MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

ACO Report:

Southcoast Health Network in partnership with Boston Medical Center HealthNet Plan

(BMCHP Southcoast)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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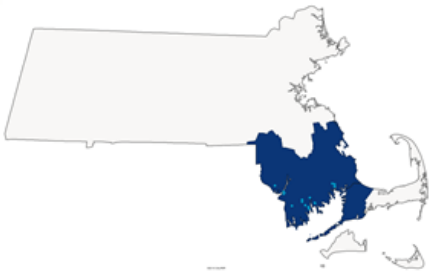
Model A ACO

BMCHP Southcoast is a MassHealth Accountable Care Partnership Plan (ACPP), a "Model A" ACO, also known as BMC HealthNet Plan Southcoast Alliance.

An ACPP is a partnership between a single health plan and a provider-led ACO that receives monthly capitated payments from MassHealth based on enrollment and member risk scores, and takes on full insurance risk for the population.

SERVICE AREA



DSRIP ATTRIBUTION AND FUNDING

2017 (Jul to Dec)	17K members	$2.0M
2018	17K members	$3.6M
2019	16K members	$2.7M

POPULATIONS SERVED

- The ACO service area has a higher share of people living in poverty compared to the state overall, and the ACO's region's cities are home to disproportionate shares of people in poverty.
- Approximately one if four people in Fall River and New Bedford live in households with annual incomes below the poverty level.
- Complex medical conditions are prevalent within the BMCHP Southcoast membership including depression, obesity, hypertension, and substance use disorders.

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

IMPLEMENTATION HIGHLIGHTS

- Southcoast created a standardized workflow to process screening results and generate registries of members who are eligible for programs or would benefit from referral to services. Southcoast maintains a public resource locator for behavioral health-related needs. Monthly reporting on quality metrics includes health-related social needs reports to enable providers to focus on subpopulations with unmet needs.
- Results of the practice site administrator survey indicate that nearly all Southcoast practices share quality and cost reports with physicians.
- Southcoast utilizes regularly occurring staff meetings, focus groups and brainstorming sessions with all staff to identify opportunities for workflow optimization related to the Medicaid ACO requirements and review qualitative and quantitative data.

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

LIST OF SOURCES FOR INFOGRAPHIC

Service area maps	Blue dots represent ACO primary care practice site locations as of 1/1/2019. Shaded area represents service area as of 7/1/2019. Service areas are determined by MassHealth by member addresses, not practice locations. Service area zip codes and practice site locations were provided to the IA by MassHealth.
DSRIP Funding & Attributed Members	Funding and attribution were provided to the IA by MassHealth. DSRIP funding is the allocated non-at-risk start-up and ongoing funding for the year; it does not include any rollover, DSTI Glide Path or Flexible Services allocations. The number of members shown for 2017 was used solely for DSRIP funding calculation purposes, as member enrollment in ACOs did not begin until March 1, 2018.
Population Served	Paraphrased from the ACO's Full Participation Plan.
Implementation Highlights	Paraphrased from the required annual and semi-annual progress reports submitted by the ACO to MassHealth.

NOTES

Performance risk is defined as the risk of being unable to treat an illness cost-effectively (unable to control controllable costs). Insurance risk is defined as the risk that a patient will become sick or that a group of patients will have higher than estimated care needs.

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, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations[1] (ACOs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019.

Progress was defined by the ACO 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[2] (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 ACO taken organizational level actions, across six 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 ACO that is the subject of this report. The ACO should carefully consider the recommendations provided by the IA, and MassHealth will encourage ACOs 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 ACO MPA findings cover six "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 Coordination and Management
6. Population Health Management

Table 1 shows the ACO actions that correspond to each focus area. The ACO 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 an ACO to take.

[1] 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. See the ACO Background section for a description of the ACO's organizational structure.

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

The focus area framework was used to assess each entity's progress. A rating of "On track" indicates that the ACO 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." See Methodology section for an explanation of the threshold setting process for the ratings.

Table 1. Framework for Organizational Assessment of ACOs

Focus Area	ACO Actions
Organizational Structure and Governance	• ACOs established with specific governance, scope, scale, & leadership • ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)
Integration of Systems and Processes	• ACOs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • ACOs establish structures and processes for joint management of performance and quality, and conflict resolution • Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the Demonstration
Workforce Development	• ACOs recruit, train, and/or re-train administrative and provider staff by leveraging Statewide Investments (SWIs) and other supports; education includes better understanding and utilization of behavioral health (BH) and long-term services and supports (LTSS)
Health Information Technology and Exchange	• ACOs develop Health Information Technology and Exchange (HIT/HIE) infrastructure and interoperability to support provision of population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. Community Partners/Community Service Agencies (CPs/CSAs), BH, LTSS, and specialty providers)
Care Coordination and Care Management	• ACOs 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))
Population Health Management	• ACOs develop capabilities and strategies for non-CP-related population health management approaches, which include risk stratification, needs screenings and assessments, and addressing the identified needs in the population via range of programs (e.g., disease management programs for chronic conditions, specific programs for co-occurring mental health (MH)/substance use disorder (SUD) conditions) • ACOs develop structures and processes for integration of health-related social needs (HRSN) into their Population Health Management (PHM) strategy, including management of flexible services • ACOs develop strategies to reduce total cost of care (TCOC; e.g. utilization management, referral management, non-CP complex care management programs, administrative cost reduction)

METHODOLOGY

The IA employed a qualitative approach to assess ACO 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. These included Full Participation Plans, annual and semi-annual reports, budgets and budget narratives. In addition, the IA developed an ACO Practice Site Administrator survey ("the survey") to investigate the activities and perceptions of provider practices participating in ACOs. For ACOs with at least 30 practice sites, a random sample of 30 sites was drawn; for smaller ACOs, all sites were surveyed. Survey results were aggregated by ACO for the purpose of assessing each ACO. A supplementary source was the transcripts of KIIs of ACO 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 ACO 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 ACOs 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 ACOs were considered to be promising practices, not expectations at midpoint. This calibrated the threshold for expected progress to the actual performance of the ACO cohort as a whole.

Qualitative coding of documents was used to aggregate the data for each ACO by focus area, and then coded excerpts and survey data were reviewed to assess whether and how each ACO 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.

ACO BACKGROUND[3]

Southcoast Health Network in partnership with BMC HealthNet Plan (BMCHP Southcoast) is an Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as BMCHP Southcoast An ACPP is a partnership between a single health plan and a provider-led ACO that receives monthly capitated payments from MassHealth based on enrollment and member risk scores, and takes on full insurance risk4 for the population.

[3] Background information is summarized from the organization's Full Participation Plan.

[4] Insurance risk is defined as the risk that a patient will become sick or that a group of patients will have higher than estimated care needs.

BMCHP provides a wide range of administrative functions including network management, member services, claims adjudication and compliance. BMCHP Southcoast is one of four Model A ACOs for which BMCHP holds a contract with EOHHS.

BMCHP Southcoast consists of the Southcoast Health Network (SHN) ACO and Boston Medical Center Health System (BMCHS). SHN ACO is a clinically integrated network with employed and community physicians and providers, the Southcoast Hospitals (Charlton Memorial, St. Luke's, and Tobey), and the Southcoast Visiting Nurses Association.

BMCHP Southcoast's service area includes Fall River, New Bedford, Wareham, Attleboro, Falmouth, Plymouth, and Taunton.

BMCHP Southcoast's MassHealth member attribution and allocated non-at-risk DSRIP Startup and Ongoing funding are summarized below.

Table 2: BMCHP Southcoast MassHealth Members and DSRIP Funding 2017-2019[5]

Year	Members	DSRIP Funding
2017 (partial year, Jul-Dec)	16,592	$2,030,425
2018	16,592	$3,593,304
2019	16,114	$2,715,089

There are significant regional and demographic issues that impact residents' health, particularly in the two major urban communities of Fall River and New Bedford and the large town of Wareham. Residents in these communities have lower incomes, a lower educational level and a historically higher unemployment rate than both the state and the region averages. The ACO service area has a higher share of people living in poverty compared to the state overall, and the ACO's region's cities are home to disproportionate shares of people in poverty. Approximately 1 in 4 people in Fall River and New Bedford live in households with annual incomes below the poverty level. Complex medical conditions are prevalent within the BMCHP Southcoast membership including depression, obesity, hypertension, and substance use disorders.

SUMMARY OF FINDINGS

The IA finds that BMCHP Southcoast is On track or On track with limited recommendations in six of six focus areas.

Focus Area	IA Findings
Organizational Structure and Engagement	On track with limited recommendations
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track with limited recommendations
Health Information Technology and Exchange	On track
Care Coordination and Care Management	On track with limited recommendations
Population Health Management	On track

[5] Funding and attribution were provided to the IA by MassHealth. DSRIP funding is the allocated non-at risk Startup and Ongoing funding for the year; it does not include any rollover, DSTI Glide Path or Flexible Services allocations.

FOCUS AREA LEVEL PROGRESS

The following section outlines the ACO's progress across the six focus areas. Each section begins with a description of the established ACO actions associated with an On track assessment. This description is followed by a detailed summary of the ACO's results across all indicators associated with the focus area. This discussion includes specific examples of progress against the ACO's participation plan as well as achievements or promising practices, and recommendations were applicable. The ACO should carefully consider the recommendations provided by the IA, and MassHealth will encourage ACOs 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 ACOs considered On track:

- ✓ **Established governance structures**
  - includes representation of providers and members, and a specific consumer advocate, on executive board;
  - receives and incorporates, through the executive board, regular input from the population health management team, and the Consumer Advisory Board/Patient Family Advisory Committee;
  - has a clear structure for the functions and committees reporting to the board, typically including quality management, performance oversight, and contracts/finance.
- ✓ **Provider engagement in delivery system change**
  - has established processes for joint management of quality and performance, including regular performance reporting to share quality and performance data, on-going performance review meetings where providers and ACO discuss areas for improvement of performance, and education and training for staff where applicable;
  - communicates a clearly articulated performance management strategy, including goals and metrics, to practice sites, but also grants sites some autonomy on how to meet those goals, and uses feedback from providers and sites in ACO-wide continuous improvement for quality and performance.

