

MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

ACO Report:

Wellforce in partnership with Fallon Community Health
Plan

(FLN Wellforce)

Report prepared by The Public Consulting Group: December 2020



PUBLIC
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DSRIP Midpoint Assessment Highlights & Key Findings

Wellforce in partnership with Fallon Community Health Plan
(FLN Wellforce)

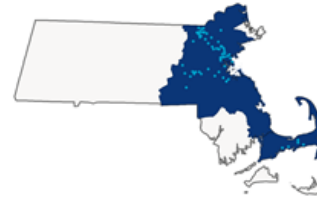


Model A ACO

FLN Wellforce is a MassHealth Accountable Care Partnership Plan (ACPP), a “Model A” ACO, and is also known as Wellforce Care Plan.

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

SERVICE AREA



DSRIP ATTRIBUTION AND FUNDING

2017 (Jul to Dec)	54K members	\$6.6M
2018	54K members	\$10.5M
2019	53K members	\$9.4M

POPULATIONS SERVED

- ▶ FLN Wellforce’s service area varies widely in terms of age, race, ethnicity, language, and prevalent health conditions.
- ▶ Unique characteristics of the population include the members served by Lowell Community Health Center, in which one out of four are foreign-born.
- ▶ Challenges include facilitating access to behavioral health services for pediatric members and supporting communities that are disproportionately impacted by the opioid epidemic.

FOCUS AREA

- Organizational Structure and Engagement
- Integration of Systems and Processes
- Workforce Development
- Health Information Technology and Exchange
- Care Coordination and Care Management
- Population Health Management

IA FINDINGS

- *On Track*
- *Limited Recommendations*
- *On Track*
- *Limited Recommendations*
- *On Track*
- *Limited Recommendations*
- *Opportunity to Improve with Recommendations*
- *Opportunity to Improve with Recommendations*

IMPLEMENTATION HIGHLIGHTS

- ACO leadership, together with Wellforce practice sites, monitor performance through regular reporting and scorecards across financial, clinical and quality domains and coordinates with sites on progress through regular meetings involving senior medical directors.
- Wellforce uses a safety-net monitoring program to identify members who are appropriate for enrollment with a Community Partner but not yet assigned. The Wellforce Care Management program leadership maintains rosters of eligible members and collaborates with CPs to ensure warm handoffs.
- The ACO is working to reduce emergency department (ED) visits through deploying nurse utilization managers at the major hospitals within the FLN Wellforce system to direct especially high utilizers to primary care when appropriate.

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

LIST OF SOURCES FOR INFOGRAPHIC

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

NOTES

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

INTRODUCTION

Centers for Medicare and Medicaid Services' (CMS') requirements for the MassHealth Section 1115 Demonstration specify that an independent assessment of progress of the Delivery System Reform Incentive Payment (DSRIP) Program must be conducted at the Demonstration midpoint. In satisfaction of this requirement, MassHealth has contracted with the Public Consulting Group to serve as the Independent Assessor (IA) and conduct the Midpoint Assessment (MPA). The IA used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations¹ (ACOs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019.

Progress was defined by the ACO actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator² (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (<https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download>).

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

¹ For the purpose of this report, the term ACO refers to all ACO health plan options: Accountable Care Partnership Plans, Primary Care ACO plans, and the Managed Care Administered ACO plan. See the ACO Background section for a description of the ACO's organizational structure.

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

The focus area framework was used to assess each entity's progress. A rating of "On track" indicates that the ACO has made appropriate progress in accomplishing the indicators for the focus area. Where gaps in progress were identified, the entity was rated "On track with limited recommendations" or, in the case of more substantial gaps, "Opportunity for improvement." See Methodology section for an explanation of the threshold setting process for the ratings.

Table 1. Framework for Organizational Assessment of ACOs

Focus Area	ACO Actions
Organizational Structure and Governance	<ul style="list-style-type: none"> • ACOs established with specific governance, scope, scale, & leadership • ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)
Integration of Systems and Processes	<ul style="list-style-type: none"> • ACOs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • ACOs establish structures and processes for joint management of performance and quality, and conflict resolution • Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the Demonstration
Workforce Development	<ul style="list-style-type: none"> • ACOs recruit, train, and/or re-train administrative and provider staff by leveraging Statewide Investments (SWIs) and other supports; education includes better understanding and utilization of behavioral health (BH) and long-term services and supports (LTSS)
Health Information Technology and Exchange	<ul style="list-style-type: none"> • ACOs develop Health Information Technology and Exchange (HIT/HIE) infrastructure and interoperability to support provision of population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. Community Partners/Community Service Agencies (CPs/CSAs), BH, LTSS, and specialty providers)
Care Coordination and Care Management	<ul style="list-style-type: none"> • ACOs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))
Population Health Management	<ul style="list-style-type: none"> • ACOs develop capabilities and strategies for non-CP-related population health management approaches, which include risk stratification, needs screenings and assessments, and addressing the identified needs in the population via range of programs (e.g., disease management programs for chronic conditions, specific programs for co-occurring mental health (MH)/substance use disorder (SUD) conditions) • ACOs develop structures and processes for integration of health-related social needs (HRSN) into their Population Health Management (PHM) strategy, including management of flexible services • ACOs develop strategies to reduce total cost of care (TCOC; e.g. utilization management, referral management, non-CP complex care management programs, administrative cost reduction)

METHODOLOGY

The IA employed a qualitative approach to assess ACO progress towards DSRIP goals, drawing on a variety of data sources to assess organizational performance in each focus area. The IA performed a desk review of participants' submitted reports and of MassHealth supplementary data, covering the period of July 1, 2017 through December 31, 2019. These included Full Participation Plans, annual and semi-annual reports, budgets and budget narratives. In addition, the IA developed an ACO Practice Site Administrator survey ("the survey") to investigate the activities and perceptions of provider practices participating in ACOs. For ACOs with at least 30 practice sites, a random sample of 30 sites was drawn; for smaller ACOs, all sites were surveyed. Survey results were aggregated by ACO for the purpose of assessing each ACO. A supplementary source was the transcripts of KII of ACO leaders conducted jointly by the IA and the IE.

