# MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

## ACO Report:

Health Collaborative of the Berkshires in partnership with Fallon Community Health Plan

(FLN Berkshire)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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# DSRIP Midpoint Assessment Highlights & Key Findings

Health Collaborative of the Berkshires in partnership with Fallon Community Health Plan (FLN Berkshire)

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Model A ACO

**FLN Berkshire is a MassHealth Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as BMC HealthNet Plan Community 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-Dec) | 17k members | $2.1M |
| 2018 | 17k members | $3.7M |
| 2019 | 16k members | $2.8M |

## POPULATIONS SERVED

- The FLN Berkshire service area has a larger population of older individuals (age 45 and older) than the state and is less racially diverse with over 90% identifying as White.
- English and Spanish are the predominant primary languages, with Russian emerging.

| FOCUS AREA | IA FINDINGS | |
|---|---|---|
| Organizational Structure & Engagement | On Track | Limited Recommendations |
| Integration of Systems & Processes | On Track | Limited Recommendations |
| Workforce Development | On Track | Limited Recommendations |
| Health Information Technology & Exchange | On Track | Limited Recommendations |
| Care Coordination & Care Management | Opportunity to Improve with Recommendations | |
| Population Health Management | On Track | Limited Recommendations |

## IMPLEMENTATION HIGHLIGHTS

- FLN Berkshire has dedicated resources to coordinating behavioral health care, including a fully-operational SUD medical home at one practice site, where an RN and LPN offer services including Medication for Addiction Treatment (MAT).
- All FLN Berkshire sites reported that they screen for tobacco use, substance use, and depression. FLN Berkshire's Wellness Programs also conduct depression screenings as part of health assessments.
- The ACO provides several opportunities for frontline staff to interact with ACO leadership as a pathway for presenting successes as well as challenges to teams. ACO leadership meets weekly with care team leaders in person where possible to receive reports on staff concerns and explore any potential remediation efforts.

*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.<br>Shaded area represents service area as of 7/1/2019.<br>Service areas are determined by MassHealth by member addresses, not practice locations.<br>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.<br>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<br>• 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)<br>• ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)<br>• ACOs establish structures and processes for joint management of performance and quality, and conflict resolution<br>• 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)<br>• 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<br>• 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]

Health Collaborative of the Berkshires in partnership with Fallon Community Health Plan (FLN Berkshire) is an Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as Berkshire Fallon Health Collaborative. 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[4] 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.

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

FLN Berkshire's service area in Western Massachusetts includes Adams and Pittsfield, as well the towns of New Ashford, Hancock, Hinsdale, Washington, Alford and Mount Washington.

FLN Berkshire's MassHealth member attribution and allocated non-at risk DSRIP funding are summarized below.

Table 2. FLN Berkshire MassHealth Members and DSRIP Funding 2017-2019[5]

| Year | Members | DSRIP Funding |
|---|---|---|
| 2017 (partial year, Jul-Dec) | 17,425 | $2,132,363 |
| 2018 | 17,425 | $3,705,358 |
| 2019 | 15,534 | $2,806,616 |

The FLN Berkshire service area has a larger population of older individuals (age 45 and older) than the state and is less racially diverse with over 90% identifying as White. English and Spanish are the predominant primary languages, with Russian emerging.

# SUMMARY OF FINDINGS

The IA finds that FLN Berkshire is On track with limited recommendations in five of six focus areas. FLN Berkshire has an Opportunity to improve with recommendations in one focus area.

| 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 with limited recommendations |
| Care Coordination and Care Management | Opportunity to improve with recommendations |
| Population Health Management | On track with limited recommendations |

# 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.

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

# 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 FLN Berkshire is **On track with limited recommendations** in the Organizational Structure and Engagement focus area.

**Established governance structures**

FLN Berkshire maintains a 14-member Governing Board which includes 11 representatives from the Health Collaborative Berkshire (HCB) the ACO's partnering provider entity, two members from Fallon Health (the health plan) and a consumer representative. A Joint Operating Committee (JOC) which is comprised of equal representatives between the two partners reports to the governing board and oversees most of the ACO's high level operational decision making.

The Clinical Affairs and Integrated Care subcommittees, both of which report to the JOC, determine and oversee the majority of the FLN Berkshire's strategic approach to areas regarding integration of medical, behavioral and social support services including Care Coordination and Care Management (CCCM), measurement improvement of outcomes as well as development of and adherence to provider protocols

The FLN Berkshire's Patient Family Advisory Council (PFAC) also reports directly to the JOC during regular meetings.

**Provider engagement in delivery system change**

FLN Berkshire developed an automated system to pull data and provide monthly performance metrics to providers. Providers use this data to actively monitor quality metrics and implement improve plans.

## *Recommendations*

The IA encourages FLN Berkshire 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:

- establishing 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

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

**Administrative coordination among ACO member organizations and with CPs**

FLN Berkshire uses an electronic flagging system to identify members appropriate for CP program referral. This electronic system assigns staff to perform assessments, care planning activities and ongoing management for the member. If a member is appropriate for BH CP services, the practice site will perform the initial assessment and the CP will assume the lead for care management by performing the comprehensive assessment, designing a care plan and managing additional services for the member. If the member is not appropriate for referral to a CP, the ACPP care management team will manage the member's care and engage BH providers as needed. If a member's initial assessment indicates a behavioral health need, the system notifies Fallon staff who then contact an appropriate BH CP and share the member's assessment results.

Fallon creates risk stratification reports and care management data and shares them with providers through a care management platform. CPs also have limited access to view care assessment data.