Results

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

Established governance structures

BMCHP Southcoast established appropriate governance structures. A Joint Operating Committee (JOC) oversees BMCHP Southcoast's overall strategic development including its DSRIP budget, marketing operations, performance oversight and overall operational strategies. BMCHP Southcoast also has a Quality Committee.

Southcoast Health Network (SHN) maintains a Board of Managers which oversees most daily operations across BMCHP Southcoast's provider sites. The Board of Managers consists of 15 representatives split between primary care and specialty care physician managers including nurses,

and member managers who represent BMCHP Southcoast and its subsidiary entities. SHN appointed a behavioral health/substance use provider as a physician manager and a consumer as a member manager of BMCHP Southcoast. The physician manager actively engages with the behavioral health staff to ensure proper provisions of care for all MassHealth members receiving Behavioral Health services.

Provider engagement in delivery system change

SHN defines the BMCHP Southcoast's overall population health management and care transformation strategies and develops improvement and transformation plans for the entire network. Individual provider sites are granted limited levels of autonomy to craft specific initiatives that reflect the needs of their specific populations, but primarily the ACO is focused on standardizing approaches to care transformation and minimizing variation across practice sites. BMCHP Southcoast uses regular staff meetings and focus groups with front line workers to solicit and receive feedback on improvement priorities and progress. BMCHP manages most of the BMCHP Southcoast's analytics concerning quality and cost metrics. Regular reports are created by BMCHP and distributed to SHN quality improvement (QI) teams and providers through various means including through BMCHP Southcoast's electronic health record (EHR) at select sites. QI teams then work with specific provider locations to identify unfavorable trends and implement care change efforts.

BMCHP Southcoast reports it intends to work toward an all-payor funds flow distribution policy based on provider performance across all applicable contracts, beyond MassHealth. Currently, BMCHP Southcoast incentivizes providers based on only a few metrics focused on BMI Management and access.

Recommendations

The IA encourages BMCHP Southcoast 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:

- providing additional details relating to the senior governance structure inside of the ACO specific to subcommittees informing the JOC; and
- providing details related to its PFAC's role in advising the ACO's senior leadership.

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

✓ **Established governance structures**

- engaging Community Partners (CPs) in ACO governance by developing a subcommittee with ACO and CP representatives focused on increasing CP integration and collaboration.
- creating a centralized PFAC to synthesize information from practice site specific PFACs and disseminate promising practices to other provider groups and practice sites within the ACO's network.
- seeking feedback from consumer representatives or PFACs related to member experience prior to adoption of new care protocols or other changes.
- including a patient representative in each of an ACO's subcommittees in addition to having a patient representative on the governing board.

- ✓ **Provider engagement in delivery system change**
    - protecting dedicated provider time for population health level activities or individual quality improvement projects.
    - engaging frontline providers in continuous feedback loops to identify areas where patient experience could be improved.
    - hosting regular meetings between providers or provider groups and senior management to collect provider feedback on care management operations and quality improvement initiatives.
    - developing provider-accessible performance dashboards with practice-site level data.
    - employing individuals in roles dedicated to QI, who assist providers and practice sites to review quality measures and identify pathways to improve care processes and provider performance.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Administrative coordination among ACO member organizations and with CPs**
    - circulates frequently updated lists including enrollee contact information and flags members who are appropriate for receiving CP supports;
    - shares reports including risk stratification, care management, quality, and utilization data with practice sites;
    - practice sites report that when members are receiving care coordination and management services from more than one program or person, these resources typically operate together efficiently.
- ✓ **Clinical integration among ACO member organizations and with CPs**
    - deploys shared team models for care management, locating ACO staff at practice sites, and providing both role-specific and process-oriented training for staff at practice sites;
    - enables PCP access to all member clinical information through an EHR; and sites are able to access results of screenings performed by the ACO;
    - co-locates BH resources and primary care where appropriate.
- ✓ **Joint management of performance and quality**
    - articulates a clear and reasoned plan for quality management that jointly engages practice sites and ACO staff, and explicitly incorporates specific quality metrics;
    - dedicates a clinician leadership role and ACO staff to reviewing performance data, identifying performance opportunities, and implementing associated change initiatives in cooperation with providers.
- ✓ **ACO/MCO coordination** (at Accountable Care Partnership Plans)
    - shares administrative and clinical data between ACO and MCO entities, and circulates regular reports including population health and cost-of-care analysis;

- is coordinated by a Joint Operating Committee for alignment of MCO and ACO activities, which manages clinical integration and is planning transitions of functions from MCO to ACO over time.

Results

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

Administrative coordination among ACO member organizations and with CPs

BMCHP Southcoast circulates a list of members engaged with CPs to PCPs. PCPs also have continuous access to the EHR, which flags patients enrolled in CP or Care Management services and those who are high-risk.

BMCHP Southcoast shares monthly performance reports with providers to identify opportunities for improvement in clinical and patient satisfaction measures. Additionally, BMCHP Southcoast shares quality data at regularly occurring interdisciplinary staff meetings.

BMCHP Southcoast develops and maintains CP relationships at the local level by performing outreach, maintaining continuous communication and collaborating on care management responsibilities. Additionally, BMCHP Southcoast population health management staff hold medical care team meetings with PCP practices and CPs to discuss patient care and coordinate services.

Staff from the CP program and BMCHP Southcoast's care management program meet regularly to coordinate care for members enrolled in both programs.

Clinical integration among ACO member organizations and with CPs

BMCHP Southcoast staff participate with practice site staff in case review meetings. BMCHP Southcoast embedded nurse care managers at the primary care practice sites to integrate with care management teams to serve members with complex medical needs. Nurse care managers connect patients to appropriate community services and primary care practices after a hospital discharge. They work with high-risk patients for ninety days and low-risk patients for 30 days. BMCHP Southcoast care managers collaborate with CPs to provide care management to members enrolled in the CP program and run QI initiatives.

All member clinical information is available to PCPs and ACO staff through the ACO's EHR.

BMCHP Southcoast's BH care team coordinates with BH CPs and BH providers to provide patient care and develop continuous care plans for all members with BH and LTSS needs.

Joint management of performance and quality

BMCHP Southcoast's Chief Quality Officer works with the Executive Board, the President, and Vice President to monitor quality assurance. The Executive Director of Quality analyzes BMCHP Southcoast quality outcomes and feeds those reports back to the President and throughout the organization to drive continuous improvement. BMCHP Southcoast deploys numerous staff to support providers and implement improvement initiatives. ACO quality analysts review quality measure performance, identify improvement opportunities and implement associated change initiatives with providers. Additionally, teams of care managers, social workers, a pharmacist, and mental health workers work with practice sites to improve performance. BMCHP Southcoast hired two practice based coordinators to help providers improve ambulatory and patient satisfaction quality metrics.

BMCHP Southcoast utilizes regularly occurring staff meetings, focus groups and brainstorming sessions with all staff to identify opportunities for workflow optimization related to ACO requirements and review qualitative and quantitative data.

BMCHP Southcoast Administrator Perspective: "*the front-line staff are integrally involved in identifying effective and ineffective approaches to care, providing input into the development of necessary data reporting (both outcomes-based as well as reporting for identifying where care should be focused), [providing] feedback on attainment of quality outcomes, and [sharing] what they are hearing from patients and providers. This feedback is…obtained by frequent staff meetings, sought out by management, and an open door policy at the top if the front-line staff feels their input is not being listened to.*"

ACO/MCO coordination (at Accountable Care Partnership Plans)

BMCHP Southcoast's JOC oversees DSRIP-related decision making and manages clinical integration The JOC oversees BMCHP Southcoast performance and makes recommendations for improvement. BMCHP shares member registries and utilization reports with Southcoast. BMCHP Southcoast shares clinical data and total cost of care reports with providers every month, highlighting performance related to organizational goals and opportunities for improvement.

Recommendations

The IA encourages BMCHP Southcoast 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:

- co-locating Behavioral Health services at primary care locations;
- sharing criteria for identifying members for CP referral, and reports that include care management, quality, and utilization data; and
- reviewing strategy for members who receive care coordination and management from multiple programs so that practice site staff and the members they serve feel that these services operate together efficiently.

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

- ✓ **Administrative coordination among ACO member organizations and with CPs**
  - establishing weekly meetings to discuss newly engaged members.
  - establishing monthly meetings with practices sites and CPs to discuss member care plans.
  - creating a case review process including care coordination, service gaps and service duplication.
  - sharing member risk stratification reports including results of predictive modeling.
- ✓ **Clinical Integration among ACO member organizations and with CPs**
  - designating a practice site champion responsible for integrating Care Coordination and Care Management (CCCM) and clinical care plans.
  - embedding CCCM staff at practice sites to participate in shared model for care management.
  - providing resiliency training to CCCM staff to improve team cohesion and offer emotional support.
  - developing a centralized care management office to support member care teams in conducting needs assessment, follow-up, disease management and transitions of care.

- following members for at least 30 days post-discharge from the hospital.
- providing laptops or other devices that enable EHR access by off-site providers during visits with members.
- holding monthly meetings of CCCM teams to share best practices, develop solutions to recent challenges and provide collegial support.

✓ **Joint management of performance and quality**

- developing practice site specific quality scorecards and reviewing them at monthly or quarterly meetings.
- having the Joint Operating Committee (JOC) review scorecards of clinical, quality, and financial measures.
- sharing individual performance reports containing benchmarks or practice wide comparisons with providers.

✓ **ACO/MCO coordination** (at Accountable Care Partnership Plans)

- reviewing performance and quality outcomes at regular governance meetings.
- developing coordinated goals related to operations, budget decisions and clinical quality outcomes

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of ACOs considered On track:

✓ **Recruitment and retention**

- successfully hired staff for care coordination and population health, leaving no persistent vacancies;
- uses a variety of mechanisms to attract and retain a diverse team, such as opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness and leadership training.

