



HEALTH CARE FOR ALL

ADDRESSING HEALTH-RELATED SOCIAL NEEDS: A report on MassHealth Accountable Care Organization and Community-Based Organization Collaboration

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EXECUTIVE SUMMARY

BACKGROUND

Health-Related Social Needs (HRSNs) are the needs that arise from social and economic factors, such as housing and food insecurity, that have a significant impact on individuals' health outcomes and costs. MassHealth – the Medicaid program for low-income individuals in Massachusetts – launched an Accountable Care Organization (ACO) program in 2017 that included requirements and targeted funding to address HRSNs for certain MassHealth members. The program relies on partnerships between ACOs and community-based organizations (CBOs) to address HRSNs related to two domains – housing and food. The research for this report consisted of structured interviews with ACOs and CBOs about their current efforts and how they view potential partnerships moving forward. It also concludes with policy recommendations for key stakeholders in the program.

METHODS

The research utilized a qualitative study with structured interview guides to conduct interviews with individuals from the nine ACOs with service areas in Greater Boston and seven CBOs in the Greater Boston area. The CBOs were selected to represent a range of sizes and ensure representation from the two domains targeted under the ACO program (housing and food insecurity), as well as one CBO outside of these domains (domestic violence). The individuals interviewed for this research hold positions in the ACOs related to addressing HRSNs or are leaders at the CBOs. Interview guides were developed by the study team with consultation from experts in the field. The questions were grouped into four categories for the ACO interviews: 1) screening processes for HRSNs, 2) referrals to CBOs, 3) partnerships between ACOs and CBOs, and 4) flexible services. CBO interview questions were grouped into five categories: 1) referrals from ACOs, 2) partnerships between CBOs and ACOs, 3) flexible services, 4) referral capacity and tracking, and 5) liaising between individuals and health providers. Interviews took place between November 2018 and June 2019.

ACO FINDINGS & RECOMMENDATIONS

Key Findings

- While ACOs differ in their perceived value of the Flexible Services Program, nearly all do see some significant value in this work.
- Most ACOs only screen MassHealth members for HRSNs, though many screen beyond the required domains.
- Referral documentation systems vary *within* ACOs across physician practices and health centers, as well as *between* ACOs.

- ACOs face challenges to manage and share data externally with CBOs.
- Many ACO practices and health centers have existing, primarily informal relationships with CBOs.
- Most ACOs did not discuss patient input, but those that did found it helpful in designing their HRSN screening and referral system.

Policy & Implementation Recommendations

- Enable internal variation across practice settings to maintain existing relationships between practice staff and CBOs, and then build on these structures rather than replacing them.
- Identify clear implementation timelines and appropriate evaluation metrics early in ACO partnerships with CBOs.
- Dedicate IT support to enhance HRSN-focused electronic health record integration.
- Engage high-level ACO leadership in the rollout and implementation of the Flexible Services Program.
- Proactively communicate to a wide range of CBOs regarding potential partnerships under the Flexible Services Program.
- Leverage the expertise of CBOs whenever possible. Develop guiding principles for reviewing the expertise of CBOs and benefits of partnering with them when considering whether to “buy” or “build” supports.

CBO FINDINGS & RECOMMENDATIONS

Key Findings

- CBOs recognize the value of their work and how it improves patient health.
- CBOs believe it would be beneficial to provide input on the HRSN screening processes at ACOs.
- Information exchange between CBOs and ACOs is a top priority and a major challenge.
- CBOs range in their preparedness to partner with ACOs, though all of those interviewed are open to it, and many had already established or attempted to establish relationships with ACO practices and health centers.
- CBOs face resource constraints and are currently operating at capacity.
- CBOs are aware of the Flexible Services Program, but program details such as “Flexible Services Plans” and evaluations are not top of mind at this stage.

Policy & Implementation Recommendations

- Focus on establishing contracts that reflect the CBO’s specific capacities and require metrics that are feasible and achievable.
- Attain information on the funding amounts the CBO will receive from the ACO and the outcomes they will be expected to achieve.

- Dedicate resources and attain technical assistance for “building” or “buying” compatible data-sharing systems for exchanging referrals and other necessary information with ACOs to ensure that the loop can be closed on referrals.
- Develop a mechanism for regularly sharing best practices with other CBOs, and dedicate staff to lead the ACO collaborations.
- Put time and effort into applying for financial and technical support from MassHealth and the Department of Public Health.

RECOMMENDATIONS FOR MASSHEALTH

- Minimize unnecessary documentation requirements to only those required for evaluation, in order to maximize ACO and CBO flexibility to implement interventions that meet the needs of their populations and practices.
- Identify clear implementation timelines and appropriate evaluation metrics for both ACOs and CBOs, with early metrics focused on implementation milestones, intermediate metrics on the use of CBO services and health outcomes, and long-term outcomes on cost and utilization.
- Develop channels for widely sharing Flexible Services Program guidance and best practices and engage a wide range of CBOs by proactively identifying potentially smaller organizations and inviting them to participate.
- Offer common resources and adequate funding to provide legal, contracting, HIPAA, IT, data and other infrastructure support to CBOs throughout contracting process, and consider providing resources specifically for evaluation.
- Implement a staggered rollout with multiple, specified rounds of contracting over more than one year.
- Seek ways to provide Flexible Services Program funding at the household-level, rather than the individual-level.

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BACKGROUND

This is a pivotal moment for health care providers and payers, as evidence has increasingly pointed to the importance of social determinants of health (SDOH) and health-related social needs (HRSNs) in impacting health care outcomes, quality of care and cost.

HRSNs refer to the health-related impacts of the social and economic factors in patients' lives, including food insecurity, housing instability and exposure to violence.¹ Health care providers and social services providers seek to respond to these needs with individual- or family-based social services and supports, such as housing assistance, SNAP enrollment support, and safety assessment and planning. The term SDOH is often used interchangeably with HRSNs. However, SDOH more accurately refers to the underlying social structures that impact the health of patients, such as lack of access to healthy food or insufficient affordable housing opportunities in a neighborhood. These social structures contribute to HRSNs but cannot be addressed with individual or family-based services; rather, they require systems and policy changes to address them, such as increasing the number of affordable housing units. Ultimately both must be addressed, however, most of the work to date under the MassHealth ACO program, and most of the collaborations examined in this report focus on addressing HRSNs.

Intuitively, it makes sense that individuals facing housing insecurity who are afraid they may lose their apartment would be unable to focus on their health needs and might forgo medications in order to pay for their rent. Chronic homelessness is directly linked to poor health outcomes and high health care costs.² There is also now clear evidence that providing patients with specific health needs with interventions such as medically tailored home delivered meals, reduces overall health care costs, while helping patients manage conditions and heal.³

Nowhere is the evidence linking HRSNs and SDOH to health outcomes more relevant than for low-income populations insured by Medicaid. That is why states have been recognizing a new role for health care providers as part of responding to these needs and building structures into payment reform efforts to support this new role. The Medicaid Accountable Care Organizations (ACO) program in Massachusetts is no different and, in some cases, has gone further than other states with dedicated funding to address HRSNs for certain members.

MassHealth – Massachusetts's Medicaid program – provides health insurance to almost 1.9 million people, two-thirds of people in low-income families in Massachusetts. In March 2018, over 800,000 MassHealth members were transitioned into ACOs as the state embarked on a

¹ Billieux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. Washington, DC: National Academy of Medicine; 2017.

² Tsai AC. Home Foreclosure, Health, and Mental Health: A Systematic Review of Individual, Aggregate, and Contextual Associations. *PLoS One* 4 (2015), doi: 10.1371/journal.pone.0123182.

³ Berkowitz SA, Terranova J, Hill C, Toyin A, Linsky T, Tishler LW, DeWalt DA. Meal Delivery Programs Reduce the Use of Costly Health Care In Dual Eligible Medicare and Medicaid Beneficiaries. *Health Affairs* Vol. 37. No 4. (Apr. 2018). <https://doi.org/10.1377/hlthaff.2017.0999>.

delivery system redesign that is part of a five-year 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services (CMS). ACOs are networks of doctors, hospitals and other facilities that collectively manage care and costs for a specific population of patients. Through the development of ACOs, MassHealth has the potential to create a more patient-centered system by better coordinating care and improving care quality and health outcomes.

Under this new program, ACOs have the opportunity to develop and adopt innovative approaches to integrating HRSN screening and support into their delivery of health care to MassHealth members. These social services are designed to mitigate the negative impacts of SDOH. To assist with the provision of these social services, ACOs that contract with MassHealth will be able to use a portion of federal funding known as Delivery System Reform Incentive Payments (DSRIP) to provide “flexible services” to address the HRSNs of their members beginning in early 2020. This program—the Flexible Services Program—will leverage almost \$150 million in funding to support interventions that address food and housing HRSNs for certain members with identified needs. For the immediate future, the provision of flexible services will be limited only to members who have health or complex care needs and who have risk factors associated with homelessness, risk of homelessness, food insecurity or a are at risk of improper nutrition. The funding will be available to ACOs, who are expected to contract with community-based social services organizations (CBOs) to deliver many of these flexible service supports to eligible members and report back to the ACO about the member’s receipt of those services. While the Flexible Services Program only addresses housing and food, ACOs may also refer members to other social services supports.

There is a risk that addressing HRSNs could become overshadowed by other priorities both for ACOs and MassHealth as they administer the broader ACO program. There is also a lack of information sharing between ACOs, CBOs and other stakeholders regarding how they are each implementing programs relating to HRSN screenings and referrals, as well as how they are planning for potential partnerships.

The objective of this research has been to assess and promote collaboration between MassHealth ACOs and CBOs that will enable meaningful supports to improve the health and lives of MassHealth members. This research examined the systems ACOs are putting into place as they use DSRIP funding to implement programs that address HRSNs, including partnerships with CBOs, challenges and best practices. It also included CBOs’ perspectives as they consider and plan for partnerships with ACOs.

Specifically, the study aimed to:

1. Identify challenges and best practices for how MassHealth ACOs are screening for and addressing HRSNs of their patients during the first year of the fully launched ACO program.
2. Learn from both the ACO and CBO perspective about the opportunities and challenges of partnering with each other.
3. Understand how the anticipation of the Flexible Services Program is impacting ACOs’ plans and processes for partnering and contracting with CBOs, as well as CBO plans to partner with ACOs.

METHODS

STUDY DESIGN AND SETTING

This study was conducted by Health Care for All (HCFA) in collaboration with the Alliance for Community Health Integration (ACHI), the Massachusetts Public Health Association (MPHA) and Harvard T.H. Chan School of Public Health (HSPH) students. This study was made possible thanks to the generous support of The Boston Foundation.