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

Guided by the focus areas, the IA performed a preliminary review of Full Participation Plans and annual and semi-annual reports. This horizontal review identified a broad range of activities and capabilities that fell within the focus areas, yielding specific operational examples of how ACOs can accomplish the logic model actions for each focus area. Once an inclusive list of specific items was compiled, the IA considered the prevalence of each item and its relevance to the focus area. A descriptive definition of On track performance for each focus area was developed from the items that had been adopted by a plurality of entities. Items that had been accomplished by only a small number of ACOs were considered to be promising practices, not expectations at midpoint. This calibrated the threshold for expected progress to the actual performance of the ACO cohort as a whole.

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

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

ACO BACKGROUND³

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

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

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

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

Wellforce Care Plan is made up of physicians and other health care providers from, or affiliated with, the following:

- Circle Health
- Floating Hospital for Children
- Hallmark Health
- Lowell Community Health Center
- Lowell General Hospital
- Lowell General Physician Hospital Organization
- New England Quality Care Alliance (NEQCA)
- Tufts Medical Center

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

Table 2. FLN Wellforce MassHealth Members and DSRIP Funding 2017-2019⁵

Year	Members	DSRIP Funding
2017 (partial year, Jul-Dec)	53,637	\$6,563,761
2018	53,637	\$10,510,453
2019	52,967	\$9,383,095

FLN Wellforce's service area varies widely in terms of age, race, ethnic and language diversity as well as other salient characteristics such as household incomes and prevalent health conditions.

Specific challenges that the ACO faces in serving this population include engaging persons experiencing homelessness, facilitating access to behavioral health services for pediatric members, and supporting the several communities in the area that are disproportionately impacted by the opioid overdose epidemic.

SUMMARY OF FINDINGS

The IA finds that FLN Wellforce is On track with limited recommendations in four of six focus areas. FLN Wellforce has an Opportunity to improve with recommendations in two focus areas.

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

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

FOCUS AREA LEVEL PROGRESS

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of ACOs considered On track:

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

Results

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

Established governance structures

FLN Wellforce established appropriate governance structures. The ACO's governance structure is clear and appears to operate efficiently, The Joint Operating Committee (JOC) ensures bilateral decision making between Fallon Health and Wellforce Care Plan with membership on the JOC evenly split between the two organizations.

The Board of Managers (BoM) works alongside the JOC and is responsible for oversight of the ACO. The Board is comprised of physician group representatives, community health center representatives,

and a consumer advocate; the Board also includes physicians from Lowell General Hospital, Lowell Community Health Center, New England Quality Care Alliance and Tufts Medical Center.

FLN Wellforce's Quality Committee oversees the ACO's quality improvement and performance analytics operations. The Finance/Funds Flow Committee tracks DSRIP spending and strategic programmatic updates. The Implementation Committee oversees five separate work groups, comprised of ACO front-line staff capable of providing direct experience with value-based payment (VBP) initiatives to the committee and ultimately to the JOC and BoM.

Provider engagement in delivery system change

Providers participate in quality and performance management through representation on the JOC, BoM, Quality Committee, and Implementation Committee. FLN Wellforce ACO medical directors regularly engage frontline staff to discuss and review key performance indicators and utilization data to inform provider performance tracking. The medical director's team additionally provides provider-facing education opportunities to assist in better understanding and optimizing Model A contract requirements.

Recommendations

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

- clearly defining PFAC (Patient and Family Advisory Committee) membership structure and ensure regular meetings occur between the PFAC and JOC or BoM.

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

✓ Established governance structures

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

✓ Provider engagement in delivery system change

- protecting dedicated provider time for population health level activities or individual quality improvement projects.
- engaging frontline providers in continuous feedback loops to identify areas where patient experience could be improved.
- hosting regular meetings between providers or provider groups and senior management to collect provider feedback on care management operations and quality improvement initiatives.

- developing provider-accessible performance dashboards with practice-site level data.
- employing individuals in roles dedicated to QI, who assist providers and practice sites to review quality measures and identify pathways to improve care processes and provider performance.

2. INTEGRATION OF SYSTEMS AND PROCESSES

On Track Description

Characteristics of ACOs considered On track:

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

Results

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

Administrative coordination among ACO member organizations and with CPs

FLN Wellforce employs a Lowell Community Programs RN Program Manager to serve as the primary point of contact between FLN Wellforce and CPs and oversee care coordination and care management (CCCM) services at practice sites through regular meetings with CP leaders. Staff from the ACO and CPs use these regular coordination meetings to cover topics such as care management program eligibility and member engagement, improving provider integration, and quality improvement.

Clinical integration among ACO member organizations and with CPs

FLN Wellforce hospital practice sites each rely on a utilization nurse to assist in ED discharge planning, inpatient/observation discharge planning, and coordinating follow-up services with all necessary providers including CPs following an encounter or admission. Beyond this, FLN Wellforce also reports using DSRIP funding to hire a consultant specifically focused on care integration and communication efforts specifically with CPs. FLN Wellforce also uses a safety-net monitoring program to identify eligible members not currently assigned to LTSS or BH CPs for engagement. The ACO's Director of Care Management ensures warm handoffs to appropriate CPs through the maintenance of a roster of all eligible members.

Joint management of performance and quality

ACO leadership, together with FLN Wellforce practice sites, monitor performance through regular reporting and scorecards on financial, clinical and quality domains. The ACO's data and analytics team shares results with sites through regular meetings as well as through the ACO's medical director meeting on a monthly basis. It is not clear if FLN Wellforce works with CPs using a similar structure.