✓ **Training**

- offers training to staff, including role-specific topics such as integrating primary care, behavioral health, health-related social needs screening and management, motivational interviewing, and trauma-informed care;
- has established policies and procedures to ensure that staff meet the contractual training requirements, and holds ongoing, regularly scheduled, training to ensure that staff are kept up to date on best practices and advances in the field as well as refreshing their existing knowledge.

✓ **Teams and staff roles designed to support person-centered care delivery and population health**

- hires nonclinical staff such as CHWs, navigators, and recovery peers, and deploy them as part of interdisciplinary care delivery teams including CCCM staff, medical providers, social workers and BH clinicians;

- deploys clinical staff in population health roles and nontraditional settings and trains a variety of staff to provide services in homes or other nonclinical settings.

Results

The IA finds that BMCHP Southcoast is **On track with limited recommendations** in the Workforce Development focus area.

Recruitment and retention

BMCHP Southcoast pursued a recruitment and retention strategy that mitigated any major or persistent gaps in staffing. BMCHP Southcoast hired its full complement of staff but did not disclose to the IA specifics of how they recruited staff.

BMCHP Southcoast performed an ACO-wide staff salary analysis near the beginning of the Demonstration to understand how salaries compared to industry averages. This effort resulted in salary adjustments for registered nurses and clinical nurse specialists/nurse practitioners which BMCHP Southcoast credits as a source of high retention rates. BMCHO Southcoast also implemented an aggressive training and professional development orientation to help limit staff turnover.

Training

BMCHP Southcoast maintains a significant course catalog for trainings that are available to staff. BMCHP Southcoast typically conducts introductory trainings at the Southcoast Health Business Center. Introductory trainings include three full days of in-person trainings that focus on the care management model and how care management roles and staffing complement set policies. Trainings also cover specific patient populations and how BMCHP Southcoast pursues quality management operations.

BMCHP Southcoast engaged an outside vendor to develop additional online and in-person training opportunities and classes. Courses range from in-person multi-day trainings focused on care management and population health fundamentals to online courses focused on medical home concepts, targeted patient populations, time management and effective communication techniques in team-based care delivery. Courses assist staff with maintaining certification levels and BMCHP Southcoast reports high levels of compliance with training requirements from both staff requiring Continuing Education Units (CEU) and those that do not.

Teams and staff roles designed to support person-centered care delivery and population health

BMCHP Southcoast developed person-centered care delivery and population health-oriented care models through the inclusion of multi-disciplinary teams in care coordination efforts. This includes care coordination and care management (CCCM) teams that oversee patients throughout the BMCHP Southcoast's risk groups consisting of nurse practitioners/clinical nurse specialists, registered nurses, (RNs), licensed clinical social workers (LCSW), pharmacists, pharmacy techs, medical assistants, community health workers, certified diabetic educators, COPD nurse navigators and CHF nurse navigators.

Care team staff engage with PCPs and medical specialists throughout patient encounters and BMCHP Southcoast maintains workflows and policies that identify when and how member issues should be elevated to PCPs or specialists. Care team staff are typically located at BMCHP Southcoast's business center though they do frequently operate out of PCP clinics, based on member needs.

BMCHP's CHWs, beyond assisting patients directly with questions they may have and administering supportive services, are also responsible for maintaining close relationships with CPs in order to engage proper resources when needed.

BMCHP Southcoast uses DSRIP investments to support costs associated with nurses, social workers, CHWs and nurse practitioners traveling to high-need patient locations to assist with care delivery and social services coordination to prevent avoidable ED use and reduce total cost of care.

Recommendations

The IA encourages BMCHP Southcoast 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 opportunities to provide workforce support through educational assistance and loan forgiveness.

Promising practices that ACOs 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 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.
- 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**

- contracting with a local social services agency capable of providing the ACO with short term CHWs, enabling the ACO to rapidly increase staff on an as-needed basis.
- onboarding cohorts of new CCCM staff with common start dates, enabling shared learning.
- implementing mentorship programs that pair newly onboarded staff with senior members to expedite training, especially amongst CCCM teams with complex labor divisions.
- providing opportunities for a staff voice in governance through regularly scheduled leadership town halls at individual practice sites.

- recruiting staff from professional associations, such as the Case Management Society of America, and from targeted colleges and universities.
- offering staff tuition reimbursement for advanced degrees and programs.
- using employee referral bonuses to boost recruitment.

✓ **Training**

- offering staff reimbursement for training from third party vendors.
- tracking staff engagement with training modules and proactively identifying staff who have not completed required trainings.
- providing additional training opportunities through on-line training programs from third party vendors.
- offering Medical Interpreter Training to eligible staff.
- sponsoring staff visits to out of state health systems to learn best practices and bring these back to the team through peer-to-peer trainings.

✓ **Teams and staff roles designed to support person-centered care delivery and population health**

- protecting provider time for pre-visit planning.
- pairing RN care managers or social workers with CHWs to provide care coordination.
- including pharmacists/pharmacy technicians and dieticians on care teams.
- developing trainings and protocols for staff providing home visits.
- developing trainings and protocols for staff using telemedicine.
- leveraging CHWs who specialize in overcoming barriers to engagement, including issues of distrust of the medical community, to build relationships with hard-to-engage members.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of ACOs considered On track:

✓ **Infrastructure for care coordination and population health**

- uses an EHR to aggregate and share information among providers across the ACO
- has a care management platform in place to facilitate collaborative patient care across disciplines and providers;
- uses a population health platform that integrates claims, administrative, and clinical data, generates registries by condition or risk factors, predictive models, utilization patterns, and financial metrics, and identifies members eligible for programs or in need of additional care coordination.

✓ **Systems for collaboration across organizations**

- has taken steps to improve the interoperability of their EHR;

- shares real-time data including event notifications, and uses dashboards to share real time program eligibility and performance data;
- creates processes to enable two-way exchange of member information with CPs and develops workarounds to solve interoperability challenges.

Results

The IA finds that BMCHP Southcoast is **On track with no recommendations** in the Health Information Technology and Exchange focus area.

Infrastructure for care coordination and population health

BMCHP Southcoast uses an EHR to aggregate and share information among providers across the ACO. Their universal EHR also allows non-affiliated providers to access a member's record through a web-based portal.

The EHR includes a care management platform to facilitate collaborative patient care across disciplines and providers. Additionally, BMCHP Southcoast utilizes care managers and quality staff to identify and assist the members most in need of care management.

BMCHP Southcoast has population health platforms in place to integrate claims, administrative and clinical data, registries by condition or risk factors, predictive models, utilization patterns and financial metrics. Practice quality coordinators and quality analysts use this data to identify high need members along with a care management platform to help their care coordination work.

Results from the ACO Practice Site Administrator Survey indicate that a majority of BMCHP Southcoast practice sites agree or strongly agree that EHR and population health platforms improve their ability to coordinate care for MassHealth members (Figure 1).

Systems for collaboration across organizations

BMCHP Southcoast has taken steps to improve data sharing. Through the web-based portal, providers, including CPs, can access member records to optimize care coordination.

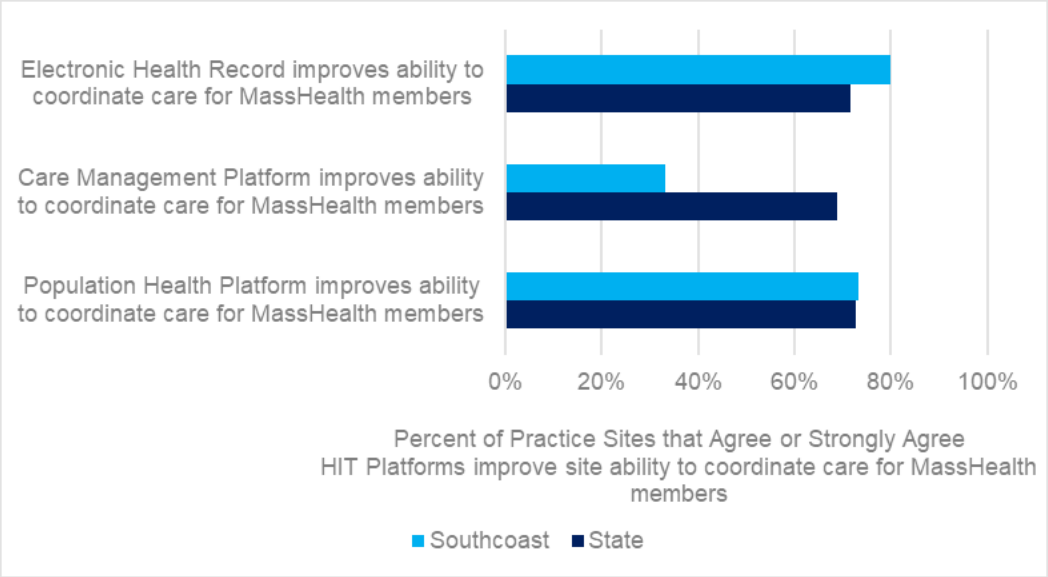
BMCHP Southcoast and all their affiliated PCP sites have full access to ADT feeds and real-time event notification and the ACO is able to fully incorporate this data into their population health analytics technology. Real-time data is shared using the EHR's event notification system, including member admission and discharge. An external event notification system assists with out-of-network admissions.

BMCHP Southcoast invested in a dashboard to share real-time program eligibility and performance data. The EHR provides individual provider dashboards to aid in quality improvement efforts. The care managers and quality staff utilize these dashboards to manage members, particularly those members flagged as critical.

The EHR provides a two-way exchange of member information to both affiliated and non-affiliated providers. The ACO also joined a network which provides a bi-directional interface with organizations utilizing different EHR platforms.