The research team, including employees of HCFA, MPHA and graduate students from HSPH, conducted a qualitative study using interviews with individuals from the nine ACOs with service areas in Greater Boston and seven CBOs in the Greater Boston area. The individuals interviewed at the ACOs held positions where they had knowledge of how the ACO is approaching HRSNs. Those interviewed at the CBOs held organizational leadership positions.

Interview questions were developed by the study team. The questions were grouped into four categories for the ACO interviews: 1) screening processes for HRSNs; 2) referrals to CBOs; 3) partnerships between ACOs and CBOs; and 4) flexible services. CBO interview questions were grouped into five categories: 1) referrals from ACOs, 2) partnerships between CBOs and ACOs, 3) flexible services, 4) referral capacity and tracking; and 5) liaising between individuals and health providers. (See Appendix 1 and 2 for the full interview guides.)

Interviews were scheduled between November 2018 and June 2019. Interviews occurred in person when feasible, but for many interviews one or more persons participated over the phone.

Due to different organizational structures within each ACO, not all individuals interviewed had the same roles or titles. Additionally, there was variability with regard to how many people from each ACO were interviewed, ranging from one participant to four.

The study team selected seven CBOs in the Greater Boston area to interview for this project. Three of the CBOs operate in the housing domain, three operate in the food domain and one operates in the domestic violence domain. The team collaborated with ACOs and the Alliance for Community Health Integration (ACHI) workgroup to identify possible CBO interviewees, and then selected CBOs from the two domains being funded under the Flexible Services Program with variation in the size and levels of engagement in the program. The team chose to interview a domestic violence organization to begin to explore the perspective of a CBO that does not qualify for the Flexible Services Program funding at this time.

DATA COLLECTION

Interviews were conducted by the study team in English, ranged from 45 to 90 minutes and followed an open-ended interview guide (Appendix 1: interview guide for ACOs, Appendix 2: interview guides for CBOs). Interviews were recorded and transcribed using NVivo, a web-

based transcription software, and the interviews were then subsequently reviewed and corrected by hand. No statements from the interviews are attributed to a specific individual or organization, and the names of specific ACOs and CBOs are not identified in this report.

ANALYSIS

Data analysis was performed by a team of three Masters of Public Health students from HSPH with support from HCFA. Analysis was performed using NVivo 12. Team members collaborated to develop a catalogue of key concepts, referred to as a codebook. The codebook was modeled on the interview questions, with additional categories added for data and overarching themes not easily captured by the structure of the interview questions. For the full codebook, refer to Appendix 3 and 4.

The results indicated consistent themes in several areas. For ACOs these included value, screenings, referrals, data collection and management, partnerships, flexible services and other funding. For CBOs themes included value, screenings, referrals, data sharing, partnerships, resource constraints, funding and absent themes. However, within these themes, there was variation and in some cases stark dichotomies.

The findings sections of this report are structured around these themes, as well as overarching themes that cross cut them. Challenges and best practices indicated in the findings are also considered, and the implications of these findings are discussed in a final section on policy recommendations.

This research and analysis reflects findings at the specific time when interviews were conducted, and the landscape will continue to shift as the Flexible Services Program is implemented and ACO-CBO collaboration develops further.

ACOs

FINDINGS

ACO Overarching Themes

The nine Boston area ACOs are diverse – varying with regard to size, resources, geographic reach and the historical relationships that existed between the providers within the organization prior to formation of the ACO. As a result, ACOs are on a spectrum regarding how far along they are in developing and incorporating processes and systems to address HRSNs into their care model. However, the following five themes have emerged as fundamental and differentiating contributors to ACO capacity to address HRSNs.

Variability in ACOs’ size, geography and composition: For most MassHealth ACOs, the geographic reach of provider practices and the span of regions they serve posed unique challenges for their ability to design, implement and sustain HRSN-related supports and impacted their ability to develop HRSN strategies. The patients that ACOs serve reside in various geographic regions that range from resource-rich to resource-poor. Patients, themselves, also have varying degrees of awareness of ACO and CBO supports available to them. An ACO’s capacity to tailor their systems based on the composition of patient populations and the needs of those populations across communities therefore also varies and is impacted by their geographic scope.

HRSN team structure: Each ACO has structured their HRSN team differently. These teams vary in size and composition but typically all involve some combination of physicians, nurses, social workers, community health workers and administrative staff. Some teams were primarily centralized, while others were comprised of broader stakeholders in the ACO. Most ACOs integrate a centralized team for HRSN programming with multiple practice- and provider-run HRSN teams. Teams meet semi-regularly to discuss best practices, challenges and updates to the system. Some ACOs already had a team in place to explicitly oversee and address HRSNs prior to the launch of the ACO. Others have recently created or are currently in the process of developing a leadership team to address HRSNs.

Previously established systems: ACOs varied on the extent to which HRSNs were screened for and addressed prior to the MassHealth ACO program launch. Some ACOs had a fairly robust network of CBOs they already worked with and standard methods for screening and responding to HRSNs prior to the launch, while others used the launch of the ACO as an opportunity to streamline, build and reform their current practices. Addressing HRSNs ultimately involves integration of and communication between a large number of providers and community-based personnel, as well as streamlined and interoperable documentation and data systems. Having an existing unified data platform or a system that enabled interoperable documentation across practices helped ACOs to more rapidly build out efforts to address HRSNs.

IT and electronic health record (EHR) systems: The ability to accurately and efficiently document, track and follow-up on a patient’s HRSNs varied between ACOs, and it was reliant on the EHR integration and systems already in place. EHR systems can be financially burdensome, and not all ACOs have the capacity to revamp these systems specifically for HRSN-related processes. However, some ACOs have used HRSN screening as the catalyst to better utilize EHR systems to drive value-based care.

Leadership and mission: Organizational culture plays a critical role in how MassHealth ACOs have approached HRSNs. ACOs that have historically viewed HRSNs as fundamental to their organization or decided to incorporate it into their ongoing health care strategy are typically further along in building their HRSN systems and capacity. The cultures of the communities ACOs serve, patient relationships to the ACO, and the nature of existing ACO-CBO relationships also affect HRSN systems. Some ACOs have integrated HRSN work into their daily practice, whereas others are at the beginning stages of developing HRSN systems into their work flow and culture. Organizational leadership influences provider and staff buy-in on the value of addressing HRSNs, making them more or less likely to execute screenings and referral processes within their practices. Identifying aligned and overlapping values across different specialties, departments, provider groups and administrative leadership is critical to implementing large-scale, ACO-wide HRSN initiatives. Many ACOs note that the presence of an administrative, physician, nurse, or other provider “champion” to help drive the overall organization towards a set of HRSN-related goals is key. Others praise a more organic process, where ACOs adopt or expand best practices stemming from certain providers or provider groups. Most ACOs are utilizing a combination of these approaches to generate a cultural shift towards accepting and incorporating HRSN work into their daily workflow.

Value of Addressing HRSNs

The vast majority of ACOs welcomed the programmatic focus on HRSNs and SDOH. There is a sense that this focus, supporting ACOs in tackling the needs providers and administrators have long recognized as important, is a helpful way to address and coordinate activities across a wide range of stakeholders. A lack of incentives and funding sometimes limited previous interventions

“THIS IS SOMETHING THAT WE'VE WANTED FOR SO LONG. THE MEDICAID ACO HAS REALLY HELPED US TAKE THIS TO THE NEXT LEVEL.”

--ACO

“I WOULD SAY WE'RE VERY EXCITED. VERY EXCITED BY THE OPPORTUNITY THAT MASSHEALTH, THE STATE AND FEDERAL [GOVERNMENT] HAVE GIVEN US TO REALLY CREATE SOME MEANINGFUL CHANGE FOR SOCIAL DETERMINANTS OF HEALTH.”

--ACO

to address HRSNs and resulted in a piecemeal rather than structured approach. This coordinated effort under the ACO program was, therefore, widely praised.

However, a few ACOs are more skeptical that the efforts to address HRSNs will be successful. A very small minority of ACOs voiced a lack of enthusiasm for these types of interventions and did not believe they were likely to have a positive impact on managing risk and costs for the ACOs.

*"I DON'T KNOW [THAT] I DEEPLY BELIEVE THAT THIS IS THE WAY WE WILL ULTIMATELY BE, AS A COMMONWEALTH, SUCCESSFUL IN THE POPULATION HEALTH SPACE AND I DON'T KNOW THIS IS GOING TO MOVE THE NEEDLE."
-- ACO*

Screening Processes for HRSNs

All ACOs interviewed have implemented a process for screening for HRSNs. Most ACOs only screen MassHealth members, though some are screening all patients regardless of payer. Others have started with only MassHealth members but have plans to expand the screenings to all patients. Those ACOs screening all members see it as a way to reduce stigma associated with screening only certain members for HRSNs.

All ACOs are screening for the domains required under the contract – food insecurity, housing instability, transportation and paying for utilities. In addition, however, most ACOs are screening for some additional domains beyond these. The most common additional domains include medication access, elder or child care, employment and education.

*"WE EVENTUALLY CAME DOWN ON THE SIDE OF SCREENING EVERYBODY BECAUSE WE DIDN'T WANT TO MISS [ANYTHING]. AND WE ALSO DIDN'T WANT TO IMPART ANY SORT OF STIGMA TO IT. SO WE JUST DIDN'T GENERALIZE IT AND IT'S EASY ENOUGH FROM A LOGISTICAL STANDPOINT IT MAKES SENSE AS WELL."
--ACO*



"WE DO 8 DOMAINS. WE DO OBVIOUSLY HOUSING, FOOD. WE DO ENERGY, TRANSPORTATION, MEDICATION ACCESS. WE DO CHILD CARE, ELDER CARE ACCESS. AND THEN WE DO DESIRE FOR MORE EDUCATION, DESIRE FOR HELP WITH A JOB."
--ACO

Screenings are conducted in varied settings. Primary care practices are the most common, but some ACOs also screen in emergency departments and inpatient settings. Some ACOs already indicate planned expansions beyond primary care to these other settings as well. Screenings are being administered using a variety of tools and mediums. The most common are iPads or tablets, paper, online platforms, or by phone.

ACOs are in different stages of integrating screening information into their EHRs and data warehouses. There is variation regarding which providers can view the results of the screens. Previous infrastructure and historical cohesiveness of the practices have a

significant impact on data systems for tracking HSRN screening data. All ACOs are putting processes in place to improve this data tracking; however, with less than a year since the ACO launch at the time of the interviews, population-level data analysis was limited.