**Clinical Integration among ACO member organizations and with CPs**

FLN Berkshire embeds care management teams at larger practice sites in their network and makes these teams available remotely for smaller practice sites. These teams, called 'pods', consist of care

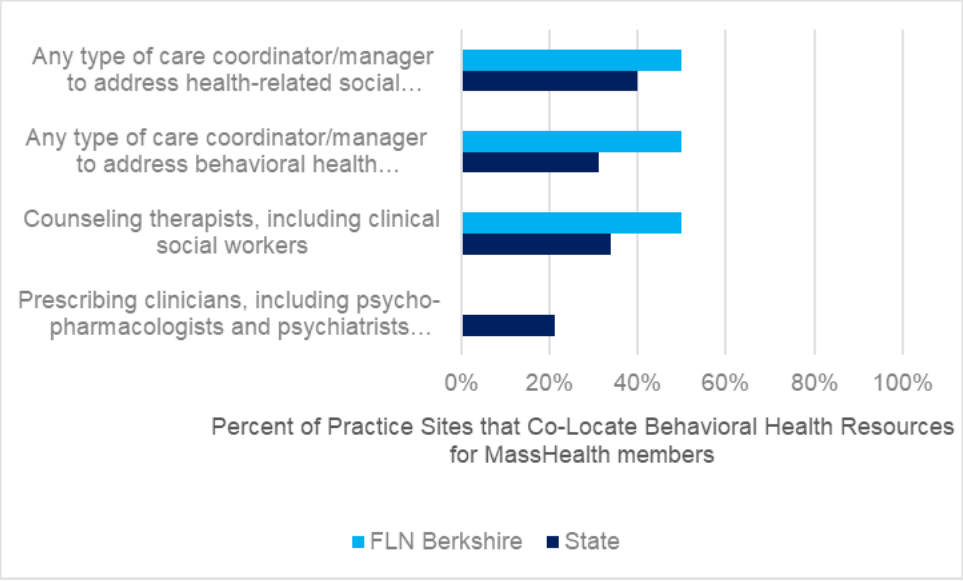
management staff, program coordinators, nurses, social workers, and community health workers (CHW). The pods facilitate warm handoffs with primary care providers at practice sites and perform case reviews at interdisciplinary team meetings. Care management pods completed a care management and team-based training programs on topics such as health coach training, De-escalation training, and care management workflows, among others. There is also a centralized care management team at the FLN Berkshire headquarters in Worcester, consisting of an RN, two health educators, an RN disease manager and a social work manager. A population health nurse collaborates with providers to manage patient transitions of care after hospital discharge.

FLN Berkshire's care management pods and all other ACO practice sites have access to member clinical information through the same EHR platform, but CPs do not currently have access to this platform.

ACO staff, practice site care teams and CP providers collaborate to manage care for members. FLN Berkshire implemented multidisciplinary meetings between practice sites and CPs to review expectations around care management processes and conduct case reviews to improve service integration. The care teams include reciprocal membership with CP staff participating in both ACO member care teams and LTSS interdisciplinary teams, and ACO PHM staff participating in BH CP care teams.

As of 2018, the FLN Berkshire had hired 12 care management team 'pod' positions, embedding these staff in primary care practice sites. Additionally, an SUD medical home is fully operational at one practice site, where an RN and LPN offer behavioral health services such as Medication for Addiction Treatment (MAT). Results from the ACO Practice Site Administrator Survey indicate that half of FLN Berkshire practice sites "usually or always" refer members with behavioral health conditions to behavioral health providers. Additionally, half of FLN Berkshire's practice sites indicated that behavioral health resources are co-located at the practice site (Figure 1).

Figure 1. Co-Location of Behavioral Health Resources




Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in FLN-Berkshire, N = 8
Figure displays responses to Q8b. *For the Behavioral Health entities you selected in the previous question, how often are they located within your practice site? For those entities to which you never refer, please select Don't Know/Not Applicable.*
Statistical significance testing was not done due to small sample size.

**Joint management of performance and quality**

FLN Berkshire has a quality manager and a quality analyst. The quality analyst ensures adherence to state reporting guidelines, maps all quality metrics to the EHR platform and coaches practice sites on reporting requirements. Fallon provides monthly performance reports about key member management metrics to the ACO, such as the percent of new assessments completed within ninety days. The ACO discusses the opportunities for improvement identified by Fallon Health in these reports at governance meetings. Additionally, FLN Berkshire's Joint Operating Committee (JOC) is responsible for reviewing outcome measures and process measures related to adherence to best practices at practice sites. The JOC dictates the population health management strategy. Practice sites are then expected to translate the strategy into local initiatives. The JOC then monitors the success of the practice site initiatives to meet the strategy goals.

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

In addition to providing oversight of the population health strategy and outcomes of practice site improvement initiatives, FLN Berkshire's JOC coordinates activities between the FLN and Berkshire and manages clinical integration. The FLN and Berkshire representatives on the JOC have equal decision-making authority regarding the integration of medical, behavioral and social support services.

## *Recommendations*

The IA encourages FLN Berkshire 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:

- reviewing strategy for members who receive care coordination and management from multiple programs to ensure 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 FLN Berkshire is **On track with limited recommendations** in the Workforce Development focus area.

**Recruitment and retention**

FLN Berkshire has pursued a recruitment and retention strategy that appears to have mitigated any major or persistent gaps in staffing. Given recent experience with several Massachusetts-based grant programs including those received through the Massachusetts Health Policy Commissions Community Hospital Acceleration, Revitalization, and Transformation (CHART) Investment program, as well as its Behavioral Health and Substance Abuse funded projects and funds from the Prevention Wellness Trust Fund (PWTF) FLN Berkshire reported having several well-trained staff members capable of transitioning to the ACO at the start of the demonstration, helping to avoid any significant gaps in staffing during the initial start-up phase of the ACO's operation.

Beyond these positions, FLN Berkshire continues to recruit candidates for care navigation positions through existing hiring channels such as local employment offices, online employment portals, partner colleges and healthcare service organizations.

FLN Berkshire provides several opportunities for frontline staff to interact with ACO leadership as a pathway for presenting successes as well as challenges to teams. FLN Berkshire leadership meets weekly with care team leaders in person where possible to receive reports on staff concerns and explore any potential remediation efforts.

The IA was unable to determine whether FLN Berkshire offers other opportunities for career development, educational assistance, and loan forgiveness or leadership training.