BMCHP Southcoast shares and receives electronic member contact information, comprehensive needs assessment results and care plans through secure and compliant means with all or the majority of their participating PCP sites, participating specialists, CPs, non-affiliated providers and the managed care plan.

Figure 11.2 Perceptions of HIT Platforms for Care Coordination



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in BMCHP Southcoast, N = 15
Figure displays responses to Q13_EHR, Q13_CMP, Q13_PHP. *To what extent do you agree that the Electronic Health Record/ Care Management Platform/Population Health Platform improves your ability to coordinate care for your MassHealth members?*
Statistical significance testing was not done due to small sample size.

Recommendations

The IA has no recommendations for the Health Information Technology and Exchange focus area.

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

- ✓ **Infrastructure for care coordination and population health**
  - leveraging EHR integrated care management and population health platforms.
  - automating risk stratification to identify high-risk, high-need members.
  - developing HIT training for all providers as part of an on-boarding plan.
  - incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress.
  - conducting ongoing review and evaluation of risk stratification algorithms to improve algorithms and refine the ACO's approach to identifying members at risk who could benefit from PHM programs.
- ✓ **Systems for collaboration across organizations**
  - establishing EHR portals that allow members to engage with their chart and their care teams.
  - providing EHR access through a web portal for affiliated providers, CPs or other entities whose EHR platforms are not integrated with the ACOs EHR.

- developing methods to aggregate data from practice sites across the ACO; particularly if sites use different EHRs.
- pushing ADT feeds to care managers in real time to mitigate avoidable ED visits and/or admissions.
- developing continuously refreshing dashboards to share real-time program eligibility and performance data.

5. CARE COORDINATION AND CARE MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Full continuum collaboration**
  - collaborates with state agencies such as DMH;
  - has established processes for identifying members eligible for BH or LTSS services and collaborating with CPs, including exchanging member information, and collaborating for care coordination when CP has primary care management responsibility;
  - designates a point of contact for CPs to facilitate communication;
  - incorporates social workers into care management teams and integrates BH services, including Office-Based Addiction Treatment (OBAT), into primary care.
- ✓ **Member outreach and engagement**
  - uses both IT solutions and manual outreach to improve accuracy of member contact information;
  - uses a variety of methods to contact assigned members who cannot be reached telephonically by going to members' homes or to community locations where they might locate the individual (e.g. a congregate meal site);
  - addresses language barriers through steps such as translating member-facing materials, providing translators for appointments, and recruiting CCCM staff who speak members' languages;
  - supports members who lack reliable transportation by providing rides or vouchers[6], and/or providing services in homes or other convenient community settings;
- ✓ **Connection with navigation and care management services**
  - locates CCCM staff in or near EDs;
  - enables staff to build 1:1 relationships with high-need members, and uses telemedicine, secure messaging, and regular telephone calls for ongoing follow up with members;
  - provides members with 24/7 access to health education and nurse coaching, through a hotline or live chat;

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

- implements best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;
- implements processes to direct members to the most appropriate care setting, including processes to re-direct members to primary care to reduce avoidable emergency department visits;

✓ **Referrals and follow up**

- standardizes processes for referrals for BH, LTSS, and health related social needs (HRSN), and ability to systematically track referrals, enabling PCPs and care coordinators to confirm that a member received a service, incorporate results into the EHR and care plan;
- conducts regular case conferences to coordinate services when a member has been referred.

Results

The IA finds that BMCHP Southcoast is **On track with limited recommendations** in the Care Coordination and Care Management focus area.

BMCHP Southcoast established collaborative relationships with state agencies, including DMH. BMCHP Southcoast has processes in place for care coordination and sharing member information between partner organizations and community-based organizations. .

BMCHP Southcoast embeds BH providers (nurse clinician and social worker) in large practice sites. PCPs refer members to the BH navigation team when BH needs are identified during a primary care visit.

The Executive Director, the Chief Quality Officer, the Executive Director of Behavioral Health Services and the Executive Director of Patient Management, in a team led by the President of the SHN, work together with Southcoast Physicians Group (SPG) staff and staff at Beacon Health Options (with whom the MCO contracts to provide BH services to its members), to facilitate communication between BMCHP Southcoast and CPs. Documented in the EHR, communication between BMCHP Southcoast and CPs is particularly relevant when the CP has primary care management responsibility, enabling the care team to mitigate service duplication or care gaps. The care team, comprised of RN's, social workers, CHWs, and clinical pharmacists, works closely with members and CPs to ensure members receive holistic wrap-around care.

Member outreach and engagement

BMCHP Southcoast uses both IT solutions and manual outreach to improve accuracy of member contact information. For hard to reach members, including members experiencing homelessness or transient members, BMCHP Southcoast's CHWs attempt to reach them in temporary shelters or other known community locations. Southcoast provides in-home care and some community-based services.

Connection with navigation and care management services

BMCHP Southcoast locates CCCM staff within EDs to redirect members to other levels of care and decrease avoidable ED visits.

BMCHP Southcoast's care team CHWs identify resources and/or services (e.g. housing insecurity or assistance with medical bills), and deploys RN navigators and social workers to build 1:1 relationships with high-need members. BMCHP Southcoast implemented warm handoffs as members

transition between levels of care and/or care teams to minimize gaps and unnecessary duplication of services.

Referrals and follow-up

The care team manages care for high-risk members, with a particular focus on health-related social needs to achieve their care plan goals. BMCHP Southcoast holds weekly case conferences and daily huddles to facilitate referrals to services. Referral results are documented in the EHR and care plan. BMCHP Southcoast's referral process appears to be heavily manual process conducted by RN care managers and care teams.

Recommendations

The IA encourages BMCHP Southcoast to review its practices in the following aspects of the Care Coordination and Care Management focus area, for which the IA did not identify sufficient documentation to assess progress:

- establishing a point of contact for CPs to facilitate communication on less urgent issues which do not require President or Executive Board involvement;
- integrating BH services, including OBAT, into primary care;
- addressing language barriers by providing translation of member-facing materials, translators for appointments, and CCCM staff who speak members' language;
- supporting members who lack reliable transportation by providing rides or vouchers[7];
- offering 24/7 health education and nurse coaching through a telephonic hotline or web-based live chat; and
- developing a standardized process for referrals for BH, LTSS and HRSN, and ability to systematically track referrals, that is not heavily dependent on manual engagement by the RN care manager or care team.

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

✓ **Full continuum collaboration**

- establishing a systematic documentation process to track members receiving care coordination from CPs.
- matching members based on their needs to interdisciplinary care coordination teams that include representatives from primary care, nursing, social work, pharmacy, community health workers and behavioral health.
- expanding BH integration through multiple strategies, including embedding staff in primary care sites, reverse integration of physical health care at BH sites, and telehealth.
- increasing two-way sharing of information between ACOs and CPs.
- leveraging EHR-integrated tools to flag members requiring a higher level of care coordination.

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

- coordinating with government agencies and community organizations to enhance care coordination and avoid duplication for members receiving other services.
- supporting families of pediatric members by offering to have care managers work with school-based personnel to address health or disability related needs identified in the Individualized Education Program.

✓ **Member outreach and engagement**

- developing a high-intensity program for extremely high-need, high-risk members with strategically low case load.
- establishing trust between members and CCCM staff by building and maintaining a 1:1 consistent relationship.
- creating a mobile phone lending program for hard-to-reach members, particularly those experiencing housing instability.[8]
- embedding CCCM staff in EDs.
- creating a "Navigation Center" to manage referrals outside the ACO, handle appointment scheduling, and coordinate testing, follow-up, and documentation transfers.
- developing an assistance fund to support transportation vouchers[9] and low-cost cell phones.[10]

✓ **Connection with navigation and care management services**

- utilizing EHR-based documentation transfer during warm handoffs.
- establishing daily or weekly care management huddles that connect PCPs and CCCM teams and streamline care transitions.

✓ **Referrals and follow up**

- utilizing EHR messaging tools to better describe the purpose of specialty consults and a plan for follow-up communication.
- automating referral tracking and management, using flags to prompt referrals, linked directories to suggest appropriate providers and services, notifications to care managers when referral results are available, and databases allowing care teams to easily identify follow-up needs.

6. POPULATION HEALTH MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

✓ **Integration of health-related social needs**

- standardizes screening for health-related social needs (HRSN) that includes housing, food, and transportation;

[8] ACOs should first utilize Lifeline program for members as appropriate
[9] ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.
[10] ACOs should first utilize Lifeline program for members as appropriate.

- incorporates HRSN with other factors to target members for more intensive services;
- Builds mature partnerships with community-based organizations to whom they can refer members for services
- has a plan approved for provision of flexible services;

✓ **Population health analysis**

- articulates a coherent strategy for stratifying members to service intensity and use of a population health analysis platform to combine varied data sources, develop registries of high-risk members, and stratify members at the ACO level.
- integrates cost data into reports given regularly to providers to facilitate cost-of-care management.

✓ **Program development informed by population health analysis**

- offers PHM programs that target all eligible members (not just facility-specific), and target members by medical diagnosis, BH needs (including non-CP eligible), HRSNs, care transitions;
- offer interactive wellness programs such as smoking cessation, diet/weight management.

Results

The IA finds that BMCHP Southcoast is **On track with no recommendations** in the Population Health Management focus area.