"THE WHOLE SYSTEM IS AVAILABLE TO ANY PATIENT. HOWEVER, WE TRIGGER THE PROMPT ONLY ON OUR MASSHEALTH PATIENTS RIGHT NOW WITH THE PLAN THAT WE WILL EXPAND THAT PROMPT TO THE FULL POPULATION SOMETIME SOON AS WE GET... OTHER SUPPORTS IN PLACE."
--ACO

Referrals to CBOs

Follow-up protocols after a positive screen identifying at least one HRSN vary depending on the patient's needs. The most common, though least in-depth approach, is providing a resource sheet that lists local CBOs that cover a variety of domains. The resource sheet is commonly provided to the patient in their after-visit summary. However, it is also fairly common to see practice staff directly respond to patients' HRSNs or make an internal referral to appropriate ACO staff charged with supporting patients with HRSNs. For example, many ACOs have in-house community health workers (CHWs) or equivalent staff to respond to positive screens. The most in-depth approaches involve a CHW or similar staff who work with the patient and communicates directly with CBOs to connect the patient to services, even if the CBO is not co-located at the ACO. This process is commonly referred to as a "warm handoff."

Data Collection and Management

Systems for tracking referrals vary both between ACOs and across different practice sites within the same ACO. Management and tracking of referrals is either handled using internally developed platforms or with the assistance of a third-party referral software. Seven of the nine ACOs use either the Aunt Bertha or Healthify platforms to help connect patients with resources and track referrals. These products act as a directory for resources and also include a tracking

component that requires agreement from both ACOs and CBOs. All ACOs face challenges of documentation, tracking and follow-up to some extent.

Partnerships with CBOs

Connecting patients with local resources is not new, and many providers that are part of ACOs have had processes in place before the ACO launch, as well as long-standing, informal and personal relationships with CBOs. These processes were primarily informal and, in many cases, practice or staff specific. Some providers had more formal partnerships prior to the MassHealth ACO launch. These interactions include

philanthropically-funded work with the ACO and/or CBO as direct grant recipients, informal collaborative partnerships between ACOs and CBOs, and volunteer work from community groups. More ACOs have now established referral relationships with CBOs, though this is with only a small number of CBOs. In a limited number of cases, CBOs already have embedded services at an ACO, and in other limited cases there are formalized referral processes. These ACO-CBO relationships have continued and evolved as ACOs focus additional attention on addressing HRSNs. Many ACOs agree that flexible services will likely formalize ACO relationships with external organizations such as CBOs.

"SOME OF THESE RELATIONSHIPS ARE NOT FORMAL, THEY ARE INFORMAL, BUT THEY ARE LONG-STANDING."

--ACO

"SO WE DON'T HAVE ANY FORMAL RELATIONSHIPS EITHER. I DID HEAR FROM OUR COMMUNITY HEALTH WORKER THAT SHE DOES REACH OUT TO THE SAME ORGANIZATIONS OVER AND OVER AGAIN."

--ACO

Another component of determining the best process for connecting patients with identified HRSNs to services is whether the ACO should "buy" or "build" certain services internally. ACOs acknowledge that they will need to "buy" services from CBOs where they don't have expertise, but they also feel there are areas they can internally "build" capacity to respond to some HRSNs that require less knowledge or staff expertise. For example, ACOs know they would need to buy housing support services given the complexity of navigating assistance for these resources, but they might be able to leverage existing CHWs to assist with nutrition support like signing members up for the Supplemental Nutrition Assistance Program (SNAP).

"SO WHILE WE WANT TO LEVERAGE WHAT WE DO VERY WELL... WE ACKNOWLEDGE AND RECOGNIZE THAT A LOT OF CBOS HAVE BEEN DOING THIS WORK FOR A VERY LONG TIME AND THEY ARE THE EXPERT IN THE FIELD AND THAT'S SOMETHING THAT YOU CAN'T REPLACE."

--ACO

Two interesting dichotomies exist among the ACOs with regard to the “build” vs. “buy” approaches. The first is with referral tracking systems. A number of ACOs have decided to internally develop a referral and tracking system, while other ACOs have chosen to purchase a platform from a vendor. The second dichotomy is regarding how they view the relationships with CBOs. While some ACOs consider CBOs as partners, suggesting a level of bi-directional engagement, others think of them more as potential vendors suggesting a contractual, deliverable-based relationship.

“WE ARE CONSTANTLY STRUGGLING WITH, YOU KNOW, WHAT DO WE BUILD, BUY OR IMBED.”
--ACO

“TO THE EXTENT THAT YOU HAVE A CRS [COMMUNITY RESOURCE SPECIALIST] OR A CHW WHO IS INTERNALLY HIRED WHO CAN DO THE ALLOWABLE TASK IT'S GOING TO BE MUCH EASIER TO MAKE THAT CONNECTION FROM PRIMARY CARE SCREENING TO THAT THAN IT IS ONCE YOU MAKE THAT REFERRAL OUT TO AN EXTERNAL ORGANIZATION THAT'S GOING TO BE DROP OFF THERE AND WE WANT TO DECREASE THAT, WE WANT TO DO AS MUCH WARM HANDOFF AS POSSIBLE.”
--ACO

Flexible Services and Other Funding

DSRIP Flexible Service Program funds were originally scheduled to be released at the launch of the ACO program, but the release was postponed several times and is now slated for January 2020. ACOs anticipate these funds will significantly change, and potentially enhance, their partnerships with CBOs. Some ACOs are eager for additional clarity on how to use these funds before building on their current structures, while others have already developed plans and systems in anticipation of the rollout of the funds. The Flexible Services Program has incentivized several ACOs to develop and invest in structures around addressing HRSNs in new ways, whereas others will use these funds in a supplementary manner to incorporate into existing supports and systems. One looming question the ACOs are considering is how to balance partnerships with both small and large CBOs, so that small CBOs have a role in the Flexible Services Program as well.

“THEY [SMALL CBOS WILL] GET LOST IN THAT SHUFFLE BECAUSE IT BECOMES LIKE THE BIG FISH... YOU'RE JUST DEALING WITH THE MAIN AGENCIES BECAUSE YOU KNOW THEY HAVE THE INFRASTRUCTURE THEY HAVE THE DOLLARS ET CETERA ET CETERA. THE SMALLER AGENCIES ARE GOING TO MISS OUT ON THIS.”
--ACO

Patient Voice

A few ACOs acknowledge the critical role that patient voice plays in addressing HRSNs. This includes ensuring that patients have agency in determining what supports they want and taking their experience into account in the design of screenings and referrals. Many of the ACOs have systems in place that are implemented with a top-down approach, involving little to no consistent input from the patient perspective. However, some ACOs are making an effort to incorporate this perspective into their approach. Some ACOs ask specifically about whether patients want help if a particular need is identified, since patients may opt to decline services for different reasons. This approach was helpful to the ACOs that adopted it. ACOs report that patients can be skeptical of larger health systems and typically do not like being transferred between multiple providers. However, addressing HRSNs often requires an integrated approach from multiple entities. Both CBOs and providers state that it is, therefore, critical to be intentional about how patients are referred to services and receive follow-up.

Issues such as food insecurity and struggles with homelessness can also be extremely stigmatizing for an individual or family. When layered on top of language barriers, family dynamics and complex social situations, addressing HRSNs can be very challenging. These issues, therefore, need to be addressed with a culturally-sensitive approach. A few ACOs spoke to fine-tuning screening processes and questions in a way that acknowledges the social and cultural stigma associated with HRSNs. Some ACOs also chose to eliminate screening for certain domains until a more robust, culturally-appropriate system could be developed, while others are aiming to develop culturally-nuanced systems alongside ones that already exist.

CHALLENGES

There are five challenges in addressing HRSNs that ACOs consistently highlight, all of which relate to the fundamental challenge of closing the loop when a need is identified, an individual is referred to services or supports, and the results of this intervention are communicated back to the provider. Collectively, all of the screening processes, referral systems and partnerships are attempting to address the holistic needs of a patient. Efficient identification of patients with HRSNs must be paired with the offering of appropriate services, with the ultimate goal of having a positive effect on health. However, accurately quantifying how addressing HRSNs improves patient health can be extremely challenging. It may be most achievable when supporting individuals with acute medical co-morbidities, but it can be especially challenging to track longitudinal effects on individuals at-risk for chronic conditions. There is also a question of how much these HRSN systems and structures require “reinventing the wheel” as opposed to building on existing efforts.

EHR Integration

Addressing HRSNs involves collecting and sharing data on personal, protected patient information. This requires the use of a robust, established IT platform that facilitates information sharing and communication. However, each ACO currently utilizes multiple EHR platforms. Some MassHealth ACOs use only a few EHRs, whereas others encompass a group of providers with many different EHR systems. In addition, most EHRs did not initially contain fields to record HRSN-related information. Some ACOs have responded to this barrier by using a

separate platform, and third-party software, while others are developing their own platform within their EHR. Only a few ACOs report satisfaction and ease of use with the systems they rely on to document and track HRSNs. Given that most CBOs currently do not have medical EHR platforms, designing ways to share HRSN-related information, much of which is HIPAA protected, is difficult but necessary.

Many ACOs also note that the manner in which screenings are conducted and the methods for referrals influence the information they are able to collect and the services they are able to track. Some providers use electronic screening processes in the clinic, whereas others use paper records

that are then inputted into EHRs. Some providers use a system where screening tools are filled out by patients themselves, whereas others are directly asked the screening questions by physicians, nurses or other staff. These processes, even if they ask the same questions, can each yield different responses based on the comfort level, health literacy, language and cultural norms of the patient and documenting provider staff. Variation across these factors can also influence an ACO's capacity to collect population-level data. At the same time, how an ACO intends to utilize the data from the screenings also influences the system they establish. Each approach to the screening process has benefits and challenges that are often compounded by the technical or staff capabilities and constraints.

"WE HAVE A LOT OF 'MOM AND POP' [PRACTICES], THEY COULD BE ONE OR TWO PROVIDERS IN IT OR YOU KNOW LARGER PRIMARY CARE CLINICS WITH MULTIPLE SITES. SO GIVEN OUR FOCUS ON PRIMARY CARE AND LOCAL CARE, THAT... INTRODUCES A LOT OF VARIABILITY IN OUR SYSTEM. SO WE HAVE MULTIPLE EHRs THROUGHOUT THE NETWORK. WE DON'T HAVE ONE EHR. WE'RE NOT CENTRALIZED LIKE THAT."
--ACO

Information Sharing and HIPAA Compliance

ACOs recognize there are likely to be challenges with sharing patient data with CBOs and maintaining HIPAA compliance.


"POTENTIALLY... WE OUGHT TO THINK ABOUT DATA SHARING AGREEMENTS AND HOW WE MANAGE THE CONFIDENTIALITY."
--ACO

They have a sense that CBOs would likely want information, not just on the HRSN screening results, but also additional background on individuals being referred. Sharing this information through an appropriate platform, while maintaining HIPAA compliance, is a significant challenge for ACOs.