Individual PCPs are then held accountable financially for performance across several categories including: ED diversion, Post-ED follow-up, Transition of Care initiatives (such as appropriate home health usage, post-acute PCP visits, medication reconciliation), referral management, adherence to appropriate site of service for patient needs (PCP office vs urgent care vs ED), and free standing labs vs hospital lab use. While individual providers are held accountable for the efficiency metrics, FLN Wellforce holds practice sites accountable for quality metrics.

ACO/MCO coordination (at Accountable Care Partnership Plans)

FLN performs care management functions and FLN performs lower-level care management and care management for specific conditions such as cancer. FLN also handles back-office functions such as materials fulfillment and call center duties. FLN and Wellforce are able to electronically share member contact information, comprehensive assessments, and care plans.

Recommendations

The IA encourages FLN Wellforce to review its practices in the following aspects of the Integration of Systems and Processes focus area, for which the IA did not identify sufficient documentation to assess progress:

- conducting regular performance and quality meetings with high-volume CPs; and
- considering approaching CP collaboration using a similar framework, as that of ACO providers and practice sites; conduct regular performance data collection and reporting along with performance meetings to formalize a systematic structure for CP partnership and oversight.

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

- ✓ **Administrative coordination among ACO member organizations and with CPs**
 - establishing weekly meetings to discuss newly engaged members.
 - establishing monthly meetings with practice sites and CPs to discuss member care plans.
 - creating a case review process including care coordination, service gaps and service duplication.
 - sharing member risk stratification reports including results of predictive modeling.
- ✓ **Clinical Integration among ACO member organizations and with CPs**
 - designating a practice site champion responsible for integrating Care Coordination and Care Management (CCCM) and clinical care plans.
 - embedding CCCM staff at practice sites to participate in shared model for care management.
 - providing resiliency training to CCCM staff to improve team cohesion and offer emotional support.
 - developing a centralized care management office to support member care teams in conducting needs assessment, follow-up, disease management and transitions of care.
 - following members for at least 30 days post-discharge from the hospital.
 - providing laptops or other devices that enable EHR access by off-site providers during visits with members.
 - holding monthly meetings of CCCM teams to share best practices, develop solutions to recent challenges and provide collegial support.
- ✓ **Joint management of performance and quality**
 - developing practice site specific quality scorecards and reviewing them at monthly or quarterly meetings.
 - having the Joint Operating Committee (JOC) review scorecards of clinical, quality, and financial measures.
 - sharing individual performance reports containing benchmarks or practice wide comparisons with providers.
- ✓ **ACO/MCO coordination (at Accountable Care Partnership Plans)**
 - reviewing performance and quality outcomes at regular governance meetings.
 - developing coordinated goals related to operations, budget decisions and clinical quality outcomes

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Recruitment and retention**
 - successfully hired staff for care coordination and population health, leaving no persistent vacancies;
 - uses a variety of mechanisms to attract and retain a diverse team, such as opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness and leadership training.
- ✓ **Training**
 - offers training to staff, including role-specific topics such as integrating primary care, behavioral health, health-related social needs screening and management, motivational interviewing, and trauma-informed care;
 - has established policies and procedures to ensure that staff meet the contractual training requirements, and holds ongoing, regularly scheduled, training to ensure that staff are kept up to date on best practices and advances in the field as well as refreshing their existing knowledge.
- ✓ **Teams and staff roles designed to support person-centered care delivery and population health**
 - hires nonclinical staff such as CHWs, navigators, and recovery peers, and deploy them as part of interdisciplinary care delivery teams including CCCM staff, medical providers, social workers and BH clinicians;
 - deploys clinical staff in population health roles and nontraditional settings and trains a variety of staff to provide services in homes or other nonclinical settings.

Results

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

Recruitment and retention

FLN Wellforce has designed a multi-faceted recruitment process focused on mutual selection. The ACO's recruitment, retention and training strategies have prevented any persistent staff vacancies, enabled the professional growth of their staff, and increased staff capacity to provide quality care.

FLN Wellforce identified candidates through targeted outreach efforts at professional and trade schools, attending job fairs, and use of various online and university jobs boards. Internal networks were also used to advertise positions, and employees were offered a referral bonus to help expedite the recruitment process. Additionally, Wellforce developed a defined internal career ladder for nurses and other medical assistants to assist in adding transparency around organizational career progression.

Training

All staff attend monthly training and skill-building meetings across a variety of topics including care management, technical capabilities, and care coordination. In addition to ACO-wide onboarding training, staff are also encouraged to complete more site-specific training upon hire. These trainings include topics in harm reduction tactics, tools for engaging patients, relationship-building with community agencies and social services, and HIT training in FLN Wellforce EHRs and care management platforms.

FLN Wellforce also developed a “Comprehensive Outreach Education Certification” program for all community health workers (CHW), a tuition reimbursement of up to \$2,500 for master’s level classes at approved institutions and bi-annual Medical Interpreter Training programs.

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

FLN Wellforce operationalizes person-centered care through the inclusion of CHWs, Behavioral Health Clinicians, and social workers in clinical settings. Clinical staff also actively serve as population health and quality officers throughout the ACO. FLN Wellforce established interdisciplinary teams including CCCM staff, medical providers, behavioral health specialists, and social workers; in accordance with MassHealth guidance.

Recommendations

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

- using a variety of mechanisms to attract and retain a diverse team, such as opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness and leadership training.