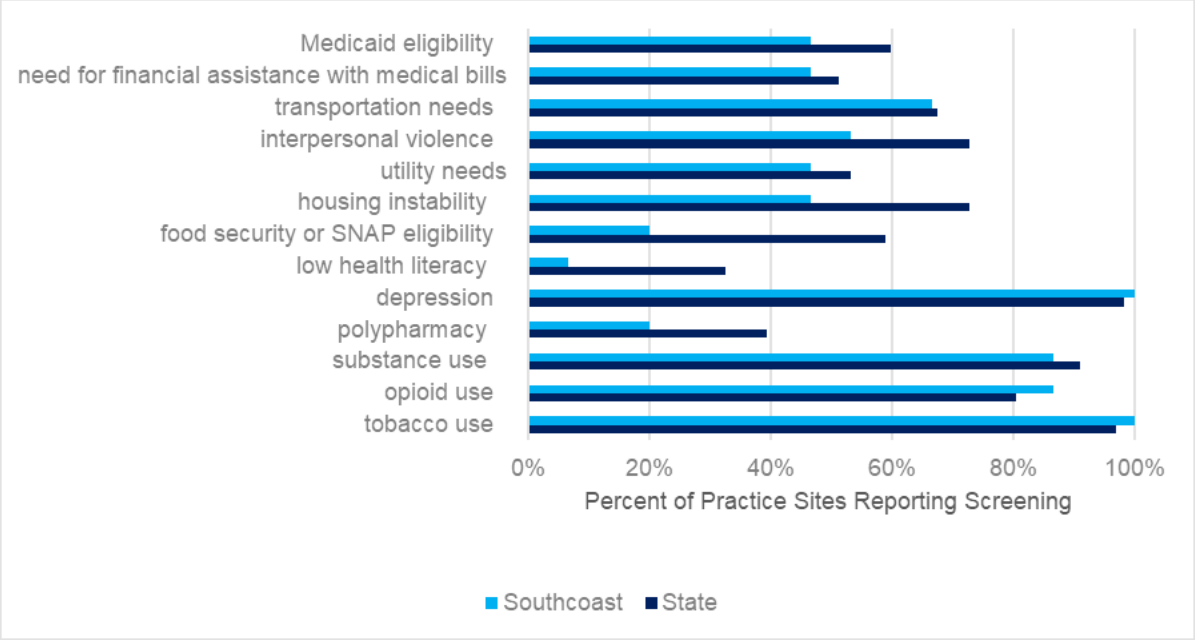
Integration of health-related social needs

BMCHP Southcoast recently adopted the BMCHP THRIVE screening tool, and documents results in the EHR. All Southcoast sites screen for tobacco use and depression, and a majority of BMCHP Southcoast sites screen for opioid use, substance use, interpersonal violence, and transportation needs. BMCHP Southcoast created a tool for screening housing instability and about half of practice sites report screening regularly (Figure 2).

BMCHP Southcoast created a standardized workflow to process screening results and generate registries of members who are eligible for programs or would benefit from referral to services. Southcoast maintains a public resource locator for BH-related needs. Monthly reporting on quality metrics includes HRSN reports to help providers focus on subpopulations with unmet needs.

The ACO has a plan approved for provision of Flexible Services.

Figure 23.4 Prevalence of Screening for Social and Oher Needs at Practice Sites



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in BMCHP Southcoast, N = 15
Figure displays responses to Q14. *For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)*
Statistical significance testing was not done due to small sample size.

Population health analysis

BMCHP Southcoast utilizes their EHR's embedded risk stratification, including medical and behavioral health risk scores, as well as the MCO's risk assessments for BH, HRSN, special health needs, and LTSS needs. Clinical data is combined with administrative data for risk analysis. BH/SUD claims are not included in BMCHP Southcoast's analysis due to incomplete availability of claims, but members that have a BH/SUD condition are identified by the MCO's existing risk stratification methodology.

BMCHP Southcoast's population health strategy stratifies members into 4 tiers: Low Risk, Moderate Risk, High Risk and Very High Risk. Members categorized as 'Very High Risk' have terminal or multiple co-morbid conditions and need palliative care or hospice; they are identified through comprehensive assessments and managed with comprehensive care plans. Approximately 5% of members are categorized as 'High Risk' due to their advanced illness, with a need for ongoing and complex care management for their chronic, complex, or BH-related medical conditions. 'High Risk' members are identified through comprehensive assessments and are managed through integrated health and social care plans. Another 15% of members are categorized as 'Moderate Risk'; these members have one or more chronic conditions or behavioral health / socio-economic health impacts. Members considered 'Moderate Risk' are identified through Care Needs Screening and are managed with goal-centered medical or behavioral care plans.

According to the Practice Site Administrator Survey, a majority of BMCHP Southcoast practices report performance measures on quality are reported and shared with physicians (93%) and performance measures on cost are reported and shared with physicians (80%).

Program development informed by population health analysis

In addition to complex care management for high-risk members, BMCHP Southcoast offers chronic care management programs tailored to members with medical conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).). A Social Care Management program provides members who have unmet HRSNs with a care manager who focuses on identifying barriers, creating a person-centered care plan based on the member's goals, connecting the member with social supports, and coordinating care with all of the member's providers. High-risk members with BH conditions are offered the BH-Intensive care management program, in which BH-trained nurses provide short-term intensive management through psychotherapy, medication adjustment, referral management or other services. Like Social Care Management, this program emphasizes the creation of a personalized comprehensive care plan based on the member's goals and ongoing care coordination and social supports. Wrap-around support is available from CHWs as well.

For lower risk members, BMCHP Southcoast offers wellness programs, such as smoking cessation, and community-based health initiatives, such as awareness of local fresh food markets, health fairs, and rail-to-trail programs.

Recommendations

The IA has no recommendations for the Population Health Management focus area.

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

- ✓ **Integration of health-related social needs**
  - implementing universal HRSN screening in all primary care sites and behavioral health outpatient sites.
  - using screening tools designed to identify members with high BH and LTSS needs.
  - using root-cause analysis to identify underlying HRSNs or unmet BH needs that may be driving frequent ED utilization or readmissions.
  - partnering with local fresh produce vendors, mobile grocery markets, and food banks to provide members with access to healthy meals.
  - providing a meal delivery service, including medically tailored meals, for members who are not able to shop for or prepare meals.
  - organizing a cross-functional committee to understand and address the impact of homelessness on members' health care needs and utilization.
  - enabling members and CCCM field staff to document HRSN screenings in the EHR using tablet devices with a secure web-based electronic platform.
  - automating referrals to community agencies in the EHR/care management platform.
- ✓ **Population health analysis**
  - developing and utilizing condition-specific dashboard reports for performance monitoring that include ED and hospital utilization and total medical expense.
  - developing key performance indicator (KPI) dashboards, viewable by providers, that track financial and operational metrics and provide insights into patient demographics and how the population utilizes services.

- developing a registry or roster that includes cost and utilization information from primary care and specialty services for primary care teams and ACO leadership to better serve MassHealth ACO members.
- implementing single sign-on and query capability into the online Prescription Monitoring Program, so that providers can quickly access and monitor past opioid prescriptions to promote safe opioid prescribing.

✓ **Program development informed by population health analysis**

- engaging top level ACO leadership in design and oversight of PHM strategy.
- developing methods to assess members' impactibility as well as their risk, so that programs can be tailored for and targeted to the members most likely to benefit.
- developing services that increase access to real-time BH care, such as a SUD urgent care center.
- developing programs that address BH needs and housing instability concurrently.
- offering SUD programs tailored to subgroups such as pregnant members, LGBT members, and members involved with the criminal justice system allowing the care team to specialize in helping these vulnerable populations.
- providing education at practice sites or community locations such as:
  - medication workshops that cover over-the-counter and prescription medication side effects, how to take medications, knowing what a medication is for, and identifying concerns to share with the doctor.
  - expectant parenting classes that cover preparation for childbirth, breastfeeding, siblings, newborn care, and child safety.
  - cooking classes that offer recipes for healthy and cost-effective meals.
- offering items that support family health such as:
  - free diapers for members who have delivered a baby as an incentive to keep a postpartum appointment within 1-12 weeks after delivery.
  - car seats, booster seats, and bike helmets.
  - dental kits.

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that BMCHP Southcoast is On track or On track with limited recommendations across all six focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Health Information Technology and Exchange
- Population Health Management

The IA encourages BMCHP Southcoast 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

- providing additional details relating to the senior governance structure inside of the ACO specific to subcommittees informing the JOC; and
- providing details related to its PFAC's role in advising the ACO's senior leadership.

Integration of Systems and Processes

- co-locating Behavioral Health services at primary care locations;
- share criteria for identifying members for CP referral, and reports that include care management, quality, and utilization data; and
- reviewing strategy for members who receive care coordination and management from multiple programs so that practice site staff and the members they serve feel that these services operate together efficiently.

Workforce Development

- exploring opportunities to provide workforce support through educational assistance and loan forgiveness.