Navigating Contracts – Formal vs. Informal

Vendors vs. partners and contracting: The relationship between a MassHealth ACO and a CBO is likely to be impacted by whether the CBO is approached as a traditional vendor of the ACO or

as a partner. This most directly affects the formal, legal relationship between them. However, it will also likely impact the timing between referrals made and services provided, as well as the frequency and quantity of services provided. Traditionally, since much HRSN work has been funded philanthropically through grants, the relationships between the ACOs and CBOs has been more informal and less contractual. Venturing into formal contracts introduces additional rigidity to HRSN-related ACO-CBO relationships, and some ACOs believe this could be problematic. Given that patient HRSNs are often fluctuating and evolving, more formalized contracts could present logistical barriers to connecting patients with services efficiently and effectively. For example, needs for housing tend to increase in the winter, whereas food insecurity for the pediatric population tends to increase in the summer. Inflexible contracts could impose performance thresholds around services that are not pragmatic for this type of variation. It could also be cumbersome for CBOs, who's relationships with health care providers has historically been less formal, especially if they must participate in multiple contracts with different providers or MassHealth ACOs.

Performance-based contracting: ACOs cite concerns around how an overemphasis on return on investment or outcomes measures could influence the sustainability and longevity of these contracts and relationships. Although ACOs believe that metrics for progress or success would be beneficial, how these metrics are defined is much less clear. Additionally, the positive health effects of addressing HRSNs like housing or food insecurity could take years to fully actualize. ACOs are concerned about their capacity to demonstrate change, growth or improvement in patient outcomes fast enough to justify value. Addressing these needs for even a few weeks or months could have a strong, positive impact on patient health, but it would still not undo years of adverse experiences. Tying funding directly to improved health outcomes might, therefore, not only be infeasible but impractical – especially in the short term.

ACOs additionally cite concerns and questions around how CBOs would be affected by this transformation in addressing HRSNs. Many ACOs explicitly mentioned how flexible services could aid or hinder the current relationships they have with CBOs by jeopardizing existing referral pathways, as well as changing the expectations around existing roles. A few ACOs are worried about the potential burden that contract development can have on CBOs, especially given the power asymmetries that exist between an ACO and CBO. There is an acknowledged power imbalance between ACOs, which are made up of some of the largest well-known health care entities in the state, and CBOs, which are often smaller, community organizations with fewer financial resources. Additionally, ACOs find that CBOs with more robust documentation and referral systems are easier to collaborate with. However, these CBOs tend to be larger so there is a concern that smaller CBOs or CBOs serving a unique marginal population could be crowded out. Additionally, an ACO's decision on what services to buy, build or embed influences both current and future ACO-CBO relationships. Some ACOs are trying to intentionally design HRSN systems that will facilitate better collaboration with larger CBOs, whereas others are focusing on maximizing internal systems and processes before looking to increase external partnerships. However, most ACOs are likely to combine some of both approaches.

Most ACOs identify gaps in tracking follow-up services: ACOs identify challenges around a range of functions required to ensure documentation of identified HRSNs and appropriate

follow-up. These challenges include communications workflows and platforms, the existence of or funding for resources beyond the scope of the Flexible Services Program (such as additional housing units), and the collection and exchange of data for tracking HSRN services.

“WE DON'T HAVE A PLATFORM. WE DON'T HAVE A STRUCTURAL INFRASTRUCTURE IN PLACE FOR THAT YET. SO THAT COULD BE A BARRIER JUST BECAUSE IT DOESN'T EXIST.”
--ACO

One of the key challenges to developing these systems is that the services needed to address each type of HRSN varies significantly. Even with the four required screening domains of housing, food insecurity, utilities and transportation, the protocols and infrastructure to move the needle on these issues vastly differ. Housing, for example, requires

increasing access to and affordability of housing stock for individuals to occupy. Solutions rely on proximity and availability of homeless shelters (which varies by seasons) and encompass a range of services that address acute and longitudinal needs. The protocols, communications and systems needed to connect patients who are homeless with appropriately tailored services are completely different from those required to address food insecurity, utilities or transportation. Additionally, different providers run their practices differently. ACOs, therefore, highlight that creating a single system that can adequately allow various providers to address different HRSN domains can be extremely challenging. Finally, given that the volume of patients needing these services can vary by month, tracking how patients are connected with these resources and evaluating the impact of these initiatives can be difficult as well.

Another key challenge is MassHealth ACO membership and how a whole family can be served. Many times, different family members are part of different ACOs. As a result, individuals within the same family may experience disparate processes, documentation, referral networks and tracking. This poses multiple challenges, especially if the same individual is served by different MassHealth ACOs at different points in their life. ACOs also highlight that since Flexible Services Program funding will be disbursed per individual, rather than per family, this poses logistical barriers to successfully addressing a particular need for the entire family unit. For example, if a parent screens positive for food insecurity, that parent will only be eligible for food services as an individual, while the entire family may be food insecure and need services.



“IN TERMS OF KNOWING WHETHER A PARTICULAR PATIENT MADE IT TO A REFERRAL AGENCY OR THE AGENCY YOU’VE REFERRED TO, WE’RE LOOKING AT AUNT BERTHA TO DO THAT.”
--ACO

BEST PRACTICES

Leveraging Existing Infrastructure

ACOs may want to consider ways to leverage the infrastructure from existing programs rather than “reinventing the wheel” with new programs to respond to HRSNs. ACOs that have existing infrastructure around HSRN screenings and care coordination and are building on these structures and their current relationships with CBOs, rather than starting completely new efforts, are further along in addressing HRSNs for their members. The systems involved in implementing HRSN services are complex and nuanced. ACOs that are having success in standing up these efforts are doing so by leveraging existing structures. These may include existing screening tools and workflows, or care management staff and protocols. Some ACOs have developed protocols around screenings, referrals and care coordination, building on their existing efforts but with some modifications. They are planning to use Flexible Services as an opportunity to bolster their existing systems and processes.

Alternatively, ACOs could build their systems more independently from the existing infrastructure, which would allow them to have more flexibility in their protocols for addressing HRSNs. However, this is a more resource-intensive path which requires additional buy-in from practice staff and leadership.

Ease of Navigation and Documentation

ACOs may want to consider ways to streamline documentation and navigation of HRSN screening and referral pathways. All ACOs state that the responsibilities of a health care system have only grown over the past few decades. Providers, staff and administration all have the daunting task of doing more within increasingly shorter patient visits. All ACOs, therefore, agree that providers are more likely to use streamlined and simplified HRSN screening and referral processes. Even moving from a “two-click” to a “one-click” system for documenting HRSNs can help to streamline these processes. Burnout from the time-intensive requirements of EHR documentation can result in apprehension, stress or frustration around HRSN documentation, and many ACOs are concerned the additional burden on providers to document HRSNs will exacerbate the situation. Transitioning to a “one-click” system for HRSN documentation and coding would help ease the burden and increase provider buy-in around HRSN significantly.

Flexibility of Referrals and Partnerships Based on Needs of the Population

ACOs may want to consider ways to ensure variability across their provider practices and HRSN domains in referral protocols and partnerships and will want to consider partnering with CBOs for services wherever possible. Many ACOs recognize the need for different models for HRSN referrals across their practices and across the different domains to respond to the unique needs of patients and offer the most relevant supports. This includes flexibility with regard to protocols for follow-up, organizational partnerships and internal staff roles. This also extends to decision-making around buying, building or embedding necessary structures, resources and services. Contracting with an external organization for services whether that be a third-party referral system or patient-facing supports does require some financial and time investment to understand the benefits and consider any hurdles to integrating the services.

However, the benefits of partnering with an external organization for services will likely help fill systemic, cultural or geographic gaps for ACOs with diverse providers and members. ACOs may have the capacity to build at least some components of their own systems, but in many instances this is simply not the case. Some ACOs have also been engaging an integrative model that bridges both buying and building resources by embedding externally contracted or purchased resources. Certain HRSN supports are especially conducive to collaborating with external organizations and platforms, such as housing, where ACO knowledge is limited. Overall, many ACOs are engaging in thoughtful discussions and planning for decisions about how buying, building or embedding different resources best supports HRSN systems. The most successful ACOs are likely to be those that are clear about the principles they are using to make these decisions and that share those principles with CBOs and other stakeholders.

Balancing Standardization with Innovation

ACOs may want to support flexibility and innovation across practices to respond to different circumstances, communities served, staff needs and relationships, while ensuring enough standardization to enable consistent documentation and evaluation. Beyond the development of baseline protocols, significant consideration must be given to determine which HRSN components should be standardized within or across ACOs and where there should be ample room for adaptation or interpretation. How each ACO addresses even one domain, or one aspect of a domain, varies significantly across the ACOs and can vary between providers within an ACO. Providers who serve a patient population that consists of greater than 50 percent of MassHealth patients have greater incentive to adopt HRSN processes than those with only five percent of MassHealth patients, given the scale necessary to make resources financially viable. Similarly, the processes, support, time, cost and staff needed to address HRSNs also differ. Enabling a screening and referral system that allows ACOs and providers flexibility for adaptation is, therefore, ideal. At the same time, documentation will have to be consistent enough to ensure evaluation of interventions. While both are necessary, flexibility may be the higher priority to ensure the initial success of HRSN supports.

Vertical and Horizontal Alignment and Integration

ACOs may want to consider ways to align and articulate their mission around HRSNs horizontally across practices, as well as vertically with organizational leadership. An organizational mission around addressing HRSNs that includes vertical alignment from the senior management to patients, as well as horizontal alignment across providers from different practices, is valuable. Provider attitudes about addressing HRSNs range from integral to holistic patient care to cumbersome, complicated and an extra responsibility. Including HRSNs in the mission, goals or priorities of the overall ACO also influences the attitude towards these systems at the individual practice and provider level.

Different ACOs also speak to diverse ways of incentivizing providers to take ownership in integrated HRSN screenings and referrals. ACOs describe both the “carrot” and “stick” approach to encouraging HRSN work, each facilitating different aspects of HRSN processes. Regardless of the approach, many ACOs acknowledge that identifying the most appropriate or accurate types of metrics to assess cultural and structural changes surrounding HRSN work can be challenging.

CBOs

FINDINGS

CBO Overarching Themes

CBOs fall on a spectrum of readiness to partner with ACOs for the Flexible Services Program. Those farthest along are beginning the process of contracting with ACOs, while others have only had limited informal discussions with ACOs to date. These differences between CBOs are related to several key factors:

CBO size and resources: Larger staffs or funding levels make it easier to pursue flexible services partnerships and access useful legal, contract and data resources.

Existing interactions between CBOs and health care entities: Established relationships with providers can streamline the partnership process, relative to CBOs who start from scratch.

CBO access to contracting and legal resources: Contract negotiations become more equitable and productive when CBOs have specialized contracting and legal supports to better position them with ACOs.

Data availability and data management platforms: CBOs that already have data collection protocols and data management systems are better positioned to explore interoperability and data sharing with ACOs.