**Training**

A range of training options have been made available to staff across FLN Berkshire in several areas including: motivational interviewing; "Bridges Out of Poverty," a training focused on understanding the origins and remedies of poverty; CREW Resource Management (CRM) focused on understanding of systems prone to error, De-escalation Training, Cultural Competency, Roles and Boundaries which explores roles across the ACO, Workplace Safety and ongoing IT trainings.

FLN Berkshire has also established CHW trainings for newly onboard CHWs to work toward receiving and maintaining certifications. The ACO is also exploring the development of CHW supervisory training modules designed to assist CHWs with learning managerial processes for overseeing more complex teams. Additional training certification courses are also in development to focus on care coordination, transition management, advocacy, education, engagement of patients and families and other population health management areas.

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

FLN Berkshire has attempted to orient around a person-centered care delivery and population health model by developing and deploying several multi-disciplinary teams across the ACO. These teams include Care Coordinators typically located at a physician office which regularly review gaps in communications between providers on topics such as appointments or needed screeners; a Licensed care manager who provides care management services including coordinating with BH and LTSS Community Partners, as well as care navigators and CHWs who conduct direct patient communications, answering patient questions, administering screenings and making referrals for needed services when necessary.

## *Recommendations*

The IA encourages FLN Berkshire 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 ways to increase opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness or leadership training across all its staff.

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

**Infrastructure for care coordination and population health**

FLN Berkshire uses the EHR to aggregate and share information among providers across the ACO. While there is not a universal EHR, FLN Berkshire developed interoperability which can aggregate data from the larger EHR systems and is developing the ability to interface with all practice sites across the county.

FLN Berkshire utilizes the MCO's care management system to securely transmit care plans among Community Partners, care team members and PCPs.

FLN Berkshire is implementing a predictive analytics tool to risk stratify members through the aggregation and analysis of data from a variety of sources, including the EHR, claims data, laboratory, pharmacy, behavioral, sociological, genomic. This tool enables the care teams and case managers to identify the high-risk members and optimize their care.

**Systems for collaboration across organizations**

FLN Bershire contracted with a health interoperability solution platform to ensure interoperability with the various vendor products utilized across the ACO. This platform offers PCPs across the ACO the ability to share member information for care coordination.

The IA did not identify sufficient documentation to assess progress regarding the use of dashboards to share real time program eligibility and performance data.

FLN Berkshire and some of their participating PCP sites have some access to ADT feeds and real-time event notification and the ACO is somewhat able to incorporate this data into their population health analytics technology.

FLN Berkshire is able to share and/or receive electronic member contact information, comprehensive assessments and care plans through secure and compliant means with all or nearly all of their participating PCP sites, participating specialists, community partners, non-affiliated providers and the MCO.

## *Recommendations*

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

- continuing efforts to improve interoperability through a third-party platform and other workarounds; and
- providing systematic training for staff when incorporating new systems and ensuring workflow integration; and
- developing continuously updating dashboards to share real time program eligibility and performance data with providers.

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;
- 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 FLN Berkshire has an **Opportunity to improve with recommendations** in the Care Coordination and Care Management focus area.

**Full continuum collaboration**

The Fallon Behavioral Health Director facilitates communication between the ACO, state agencies such as DMH and CPs.

FLN Berkshire has a strong relationship with the larger area CPs, such as the Brien Center; integrating CP staff as critical members of the interdisciplinary care team to support optimal member care coordination. The ACO's care teams review member eligibility for BH and LTSS services in order to identify gaps and avoid service duplication.

FLN Berkshire utilizes a regional pod care management model of care management staff, program coordinators, nurses, social workers, and CHWs to coordinate member care, including complex care

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

management and specialized programs. The care team supports members with the integration of BH services, including OBAT, into primary care services.

**Member outreach and engagement**

While FLN Berkshire has "scrubbing software" that can identify bad phone numbers and access the EHR to cross reference telephone numbers, the IA did not identify sufficient documentation to assess whether the ACO uses manual outreach to improve member contact information.

FLN Berkshire mails information to assigned members if telephonic outreach fails after three attempts. The IA did not find sufficient documentation to assess the ACO's use of community based in-person outreach, should telephonic and postal outreach fail to reach a member.

**Connection with navigation and care management services**

To mitigate inappropriate use of the ED, FLN Berkshire assigned CCCM staff in the ED to identify the reason the member is seeking care and counsel them, as appropriate, on more appropriate alternatives for addressing future care needs.

While FLN Berkshire provides members with 24/7 RN-staffed health information coaching, the ACO indicated member utilization is low. Additionally, the IA was unable to find sufficient documentation to assess whether the FLN Berkshire's CCCM staff is able to build 1:1 relationships with high-need members.

FLN Berkshire promotes best practices for care transitions through collaboration of nursing staff with other members of the care team to ensure a warm handoff.

**Referrals and follow-up**

FLN Berkshire utilizes its EHR to digitally transfer member information, including referrals, to PCPs and other providers. Staff have been added recently to improve overall care coordination and automatically track appropriate prior authorization for care; currently, referrals are manually tracked and documented by the ACO staff.

## *Recommendations*

The IA encourages FLN Berkshire 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 stronger relationships and communication with all affiliated CP's, not just larger sites;
- using both IT solutions and manual outreach to improve accuracy of member contact information;
- developing community based outreach in an attempt to reach members who cannot be reached telephonically;
- addressing member language barriers by translating member-facing materials, providing translators for appointments and recruiting CCCM staff who speak member languages;
- encouraging more member utilization of the 24/7 health information coaching service;
- enabling staff to develop 1:1 relationships with high-need members and utilize a variety of methods to provide follow-up;

- developing a standardized referral process and the ability to systematically track these referrals; and
- conducting regular case conferences to coordinate services once a member is referred.
- addressing member transportation barriers by providing rides or vouchers[7], and/or providing services in their homes or other convenient community settings;

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.
- 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]

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

- ✓ **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;
    - 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 FLN Berkshire is **On track with limited recommendations** in the Population Health Management focus area.