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

✓ Promoting diversity in the workplace

- compensating staff with bilingual capabilities at a higher rate.
- establishing a Diversity and Inclusion Committee to assist HR with recruiting diverse candidates.
- advertising in publications tailored to non-English speaking populations.
- attending minority focused career fairs.
- recruiting from diversity-driven college career organizations.
- tracking the demographic, cultural, and epidemiological profile of the service population to inform hiring objectives.
- implementing an employee referral incentive program to leverage existing bilingual and POC CP staff’s professional networks for recruiting.
- advertising positions with local professional and civic associations such as the National Association of Social Work, Spanish Nurses Association, Health Care Administrators, National Association of Puerto Rican and the Hispanic Social Workers.

- recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.
- ✓ **Recruitment and retention**
 - contracting with a local social services agency capable of providing the ACO with short term CHWs, enabling the ACO to rapidly increase staff on an as-needed basis.
 - onboarding cohorts of new CCCM staff with common start dates, enabling shared learning.
 - implementing mentorship programs that pair newly onboarded staff with senior members to expedite training, especially amongst CCCM teams with complex labor divisions.
 - providing opportunities for a staff voice in governance through regularly scheduled leadership town halls at individual practice sites.
 - recruiting staff from professional associations, such as the Case Management Society of America, and from targeted colleges and universities.
 - offering staff tuition reimbursement for advanced degrees and programs.
 - using employee referral bonuses to boost recruitment.
- ✓ **Training**
 - offering staff reimbursement for training from third party vendors.
 - tracking staff engagement with training modules and proactively identifying staff who have not completed required trainings.
 - providing additional training opportunities through on-line training programs from third party vendors.
 - offering Medical Interpreter Training to eligible staff.
 - sponsoring staff visits to out of state health systems to learn best practices and bring these back to the team through peer-to-peer trainings.
- ✓ **Teams and staff roles designed to support person-centered care delivery and population health**
 - protecting provider time for pre-visit planning.
 - pairing RN care managers or social workers with CHWs to provide care coordination.
 - including pharmacists/pharmacy technicians and dieticians on care teams.
 - developing trainings and protocols for staff providing home visits.
 - developing trainings and protocols for staff using telemedicine.
 - leveraging CHWs who specialize in overcoming barriers to engagement, including issues of distrust of the medical community, to build relationships with hard-to-engage members.

4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Infrastructure for care coordination and population health**
 - uses an EHR to aggregate and share information among providers across the ACO
 - has a care management platform in place to facilitate collaborative patient care across disciplines and providers;
 - uses a population health platform that integrates claims, administrative, and clinical data, generates registries by condition or risk factors, predictive models, utilization patterns, and financial metrics, and identifies members eligible for programs or in need of additional care coordination.
- ✓ **Systems for collaboration across organizations**
 - has taken steps to improve the interoperability of their EHR;
 - shares real-time data including event notifications, and uses dashboards to share real time program eligibility and performance data;
 - creates processes to enable two-way exchange of member information with CPs and develops workarounds to solve interoperability challenges.

Results

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

Infrastructure for care coordination and population health

FLN Wellforce prioritized investments in EHR infrastructure and in training clinical care staff in EHR use.

Although FLN Wellforce's provider sites use a variety of EHR platforms, data from various platforms is integrated into a single data warehouse from which provider-specific reports are generated monthly. Additionally, care management teams have portal access to a performance data dashboard. The variety of EHR platforms across provider sites does not appear to hinder Wellforce's ability to generate, collect or access essential data from across the ACO.

FLN Wellforce uses a third-party Event Notification System (ENS) to collect real-time data on patients. FLN Wellforce is also developing a behavioral health ENS. Wellforce reports being able to mostly incorporate ADT Feeds/Real-Time Event Notification into population health analytics or related technologies and some ACO PCP sites have access to ADT feeds/real-time event notification. FLN Wellforce also uses ADT feeds, secure faxes, Mass Hlway, and secure emails to disseminate event notifications to PCPs

Systems for collaboration across organizations

Recognizing gaps in information available to providers, FLN Wellforce is also developing a data warehouse to further connect providers to patient records. FLN Wellforce's system will integrate clinical, claims, and ENS data giving providers additional patient and population information. FLN

Wellforce plans to use this HIE and data warehouse to develop and maintain registries of patients by risk factors, utilization levels, and health conditions.

Processes for data sharing with Community Programs are less explicitly defined by FLN Wellforce. FLN Wellforce was working to develop consistent and repeatable processes for two-way information sharing across all their CP partners at the inception of the Demonstration Project.

Recommendations

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

- using a population health platform that integrates claims, administrative, and clinical data, generates registries by condition or risk factors, predictive models, utilization patterns, and financial metrics, and identifies members eligible for programs or in need of additional care coordination; and
- creating processes to enable two-way exchange of member information with CPs and develops workarounds to solve interoperability challenges.

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

- ✓ **Infrastructure for care coordination and population health**
 - leveraging EHR integrated care management and population health platforms.
 - automating risk stratification to identify high-risk, high-need members.
 - developing HIT training for all providers as part of an on-boarding plan.
 - incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress.
 - conducting ongoing review and evaluation of risk stratification algorithms to improve algorithms and refine the ACO's approach to identifying members at risk who could benefit from PHM programs.
- ✓ **Systems for collaboration across organizations**
 - establishing EHR portals that allow members to engage with their chart and their care teams.
 - providing EHR access through a web portal for affiliated providers, CPs or other entities whose EHR platforms are not integrated with the ACOs EHR.
 - developing methods to aggregate data from practice sites across the ACO; particularly if sites use different EHRs.
 - pushing ADT feeds to care managers in real time to mitigate avoidable ED visits and/or admissions.
 - developing continuously refreshing dashboards to share real-time program eligibility and performance data.