Domain of social services: Interventions to address housing insecurity versus food insecurity differ in feasibility, timeliness and level of structural support (i.e., funding, laws, regulations).

Value of CBO Services

CBOs recognize the value they bring to the Flexible Services Program and the value of this program to improve patient outcomes. They are well-positioned to address the upstream health-related factors – such as food or housing insecurity – that affect cost, utilization and health outcomes.

“OUR ABILITY TO SEE INTO PEOPLE'S LIVES IS GREATER THAN A PHYSICIAN'S, YOU KNOW, AND SO IT'S LIKE HOW CAN WE BE HELPFUL AND WHAT INFORMATION IS APPROPRIATE TO PROVIDE.”
--CBO

CBOs also recognize the potential of the Flexible Services Program to improve their ability to serve their communities more broadly beyond just the MassHealth members that are eligible for supports under the program.

Screenings and Referrals to CBOs

The new MassHealth ACOs are required to screen for HRSNs and are expected to make

referrals, in many cases, to CBOs that address identified needs. CBOs have traditionally received a number of their referrals from health care entities, a process that relies heavily on relationships between CBOs and individual providers or health centers that are often ACO-affiliated. This system is tenuous, as providers switch positions or institutions and the institutional knowledge of the relationship may be lost, thereby disrupting patient access or continuity of care. Referrals resulting from a formal relationship with the broader ACO are a nascent practice that the Flexible Services Program should further encourage.

"FOOD CAN BE SOLVED WITHIN AN HOUR...WE CAN DRIVE PEOPLE TO FOOD WHERE THEY CAN GET CONSISTENT ACCESS TO FOOD WITHIN AN HOUR OF THEM BEING SCREENED POSITIVE AND THERE IS NOTHING ELSE IN THE SOCIAL DETERMINANTS OF HEALTH THAT CAN RESPOND THAT QUICKLY."

--CBO

CBO tracking of referrals: CBOs vary in their ability to track the source of their referrals. All

CBOs have at least a high-level sense of how many referrals come from health care entities in general, but most do not track which referrals are coming from MassHealth ACOs specifically. Several CBOs use Salesforce or other online platforms that connect their referral partners, while others lack the infrastructure to pinpoint an exact health center or provider.

Changes in referral patterns: ACO referrals to CBOs are slowly increasing, although they did not spike with the launch of the MassHealth ACO program. Several CBOs are actively discussing how to respond to potential rapid increases in referrals should that occur with the launch of the Flexible Services Program.

CBO concerns with screenings and referrals: CBOs cite several concerns and questions regarding the existing ACO screening and referral processes, which fall into three main categories: 1) consistency – are ACO providers complying with MassHealth requirements to screen all MassHealth ACO members across the four specified domains? 2) validity – are the screening tools accurately measuring patient needs in the screening domains?

Are the screening tools culturally appropriate and accessible to patients whose first language is not English? and 3) standardization – are providers using the same screening tools within and between ACOs to facilitate data aggregation, reduce the need to screen patients multiple times and ease CBO administrative burden?

"RE-EMPHASIZING THE INCONSISTENCY WITH WHICH PATIENTS ARE BEING SCREENED, THE TOOLS THAT ARE BEING USED TO SCREEN, AND THEN THE PROCESS FOR A REFERRAL IS JUST NOT ONLY DIFFERENT AT EVERY HEALTH CENTER BUT DIFFERENT WITHIN THE HEALTH CENTER DEPENDING ON THE PATIENT'S POINT OF ACCESS." -CBO

"I THINK THIS IS WHERE IT'S IMPORTANT TO KIND OF UNDERSTAND THE CULTURAL NEED IN AN ACO. IT'S NOT JUST ASKING CERTAIN QUESTIONS IT'S HOW THEY'RE ASKED; IT'S WHO ASKS THEM. IT'S THE WAY THE QUESTION IS FRAMED. IT'S ALL THAT. OTHERWISE YOU'RE LIKELY TO GET NO NONE OF IT. LIKE NO RESPONSE"
--CBO

Successful screening also depends on strong patient trust in their provider. This is especially relevant when screening for issues such as domestic violence, but it has implications for any screening domain. Patient trust underpins openness to share what could be a stigmatizing or shameful experience – intimate partner violence, food insecurity, housing insecurity or the general need to ask for help.

For referrals, CBOs cite numerous concerns. The existing mix of formal and informal provider referrals makes it challenging to keep track of handoffs, since CBOs do not get notified every time a referral is made from an ACO. ACO providers may not fully explain the referral process to eligible patients. It is then unclear whether ACOs or CBOs are responsible for ensuring that the patient makes it to the referred services, or whether the onus falls

onto the patient instead. Finally, there is confusion as to whether ACOs or CBOs are responsible for verifying that patients are eligible and remain eligible for MassHealth and the Flexible Services Program.

Data Sharing

CBOs universally consider information exchange between ACOs and CBOs to be a top priority going into the Flexible Services Program but are acutely aware of the difficulties involved, including the current deficiency of existing structures.

Data collection: All CBOs collect both qualitative and quantitative patient data that encompasses information on referrals, service delivery, patient characteristics and health outcomes. They often struggle, however, to share such data with their health care counterparts. Likewise, CBOs are unable to access EHRs or other clinical patient data from providers. Thus, ACOs and CBOs each hold different patient data, but neither can access all the data they need to fully inform care planning and service delivery for addressing HRSNs. This makes it difficult to close the loop with providers when HRSN services are rendered as well.

"WE'RE NOT, TO OUR KNOWLEDGE, IN ANY TYPE OF LIKE ELECTRONIC MEDICAL RECORD WHERE THERE'S SORT OF BI-DIRECTIONAL COMMUNICATION ABOUT REFERRALS...THE CHANCE THAT THE DOCTOR ACTUALLY KNOWS THE INFORMATION IF IT'S NOT THROUGH A PAYER SET UP IS VERY SLIM."

"THERE NEEDS TO BE A RELATIONSHIP THAT'S BUILT. AND YOU NEED TO REALLY BRING IN CULTURALLY SPECIFIC ORGANIZATIONS THAT HAVE THE EXPERTISE TO KIND OF WORK WITH AN ACO ON HOW THAT NEEDS TO HAPPEN AND BUILD THOSE RELATIONSHIPS. IT'S A COMMUNITY PARTNERSHIP."
--CBO

Data management: Several CBOs have built or want to build bi-directional data platforms to share information with health care entities or other CBOs. They hope to share information on referrals, service delivery and outcomes. They either currently use or have considered using the following platforms: Salesforce, Aunt Bertha, HelpSteps, Health Leads Reach or other existing EHRs. These data-sharing platforms are in various stages of development and in some cases active use, with a few currently fully functioning. However, none yet appear to be capable of connecting data between a CBO and an entire ACO system.

INTERVIEWER: “ONCE YOU'RE ABLE TO HOPEFULLY CONNECT WITH THE PERSON WHO'S BEEN REFERRED OVER AND PROVIDE SERVICES, IS THERE ANY WAY THAT INFORMATION IS THEN SHARED BACK WITH THE HEALTH CENTER?”

INTERVIEWEE: “NO. AND BOY THAT'S SOMETHING WE'D LIKE TO DO.”

data sharing. CBOs are aware of HIPAA requirements and their general purpose, but most CBOs do not understand enough to be comfortable navigating these privacy protections in their ongoing data-sharing conversations with health care entities. Requirements around HIPAA protections appear to overwhelm many CBOs and can significantly stall discussions around data-sharing. However, CBOs are openly looking for guidance on how to ensure compliance as they work to exchange more data with ACOs.

Several CBOs consider one standardized data-sharing platform across all ACOs and CBOs as ideal but appreciate the tremendous challenges associated with agreeing on and transitioning to such a system. CBOs seem open to working with the multiple existing data platforms, while working to simplify the system and facilitate interoperability.

Data privacy and security: CBOs name HIPAA as a major source of confusion that causes a bottleneck for

“TO BE CANDID WE DON'T WANT HIPAA RESPONSIBILITY... THERE IS SO MUCH LEGAL DOCUMENTATION... THESE ARE ALL ACRONYMS THAT WE KNOW NOTHING ABOUT”
--CBO

CBOs expect to have to share data with ACO providers, billing staff, CBO staff, third-party data managers/vendors and MassHealth. Protecting patient data remains imperative to CBOs, and they acknowledge the challenges of gaining patient trust enough for them to be comfortable with the CBOs sharing data with ACOs. CBOs recognize that proactively building patient trust by protecting their information will make patients more willing to respond to screenings and will improve the quality of HRSN data in the future.

ACO-CBO Partnerships

CBOs range in their preparedness to partner with ACOs, with all CBOs that were interviewed being open to it. Most CBOs interviewed have already established or attempted to develop partnerships with individual health care providers and health centers. Several also partner with other local CBOs. A few of these relationships have formalized agreements with MOUs or contracts, while many have informal relationships. A small number of CBOs are already partnering with ACOs at the organizational level, as opposed to with the individual health centers or providers within them.

CBOs indicate several obstacles to partnering with ACOs for the Flexible Services Program:

"WE HAVE A CONSULTANT ON STAFF WHO'S MANAGING THE CONTRACTING FOR US, NOT ON STAFF BUT A CONSULTANT, AND WE WERE ABOUT TO HIRE A BUSINESS DEVELOPMENT PERSON BECAUSE IF WE WERE TO PURSUE SAY 20 CONTRACTS...WE HAVE THE CAPACITY TO FEED THEM. WE DON'T HAVE THE CAPACITY TO NEGOTIATE THE CONTRACTS."
--CBO

ACOs appear to lack a centralized entry point or contact person who CBOs can engage with: CBOs often do not know who in the ACO hierarchy is aware of the Flexible Services Program and has the knowledge or authority to discuss it, which stymies communications. While MassHealth posted a list with ACO contact names for the Flexible Services Program before these CBO interviews occurred, many CBOs did not know about this resource.

A power imbalance exists in favor of ACOs when negotiating ACO-CBO contracts: CBOs lack the necessary legal or contractual resources to engage in these negotiations relative to ACOs, which have dedicated legal departments and staff that manage this type of contracting. The negotiating process, therefore, risks being inflexible to CBO needs. CBOs anticipate that some ACOs may propose using boilerplate

contractual language that does not fit with their structure and requires CBOs to take the contract as-written or walk away.

ACO and CBO perceptions of the CBO services do not always align: ACOs are not always aware of the type, scale or complexity of services that some CBOs offer in their respective HRSN domains. If ACOs don't have a complete picture of the services offered by CBOs, it could constrain their partnerships or leave valuable services that are available underutilized. CBOs repeatedly assert that a key strategy for success is to base the Flexible Services Program on strong, formal ACO-CBO partnerships. In that vein, CBOs ask that these partnerships begin with ACOs listening to and respecting CBOs as equal partners in this initiative.



