive assessments for members with a signed participation form to inform this QI initiative. The QMC established an 80% comprehensive assessment completion rate as SSTAR's goal for this measure and continues to monitor SSTAR's performance towards this benchmark. SSTAR's Senior Quality Assurance Technician oversees all QI initiatives.

SSTAR's Medical Director and the Senior Quality Assurance Technician both chair the QMC. Additional QMC membership includes representatives from all APs. The QMC oversees SSTAR's progress on established QI initiatives and performance metrics.

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

[5] CPs should first utilize Lifeline program for members as appropriate.
[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.

- 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 SSTAR is **On track with no recommendations** in the Integration of Systems and Processes focus area.

Joint approach to member engagement

SSTAR implemented a centralized process to exchange care plans and other member files with ACO/MCO partners. These Documented Processes include the exchange of member files via Secure File Transfer Protocols (SFTP), secure email, a secure file-sharing app, and Mass HIway[7]. SSTAR developed more robust Documented Processes with the three ACOs and one MCO partner with whom they have a large proportion of shared members. SSTAR reports that working with fewer ACO/MCO partners allowed them to integrate into these ACO/MCO partners' systems more fully.

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

SSTAR maintains close relationships with PCPs and other providers to facilitate care plan sign-off. SSTAR has seen a greater rate of sign-off on care plans in a timely manner when they engage the provider on a personal level and communicate how SSTAR's program benefits the PCP practice. SSTAR encourages bi-directional communication with PCPs. PCPs contact SSTAR when potential members, who have been difficult to reach or engage, present at their offices.

SSTAR established a connection between its care management platform and its co-located health center's electronic health record (EHR). This connection allows medical providers and SSTAR staff to access member information and identify shared members on a regular basis, streamlining members' care experience. SSTAR also created shared appointment calendars. SSTAR uses Mass HIway[8] to import member appointments from its three health center partners as well as SSTAR's Ambulatory Behavioral Health Center. This shared calendar solution helps SSTAR members attend their upcoming appointments because it enables SSTAR staff to confirm members have transportation[9] to and understand the nature of the appointment.

Integration with ACOs and MCOs

SSTAR established regular team meetings with ACO/MCO partners. SSTAR uses these meetings to discuss member cases. The team meetings improved familiarity between SSTAR and ACO teams and improved co-management of members with complex cases.

SSTAR prioritizes developing relationships with the three ACOs and one MCO it has the most shared members with. SSTAR reports that it has less than ten shared members with the remaining ACOs/MCOs in the state.

SSTAR's care team works collaboratively with their co-located health center's care team who is affiliated with BMC HealthNet Plan. The care teams routinely discuss shared members to eliminate any potential duplication of services. By maintaining more robust relationships with a smaller number of ACO/MCO partners, SSTAR achieved advanced integration strategies such as the integration of EHR systems, utilization of an internal care management platform for data sharing, use of real-time secure email to transmit files between the SSTAR care team and the medical/BH care team, and coordination of medial and BH appointments so that SSTAR can prepare members to attend scheduled appointments.

Two nurses review SSTAR's daily ENS/ADT notifications and follow specific workflows to manage the information received. Daily ENS/ADT review aids SSTAR's outreach to members, improves their ability to meet the requirements for a member's visit after discharge, and helps further integrate the care teams since the information can be shared with the member's medical and/or BH providers.

Joint management of performance and quality

SSTAR leverages care management platform dashboards to track performance on quality measures including the number of Qualifying Activities[10] conducted, frequency of contact with members, frequency of phone calls to members, and other metrics that measure care coordinator and CP program performance. SSTAR also tracks the percent of members who receive a comprehensive care plan assessment after completing a participation form to support their established QI initiative.

SSTAR established a process with ACOs/MCOs to support the care plan review and approval process. SSTAR's care management platform tracks care plan approvals and generates a reminder list that they share with PCPs when care plans are approaching their approval due date. SSTAR

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

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

[10] 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.

nurse managers and social workers further support care coordinators in the care plan review process by reviewing each care plan prior to submission to the PCPs. This process slows down the care plan transmittal process but ensures that a high-quality care plan is delivered to the provider and is more likely to receive approval.