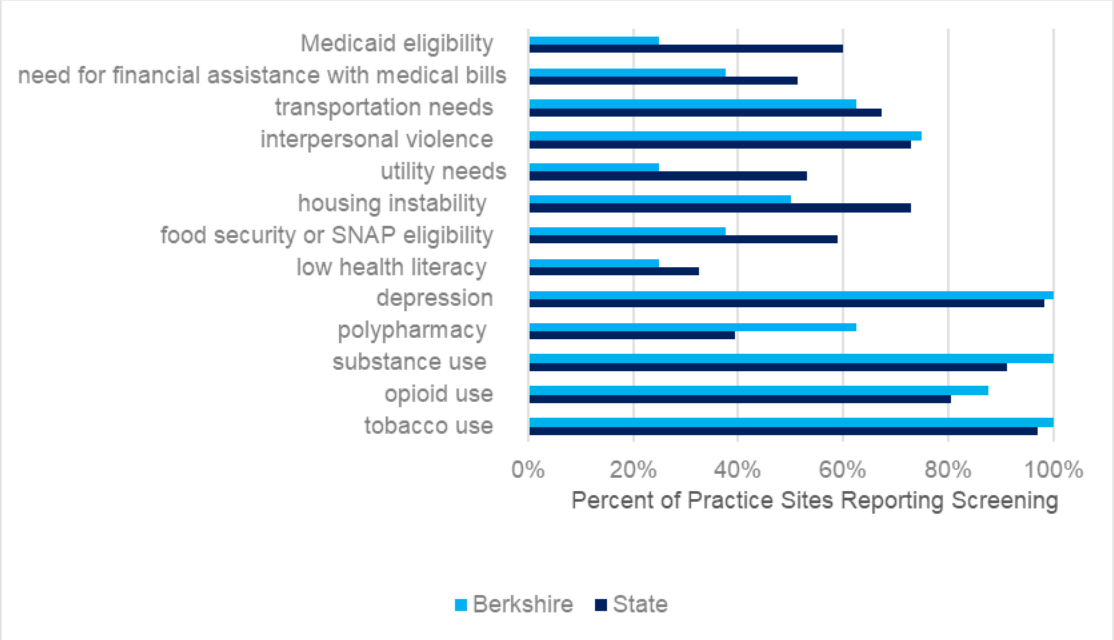
### Integration of health-related social needs

A majority of FLN Berkshire sites reported that they screen for opioid use, polypharmacy, interpersonal violence, and transportation needs. Half of FLN Berkshire sites reported that they screen for housing instability. All FLN Berkshire sites reported that they screen for tobacco use, substance use, and depression. FLN Berkshire's Wellness Programs also conduct depression screenings as part of health assessments.

Members who are experiencing homelessness or have complex social needs are targeted for complex care management services provided by RNs. FLN Berkshire coordinates with social service agencies or state agencies such as DMR, DMH, and DYS for members receiving services.

FLN Berkshire has a plan approved for provision of Flexible Services.

Figure 2. Prevalence of Screening for social and other needs at Practice Sites




Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in FLN-Berkshire, N = 8
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

FLN Berkshire uses claims data together with EHR data from providers and community risk scores from CPs and the MCO for stratifying members. The MCO performs the data analysis for stratification and generates high-risk member registries.

FLN Berkshire assigns members to three service intensity levels: Complex Care Management, Care Management, and Care Coordination. Complex Care Management serves members with the highest needs, including complex or uncontrolled medical or BH conditions, polypharmacy, high utilization of acute care, unmet housing or psychosocial needs, disabilities, and children with substantial medical needs. Members with moderate needs due to acute or chronic medical and BH conditions are stratified to Care Management. Both strata receive services delivered by RNs and social workers.

The care coordination stratum is for members who are medically and psychiatrically stable and need assistance primarily with HRSNs such as transportation[11], and accessing benefits. FLN Berkshire provides services for these members through navigators and CHWs.

Fallon creates custom performance reports for providers at practice sites that include quality and cost metrics. Survey data indicates that a majority of Fallon sites' physicians are receiving cost data regularly from the ACO. Physicians receive performance data on quality and cost at a majority of practice sites (75% quality and 63% cost).

**Program development informed by population health analysis**

FLN Berkshire offers ACO-wide programs tailored for members with chronic health conditions such as congestive heart failure (CHF), diabetes, and depression. These include services such as health education and coaching, regular monitoring, PCP-based education, and navigation to appropriate services. *Get Cuffed,* a community-based hypertension program aimed at providing outreach and education to at-risk county residents. This program strives to integrate existing outreach programs and public health services to provided evidence-based care which includes blood pressure screening. Those who screen at higher risk for hypertension are provided an educational session, a blood pressure cuff and training on its use. Recently the program further expanded to include partnerships with area restaurants who support members through the “Healthy Dining Resolution”.

FLN Berkshire addresses SUD through programs including the SUD medical home, a service based in primary care providing ongoing outpatient visits where MAT and supportive therapies are offered. Berkshire also partners with The Brien Center to offer a reverse-integrated model of care, where primary care is provided at Brien’s SUD treatment facility.

FLN Berkshire identified transitions of care as an area needing more development and engaged two TA vendors for an assessment of the current state recommendations for improved processes for care transitions across the continuum.

In addition. the ACO offers wellness programs such as smoking cessation, and community based health initiatives such as biometric screenings, nutrition counseling, and childbirth education. The IA did not identify documentation of programs specifically targeting members experiencing transitions of care, or SUD.

## *Recommendations*

The IA encourages FLN Berkshire to review its practices in the following aspects of the Population Health Management focus area, for which the IA did not identify sufficient documentation to assess progress:

- developing programs based on best practices for members experiencing transitions of care.

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.

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

- 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 FLN Berkshire is On track with limited recommendations across five focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. FLN Berkshire has an Opportunity to improve in one focus area.

The IA recommends that FLN Berkshire 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***

- establishing 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

***Integration of Systems and Processes***

- reviewing strategy for members who receive care coordination and management from multiple programs to ensure that practice site staff and the members they serve feel that these services operate together efficiently.