5. CARE COORDINATION AND CARE MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Full continuum collaboration**
 - collaborates with state agencies such as DMH;
 - has established processes for identifying members eligible for BH or LTSS services and collaborating with CPs, including exchanging member information, and collaborating for care coordination when CP has primary care management responsibility;
 - designates a point of contact for CPs to facilitate communication;
 - incorporates social workers into care management teams and integrates BH services, including Office-Based Addiction Treatment (OBAT), into primary care.
- ✓ **Member outreach and engagement**
 - uses both IT solutions and manual outreach to improve accuracy of member contact information;
 - uses a variety of methods to contact assigned members who cannot be reached telephonically by going to members' homes or to community locations where they might locate the individual (e.g. a congregate meal site);
 - addresses language barriers through steps such as translating member-facing materials, providing translators for appointments, and recruiting CCCM staff who speak members' languages;
 - supports members who lack reliable transportation by providing rides or vouchers⁶, and/or providing services in homes or other convenient community settings;
- ✓ **Connection with navigation and care management services**
 - locates CCCM staff in or near EDs;
 - enables staff to build 1:1 relationships with high-need members, and uses telemedicine, secure messaging, and regular telephone calls for ongoing follow up with members;
 - provides members with 24/7 access to health education and nurse coaching, through a hotline or live chat;
 - implements best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;
 - implements processes to direct members to the most appropriate care setting, including processes to re-direct members to primary care to reduce avoidable emergency department visits;
- ✓ **Referrals and follow up**
 - standardizes processes for referrals for BH, LTSS, and health related social needs (HRSN), and ability to systematically track referrals, enabling PCPs and care

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

coordinators to confirm that a member received a service, incorporate results into the EHR and care plan;

- conducts regular case conferences to coordinate services when a member has been referred.

Results

The IA finds that FLN Wellforce has an **Opportunity to improve with recommendations** in the Care Coordination and Care Management focus area.

Full continuum collaboration

FLN Wellforce has developed its care management teams to prioritize integrating CCCM programs with CPs to ensure efficient coordination. Survey results also indicate that practice sites view CP relationships favorably.⁷ FLN Wellforce drives care coordination through strategic relationships with CPs via nurse program managers and a Clinical Program Director focused on enhancing CP collaboration. The program managers act as liaisons between the CCCM team and the CP to ensure warm handoffs occur systematically.

FLN Wellforce deploys CHWs, Behavioral Health clinicians, and social workers in clinical settings. Additionally, each ACO practice site has nurse care managers who focus on coordinating PCPs, and facilitating care information between providers, program managers, BH providers, and acute and subacute care providers.

Member outreach and engagement

FLN Wellforce approaches member engagement via three primary means: providing important member information through educational sessions and CHW outreach, embedding CCCM personnel in EDs to engage at risk patients and ensuring culturally appropriate access capacities are available across practice sites. This approach appears to be enabled through a care management platform capable of capturing up-to-date patient preferences and contact information.

FLN Wellforce offers member health education through disease management workshops for members with chronic conditions such as asthma and diabetes. These educational sessions are also offered telephonically. The RN Care Managers and Community Health Workers (CHWs) also provide individualized patient education and informational resources to members.

CCCM staff are embedded in FLN Wellforce EDs and primary care clinics to enroll eligible members into specialized care management and outreach programs. CHWs also conduct outreach to patients via in-person community visits to shelters, tent encampments, and community centers.

FLN Wellforce focuses on providing linguistically appropriate materials by employing video interpretation services, hiring onsite interpreters, providing bi-annual medical interpretation training to selected bi-lingual staff. It also uses outreach marketing materials in multiple languages and developed medical translation training bi-annually for all interested staff to ensure members can receive care in their preferred language.

FLN Wellforce ensures that member contact information can be updated via their Care Management platform, exchanges information with CPs when possible, and also documents a member's preferred contact method in their EHR systems.

⁷ As Question 33 from the ACO Practice Site Administrator Survey indicates, 54% of FLN Wellforce practices indicated that the existence of CPs beneficially impacted their ability to provide high quality care for their MassHealth members, compared to 44% statewide.

Connection with navigation and care management services

FLN Wellforce has increased their capacity for care management through focusing on formalizing processes of warm handoffs, reducing ED visits of high utilizers and providing 24/7 patient access to nurses.

FLN Wellforce appears to have formalized policies around warm handoffs. Following care, CCCM staff emphasize assisting patients in accessing social services. CHWs navigate patients to community resources such as housing, transportation⁸, nutrition, and legal assistance when needed.

FLN Wellforce is also working to reduce ED visits through deploying nurse utilization managers at the major hospitals within the FLN Wellforce system to direct especially high utilizers to primary care when appropriate. This initiative is centered on improving communication with members regarding where they can access urgent, but non-emergent care.

Patients are also provided 24/7 access to health education and nurse coaching via a third-party nurse hotline, ensuring timely access to patient services.

Referrals and follow up

FLN Wellforce appears to track and manage referrals primarily through its Quality Management Committee which develops monthly reports and shares them with appropriate providers. Although a detailed referral management process was not reviewed by the IA, the ACO Site Administrator survey indicates that certain service lines have access to and actively adhere to formalized referral management practices⁹.

The FLN Wellforce CCCM program attempts to schedule follow-up care in coordination with PCPs through pre-discharge patient assessments considering all post-discharge needs from rehabilitation services, including transportation needs, home care needs, and any CP-related services. While it appears that FLN Wellforce has strong practices in post-discharge follow-up, no direct evidence indicates that the ACO is using its EHR systems to track referrals. Additionally, no evidence definitively supports that case conferences occur with regularity in the patient follow-up process.