Twice a month, SSTAR generates reports that assess individual care coordinators' performance on quality metrics covering signed participation forms, engaged members, billable percentage, and members who have no Qualifying Activities[11] entered in the EHR. From this data, SSTAR generates a "Percentage of Error" file that demonstrates staff improvement or regression on performance indicators overtime. Staff with an error rate in documentation greater than five percent are re-trained on that area of the care model.

Recommendations

The IA has no recommendations for the Integration of Systems and Processes focus area.

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;

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

- developing a single point of contact for ACO/MCO partner referrals to review prospective members, research previous treatment history, and to strategize on how to accommodate new members with current CP care team capacity;
- identifying a lead member organization or CP care team to align with each ACO/MCO partner to promote and facilitate relationship building between CP care teams and ACO/MCO clinical staff; and
- implementing a real-time communication tool such as secure texting to communicate with ACO practices about shared members.

✓ **Integration with ACOs and MCOs**

- attending regularly occurring case conferences with PCPs to review member cases and obtain PCP sign-off on care plans;
- collaborating with state agencies to improve management of mutual members. For example, creating an FAQ document to explain how the two organizations may effectively work together to provide the best care for members or conducting complex case conferences;
- scheduling joint visits with the PCP, ACO/MCO clinical care team representative, and the CP care coordinator to present a unified team to the member and establish distinct support roles and who the member can contact in to address various needs; and
- collaborating with PCP practice sites so that CP care coordinators are invited to meet with members onsite prior to their clinical appointments.

✓ **Joint management of performance and quality**

- monitoring process metrics associated with member outreach and engagement such as the number of interactions staff have with members, how many interactions typically lead to member engagement, and the types of actions most conducted by CP staff;
- sending weekly updates to all ACO partners listing members who recently signed a participation form, members who have a comprehensive assessment outstanding, and members who have unsigned care plans that are due or overdue;
- having clinical staff perform comprehensive care plan reviews to improve the quality and thoroughness of those plans prior to submission to PCPs for sign-off;
- developing dashboards that combine data from MassHealth, ACO and MCO partners, and the EHR to track members' affiliations and enrollment status, thus helping staff target members for engagement;
- generating a reminder list of unsigned care plans for ACO and MCO key contacts;
- maintaining a dedicated web portal to share information with CP care teams across member organizations. Shared information includes contact information of primary care practices; the LTSS/BH provider network and local social services providers; training materials; and policies and procedures;
- developing a daily report that compares ACO member information in the Eligibility Verification System (EVS) to information contained in the CP's EHR to identify members' ACO assignment changes and keep the members' records in the EHR up to date; and

- embedding staff at local Emergency Departments (EDs) to improve outreach to members not engaged in regular care, particularly members experiencing homelessness, and connect them to care coordination supports.

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of CPs considered On track:

- ✓ **Recruitment and retention**
  - does not have persistent vacancies in planned staffing roles;
  - offers a variety of incentives to attract candidates and retain staff, and uses a variety of mechanisms to recruit and retain staff; and
  - employs tactics to ensure diversity in the workplace and design staff incentives and performance bonuses around CP priorities such as enrollee engagement, signed care plans and intensive care coordination.
- ✓ **Training**
  - develops policies and procedures to ensure staff meet the contractual training requirements and offer training to all new staff based on program requirements; and
  - holds ongoing (often monthly) training to ensure staff are up to date on best practices and advancements in the field.

Results

The IA finds that SSTAR is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

SSTAR does not have persistent vacancies in planned staff roles. SSTAR uses a variety of mechanisms to recruit and retain staff such as developing relationships with local schools and partnering with these institutions on workforce development initiatives and student training opportunities. SSTAR works collaboratively with these educational institutions to develop and recruit potential members of SSTAR's workforce. SSTAR allows APs to set their own salary and benefits packages that are tailored to meet their unique geographic market areas. SSTAR also incentivizes employment with flexible work schedules and the opportunity to work while attaining additional certifications and degrees. Additionally, SSTAR makes professional development opportunities available to staff during the workday whenever possible. SSTAR also offers staff tuition reimbursement through the DSRIP Statewide Investment (SWI) Student Loan Repayment program.

To ensure diversity in the workplace, SSTAR advertises open positions in local papers and at community agencies that serve Spanish and Portuguese speaking residents. SSTAR emphasizes the need for bilingual/bicultural candidates in all job opportunities. SSTAR also depends on staff referrals to facilitate the recruitment of bilingual/bicultural staff. SSTAR offers financial bonuses to staff who refer candidates who are hired by SSTAR.