***Workforce Development***

- exploring ways to increase opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness or leadership training across all its staff.

***Health Information Technology and Exchange***

- continuing efforts to improve interoperability through a third-party platform and other workarounds; and
- providing systematic training for staff when incorporating new systems and ensuring workflow integration; and
- developing continuously updating dashboards to share real time program eligibility and performance data with providers.

***Care Coordination and Care Management***

- establishing stronger relationships and communication with all affiliated CP’s, not just larger sites;
- using both IT solutions and manual outreach to improve accuracy of member contact information;
- developing community based outreach in an attempt to reach members who cannot be reached telephonically;

- addressing member language barriers by translating member-facing materials, providing translators for appointments and recruiting CCCM staff who speak member languages;
- encouraging more member utilization of the 24/7 health information coaching service;
- enabling staff to develop 1:1 relationships with high-need members and utilize a variety of methods to provide follow-up;
- developing a standardized referral process and the ability to systematically track these referrals; and
- conducting regular case conferences to coordinate services once a member is referred.
- addressing member transportation barriers by providing rides or vouchers[12], and/or providing services in their homes or other convenient community settings;

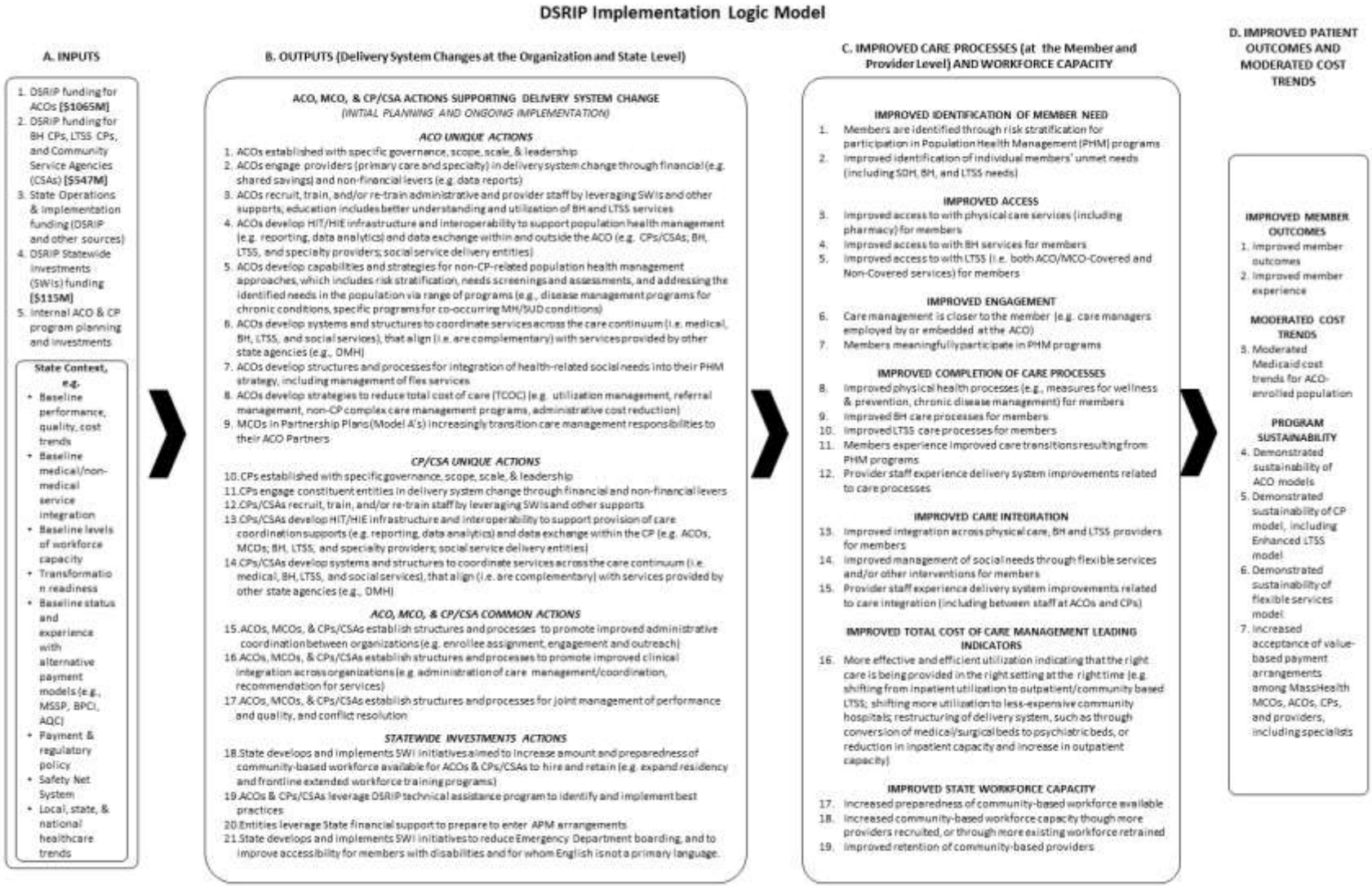
***Population Health Management***

- developing programs based on best practices for members experiencing transitions of care.

FLN Berkshire 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.

[12] 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[13] (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[14] (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

[13] 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).
[14] 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<br>• 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)<br>• ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)<br>• ACOs establish structures and processes for joint management of performance and quality, and conflict resolution<br>• 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)<br>• 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<br>• 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 2) and across geographical region (Table 3).

Table 2. 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 3. 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.[15] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[15] 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: FLN BERKSHIRE 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.