"WE'RE TRYING TO FIGURE OUT...WHO ARE THE RIGHT PEOPLE THAT NEED TO BE PART OF THE CONVERSATION TO CREATE SOMETHING THAT'S GOING TO STICK."
--CBO

CBO Resource Constraints

All CBOs interviewed indicate they are currently operating at or beyond capacity. Absorbing referrals from the Flexible Services Program into their existing functions requires: 1) dedicated resources to build out both staffing and operations, and 2) external supports to navigate contracting and data management. CBOs in the food and housing domains share many similar hurdles to participate in the Flexible Services Program, including funding constraints, limited HIPAA knowledge, smaller staff size, and lack of access to contracting or legal resources.

CBOs in both the housing and food domains remarked on the major shortage of available housing units and the limited options available to help housing-insecure households. Fair housing laws are clear on how to fill new units as they become available, but available units are in dramatically short supply. This shortage means CBOs ultimately have few strategies beyond placing many individuals onto years-long waiting lists and helping households navigate the housing lottery system.

"NO ONE'S THOUGHT ABOUT THE FACT WHETHER ANY OF THESE CBOs ACTUALLY HAVE THE CAPACITY TO MAKE THIS HAPPEN LET ALONE LAWYERS ON STAFF TO NEGOTIATE CONTRACTS AND A REAL SENSE OF...GETTING A SENSE OF REAL COSTS AND ALL OF THAT IS ALSO A PIECE OF THIS."
--CBO

Furthermore, different degrees of housing insecurity require different levels of support. Financial supports and eligibility for units can be more difficult to find for those who are "doubled-up" by sharing housing or couch surfing, as opposed to those who are chronically homeless. Housing CBOs anticipate that their Flexible Services Program patients would likely include these housing-insecure households that have limited supports. The needs of housing-insecure households are also more varied than in other domains. Whereas food funds may not distinguish in many cases between types of food, housing funds are needed for movers, cleaners, first month, last month, security and landlord back-pay. Housing funds are not



"MOST OF THEM [HEALTH CARE ORGANIZATIONS] ACTUALLY WANT SOMEBODY ON SITE, BUT WE CAN'T DO THAT FOR EVERYONE."
--CBO



"THERE'S NO CENTRAL POINT OF ENTRY, PEOPLE NEED TO APPLY PER FAIR HOUSING LAWS AND EVERYTHING TO EACH UNIT SEPARATELY. AND THEN OUR SHORTEST WAITLIST IS ANYWHERE FROM FIVE OR SEVEN YEARS LONG...WE HAD THE LOTTERY FOR 49 UNITS, 3,000 PEOPLE APPLIED."
--CBO

"WE CANNOT ABSORB IT [PARTNERING WITH ACOs] INTO OUR CURRENT SERVICES. SO IT REALLY WOULD HAVE TO BE ITS OWN THING."

--CBO

necessarily earmarked for each of these purposes. Although housing CBOs do not see these difficulties as jeopardizing a future partnership with ACOs for the Flexible Services Program, ACOs and MassHealth will need to understand these challenges as they implement the Flexible Services Program.

Housing may be unique in the scale of challenges, however, other domains also face difficulties. The Flexible Services Program allows CBOs in the food domain to use funds to feed only the eligible food-insecure person regardless of the food security status of the rest of the household. In these cases, the person would likely share food with the rest of the family, thereby attenuating the efficacy of the intervention.

"THERE'S NO SUBSIDY FOR SOMEONE WHO IS DOUBLED UP AND THAT'S WHAT THEY WILL NEED BUT THEY'RE NOT HOMELESS. OR THEY DON'T HAVE PRIORITY...I THINK THE CHALLENGE CAN BE... [ACOs] WOULD BE REFERRING FOLKS WHOSE NEEDS OUR SOCIETY AT LEAST MASSACHUSETTS [AND] BOSTON SPECIFICALLY IS NOT PUTTING ANY MONEY INTO."

--CBO

Funding for CBOs

CBOs currently receive external funding from sources such as federal and state grants, philanthropic dollars and individual donations. Many are excited about the prospect of accessing funds to support their work through the Flexible Services program.

CBO awareness of Flexible Services Program funding: All the CBOs interviewed have heard of the Flexible Services Program and most welcome the program to jumpstart ACO-CBO

collaborations to address HRSNs. Interactions with ACOs to date suggest that ACOs have not been as directly or broadly focused on addressing HRSNs prior to the introduction of the Flexible Services Program, and CBOs view the program as an opportunity to engage health care entities in this work.

Uncertainty with Flexible Services Program: CBOs have questions about Flexible Services Program funding allotments and qualifying services. Several CBOs, especially those in the housing space, are unclear on which support services flexible services can finance. A few CBOs are seeking clarity on how ACOs will distribute funds across and within domains (e.g., how


*"I SEE THE ADVANTAGE OF THIS FLEX SERVICES IS THAT THERE IS ACTUALLY INCENTIVE TO DO IT WHEREAS NOT US GOING DOWN TO [A HEALTH CENTER] AND SAYING CAN YOU DO THIS AND LET'S TALK THIS OUT."
--CBO*

much would go to food vs. housing), how much is expected to go directly to CBOs through contracts, and if ACOs will prioritize one type of intervention model over another. One CBO is concerned that ACOs might prefer to fund interventions that have established clear and compelling return-on-investment figures, which may not be feasible for some CBOs to produce due to data constraints or intervention realities. There is also

confusion over whether or how CBOs outside of the flexible services eligible domains, that still provide services in those areas (e.g., a domestic violence CBO that operates a shelter), could qualify for Flexible Services Program funds. CBOs are also unclear what may happen with the Flexible Services Program and partnerships after the initial funding period ends.

*"THE ACOs, THEY DON'T HAVE TO WAIT FOR THE FLEXIBLE SERVICES PROGRAM TO START INTEGRATING A SERVICE LIKE THIS INTO MODELS OF CARE. AND SO IT IS A BIT FRUSTRATING TO US THAT THEY KNOW WE ARE BEING KIND OF CATEGORIZED AS A SOCIAL DETERMINANT THAT IS APPROPRIATE FOR THE FLEX SERVICES PROGRAM...WE WOULD REALLY LIKE TO SEE BROADER THINKING ON THE PARTS OF THE ACOs AND THAT THEY'RE NOT LIMITED TO [OR] BY THESE FUNDS."
--CBO*

*"IT'S A GREAT OPPORTUNITY BUT SEEMS LIKE RIGHT NOW A LOT OF ACOs DON'T KNOW WHAT THEY WANT TO DO OR HOW THEY WANT TO SPEND THAT MONEY OR WHAT COMMUNITY OR... POPULATION THEY WANT TO FOCUS ON YET SO WE DON'T HAVE THAT INFORMATION [AND] WITHOUT THAT INFORMATION WE CAN'T IDENTIFY A PROJECT THAT WE CAN PARTICIPATE IN."
--CBO*

Infrequently Discussed Topics

Equally important in the CBO interviews are the topics that rarely or never emerged. Only one CBO discussed logistics to evaluate the Flexible Services Program, and no CBOs mentioned the “Flexible Services Plans” that are a required program element for flexible services-eligible patients.

Evaluation logistics: Few CBOs discussed evaluations, likely due to being in early stages of engaging with the Flexible Services Program. However, those CBOs that did discuss it, raised some potential challenges. These included unreasonable expectations for health care cost impacts of interventions, how to balance evaluations of different interventions with some consistency and a lack of funds specified for this work.

“THERE'S THIS ATTRACTION TO DO THREE WEEKS POST DISCHARGE AS IF YOU'RE GOING TO SEE A SIGNIFICANT CHANGE.... YOU MAY ADDRESS RE-HOSPITALIZATION, BUT YOU'RE NOT REALLY GOING TO SEE A COST SAVINGS IN THE SAME WAY AS YOU WOULD WITH YOU KNOW TWELVE WEEKS OR 24 WEEKS.”

--CBO

Overall, the minimal discussion on this topic across interviews suggests that many CBOs are not yet at the point of considering the logistics of evaluating their services in the context of the Flexible Services Program. The questions above also lead to additional questions, such as which entities would be responsible for formulating the evaluation parameters and whether the analysis would be adjusted for any underlying differences in ACO or CBO populations served. A small number of CBOs report they have previously evaluated their services; such evaluations could inform subsequent MassHealth discussions on how to evaluate the Flexible Services Program.

Flexible services plans: There was generally not wide-spread knowledge among many CBOs of some of the specific requirements of the Flexible Services Program such as the need to draft Flexible Services Plans. This reflected the fact that most CBOs were at an early stage of engagement with the program, and there likely is a need for additional communication regarding the program’s requirements.

“IF YOU'RE NOT CAREFUL IN HOW YOU DO THIS AND HAVE CONSISTENCY IN TERMS OF APPLICATION EVALUATION [AND] DURATION... YOU COULD REALLY END UP WITH, YOU KNOW, MASSHEALTH GOING BACK TO CMS WITH NOTHING. YOU KNOW, WITH NO GOOD METRICS OR NO GOOD DATA TO SHARE”

--CBO

“ARE WE REALLY GOING TO DO SEPARATE EVALUATIONS WITH 15 DIFFERENT CONTRACTS?”
--CBO

CHALLENGES

CBOs face challenges as they seek to ensure their efforts are aligned, effective and complementary to ACO efforts, rather than duplicative. CBOs must navigate this challenge while managing their capacity constraints, limited resources to equitably negotiate contracts, data sharing needs including HIPAA compliance, and the remaining uncertainty regarding the various aspects of the Flexible Services Program.

Capacity Constraints

CBOs have relatively smaller staff sizes and smaller budgets compared to ACOs, and they are often operating at or beyond capacity. They also have limited resources to assign to contract negotiations, HIPAA compliance programs and expanded service delivery. In addition, CBOs face constraints specific to their service domains. For example, food-related CBOs are only allowed to use Flexible Services Program

funds to feed their patients regardless of whether the entire household of the patient is food insecure. Housing CBOs contend with a shortage of available housing units and a lack of social services funding for those facing less extreme forms of homelessness.



“ONE OF THE BIGGEST BARRIERS FOR US IS YOU CAN GET A CONTRACT THAT DOESN'T MEAN YOU ACTUALLY HAVE ANY PATIENTS BECAUSE THE TWO ARE NOT NECESSARILY CONNECTED.”

--CBO

Issues with Contract Negotiations

As part of CBO capacity constraints, contract negotiations remain a salient challenge given that ACO-CBO contracts will be the backbone of Flexible Services Program operations. Given that the power imbalance with negotiations favor ACOs, CBOs risk facing an offer for a contract that is unfeasible and may believe they have to take it or leave it. This runs counter to the idea of ACOs and CBOs working as *partners* in this program.