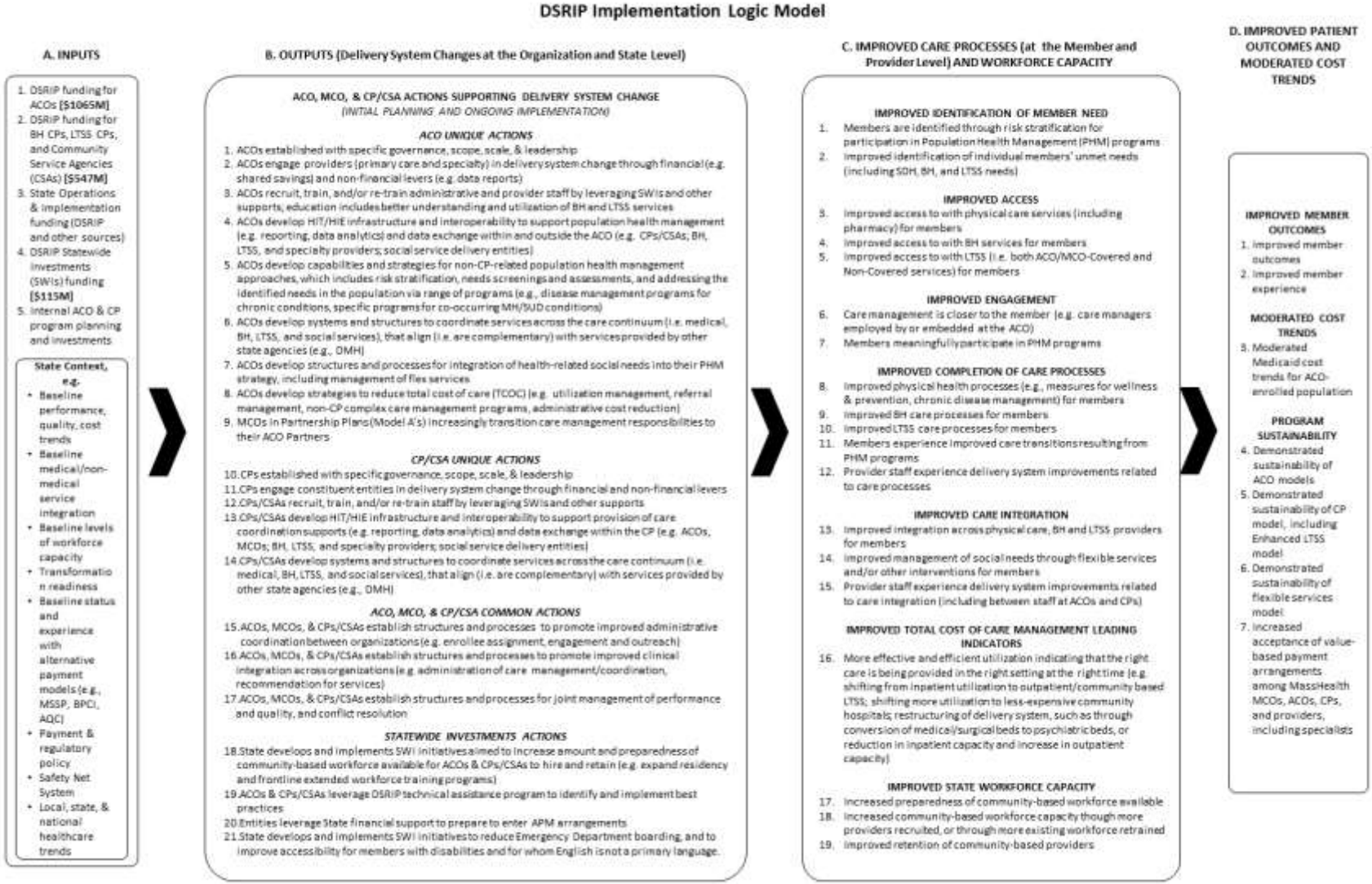
Care Coordination and Care Management

- establishing a point of contact for CPs to facilitate communication on less urgent issues which do not require President or Executive Board involvement;
- integrating BH services, including OBAT, into primary care;
- addressing language barriers by providing translation of member-facing materials, translators for appointments, and CCCM staff who speak members' language;
- supporting members who lack reliable transportation by providing rides or vouchers[11];
- offering 24/7 health education and nurse coaching through a telephonic hotline or web-based live chat; and
- developing a standardized process for referrals for BH, LTSS and HRSN, and ability to systematically track referrals, that is not heavily dependent on manual engagement by the RN care manager or care team.

BMCHP Southcoast 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.

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations[12] (ACOs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019.

Progress was defined by the ACO 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[13] (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 ACO taken organizational level actions, across six 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 ACOs 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 ACOs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. In addition, the IA developed and conducted an ACO Practice Site Administrator survey to investigate the practices and perceptions of participating primary care practices. The IE developed a protocol for ACO Administrator KIIs, which were conducted jointly by the IA and the IE.

List of MPA data sources:

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

- Full Participation Plans (FPPs)
- Semi-annual and Annual Progress Reports (SPRs, APRs)
- Budgets and Budget Narratives (BBNs)

Newly Collected Data

- ACO Administrator KIIs
- ACO Practice Site Administrator Survey

[12] See the ACO Background section for a description of the organization. In the case of a Model A ACO, an Accountable Care Partnership Plan, the assessment encompasses the partner managed care organization (MCO).
[13] The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

FOCUS AREA FRAMEWORK

The ACO MPA assessment findings cover six "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
3. Workforce Development
4. Health Information Technology and Exchange
5. Care Coordination and Management
6. Population Health Management

Table 1 shows the ACO actions that correspond to each focus area. This framework was used to assess each ACO's progress. A rating of On track indicates that the ACO has made appropriate progress in accomplishing each of the actions for the focus area. Where gaps in progress were identified, the ACO 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 ACOs

Focus Area	ACO Actions
Organizational Structure and Governance	• ACOs established with specific governance, scope, scale, & leadership • ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)
Integration of Systems and Processes	• ACOs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • ACOs establish structures and processes for joint management of performance and quality, and conflict resolution • Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the Demonstration
Workforce Development	• ACOs recruit, train, and/or re-train administrative and provider staff by leveraging Statewide Investments (SWIs) and other supports; education includes better understanding and utilization of behavioral health (BH) and long-term services and supports (LTSS)
Health Information Technology and Exchange	• ACOs develop Health Information Technology and Exchange (HIT/HIE) infrastructure and interoperability to support provision of population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. Community Partners/Community Service Agencies (CPs/CSAs), BH, LTSS, and specialty providers)
Care Coordination and Care Management	• ACOs 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))

Population Health Management	• ACOs develop capabilities and strategies for non-CP-related population health management approaches, which include risk stratification, needs screenings and assessments, and addressing the identified needs in the population via range of programs (e.g., disease management programs for chronic conditions, specific programs for co-occurring mental health (MH)/substance use disorder (SUD) conditions) • ACOs develop structures and processes for integration of health-related social needs (HRSN) into their Population Health Management (PHM) strategy, including management of flexible services • ACOs develop strategies to reduce total cost of care (TCOC; e.g. utilization management, referral management, non-CP complex care management programs, administrative cost reduction)

ANALYTIC APPROACH

The ACO actions are broad enough to be accomplished in a variety of ways by different ACOs, and the scope of the IA is to assess progress, not to prescribe the best approach for an ACO. 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 ACOs 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 ACOs. Items that had been accomplished by only a small number of ACOs 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 ACO had accomplished the actions for each focus area. The assessment was holistic, and as such did not require that ACOs 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 ACO 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

ACO Practice Site Administrator Survey Methodology

The aim of the ACO Practice Site Administrator Survey was to systematically measure ACO implementation and related organizational factors from the perspective of the ACOs' participating primary care practice sites. For the purpose of this report, "practice site" refers to an adult or pediatric primary care practice location.

The results of the survey were used in combination with other data sources to assess ACO cohort-wide performance in the MPA focus areas. The survey did not seek to evaluate the success of the DSRIIP

program. Rather, the survey focused on illuminating the connections between structural components and implementation progress across various ACO types and / or cohorts for the purpose of midpoint assessment.

Survey Development: The survey tool was structured around the MPA focus areas described previously, with questions pertaining to each of the six areas. Following a literature review of existing validated survey instruments, questions were drawn from the National Survey of ACOs, National Survey of Healthcare Organizations and Systems, and the Health System Integration Manager Survey to develop measures relevant to the State and appropriate for the target group. Cognitive testing (field testing) of the survey was conducted at 4 ACO practice sites. Following the cognitive testing and collaboration with the State, survey questions were added or modified to better align with the purpose of the MPA and the target respondents.

Sampling: A sampling methodology was developed to yield a sample of practice sites that is reasonably representative of the ACO universe of practice sites. First, practice sites serving fewer than 50 attributed members were excluded. Next, a random sample of 30 sites was selected within each ACO; if an ACO had fewer than 30 total sites, all sites were included. A stratified approach was applied in order to draw a proportional distribution of sites across Group Practices and Health Centers (Health Centers include both Community Health Centers and Hospital-Licensed Health Centers). A 64% survey response rate was achieved; 225 practice sites completed the survey, out of 353 sampled sites. The responses were well-balanced across practice site type (Table 1) and across geographical region (Table 2).

Table 1. Distribution of Practice Site Types

Distribution of Sites by Practice Site Type		
	Group Practices	Health Centers
Percentage of Practice Site Types in Survey Sample (N=353)	80%	20%
Percentage of Practice Site Types in Surveys Completed (N=225)	78%	22%

Table 2. Distribution of Practices Across Geography

Regional Distribution of Practice Sites					
	Central	Greater Boston	Northern	Southern	Western
Distribution of Practice Sites in Sample (N=353)	16%	22%	25%	24%	13%
Distribution of Practice Sites Responses (N = 225)	16%	19%	25%	25%	14%

Administration: The primary contact for each ACO was asked to assist in identifying the best individual to respond to the survey for each of the sites sampled. The survey was administered using an online platform; the survey opened July 18, 2019 and closed October 2, 2019. Survey recipients were e-mailed an introduction to the survey, instructions for completing it, a link to the survey itself, and information on where to direct questions. Multiple reminders were sent to non-responders, followed by phone calls reminding them to complete the survey.

Analysis: Results were analyzed using descriptive statistics at both the individual ACO level (aggregating all practice site responses for a given ACO) and the statewide ACO cohort level (aggregating all responses). Given the relatively small number of sites for each ACO, raw differences among ACOs, or between an ACO and the statewide aggregate results, should be viewed with caution. The sample was not developed to support tests of statistical significance at the ACO level.

Key Informant Interviews

Key Informant Interviews (KII) of ACO Administrators were conducted in order to understand the degree to which participating entities are adopting core ACO competencies, the barriers to transformation, and the organization's experience with state support for transformation.[14] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[14] 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: BMCHP SOUTHCOAST PRACTICE SITE ADMINISTRATOR SURVEY RESULTS

The ACOs survey results, in their entirety, are provided in this appendix. The MassHealth DSRIP Midpoint Assessment Report provides statewide aggregate results.

- 23 practice sites were sampled; 15 responded (65% response rate)
- Survey questions are organized by focus area.
- The table provides the survey question, answer choices, and percent of respondents that selected each available answer. Some questions included a list of items, each of which the respondent rated. For these questions (i.e., Q# 12), the items rated appear in the answer choices column.
- NA indicates an answer choice that is not applicable to the survey question.