- 19 practice sites were sampled; 8 responded (42% 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?<br><br>*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% | 13% | 25% | 0% | 13% | NA | NA | 50% |
| | | b. Performance management of physicians | 0% | 0% | 38% | 38% | 13% | NA | NA | 13% |
| | | c. Care processes and team structure | 0% | 0% | 25% | 25% | 38% | NA | NA | 13% |
| | | d. Hospital discharge planning and follow-up | 0% | 0% | 38% | 25% | 38% | NA | NA | 0% |
| | | e. Recruiting and performance review | 0% | 0% | 25% | 25% | 25% | NA | NA | 25% |
| | | f. Data elements in the electronic health record | 0% | 0% | 25% | 13% | 38% | NA | NA | 25% |
| 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)<br>b. Yes, with some of the clinical providers and practices that now compose this ACO (2)<br>c. No, this is our first time participating in a payment contract with the clinical providers and practices that compose this ACO (3)<br>d. Don't know | 0% | 13% | 50% | NA | NA | NA | NA | 38% |
| 22 | Has your practice received any financial distributions (DSRIP dollars) as part of its engagement with the MassHealth Accountable Care Organization? | Yes (1)<br>No (2)<br>Don't know | 38% | 13% | NA | NA | NA | NA | NA | 50% |
| 23 | Is a representative from your practice site engaged in ACO governance? | Yes (1)<br>No (2)<br>Don't know | 38% | 25% | NA | NA | NA | NA | NA | 38% |
| 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)<br>Rarely had a say (2)<br>Sometimes had a say (3)<br>Usually had a say (4)<br>Almost always had a say (5)<br>Don't Know/Not Applicable | 0% | 13% | 38% | 0% | 13% | NA | NA | 38% |
| 25 | Please indicate the extent to which you agree or disagree with the following<br>statement: ACO leaders have communicated to this practice site a vision for the MassHealth ACO and the care it delivers. | Strongly disagree (1)<br>Disagree (2)<br>Neither agree nor disagree (3)<br>Agree (4)<br>Strongly agree (5)<br>Don't know/ Not applicable | 0% | 0% | 25% | 50% | 13% | NA | NA | 13% |

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|---|---|---|---|---|---|---|---|---|---|---|
| 26 | To what extent do you agree or disagree with each of the following statements?<br>*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% | 13% | 25% | 38% | 13% | NA | NA | 13% |
| | | b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions. | 0% | 13% | 25% | 25% | 13% | NA | NA | 25% |
| | | c. All entities in this MassHealth ACO work together to solve problems when needed. | 0% | 13% | 25% | 13% | 38% | NA | NA | 13% |
| 28 | Overall, how satisfied are you with your practice's experience as part of this<br>MassHealth ACO? | Highly dissatisfied (1)<br>Somewhat dissatisfied (2)<br>Neither satisfied nor dissatisfied (3)<br>Somewhat satisfied (4)<br>Highly satisfied (5) | 0% | 13% | 75% | 13% | 0% | NA | NA | NA |
| 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)<br>b. A lot of change (2)<br>c. Some change (3)<br>d. Very little change (4)<br>e. No change (5) | 0% | 13% | 38% | 13% | 38% | NA | NA | NA |
| 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)<br>Gotten a little harder (2)<br>No change (3)<br>Gotten a little easier (4)<br>Gotten a lot easier (5) | 0% | 50% | 38% | 13% | 0% | NA | NA | NA |
| 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)<br>b. Performance measures on cost are reported and shared with physicians (2)<br>c. One-on-one review and feedback is used (3)<br>d. Individual financial incentives are used (4)<br>e. Individual non-financial awards or recognition is used (5) | 75% | 63% | 38% | 25% | 25% | NA | NA | NA |
| 38 | To the best of your knowledge, has your practice ever participated in any of the<br>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)<br>b. Primary care improvement and support programs (e.g. Comprehensive Primary Care Initiative, Patient Centered Medical Home, Primary Care Payment Reform etc.) (2)<br>c. Pay for performance programs in which part of payment is contingent on quality measure performance (3)<br>d. Capitated contracts with commercial health plans (e.g. Blue Cross Blue Shield Alternative Quality Contract), etc.) (4)<br>e. Medicare ACO upside-only risk bearing contracts (Medicare Shared Savings Program tracks one and two) (5)<br>f. Medicare ACO risk bearing contracts (Pioneer ACO, Next Generation ACO, Medicare Shared Savings Program track three) (6)<br>g. Commercial ACO contracts (7) | 14% | 71% | 86% | 29% | 43% | 0% | 14% | NA |

## 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)?<br>*None, Some, Most, or All of the Resources (1-4)* | a. An ACO/MCO | 0% | 50% | 38% | 13% | NA | NA | NA | NA |
| | | b. The physical location and department where you work | 25% | 25% | 50% | 0% | NA | NA | NA | NA |
| | | c. A community-based organization | 13% | 88% | 0% | 0% | NA | NA | NA | NA |
| | | d. A different practice site, department, or location in your organization | 38% | 50% | 13% | 0% | NA | NA | NA | NA |
| | | e. Other organization, entity, or location | 25% | 75% | 0% | 0% | NA | NA | NA | NA |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 0% | 50% | 38% | 13% | NA | NA | NA | NA |
| | | b. The physical location and department where you work | 38% | 25% | 38% | 0% | NA | NA | NA | NA |
| | | c. A community-based organization | 13% | 75% | 13% | 0% | NA | NA | NA | NA |
| | | d. A different practice site, department, or location in your organization | 38% | 50% | 13% | 0% | NA | NA | NA | NA |
| | | e. Other organization, entity, or location | 25% | 50% | 13% | 13% | NA | NA | NA | NA |
| 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)<br>Rarely (2)<br>Sometimes (3)<br>Usually (4)<br>Always (5)<br>Don't Know/Not Applicable | 0% | 0% | 50% | 38% | 0% | NA | NA | 13% |
| 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) | 63% | 13% | 13% | 0% | 0% | NA | NA | 13% |
| | | b. counseling therapists, including clinical social workers | 25% | 0% | 13% | 38% | 13% | NA | NA | 13% |
| | | c. any type of care coordinator/manager to address behavioral health treatment, including addiction services | 38% | 0% | 0% | 13% | 38% | NA | NA | 13% |
| | | d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.) | 25% | 0% | 13% | 0% | 50% | NA | NA | 13% |
| 10 | How difficult is it for your practice to obtain treatment for your MassHealth members with opioid use disorders? | Nearly impossible (1)<br>Very difficult (2)<br>Somewhat difficult (3)<br>A little difficult (4)<br>Not at all difficult (5)<br>Don't Know/Not Applicable | 13% | 38% | 25% | 0% | 13% | NA | NA | 13% |
| 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)<br>Not Applicable | 0% | 25% | 0% | 38% | 13% | NA | NA | 25% |
| 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)<br>More than very few, but not many (2)<br>About half (3)<br>A majority (4)<br>Nearly all (5)<br>I don't know/I'm not aware) | 25% | 13% | 0% | 0% | 0% | NA | NA | 63% |
| 32 | How frequently have clinicians, staff and/or administrators interacted with Community Partner organization staff in coordinating these patients' care? | Almost Never (1)<br>Rarely (2)<br>Sometimes (3)<br>Often (4)<br>Almost Always (5)<br>Don't know | 0% | 67% | 33% | 0% | 0% | NA | NA | 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)<br>Has made it harder some of the time (2)<br>Has made little or no change (3)<br>Has made it easier some of the time (4)<br>Has made it easier almost all of the time (5)<br>Don't know | 0% | 0% | 0% | 67% | 33% | NA | NA | 0% |