Recommendations

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

- clarifying the process through which a CP is declared responsible for primary care management and ensuring that this process is clearly indicated in the ACO's EHR systems;
- collaborating with state agencies such as DMH and creating a directory/resource map used by CCCM staff;
- incorporating social workers into care management teams and integrating BH services, including OBAT, into primary care;

⁸ ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

⁹ When looking at Ophthalmology referral management, 84% of practice sites indicated that they either agree or strongly agree that providers and/or staff follow a clear, established process arranging eye care from an ophthalmologist or optometrist. 76% of practice sites indicated that they either agree or strongly agree that providers and/or staff follow a clear, established process confirming that a diabetic eye exam was performed.

- supporting members who lack reliable transportation by providing rides or vouchers¹⁰, and/or providing services in homes or other convenient community settings;
- using Peer Support and/or CHW throughout the provision of ACO supports and activities;
- training staff in techniques for engagement such as motivational interviewing;
- enabling staff to build 1:1 relationships with high-need members, and using secure messaging, and regular telephone calls for ongoing follow up with members;
- implementing best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;
- standardizing processes for referrals for BH, LTSS, and health related social needs (HRSN) services and systematically tracking referrals, enabling PCPs and care coordinators to confirm that a member received a service, incorporate results into the EHR and care plan; and
- conducting regular case conferences to coordinate services when a member has been referred.

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

✓ **Full continuum collaboration**

- establishing a systematic documentation process to track members receiving care coordination from CPs.
- matching members based on their needs to interdisciplinary care coordination teams that include representatives from primary care, nursing, social work, pharmacy, community health workers and behavioral health.
- expanding BH integration through multiple strategies, including embedding staff in primary care sites, reverse integration of physical health care at BH sites, and telehealth.
- increasing two-way sharing of information between ACOs and CPs.
- leveraging EHR-integrated tools to flag members requiring a higher level of care coordination.
- coordinating with government agencies and community organizations to enhance care coordination and avoid duplication for members receiving other services.
- supporting families of pediatric members by offering to have care managers work with school-based personnel to address health or disability related needs identified in the Individualized Education Program.

✓ **Member outreach and engagement**

- developing a high-intensity program for extremely high-need, high-risk members with strategically low case load.
- establishing trust between members and CCCM staff by building and maintaining a 1:1 consistent relationship.

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

- creating a mobile phone lending program for hard-to-reach members, particularly those experiencing housing instability.¹¹
 - embedding CCCM staff in EDs.
 - creating a “Navigation Center” to manage referrals outside the ACO, handle appointment scheduling, and coordinate testing, follow-up, and documentation transfers.
 - developing an assistance fund to support transportation vouchers¹² and low-cost cell phones.¹³
- ✓ **Connection with navigation and care management services**
- utilizing EHR-based documentation transfer during warm handoffs.
 - establishing daily or weekly care management huddles that connect PCPs and CCCM teams and streamline care transitions.
- ✓ **Referrals and follow up**
- utilizing EHR messaging tools to better describe the purpose of specialty consults and a plan for follow-up communication.
 - automating referral tracking and management, using flags to prompt referrals, linked directories to suggest appropriate providers and services, notifications to care managers when referral results are available, and databases allowing care teams to easily identify follow-up needs.

6. POPULATION HEALTH MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Integration of health-related social needs**
- standardizes screening for health-related social needs (HRSN) that includes housing, food, and transportation;
 - incorporates HRSN with other factors to target members for more intensive services;
 - Builds mature partnerships with community-based organizations to whom they can refer members for services
 - has a plan approved for provision of flexible services;
- ✓ **Population health analysis**
- articulates a coherent strategy for stratifying members to service intensity and use of a population health analysis platform to combine varied data sources, develop registries of high-risk members, and stratify members at the ACO level.
 - integrates cost data into reports given regularly to providers to facilitate cost-of-care management.

¹¹ ACOs should first utilize Lifeline program for members as appropriate

¹² ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

¹³ ACOs should first utilize Lifeline program for members as appropriate.

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

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

Results

The IA finds that FLN Wellforce has an **Opportunity to improve with recommendations** in the Population Health Management focus area.

Integration of health-related social needs

FLN Wellforce CCCM teams conduct HRSN screenings that cover housing, nutrition, and transportation. FLN Wellforce also screens for transportation and other needs as part of post-discharge assessment and CHWs assist patients in obtaining these services.

FLN Wellforce has a plan approved for provision of flexible services.

Population health analysis

FLN Wellforce utilizes a third-party population health tool for risk stratification and modeling. The software generates patient registries based on FLN Wellforce claims data. The program focuses specifically on reducing inpatient utilization and ED visits by the top 5% of FLN Wellforce's highest resource utilizing patients. FLN Wellforce EHR systems also tracks patient risk stratification information, making it readily available to CCCM staff. Additionally, FLN Wellforce uses clinical data and HRSN screenings to generate a registry of members appropriate for more intensive care coordination.

FLN Wellforce reports using TCOC performance accountability goals, based on TCOC analysis. Additionally, FLN Wellforce reports that providers are given access to TCOC data via budgeting software.

Program development informed by population health analysis

FLN Wellforce provides several chronic condition management programs for diabetes management, cancer patient navigation, and other various disease diagnoses. These programs focus on disease education in face to face meetings, connecting members to additional care and re-directing patients from inpatient admissions when appropriate.

In order to expand access, FLN Wellforce has also increased telemedicine capacities. Specifically, the ACO uses telemedicine to target high risk members or patients with two or more chronic conditions to increase capacity for follow-ups.

FLN Wellforce has also described its plans to develop additional programs based on findings from population health analytics and its risk stratification registries. FLN Wellforce plans to share rosters of high-risk patients who have proven difficult to engage, with CHWs and CPs to identify best practices in engaging these members. FLN Wellforce also reports developing a program for SUD management specifically targeted at members with high utilization.