SSTAR offers incentives to care coordinators who have met performance benchmarks for their member panel. SSTAR hosts team building and support activities that they report have led to a highly motivated, productive, and professional team.

Training

SSTAR developed a training curriculum that addresses the topics required by the CP program contract including trauma-informed care, motivational interviewing, LTSS, and cultural competency. In addition, SSTAR trains staff on overdose prevention, management of HIV, non-violent crisis intervention, and other topics pertinent to staff roles. SSTAR's IT Trainer trains staff on use of the EHR in conjunction with the EHR vendor.

SSTAR staff completed a series of required annual trainings through an online learning platform. The online learning platform provides staff with access to additional educational courses that they can browse through and engage with on their own. SSTAR also encourages staff to continue their education through attendance at external conferences.

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

Implementation of EHR and care management platform

SSTAR implemented a care management platform across all APs and contracted with three vendors to receive real-time ENS/ADT notifications. The care management platform has the capacity to collect member outreach information, share and exchange information with MassHealth and ACO/MCO partners, and generate reports on key program activities.

Interoperability and data exchange

SSTAR has the capability to exchange member files via SFTP, secure email, a secure file-sharing app, and Mass HIway[13]. SSTAR reports that having a co-located health center, that is part of an ACO, is advantageous to SSTAR's interoperability and data exchange efforts. In 2019, SSTAR implemented an interoperability solution with the co-located health center's EHR that allows all members of the care team to see relevant information about shared members.

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

SSTAR Administrator Perspective: "*SSTAR…CP has made significant progress in integration with SSTAR health center including EHR integration between [CP's EHR vendor] and [Health*

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

Center EHR Vendor]. The integration will allow medical providers and CP staff to be identified to each member's care team and more easily share information. SSTAR… has integrated services with the health center's CCM [care coordination and management] team so that shared members are easily identified and reviewed on a regular basis. Further, progress has been made on streamlining health center patient referral to all services (e.g. CP, CCM, Regional Support Network, Residential Care) so that algorithms, availability of services are reviewed for medical and behavioral health utilization."

Data analytics

SSTAR tracks and evaluates CP performance on quality metrics through their EHR. The EHR is SSTAR's central data warehouse. SSTAR has developed a quality dashboard to track and analyze CP performance based on EHR data.

In addition to required quality measures, SSTAR reviews measures related to the completion of comprehensive assessments and member engagement. This data is shared with program management and clinical staff for them to review with their teams. The QMC also reviews this data to inform its comprehensive assessment QI work. SSTAR generates quarterly reports on quality measures and shares the results with all partner entities including ACOs, MCOs, and MassHealth.

Recommendations

The IA encourages SSTAR 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; and
- using ENS/ADT alerts and integrating ENS notifications into the care management platform.

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 SSTAR is **On track with limited recommendations** in the Care Model focus area.

Outreach and engagement strategies

SSTAR ensures that staff are providing services that are tailored to and reflective of the member population. SSTAR staff have a wide range of work and lived experiences in medicine, mental health, addiction, and the legal system. SSTAR employs staff who speak Spanish, Portuguese, Cape Verdean Creole, and American Sign Language so that SSTAR can serve members in their primary languages. SSTAR also contracted with an interpreter service to support members with language needs not met by their own staff.

SSTAR has 25 care coordinators who are trained community health workers. These staff completed their training in December 2019 and are positioned to support members through the provision of CP supports and activities.

To reach assigned members who cannot be easily reached telephonically, SSTAR implemented community outreach strategies. SSTAR conducts outreach at health center Opioid Treatment Centers and inpatient facilities and reports increased success outreaching potential members when the first contact occurs in the community at a point in time when the member is at the greatest need of services. SSTAR also reports that providing members with small incentives like a coffee shop gift card encourages members to meet with their assigned care coordinator for coffee and makes outreach less intimidating for members than attending meetings that are scheduled in the member's home or in the SSTAR office.

In addition to community outreach strategies, SSTAR reports that being able to connect members to basic services, especially members experiencing homelessness, has led to better engagement with the program. SSTAR connects members to transportation[14] and essentials to help stabilize members experiencing homelessness and start them on a path to engagement with the CP program. SSTAR has also implemented a member cell phone program[15] that is utilized by 600 CP members. SSTAR feels that members with a CP-provided cell phone have higher engagement and contact rates with their care teams than members without a CP-provided cell phone.