This concern is especially pronounced given the short, initial timeline of three months for when the first contracts need to be in place. CBOs need timely support to negotiate these contracts with ACOs and establish a solid foundation to launch the strongest possible partnerships. These contracts would need to cover data-sharing, HIPAA compliance, delineation of responsibilities, funding amounts, supervisor roles and safeguards, expectations of the number of referrals, and plans for if expected services are not rendered.

Data Sharing and HIPAA

CBOs are still experimenting with shared or interoperable data systems that protect patient data while sharing information between relevant stakeholders. This requires navigating HIPAA compliance, juggling the myriad data platforms used within different ACOs and CBOs, and earning patient trust and consent to collect data for this program. While problems are relatively straightforward, their solutions are likely to be complicated and require substantial and timely investments.

Flexible Services Program Uncertainty

CBOs continue to have questions about what qualifies under the Flexible Services Program. The release of the detailed MassHealth guidance in August 2019 answered many questions and concerns, but other matters will remain unclear until ACO-CBO contract negotiations get underway. These may include the exact funding amounts that CBOs would receive from ACOs, as well as ACO's thoughts on which services they plan to "build" internally versus "buy" from the CBOs.

BEST PRACTICES

Dedicated Coordination Team

CBOs may want to dedicate staff for coordinating with ACOs and request ACOs to do the same: The Flexible Services Program requires sustained, intentional communication between ACOs and CBOs in order to succeed. Approaching the Flexible Services Program partnerships as a team effort, with designated staff from both ACOs and CBOs, would make the initiative more manageable and facilitate communication and troubleshooting between ACOs and CBOs. The team would function as a centralized point of contact where ACOs or CBOs could send their questions, feedback and concerns. For CBOs this would mean having dedicated staff focused on coordinating with ACOs and asking ACOs to do the same as a stipulation of the partnerships.

CBO-Led Provider Training and Input on Screeners

CBOs may want to offer ACOs trainings on engaging individuals around HRSNs and offering input on SDOH screening protocols: CBOs are immersed in the communities the Flexible Services Program seeks to target for HRSN supports. They have invaluable insights into communities and the screening tools, approaches and referral processes that are likely to be best received and most successful. CBOs could, therefore, provide training for providers in these areas to improve the entire screening and referral processes. CBOs can also incorporate cultural and linguistic considerations into this training to aid in the screening of patients for whom English is not their first language. Aligning ACO screening and referral processes with CBO best practices will reduce administrative burdens, improve validity of the data and most effectively address the needs of patients.

Contract Flexibility and Assistance

CBOs may want to consider ways to build flexibility and safeguards into their contracts through a careful and iterative contracting process: CBOs often lack the contracting and legal resources that ACOs have to negotiate contracts. This can lead to a power imbalance that could jeopardize the contracting process and result in CBOs committing to a contract that they have not been able to fully process and review. CBOs would benefit from external, affordable contracting and legal supports to advocate for or guide them as they navigate the Flexible Services Program contract negotiation process. These negotiations should be iterative and collaborative, rather than one-sided. To protect themselves financially, CBOs may want contractual safeguards should referrals for flexible services be lower than anticipated. The contracts should set clear expectations and responsibilities for ACOs and CBOs, such as for HIPAA compliance, patient eligibility verification and the referral handoff processes. CBOs may

also want to advocate for maintaining flexibility in how they serve referred patients to best address the diverse needs of each individual, even within the same HRSN domain. Despite potential challenges, CBOs do view formal partnerships as key to serving patients in the Flexible Services Program.

Resources to Support IT Needs

CBOs may want to pursue additional IT supports that will meet their internal needs while enabling interoperability and HIPAA compliance: Given the diverse number of data platforms in use at ACOs and CBOs, interoperability is essential to sharing data on the Flexible Services Program. However even with interconnected platforms, ACOs and CBOs must ensure they comply with HIPAA, build patient trust and safeguard patient data. CBOs would benefit from external, affordable IT supports to help build and connect secure data management platforms to collect and share data with ACOs. CBOs should be allowed to choose their preferred data platform, provided it does not compromise privacy or interoperability.

CBOs also expressed interest in using IT to improve other aspects of the Flexible Services Program. This included consideration of having ACOs establish a centralized referral database where all referrals, regardless of department, would funnel through to enable clearer referral lines with the CBO and its staff.

Setting Expectations Early

CBOs may want to clarify expectations with ACOs early in their pursuit of partnerships: Setting reasonable expectations for what ACOs and CBOs can expect to accomplish in the Flexible Services Program is important to appropriately assess performance. CBOs understand the realities, possibilities and limitations of providing services in their respective domains. ACOs must engage CBOs early as they craft their expectations for the program to ensure they set accomplishable targets. Such collaboration could help prevent future frustrations between ACOs and CBOs that could stem from misaligned expectations.

"I THINK THE THINGS THOUGH THAT WOULD MAKE RELATIONSHIPS SUCCESSFUL IS CLARITY OF EXPECTATIONS...THE ACO IS NOT EXPECTING THAT WHOEVER THEY PARTNER WITH WILL SOLVE ALL THE PROBLEMS HOUSING-RELATED PROBLEMS FOR THEIR PATIENTS WITHIN A MONTH."

--CBO

POLICY RECOMMENDATIONS

ACOs

Flexibility: ACOs should enable internal variation across practice settings to maintain existing relationships between practice staff and CBOs, and then build on these structures rather than replacing them. This may require ACOs to enable variation in the referral processes for different HRSN domains (i.e. housing insecurity vs. food insecurity) and potential partner organizations. Different domains and organizations will require different contract structures and workflows.

Expectation setting: ACOs should identify clear implementation timelines and appropriate evaluation metrics early in their partnerships with CBOs. Establishing these expectations early will facilitate trust with CBOs and enable clear assessments of capabilities that will allow for more successful execution of HRSN interventions and supports.

IT support: ACOs should dedicate IT support to enhance HRSN-focused EHR integration. EHR integration is a key factor in ACOs' abilities to collect and analyze screening data across their practices, and it enables progress toward referral systems. ACOs will need to dedicate resources to building out these structures in order to form successful partnerships with CBOs.

Coordination team: ACOs should designate dedicated staff to supporting HRSN work. This research also suggests that in order to enable progress on the HSRN screening and referral structures, ACOs will need to engage their high-level leadership in the rollout and implementation of the Flexible Services Program. In addition, ACOs will be more successful if they communicate proactively to a wide range of CBOs regarding potential partnerships under the Flexible Services Program. Sharing information with CBOs, beyond those that have approached the ACO, could result in ACOs including a wider-range of culturally-competent supports in their programs that they might otherwise have missed. Finally, ACOs will benefit from developing mechanisms for regularly sharing best practices with one another and with other CBOs.

Build vs. buy: When grappling with the question of “build,” vs. “buy” ACOs should develop guiding principles for reviewing the expertise and benefits of CBOs. Developing this framework and communicating it externally will help the ACO decision-making process and support CBOs in knowing which services ACOs will be looking for in community partners. ACOs should consider both technical expertise, as well as cultural competencies, community relationships and multiplier-effects of CBO work in considering which services to “buy.” ACOs will likely want to consider “buying” flexible services wherever possible, in accordance with their principles, to leverage these benefits.

CBOs

Flexibility: CBOs should focus on establishing contracts that reflect their specific capacities and require metrics that are feasible and achievable. Attempting to stretch beyond their competencies and capacities could result in execution challenges. In addition, agreeing to metrics that are not achievable will ultimately lead to strained partnerships.

Expectation setting: CBOs will need to attain information on the specific funding amounts they will be provided from ACOs and the outcomes they will be expected to achieve. Without certainty of funding, staffing for the additional capacity needs and delivery of additional services within existing structures will be difficult. CBOs should also identify implementation timelines and appropriate evaluation metrics to share with ACOs.

IT support: CBOs will need to dedicate resources and attain technical assistance for “building” or “buying” compatible data-sharing systems for exchanging referrals and other necessary information with ACOs to ensure that the loop can be closed on referrals.

Coordination team: CBOs will benefit from developing a mechanism and having dedicated staff to regularly share best practices with one another and lead their ACO collaborations. CBOs are unlikely to be successful without dedicated staff for these partnerships.

Infrastructure support: CBOs will need to put time and effort into applying for financial and technical support from MassHealth and the Department of Public Health. Financial, IT and legal (i.e., HIPAA compliance) support will be critical, and CBOs should be planning for how resources can be used to position them to successfully contract with ACOs.

MASSHEALTH

Flexibility: MassHealth should minimize unnecessary documentation requirements to the maximize flexibility of program implementation. Documentation requirements should be limited to those considered essential for effective evaluation of the program. This approach would allow ACOs and CBOs to develop the most effective referral protocols that are tailored to the specific needs of their populations and practices.

Expectation setting: MassHealth should identify clear implementation timelines and appropriate evaluation metrics for both ACOs and CBOs. Early metrics should focus on implementation milestones, intermediate metrics on the use of CBO services and health outcomes, and long-term outcomes on cost and utilization. By setting clear and achievable first-, second- and third-order metrics, MassHealth can support stronger partnerships between ACOs and CBOs while enabling more partnerships with a wider range of CBOs.

Coordination team: MassHealth should develop channels for widely sharing Flexible Services Program guidance and best practices. Currently, there is a lack of information on the program among CBOs, and additional effort should be put into widely sharing and communicating information and guidance. A central repository of all relevant information would be an important part of this strategy. MassHealth should also engage a wide range of CBOs by proactively identifying potentially smaller organizations and inviting them to participate.

Infrastructure support: MassHealth should offer common resources and provide adequate funding for legal, contracting, HIPAA, IT, data and other infrastructure support to CBOs throughout the contracting process. Without these resources, many if not most mid-size to smaller CBOs will be unable and unwilling to contract with ACOs under the Flexible Services Program. MassHealth should also consider providing resources specifically for evaluation purposes to ACOs and CBOs to incentivize them to focus on this aspect of the work.

Flexible Services Program implementation: MassHealth should implement a staggered rollout with potentially multiple specified rounds of contracts over more than one year. This would ensure that smaller CBOs have an opportunity to participate if they would benefit from additional time and infrastructure support before they are ready to contract. This would potentially broaden the range of culturally-competent CBOs with valuable community knowledge that could partner with ACOs. MassHealth should also seek ways to provide Flexible Services Program funding at the household, rather than the individual level, as that is often how resources including food supports function in reality.

APPENDIX 1 – INTERVIEW GUIDE FOR ACOs

Interview Question Guide for ACOs

I. Overall strategy to address Social needs

Please describe what decisions and/or actions have been taken at the ACO to date to address patients' health-related social needs (HRSNs).

1. What is completely new in this work compared to what the ACO member organizations were already doing?
2. *Which departments/divisions within the ACO are charged with leading the design/implementation of the work to address social needs?*

II. Screenings

We have a particular interest in understanding how the ACO is screening patients for social needs. Could you share what domains are currently being screened for and describe that process?