# 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<br>(2) The MassHealth ACO has provided resources and/or assistance to help train providers and/or staff<br>(3) Providers and/or staff have taken part in trainings made available directly by MassHealth<br>(4) Providers and/or staff have received training focused on behavioral health and long-term services and supports.<br>(5) DSRIP Statewide Investments (e.g. Student Loan Repayment Program) have been provided to help in training and/or recruiting. | 0% | 67% | 33% | 50% | 17% | 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<br>(2) Care management platform<br>(3) Population health management platform<br>(4) Other technology | 100% | 38% | 63% | 13% | NA | NA | NA | NA |
| 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* | 0% | 13% | 38% | 25% | 25% | NA | NA | 0% |
| 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* | 0% | 0% | 33% | 0% | 67% | NA | NA | 0% |
| 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* | 0% | 0% | 60% | 20% | 20% | NA | NA | 0% |

# 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)<br>Patient Navigators/Referral Navigators (2)<br>Nurse Manager/Care Coordinator (3)<br>Any other (non-nurse) Care Coordinator/Manager (4)<br>Social Worker (5)<br>Other title (6) | 75% | 75% | 75% | 38% | 50% | 0% | NA | NA |
| 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)* | 13% | 0% | 38% | 38% | 13% | NA | NA | NA |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 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?<br>*Always, Usually, Sometimes, Rarely, Never Difficult (1-5)*<br>*Don't Know* | a. Learn the result of a test your practice site ordered | 0% | 13% | 0% | 63% | 25% | NA | NA | 0% |
| | | b. Know that a patient referred by your practice site was seen by the consulting clinician | 0% | 13% | 50% | 38% | 0% | NA | NA | 0% |
| | | c. Learn what the consulting clinician recommends for your practice site's patient | 0% | 13% | 25% | 50% | 13% | NA | NA | 0% |
| | | d. Transmit relevant information about a patient who your practice site refers to a consulting clinician | 0% | 13% | 0% | 50% | 38% | NA | NA | 0% |
| | | e. Reach the consulting clinician caring for a patient when your staff need to | 0% | 0% | 25% | 50% | 13% | NA | NA | 13% |
| 5 | To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following?<br>*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% | 13% | 50% | 25% | NA | 13% |
| | | b. Confirming that a diabetic eye exam was performed | 0% | 0% | 13% | 13% | 50% | 25% | NA | 0% |
| | | c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note | 0% | 13% | 13% | 13% | 38% | 25% | NA | 0% |
| 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?<br>*Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)* | a. Any type of care coordinator/manager | 13% | 13% | 38% | 13% | 25% | NA | NA | NA |
| | | b. Any type of non-clinician (e.g., community health worker) | 13% | 13% | 38% | 13% | 25% | NA | NA | NA |
| | | c. Targeted interventions for patients who have been risk stratified into a high need sub-group | 13% | 13% | 38% | 25% | 13% | NA | NA | NA |
| | | d. Home visits | 38% | 13% | 38% | 13% | 0% | NA | NA | NA |
| 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?<br>*Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)* | a. Referral to community-based services for health-related social needs | 0% | 0% | 38% | 50% | 13% | NA | NA | NA |
| | | b. Communication with the patient within 72 hours of discharge | 0% | 0% | 25% | 38% | 38% | NA | NA | NA |
| | | c. Home visit after discharge | 50% | 13% | 13% | 0% | 25% | NA | NA | NA |
| | | d. Discharge summaries sent to primary care clinician within 72 hours of discharge | 0% | 0% | 0% | 38% | 63% | NA | NA | NA |
| | | e. Standardized process to reconcile multiple medications | 13% | 0% | 0% | 25% | 63% | NA | NA | NA |
| 8a | In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed?<br>*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) | 13% | 0% | 0% | 38% | 50% | NA | NA | 0% |
| | | b. counseling therapists, including clinical social workers | 0% | 0% | 0% | 38% | 63% | NA | NA | 0% |
| | | c. any type of care coordinator/manager to address behavioral health treatment, including addiction services | 0% | 0% | 13% | 25% | 63% | NA | NA | 0% |
| | | d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.) | 0% | 0% | 0% | 25% | 75% | NA | NA | 0% |
| 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?<br>*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 | 13% | 13% | 0% | 0% | 50% | 25% | NA | 0% |
| | | b. Confirming that behavioral health services were received | 13% | 0% | 13% | 38% | 13% | 13% | NA | 13% |
| | | 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% | 0% | 0% | 38% | 25% | 13% | NA | 13% |
| | | 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% | 0% | 13% | 38% | 13% | 13% | NA | 13% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 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% | 13% | 13% | 25% | 13% | NA | 38% |
| | | b. Choosing among LTSS providers? | 13% | 0% | 0% | 38% | 0% | 13% | NA | 38% |
| | | c. Referring patients to specific LTSS providers with which your office has a relationship? | 0% | 0% | 0% | 38% | 13% | 25% | NA | 25% |
| | | d. Confirming that the recommended LTSS have been provided? | 13% | 0% | 13% | 25% | 0% | 25% | NA | 25% |
| | | e. Establishing relationships with LTSS providers who serve your patients? | 13% | 0% | 0% | 50% | 0% | 13% | NA | 25% |
| | | f. Getting updates about a patient's condition from the LTSS providers? | 13% | 0% | 0% | 38% | 0% | 25% | NA | 25% |
| 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)<br>Not Applicable | 0% | 38% | 0% | 38% | 0% | NA | NA | 25% |
| 18 | Does your practice regularly provide any of the following? Select all that apply. | Scheduling to enable same day appointments (1)<br>Appointments on weekdays before 8 am or after 5 pm (2)<br>Appointments on weekends (3)<br>Home visits carried out by practice staff or a clinician (4)<br>Clinical pharmacy services provided after discharge at the practice site (5)<br>Care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology) (6) | 88% | 50% | 38% | 0% | 0% | 75% | NA | NA |