Person-centered care model

Care coordinators all complete a course on person-centered care planning and regularly review care plan goals with nursing and social work supervisors to ensure that care plans align with person-centered practices.

During the initial assessment and development of the person-centered care plan, care coordinators discuss specific services the member is eligible for, what the eligibility criteria are, and empower members to set their own goals. Care coordinators document member's goals, including health and wellness goals, in the EHR. Care plans and goals are reviewed by the member and care coordinator every six months or sooner in cases when there are major changes in a member's health, or the member has achieved certain goals and objectives.

Managing transitions of care

To support members through transitions of care, SSTAR assigned two members of the nursing staff to manage all ADT notifications. When SSTAR is notified that a member has been admitted to an inpatient facility or presents to the emergency department (ED) the SSTAR CP nurse reaches out to the facility to establish contact with the member's inpatient care team. The CP nurse and care coordinator then work with the inpatient facility around care planning and discharge planning.

SSTAR implemented a transitions of care program with Boston Accountable Care Organization in partnership with Boston Medical Center HealthNet Plan (BACO) that focuses on reducing duplication of services and promoting integration between the ACO and CP programs. To further support members during transitions of care, SSTAR has begun engaging pharmacists and health center technicians in the integrated care team.

Improving members' health and wellness

As part of the care plan development process, care coordinators are responsible for determining which specific services the member is eligible for, reviewing information from the MassHealth third-party administrator regarding authorization of these services for members and making appropriate referrals.

[14] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[15] CPs should first utilize Lifeline program for members as appropriate.

Additionally, SSTAR provides members with health and wellness education materials. Materials cover topics such as diabetes prevention and management, healthy eating, nutrition, weight loss, and smoking cessation. SSTAR hosts more than ten weekly wellness groups on a variety of health-related topics. To help members achieve their health and wellness goals, CP members have access to these groups and other health and wellness programming offered at AP locations.

> SSTAR Administrator Perspective: "*While most service providers are polite and professional [to members], frankly some are [not], so having a professional with them makes a major difference. Members do not have the ability to navigate these systems themselves and often, sadly they have no one to help them. ...Our care coordinators figure things out- such as getting a member a bicycle so he can commute three miles to and from work every day, just as one example."*

Continuous quality improvement

SSTAR relies on its CAB to develop strategies that improve member experience. CAB members provide insight about program operations and how members can be more empowered. In 2019, the CAB developed a member cell phone policy that gives members more responsibility and ownership for the SSTAR CP cell phone[16]. The CAB was also helpful in developing a series of classes that they felt would be of interest to members; SSTAR scheduled these classes for 2020.

SSTAR's QMC enables continuous QI in quality of care by monitoring SSTAR's performance on CP quality metrics.

Recommendations

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

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

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

✓ **Outreach and engagement strategies**

- acknowledging and/or celebrating members' engagement milestones (e.g., signing the participation form and completing a person-centered treatment plan);
- creating a full-time staff position responsible for initial contact of all referrals including difficult to reach members and community engagement;
- providing free transportation options for members to engage with services[17];
- 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.

[16] CPs should first utilize Lifeline program for members as appropriate.
[17] CPs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

- ✓ **Person-centered care model**
    - addressing a member's most pressing social needs, such as homelessness, in order to build trust before tackling longer-term goals;
    - setting small initial goals that a member is likely to achieve to build member confidence in the engagement;
    - developing a care planning guide to help care coordinators develop intentional short- and long-term person-centered goals that address the member's medical, behavioral health, recovery and social needs; and
    - allowing members to attend care planning meetings by phone or teleconference.
- ✓ **Managing transitions of care**
    - assigning a registered nurse (RN) to make the first outreach call to a hospital or emergency department where a member was admitted to increase the likelihood of a timely response;
    - establishing a key point of contact at hospital units that CP staff can call to improve coordination of member transitions and gather details about the member's discharge;
    - meeting an enrollee in person once care coordinators receive alerts that they were admitted;
    - visiting detox facilities and other relevant programs not included in automated alert systems to monitor for recent member discharges[18];
    - 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;

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

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

- Organizational Structure and Engagement
- Integration of Systems and Processes
- Workforce Development

The IA encourages SSTAR 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:

Health Information Technology and Exchange

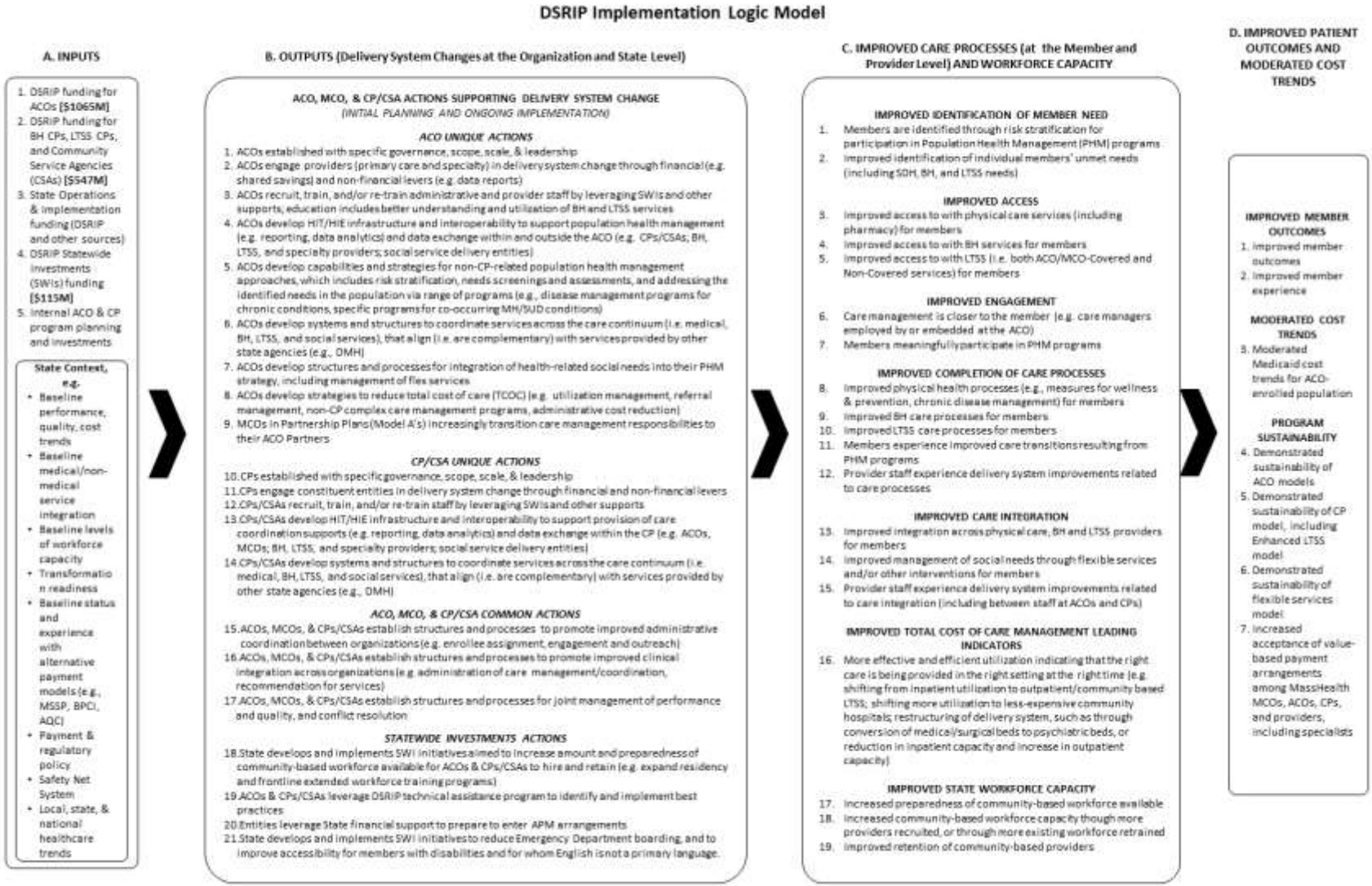
- using SFTP or other compliant and secure technology to set monitors and alerts for daily receipt of client files; and
- using ENS/ADT alerts and integrating ENS notifications into the care management platform.

Care Model

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

SSTAR 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[19] (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

[19] 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.[20] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[20] 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
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

It was suggested we use the SFTP in the quality section, but you reference our use of it in other sections as a form of communication between the ACO/MH/CP. it is something we already do. We have a dedicated staff person who is responsible for pulling daily reports from the SFTP for BH and inpatient stays outside of patient pings.