Recommendations

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

- documenting responses to HRSN screening assessments in the EHR;
- using HRSN screening assessment responses stratify members by risk or increase access to care;
- building mature partnerships with community-based organizations to whom they can refer members for services;
- offering PHM programs that target members by BH needs (including non-CP eligible), HRSNs, and care transitions;
- actively disseminating cost data to providers to facilitate cost-of-care management; and
- offering interactive wellness programs such as smoking cessation, diet/weight management.

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

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

- implementing universal HRSN screening in all primary care sites and behavioral health outpatient sites.
- using screening tools designed to identify members with high BH and LTSS needs.
- using root-cause analysis to identify underlying HRSNs or unmet BH needs that may be driving frequent ED utilization or readmissions.
- partnering with local fresh produce vendors, mobile grocery markets, and food banks to provide members with access to healthy meals.
- providing a meal delivery service, including medically tailored meals, for members who are not able to shop for or prepare meals.
- organizing a cross-functional committee to understand and address the impact of homelessness on members' health care needs and utilization.
- enabling members and CCCM field staff to document HRSN screenings in the EHR using tablet devices with a secure web-based electronic platform.
- automating referrals to community agencies in the EHR/care management platform.

✓ **Population health analysis**

- developing and utilizing condition-specific dashboard reports for performance monitoring that include ED and hospital utilization and total medical expense.
- developing key performance indicator (KPI) dashboards, viewable by providers, that track financial and operational metrics and provide insights into patient demographics and how the population utilizes services.
- developing a registry or roster that includes cost and utilization information from primary care and specialty services for primary care teams and ACO leadership to better serve MassHealth ACO members.
- implementing single sign-on and query capability into the online Prescription Monitoring Program, so that providers can quickly access and monitor past opioid prescriptions to promote safe opioid prescribing.

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

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

OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that FLN Wellforce is On track with limited recommendations across four focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. FLN Wellforce has an Opportunity to improve in two focus areas.

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

Organizational Structure and Engagement

- clearly defining PFAC (Patient and Family Advisory Committee) membership structure and ensure regular meetings occur between the PFAC and JOC or BoM.

Integration of Systems and Processes

- conducting regular performance and quality meetings with high-volume CPs; and
- considering approaching CP collaboration using a similar framework, as that of ACO providers and practice sites; conduct regular performance data collection and reporting along with performance meetings to formalize a systematic structure for CP partnership and oversight.

Workforce Development

- using a variety of mechanisms to attract and retain a diverse team, such as opportunities for career development, educational assistance, ongoing licensing and credentialing, loan forgiveness and leadership training.

Health Information Technology and Exchange

- using a population health platform that integrates claims, administrative, and clinical data, generates registries by condition or risk factors, predictive models, utilization patterns, and financial metrics, and identifies members eligible for programs or in need of additional care coordination; and
- creating processes to enable two-way exchange of member information with CPs and develops workarounds to solve interoperability challenges.

Care Coordination and Care Management

- clarifying the process through which a CP is declared responsible for primary care management and ensuring that this process is clearly indicated in the ACO's EHR systems;
- collaborating with state agencies such as DMH and creating a directory/resource map used by CCCM staff;
- incorporating social workers into care management teams and integrating BH services, including OBAT, into primary care;
- supporting members who lack reliable transportation by providing rides or vouchers¹⁴, and/or providing services in homes or other convenient community settings;
- using Peer Support and/or CHW throughout the provision of ACO supports and activities;
- training staff in techniques for engagement such as motivational interviewing;
- enabling staff to build 1:1 relationships with high-need members, and using secure messaging, and regular telephone calls for ongoing follow up with members;
- implementing best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;
- standardizing processes for referrals for BH, LTSS, and health related social needs (HRSN) services and systematically tracking referrals, enabling PCPs and care coordinators to confirm that a member received a service, incorporate results into the EHR and care plan; and
- conducting regular case conferences to coordinate services when a member has been referred

Population Health Management

- documenting responses to HRSN screening assessments in the EHR;
- using HRSN screening assessment responses stratify members by risk or increase access to care;
- building mature partnerships with community-based organizations to whom they can refer members for services;