1. If supplemental domains were provided – How and why were these chosen?
 - a. Note: Required by Mass Health – housing, food insecurity, transportation, utility support
2. When did the ACO begin to conduct these screenings?
 - a. If the ACO is not yet conducting social needs screenings, please describe why not.
3. Where do/will these screenings occur?
 - a. For example, will they occur during primary care visits, via Community Partners, multiple/single-entry points, etc.?
 - b. Why were those locations/mechanisms chosen?
4. How is screening data collected and organized?
 - a. How is screening information integrated into EMRs and communicated with other providers in the ACO?
 - b. *Is the ACO using a particular IT platform/software to collect and organize screening results?*
5. How is screening data used?
 - a. How do screening results prompt follow-up/need for referral for patients?

III. Referrals to CBOs

We are also interested in the logistics and tracking/documenting of referrals made to CBOs. Can you please describe the referral process to a CBO for a patient needing services to address social needs?

1. How is the referral created and documented?
 - a. How are referrals recorded in the patient's EMR?
 - b. *What IT platform or software is the ACO planning to use to make referrals and track results?*
2. How does your ACO track the referral?
 - a. Who oversees the referral process and what supports or navigation assistance do patients receive throughout this process?
 1. Supports – warm vs cool referral

- 2. Overseen by: Community Health Worker, Case Manager, Care Coordinator etc.
- b. *If so, how does the ACO determine who receives navigation assistance?*
- 3. How does the ACO determine if the need was addressed by the referral?
 - a. How does the ACO verify if services were received?
 - b. How does the ACO determine if the services were effective? *How is this measured?*
 - c. How are these results recorded in the EMR?

IV. Partnerships with CBOs

In thinking about how to help address patients' health-related social needs, how are you partnering with CBOs?

- How are these partnerships formed?
 - a. How do you identify which CBOs to partner with?
 - b. Which types of CBOs do you currently partner with?
 - i. If you partner with CBOs that work in the areas of housing or experience of violence, could you provide the names of those organizations?
- How do you describe the nature of these relationships or partnerships?
 - a. Ex: Formal contracts, informal referral relationships, funded or unfunded, etc.?
 - b. Since the launch of the ACO program, how have these relationships changed?
- When forming these partnerships, can you describe what is working well and any challenges associated with these partnerships?
- How do you anticipate these relationships evolving in the future?
 - a. Specifically, considering the impact of flexible services funding?
- How much are you building/using internal resources within the ACO vs. partnering with CBOs outside of the ACO?

V. Flexible Services & Resources:

- When flexible services will be implemented in 2020, is the ACO thinking about how relationships with CBOs will differ to meet patients' social needs?
- Is the ACO planning to use non-Flexible Services funding dollars to address the health-related social needs of patients?
 - a. If so, where is the ACO thinking of pursuing such funding?
 - b. How will those resources be used?

Summary: Aside from what was covered today, is there anything else you would like to share regarding how your ACO is working to address your patients' social needs?

APPENDIX 2 – INTERVIEW GUIDE FOR CBOs

Interview Question Guide for CBOs

General

- Please share your name and title and describe your role within your organization.
- What services does your organization provide?
- What is the size of your organization? (number of staff and budget)
- What areas does your organization serve? (regions, neighborhoods)

Connecting with Clients and Health Providers

- How do clients find out about your organization and the services you offer?
- How is your organization interacting with providers, hospitals, and/or ACOs to address social needs?
- Are you aware of the Accountable Care Organization (ACO) program for MassHealth members, and their efforts to screen for and address health-related social needs?

CBO Referral Capacity & Tracking

- Quantity/Capacity
 - Do you track the number or types of referrals that your organization receives?
 - How many referrals does your organization receive in a typical month or year?
 - Do you feel your organization is currently operating at, below or above capacity?
 - Does your organization have the capacity to absorb additional referrals? If so, how much?
- Tracking
 - Is your organization tracking the source of referrals?
 - If so, could you describe the tracking process?
 - If not, what barriers to tracking referrals has your organization encountered?
 - What portion of your referrals are coming from healthcare entities (Ex: Community health centers, private practices, hospitals, ACOs, other)?
 - If available, what is the breakdown of referrals from each entity?
 - Please describe the referrals your organization receives from these various entities.
 - How often are navigators from health care/other organizations actively supporting clients to connect with you (i.e., setting up an appointment, attending an appointment, making a connection to an embedded person in a health care setting,
 - Are you involved in any electronic referral systems?

- Changes in Referral Patterns
 - Have you noticed any changes in referrals since the launch of the ACO program (March 1, 2018)?
 - Ex: Changes in **quantity**, service requested, method?

CBO Partnerships with ACOs

- Does your organization currently have any partnerships with health care provider organizations, such as hospitals or community health centers?
 - If yes, please explain the types of these partnerships. (Formal/informal etc.)
 - How many different provider organizations do you work with?
- Please describe any specific partnerships you have with MassHealth ACOs, and the nature of those partnerships.
 - E.g, funded or unfunded?
 - Formal (e.g. in writing or as a memorandum of understanding, or vendor contracts) or informal (e.g. a verbal agreement or through established practice)?

How have these partnerships changed, if at all, due to the launch of the ACO program on March 1, 2018?

MOVE TO APPROPRIATE SUBSET OF QUESTIONS BELOW

CBOs that *are* currently partnering with ACOs

- Funding
 - Is your CBO receiving funding from the ACO?
 - If so: is this sufficient funding to pay for services from ACO referrals?
 - If not: how is the CBO currently funding services from ACO referrals? (e.g. state grants, federal grants, philanthropy?)
- Data sharing
 - Are you sharing any information or data with ACOs about services provided and the outcomes of those services?
 - If not providing data, what are the barriers to data sharing?
- Partnerships
 - What's working well with your organization's partnerships with ACOs?
 - What makes an ACO an effective partner?
 - What have been the challenges with these partnerships?
 - What changes would you like to see ACOs make to be more effective partners?
 - Is your organization making any changes to improve your existing partnerships with ACOs?
 - Is your organization currently taking any action, or planning to do, in order to secure new partnerships with ACOs?

- What changes would you hope to see from the CBO sector in order to be more effective partners with ACOs?
- What additional resources/capacity does your organization need to partner with ACOs?

CBOs that *are not* currently partnering with ACOs

- Are you interested in partnering with ACOs?
- If so, what barriers are you facing to doing so?
- Does your organization anticipate partnering with ACOs in the future?
 - Why or why not?
 - What changes, if any are being made in your organization to do so?
- What changes would you like to see ACOs make to be more effective partners?
- What additional resources/capacity does your organization need to partner with ACOs?
- What changes would you hope to see from the CBO sector overall in order to be more effective partners with ACOs?

Flexible Services

- Are you aware of the MassHealth ACO Flexible Services program?
- Does your organization hope to receive Flexible Services funding as part of your partnerships with ACOs?
- What kinds of changes do you anticipate needing to make once the Flexible Services program begins?

Overall:

- From the CBO perspective, what do you see as the biggest barrier(s) or has the greatest potential to close the loop between a patient’s need and addressing that need?
 - Ex: Communications, tracking, logistics, partnership, screening, etc.?
- Is there anything else you would like to share about connecting patients with the services they need to address health-related social needs?

Summary: Aside from what was covered today, is there anything else you would like to share regarding how your ACO is working to address your patients’ social needs?

APPENDIX 3 – CODEBOOK FOR ACO INTERVIEWS

Name	Description	Files	References
1_Overarching Themes		0	0
1_Value	Perceived value/need of addressing SDOH, of screenings, referral systems, partnerships etc. How do ACOs feel about the importance of these processes? For ex: Do they feel like this is unnecessary/extra OR integral to patient health?	8	42
2_Facilitators (Best Practices)	What are structures/systems etc that facilitate ACOs to meet HRSN of patients?	8	36
3_Barriers	To Address HRSN	9	134
4_Impact of ACO Launch	Addressing HRSN and partnerships with CBOs before ACO launch	9	46
5_Geographic Reach		9	39
6_Spillover Effect	How Medicaid programming in SDOH/HRSN is affecting other patients/patients with other payers	5	9
7_Closing the Loop	Is the ACO tracking if needs are addressed?	7	50
ACO Structure & Personnel	About the ACO, and key roles involved in HRSN (community health workers, nursing, etc)	4	48
2_Screening		2	6
1_Domains	Which HRSN domains are being screened	9	34
2_Population Screened	Who is being screened? Is it just ACO members or everybody? All affiliated providers?	9	44
3_Screening Processes (who, where, when)	iPad, paper, PCP, Specialist, Phone etc	9	119
4_Screening documentation		8	40
5_How is screening data used		8	50
3_Referrals		5	15
1_Cold Referrals		7	40
2_Warm Referrals	Community Health Worker, Community	8	64

Name	Description	Files	References
	Resource Specialist, Case Worker etc		
3_Third party referral software	Aunt Bertha, Healthify	7	48
4_Referral documentation and tracking		8	49
4_Partnerships		4	11
1_Existing partnerships		8	55
2_Formal vs. Informal		8	51
3_Evolving partnerships	How are partnerships changing or expected to change between ACOs and CBOs	8	50
4_Buy vs. Build		7	35
5_Funding Streams		1	1
1_Flex Services		9	75
2_Other Funding Streams	Philanthropy, Grants	8	34
6_Data		1	1
1_Role of IT and Data Storage	Level of EMR integration, challenges, communication, HIPAA compliance	9	54
2_Population Level Data Analysis		8	31
7_Misc		9	89
99	Especially notable quotes	8	51

APPENDIX 4 – CODEBOOK FOR CBO INTERVIEWS

Name	Description	Files	References
1_Organization Background		7	60
2_Referrals		0	0
1_Existing Referral Structure		7	42
2_CBO Referral Concerns		7	36
3_Pre- vs Post-ACO Patterns	Changes in referrals after ACO launch	6	8
4_Tracking Provenance	CBO ability to detect referral origin	7	13
5_CBO Recommendations		7	29
3_Partnerships		0	0
1_Existing Healthcare Partnerships		7	38
2_Existing Other Partnerships		6	14
3_Insights on Existing Teamwork Challenges	Known or expected collaboration challenges based on CBO experiences with existing partnerships	6	56
4_Strategies for Evolving Partnerships	CBO recommendations for successful ACO-CBO partnerships	7	46
4_CBO Resource Constraints		7	42
5_Funding for CBOs		0	0
1_Flex Services		7	21
2_Other Funding Sources		5	26
3_Funding Uncertainty		7	20
6_Data		0	0
1_Data Collection and Sharing		7	44
2_Data Privacy and Security		6	10
3_Data Technology Platforms		7	35
7_Evaluation Logistics		2	5
99_Quotes		7	85