## 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% | NA | NA | NA | NA | NA | NA | NA |
| | | b. opioid use | 88% | NA | NA | NA | NA | NA | NA | NA |
| | | c. substance use | 100% | NA | NA | NA | NA | NA | NA | NA |
| | | d. polypharmacy | 63% | NA | NA | NA | NA | NA | NA | NA |
| | | e. depression | 100% | NA | NA | NA | NA | NA | NA | NA |
| | | f. low health literacy | 25% | NA | NA | NA | NA | NA | NA | NA |
| | | g. food security or SNAP eligibility | 38% | NA | NA | NA | NA | NA | NA | NA |
| | | h. housing instability | 50% | NA | NA | NA | NA | NA | NA | NA |
| | | i. utility needs | 25% | NA | NA | NA | NA | NA | NA | NA |
| | | j. interpersonal violence | 75% | NA | NA | NA | NA | NA | NA | NA |
| | | k. transportation needs | 63% | NA | NA | NA | NA | NA | NA | NA |
| | | l. need for financial assistance with medical bills | 38% | NA | NA | NA | NA | NA | NA | NA |
| | | m. Medicaid eligibility | 25% | NA | NA | NA | NA | NA | NA | NA |
| | | n. none of the above | 0% | NA | NA | NA | NA | NA | NA | NA |
| 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)<br>Not Applicable | 0% | 13% | 38% | 38% | 13% | NA | NA | 0% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 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)<br>b. We regularly apply systematic risk stratification algorithms in our practice using our patient data (2)<br>c. We receive risk stratification information from a managed care organization or accountable care organization (3)<br>d. We do not have a way of knowing which patients are complex/high need (4)<br>e. Don't know | 0% | 13% | 63% | 0% | NA | NA | NA | 25% |
| 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)<br>Gotten a little harder (2)<br>No change (3)<br>Gotten a little easier (4)<br>Gotten a lot easier (5) | 13% | 0% | 63% | 25% | 0% | NA | NA | NA |
| 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)<br>Bi-annually (2)<br>Quarterly (3)<br>Monthly (4)<br>On an ad hoc basis (5)<br>We do not have access to this type of data. (6)<br>We have access to this type of data but do no analyze it for health inequities. (7) | 0% | 0% | 25% | 13% | 38% | 25% | 0% | NA |

## GENERAL QUESTIONS

| Q# | Question | Question Components or Answer Choices | Focus Area | 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)<br>I am not aware of this (2) | General | 100% | 0% | NA | NA | NA | NA | NA | NA |
| 20_O | Were you able to find a colleague who can help you answer questions about [ACO Name]? | Yes (1)<br>No (2) | General | NA | NA | NA | NA | NA | NA | NA | NA |
| 20a | Currently, which of the following best describes how many of your practice's patients are covered by [ACO Name]? | Very few (1)<br>A minority (2)<br>About half (3)<br>A clear majority (4)<br>Nearly all (5) | General | 22% | 39% | 33% | 6% | 0% | NA | NA | NA |
| 36 | Who owns your practice? (select one) | a. Independently owned (1)<br>b. A larger physician group (2)<br>c. A hospital (3)<br>d. A healthcare system (may include a hospital) (4)<br>e. Other (please specify) (5) | General | 28% | 0% | 0% | 61% | 11% | NA | NA | NA |
| 39 | Which of the following best describes your practice site? | Adult (1)<br>Pediatric (2)<br>Both (3) | General | 6% | 6% | 89% | NA | NA | NA | NA | NA |
| 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)<br>A minority (2)<br>About half (3)<br>A majority (4)<br>Nearly all (5) | General | 22% | 33% | 39% | 6% | 0% | NA | NA | NA |
| 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)<br>Disagree (2)<br>Neither agree nor disagree (3)<br>Agree (4)<br>Strongly agree (5) | General | 0% | 6% | 56% | 11% | 28% | NA | NA | NA |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 42 | What is your professional discipline? (select one) | a. Primary care physician (1)<br>b. Physician assistant/nurse practitioner (2)<br>c. Registered nurse/nurse care manager/ LVN/LPN (3)<br>d. Professional administrator (e.g., practice manager) (4)<br>e. Other-please specify: (5) | General | 28% | 0% | 6% | 61% | 6% | NA | NA | NA |
| 43 | How long have you worked at this practice site? (select one) | a. Less than 6 months (1)<br>b. 6-12 months (2)<br>c. 1-2 years (3)<br>d. 3-5 years (4)<br>e. More than 5 years (5) | General | 0% | 28% | 11% | 6% | 56% | NA | NA | NA |
| 44 | Did you ask a colleague for help in answering questions on the survey? | Yes (1)<br>No (2) | General | 39% | 61% | NA | NA | NA | NA | NA | NA |

# 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.*