FOCUS AREA: ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
12	In the past year, to what degree have the following practices in your clinic become more standardized, less standardized or not changed? *A lot less, a little less, no change, a little more, a lot more standardized (1-5), I Don't Know*	a. Physician compensation	0%	7%	20%	13%	20%	N/A	N/A	40%
		b. Performance management of physicians	0%	0%	20%	20%	47%	N/A	N/A	13%
		c. Care processes and team structure	0%	0%	13%	20%	47%	N/A	N/A	20%
		d. Hospital discharge planning and follow-up	0%	0%	7%	13%	67%	N/A	N/A	13%
		e. Recruiting and performance review	0%	0%	7%	13%	40%	N/A	N/A	40%
		f. Data elements in the electronic health record	0%	0%	13%	13%	67%	N/A	N/A	7%
21	To the best of your knowledge, in the past, has your practice participated in payment contract(s) together with the other clinical providers and practices that are now participating in the [ACO Name]? Select one.	a. Yes, with most of the clinical providers and practices that now compose this ACO (1) b. Yes, with some of the clinical providers and practices that now compose this ACO (2) c. No, this is our first time participating in a payment contract with the clinical providers and practices that compose this ACO (3) d. Don't know	21%	7%	0%	N/A	N/A	N/A	N/A	71%
22	Has your practice received any financial distributions (DSRIP dollars) as part of its engagement with the MassHealth Accountable Care Organization?	Yes (1) No (2) Don't know	0%	0%	N/A	N/A	N/A	N/A	N/A	100%
23	Is a representative from your practice site engaged in ACO governance?	Yes (1) No (2) Don't know	29%	29%	N/A	N/A	N/A	N/A	N/A	43%
24	To what extent do you feel your practice has had a say in important aspects of planning and decision making within the MassHealth Accountable Care Organization that affect your practice site?	Almost never had a say (1) Rarely had a say (2) Sometimes had a say (3) Usually had a say (4) Almost always had a say (5) Don't Know/Not Applicable	21%	14%	29%	0%	0%	N/A	N/A	36%
25	Please indicate the extent to which you agree or disagree with the following statement: ACO leaders have communicated to this practice site a vision for the MassHealth ACO and the care it delivers.	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5) Don't know/ Not applicable	0%	7%	7%	57%	0%	N/A	N/A	29%

26	To what extent do you agree or disagree with each of the following statements? *Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know/Not Applicable*	a. The MassHealth ACO is a resource and partner in problem-solving for our practice.	0%	0%	64%	14%	7%	N/A	N/A	14%
		b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions.	7%	0%	64%	14%	0%	N/A	N/A	14%
		c. All entities in this MassHealth ACO work together to solve problems when needed.	0%	0%	57%	29%	0%	N/A	N/A	14%
28	Overall, how satisfied are you with your practice's experience as part of this MassHealth ACO?	Highly dissatisfied (1) Somewhat dissatisfied (2) Neither satisfied nor dissatisfied (3) Somewhat satisfied (4) Highly satisfied (5)	0%	0%	64%	36%	0%	N/A	N/A	N/A
34	In the past year, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	a. Massive change - completely redesigned their care (1) b. A lot of change (2) c. Some change (3) d. Very little change (4) e. No change (5)	0%	0%	47%	7%	47%	N/A	N/A	N/A
35	In the past year, to what extent has your practice's ability to deliver high quality care to MassHealth members gotten better, gotten worse, or stayed the same?	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	0%	7%	73%	20%	0%	N/A	N/A	N/A
37	Which of the following approaches are used to manage the performance of individual physicians who practice at your site? Select all that apply.	a. Performance measures on quality are reported and shared with physicians (1) b. Performance measures on cost are reported and shared with physicians (2) c. One-on-one review and feedback is used (3) d. Individual financial incentives are used (4) e. Individual non-financial awards or recognition is used (5)	93%	80%	67%	40%	27%	N/A	N/A	N/A
38	To the best of your knowledge, has your practice ever participated in any of the following, either directly or through participation in a physician group or other organization authorized to enter into such an agreement on behalf of the practice? Select all that apply.	a. Bundled or episode-based payments (1) b. Primary care improvement and support programs (e.g. Comprehensive Primary Care Initiative, Patient Centered Medical Home, Primary Care Payment Reform etc.) (2) c. Pay for performance programs in which part of payment is contingent on quality measure performance (3) d. Capitated contracts with commercial health plans (e.g. Blue Cross Blue Shield Alternative Quality Contract), etc.) (4) e. Medicare ACO upside-only risk bearing contracts (Medicare Shared Savings Program tracks one and two) (5) f. Medicare ACO risk bearing contracts (Pioneer ACO, Next Generation ACO, Medicare Shared Savings Program track three) (6) g. Commercial ACO contracts (7)	0%	7%	20%	13%	20%	N/A	N/A	40%

FOCUS AREA: INTEGRATION OF SYSTEMS AND PROCESSES

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1b	For the care coordination and management resources used by your practice, how many of these resources are MANAGED by people at the following organizations (e.g., overseen, supervised)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	0%	67%	27%	7%	N/A	N/A	N/A	N/A
		b. The physical location and department where you work	27%	53%	20%	0%	N/A	N/A	N/A	N/A
		c. A community-based organization	27%	40%	33%	0%	N/A	N/A	N/A	N/A
		d. A different practice site, department, or location in your organization	27%	53%	13%	7%	N/A	N/A	N/A	N/A
		e. Other organization, entity, or location	27%	47%	20%	7%	N/A	N/A	N/A	N/A

1c	For the care coordination and management resources used by your practice, how many of these resources are HOUSED at the following locations (by housed we mean the place where these resources primarily provide patient services)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	20%	60%	7%	13%	N/A	N/A	N/A	N/A
		b. The physical location and department where you work	40%	47%	13%	0%	N/A	N/A	N/A	N/A
		c. A community-based organization	27%	47%	13%	13%	N/A	N/A	N/A	N/A
		d. A different practice site, department, or location in your organization	33%	33%	13%	20%	N/A	N/A	N/A	N/A
		e. Other organization, entity, or location	33%	47%	7%	13%	N/A	N/A	N/A	N/A
3	For your MassHealth members who receive care coordination and management services from more than one program or person, how often do these resources operate together efficiently?	Never (1) Rarely (2) Sometimes (3) Usually (4) Always (5) Don't Know/Not Applicable	0%	0%	47%	33%	0%	N/A	N/A	20%
8b	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5), I Don't Know*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	47%	0%	7%	13%	7%	N/A	N/A	27%
		b. counseling therapists, including clinical social workers	47%	0%	7%	13%	7%	N/A	N/A	27%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	47%	13%	13%	0%	7%	N/A	N/A	20%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	47%	20%	7%	0%	7%	N/A	N/A	20%
10	How difficult is it for your practice to obtain treatment for your MassHealth members with opioid use disorders?	Nearly impossible (1) Very difficult (2) Somewhat difficult (3) A little difficult (4) Not at all difficult (5) Don't Know/Not Applicable	7%	33%	27%	13%	13%	N/A	N/A	7%
15	If screening for the needs in the previous question is performed at a level other than the practice (e.g., by an accountable care organization), how often does your practice have access to the results?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	0%	7%	13%	13%	40%	N/A	N/A	27%
31	Currently which of the following best describes how many MassHealth members in your practice are receiving care coordination services from a MassHealth designated Community Partner?	Very few (1) More than very few, but not many (2) About half (3) A majority (4) Nearly all (5) I don't know/I'm not aware)	7%	33%	0%	7%	0%	N/A	N/A	53%
32	How frequently have clinicians, staff and/or administrators interacted with Community Partner organization staff in coordinating these patients' care?	Almost Never (1) Rarely (2) Sometimes (3) Often (4) Almost Always (5) Don't know	0%	0%	86%	14%	0%	N/A	N/A	0%
33	To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members?	Has made it harder almost all of the time (1) Has made it harder some of the time (2) Has made little or no change (3) Has made it easier some of the time (4) Has made it easier almost all of the time (5) Don't know	0%	0%	29%	57%	0%	N/A	N/A	14%

FOCUS AREA: WORKFORCE DEVELOPMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
27	In the past year, which of the following resources has your practice accessed as part of its involvement in this MassHealth ACO? Select all that apply.	(1) The MassHealth ACO has provided resources and/or assistance to help recruit providers and/or staff (2) The MassHealth ACO has provided resources and/or assistance to help train providers and/or staff (3) Providers and/or staff have taken part in trainings made available directly by MassHealth (4) Providers and/or staff have received training focused on behavioral health and long-term services and supports. (5) DSRIP Statewide Investments (e.g. Student Loan Repayment Program) have been provided to help in training and/or recruiting.	33%	33%	0%	33%	0%	NA	NA	NA

FOCUS AREA: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
13	Which of the following technologies are in use at your practice? Select all that apply.	(1) Electronic health record (2) Care management platform (3) Population health management platform (4) Other technology	100%	0%	N/A	N/A	N/A	N/A	N/A	N/A
13_EHR	To what extent do you agree that the Electronic Health Record improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	20%	80%	N/A	N/A	N/A	N/A	N/A	N/A
13_CMP	To what extent do you agree that the Care Management Platform improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	33%	67%	N/A	N/A	N/A	N/A	N/A	N/A
Q13_PHP	To what extent do you agree that the Population Health Platform improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	13%	87%	N/A	N/A	N/A	N/A	N/A	N/A

FOCUS AREA: CARE COORDINATION AND CARE MANAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1a	Which of the following care coordination and management resources has your practice used in the past 12 months for your MassHealth members? Select all.	Community Health Workers (1) Patient Navigators/Referral Navigators (2) Nurse Manager/Care Coordinator (3) Any other (non-nurse) Care Coordinator/Manager (4) Social Worker (5) Other title (6)	53%	60%	67%	0%	33%	7%	N/A	N/A
2	In the past 12 months to what extent have these coordination and management resources helped your practice's efforts to deliver high quality care to your MassHealth members?	*Not at all, A little, Somewhat, Mostly, A great deal (1-5)*	0%	6%	13%	69%	13%	N/A	N/A	N/A

4	In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members? *Always, Usually, Sometimes, Rarely, Never Difficult (1-5)* *Don't Know*	a. Learn the result of a test your practice site ordered	0%	0%	33%	20%	40%	N/A	N/A	7%
		b. Know that a patient referred by your practice site was seen by the consulting clinician	0%	0%	47%	40%	0%	N/A	N/A	13%
		c. Learn what the consulting clinician recommends for your practice site's patient	0%	7%	47%	33%	0%	N/A	N/A	13%
		d. Transmit relevant information about a patient who your practice site refers to a consulting clinician	0%	7%	40%	47%	0%	N/A	N/A	7%
		e. Reach the consulting clinician caring for a patient when your staff need to	0%	7%	40%	47%	7%	N/A	N/A	0%
5	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Arranging eye care from an ophthalmologist or optometrist	0%	0%	0%	20%	47%	20%	N/A	13%
		b. Confirming that a diabetic eye exam was performed	7%	0%	0%	20%	33%	27%	N/A	13%
		c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note	7%	0%	0%	27%	27%	27%	N/A	13%
6	For your complex high-need MassHealth patients, how often is any type of care coordination or management resource involved in helping the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Any type of care coordinator/manager	7%	13%	67%	13%	0%	N/A	N/A	N/A
		b. Any type of non-clinician (e.g., community health worker)	0%	13%	73%	13%	0%	N/A	N/A	N/A
		c. Targeted interventions for patients who have been risk stratified into a high need sub-group	7%	13%	73%	7%	0%	N/A	N/A	N/A
		d. Home visits	13%	20%	47%	7%	13%	N/A	N/A	N/A
7	For complex, high-need MassHealth members, how often does your practice use each of the following resources to help the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Referral to community-based services for health-related social needs	13%	7%	53%	20%	7%	N/A	N/A	N/A
		b. Communication with the patient within 72 hours of discharge	0%	7%	27%	13%	53%	N/A	N/A	N/A
		c. Home visit after discharge	27%	13%	40%	13%	7%	N/A	N/A	N/A
		d. Discharge summaries sent to primary care clinician within 72 hours of discharge	0%	0%	47%	27%	27%	N/A	N/A	N/A
		e. Standardized process to reconcile multiple medications	0%	0%	20%	33%	47%	N/A	N/A	N/A
8a	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Usually, Almost Always within the practice site (1-5), Don't Know/Not Applicable*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	7%	0%	7%	20%	67%	N/A	N/A	0%
		b. counseling therapists, including clinical social workers	7%	0%	7%	7%	80%	N/A	N/A	0%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	13%	0%	7%	13%	67%	N/A	N/A	0%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	13%	0%	20%	7%	53%	N/A	N/A	7%
9	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for MassHealth members obtaining the following behavioral health services? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Scheduling the appropriate behavioral health services	7%	0%	0%	0%	33%	53%	N/A	7%
		b. Confirming that behavioral health services were received	7%	7%	0%	7%	33%	40%	N/A	7%
		c. Ensuring that your practice site receives the prescribing clinician, counseling therapist, or any type of care coordinator/manager's consult note, as appropriate	13%	7%	0%	13%	33%	27%	N/A	7%
		d. Establishing when a prescribing clinician, counseling therapist, or any type of care coordinator/manager will share responsibility for co-managing the patient's care	13%	7%	0%	7%	27%	40%	N/A	7%

11	To what extent do you agree or disagree that providers follow a clear, established process for the following activities? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Screening for service needs at home that are important for the patient's health?	0%	0%	0%	27%	40%	20%	N/A	13%
		b. Choosing among LTSS providers?	0%	7%	0%	27%	33%	27%	N/A	7%
		c. Referring patients to specific LTSS providers with which your office has a relationship?	0%	0%	7%	27%	33%	13%	N/A	20%
		d. Confirming that the recommended LTSS have been provided?	0%	0%	0%	27%	33%	20%	N/A	20%
		e. Establishing relationships with LTSS providers who serve your patients?	7%	0%	0%	33%	27%	20%	N/A	13%
		f. Getting updates about a patient's condition from the LTSS providers?	7%	0%	0%	27%	33%	20%	N/A	13%
17	When MassHealth members receive referrals to social service organizations, how often is your practice aware that those patients have received support from those organizations?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	7%	7%	40%	13%	20%	N/A	N/A	13%
18	Does your practice regularly provide any of the following? Select all that apply.	Scheduling to enable same day appointments (1) Appointments on weekdays before 8 am or after 5 pm (2) Appointments on weekends (3) Home visits carried out by practice staff or a clinician (4) Clinical pharmacy services provided after discharge at the practice site (5) Care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology) (6)	100%	60%	7%	27%	13%	60%	N/A	N/A

FOCUS AREA: POPULATION HEALTH MANAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
14	For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)	a. tobacco use	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		b. opioid use	87%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		c. substance use	87%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		d. polypharmacy	20%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		e. depression	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		f. low health literacy	7%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		g. food security or SNAP eligibility	20%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		h. housing instability	47%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		i. utility needs	47%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		j. interpersonal violence	53%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		k. transportation needs	67%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		l. need for financial assistance with medical bills	47%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		m. Medicaid eligibility	47%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		n. none of the above	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	How often are MassHealth members referred from your practice to social service organizations to address health-related social needs (e.g., housing, food security)?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	7%	7%	40%	7%	27%	N/A	N/A	13%

19	What is the main source of information that your practice uses to identify which of your MassHealth members are complex, high need patients? Select one.	a. We perform an ad hoc review of information from our own practice's system(s) (e.g., EHR) when we think it is relevant (1) b. We regularly apply systematic risk stratification algorithms in our practice using our patient data (2) c. We receive risk stratification information from a managed care organization or accountable care organization (3) d. We do not have a way of knowing which patients are complex/high need (4) e. Don't know	27%	0%	20%	7%	N/A	N/A	N/A	47%
29	Please select the option below that best describes the change in the past year in your practice site's ability to tailor delivery of care to meet the needs of patients affected by health inequities (e.g., by using culturally and linguistically appropriate services):	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	0%	13%	73%	13%	0%	N/A	N/A	N/A
30	How often does your practice site use site-specific data to identify health inequities within its served population? For example, data might include EHR charts or ACO reports.	Annually (1) Bi-annually (2) Quarterly (3) Monthly (4) On an ad hoc basis (5) We do not have access to this type of data. (6) We have access to this type of data but do no analyze it for health inequities. (7)	7%	0%	20%	33%	13%	27%	0%	N/A

GENERAL QUESTIONS

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
20	Our records show that your practice is participating in the [ACO name] for some or all of its MassHealth Medicaid patients. Is that correct?	Yes (1) I am not aware of this (2)	93%	7%	N/A	N/A	N/A	N/A	N/A	N/A
20_O	Were you able to find a colleague who can help you answer questions about [ACO Name]?	Yes (1) No (2)	0%	100%	N/A	N/A	N/A	N/A	N/A	N/A
20a	Currently, which of the following best describes how many of your practice's patients are covered by [ACO Name]?	Very few (1) A minority (2) About half (3) A clear majority (4) Nearly all (5)	14%	21%	36%	21%	7%	N/A	N/A	N/A
36	Who owns your practice? (select one)	a. Independently owned (1) b. A larger physician group (2) c. A hospital (3) d. A healthcare system (may include a hospital) (4) e. Other (please specify) (5)	7%	0%	13%	73%	7%	N/A	N/A	N/A
39	Which of the following best describes your practice site?	Adult (1) Pediatric (2) Both (3)	60%	7%	33%	N/A	N/A	N/A	N/A	N/A
40	Currently which of the following best describes how many of your practice's patients are covered by any contracts with cost of care accountability?	Very few (1) A minority (2) About half (3) A majority (4) Nearly all (5)	29%	36%	14%	14%	7%	N/A	N/A	N/A
41	To what extent do providers and staff at your practice site seem to agree that "total cost of care" contracts will become a major and sustained model of payment at your practice in the near-term (i.e., within five years)?	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5)	0%	0%	87%	13%	0%	N/A	N/A	N/A

42	What is your professional discipline? (select one)	a. Primary care physician (1) b. Physician assistant/nurse practitioner (2) c. Registered nurse/nurse care manager/ LVN/LPN (3) d. Professional administrator (e.g., practice manager) (4) e. Other-please specify: (5)	7%	0%	7%	73%	13%	N/A	N/A	N/A
43	How long have you worked at this practice site? (select one)	a. Less than 6 months (1) b. 6-12 months (2) c. 1-2 years (3) d. 3-5 years (4) e. More than 5 years (5)	0%	7%	0%	7%	87%	N/A	N/A	N/A
44	Did you ask a colleague for help in answering questions on the survey?	Yes (1) No (2)	13%	87%	N/A	N/A	N/A	N/A	N/A	N/A

APPENDIX IV: ACRONYM GLOSSARY

ACPP	Accountable Care Partnership Plan
ACO	Accountable Care Organization
ADT	Admission, Discharge, Transfer
BH CP	Behavioral Health Community Partner
CCCM	Care Coordination & Care Management
CCM	Complex Care Management
CHA	Community Health Advocate
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
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
FPP	Full Participation Plan
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HRSN	Health Related Social Need
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
OBAT	Office-Based Addiction Treatment
PCP	Primary Care Provider
PFAC	Patient and Family Advisory Committee
PHM	Population Health Management
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 V: ACO COMMENT

Each ACO was provided with the opportunity to review their individual MPA report. The ACO had a two week comment period, during which it had the option of making a statement about the report. ACOs were provided with a form and instructions for submitting requests for correction (e.g., typos) and a comment of 1,000 word or less. ACOs 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 ACO submitted a comment, it is provided below. If the ACO 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 ACO in the request for correction is shown below.

ACO Comment

None submitted.