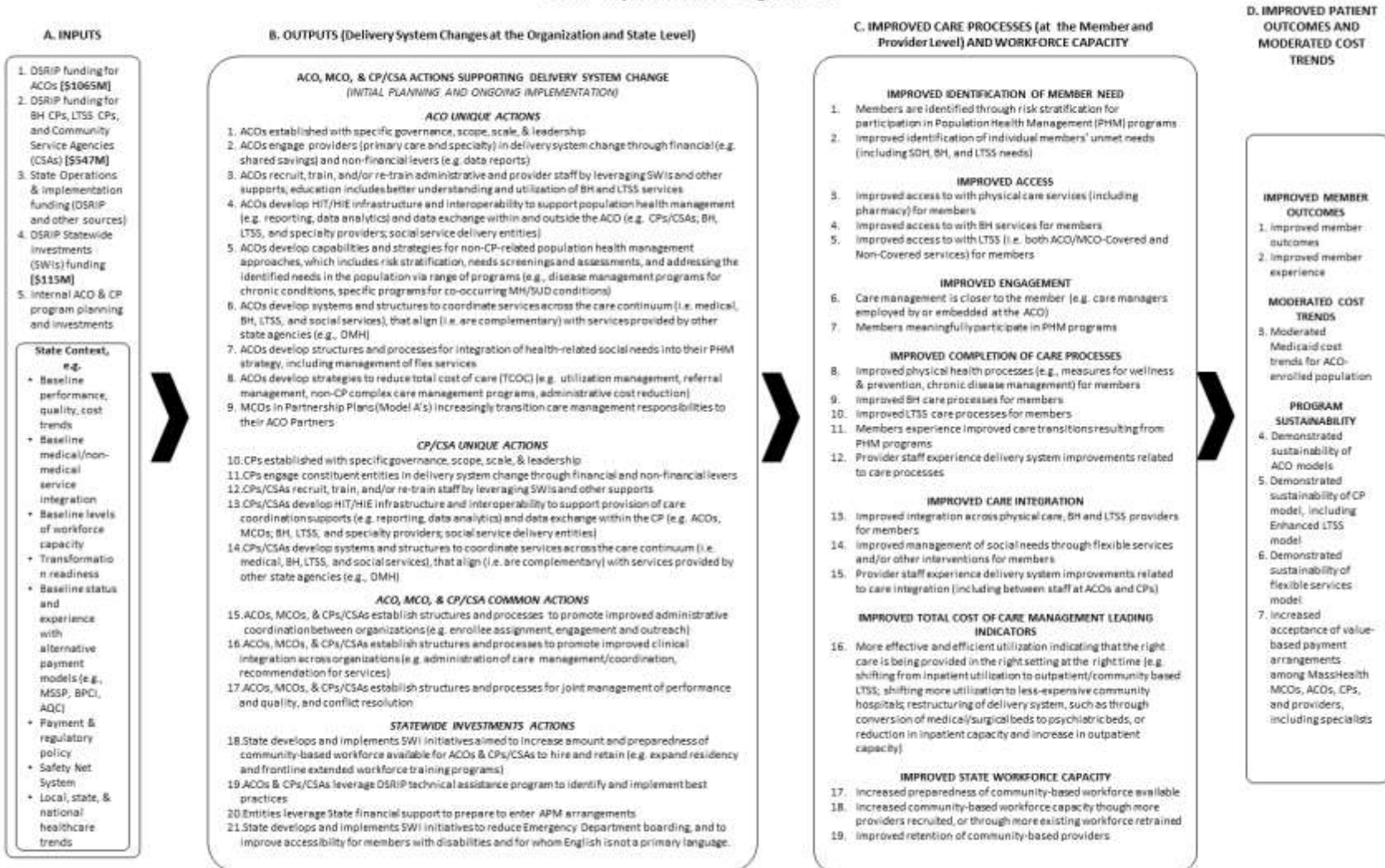
¹⁴ ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

- offering PHM programs that target members by BH needs (including non-CP eligible), HRSNs, and care transitions;
- actively disseminating cost data to providers to facilitate cost-of-care management; and
- offering interactive wellness programs such as smoking cessation, diet/weight management.

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL

DSRIP Implementation Logic Model



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations¹⁵ (ACOs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019.

Progress was defined by the ACO actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator¹⁶ (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (<https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download>).

The question addressed by this assessment is:

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

DATA SOURCES

The MPA drew on multiple data sources to assess organizational performance in each focus area, including both historical data contained in the documents that ACOs were required to submit to MassHealth, and newly collected data gathered by the IA and/or IE. The IA performed a desk review of documents that ACOs were required to submit to MassHealth, including participation plans, annual and semi-annual reports. In addition, the IA developed and conducted an ACO Practice Site Administrator survey to investigate the practices and perceptions of participating primary care practices. The IE developed a protocol for ACO Administrator KIIs, which were conducted jointly by the IA and the IE.

List of MPA data sources:

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

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

Newly Collected Data

- ACO Administrator KIIs
- ACO Practice Site Administrator Survey

¹⁵ See the ACO Background section for a description of the organization. In the case of a Model A ACO, an Accountable Care Partnership Plan, the assessment encompasses the partner managed care organization (MCO).

¹⁶ The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor – is responsible for evaluating the outcomes of the Demonstration.

FOCUS AREA FRAMEWORK

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

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

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

Table 1. Framework for Organizational Assessment of ACOs

Focus Area	ACO Actions
Organizational Structure and Governance	<ul style="list-style-type: none"> • ACOs established with specific governance, scope, scale, & leadership • ACOs engage providers (primary care and specialty) in delivery system change through financial (e.g. shared savings) and non-financial levers (e.g. data reports)
Integration of Systems and Processes	<ul style="list-style-type: none"> • ACOs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach) • ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services) • ACOs establish structures and processes for joint management of performance and quality, and conflict resolution • Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the Demonstration
Workforce Development	<ul style="list-style-type: none"> • ACOs recruit, train, and/or re-train administrative and provider staff by leveraging Statewide Investments (SWIs) and other supports; education includes better understanding and utilization of behavioral health (BH) and long-term services and supports (LTSS)
Health Information Technology and Exchange	<ul style="list-style-type: none"> • ACOs develop Health Information Technology and Exchange (HIT/HIE) infrastructure and interoperability to support provision of population health management (e.g. reporting, data analytics) and data exchange within and outside the ACO (e.g. Community Partners/Community Service Agencies (CPs/CSAs), BH, LTSS, and specialty providers)
Care Coordination and Care Management	<ul style="list-style-type: none"> • ACOs develop systems and structures to coordinate services across the care continuum (i.e. medical, BH, LTSS, and social services), that align (i.e. are complementary) with services provided by other state agencies (e.g., Department of Mental Health (DMH))

Population Health Management

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

ANALYTIC APPROACH

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

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

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

DATA COLLECTION

ACO Practice Site Administrator Survey Methodology

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

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

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

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

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

Table 1. Distribution of Practice Site Types

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

Table 2. Distribution of Practices Across Geography

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

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

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

Key Informant Interviews

Key Informant Interviews (KII) of ACO Administrators were conducted in order to understand the degree to which participating entities are adopting core ACO competencies, the barriers to transformation, and the organization's experience with state support for transformation.¹⁷ Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

¹⁷ KII were developed by the IE and conducted jointly by the IE and the IA. The IA utilized the KII transcripts as a secondary data source; the IA did not perform a full qualitative analysis of the KII.

APPENDIX III: FLN WELLFORCE PRACTICE SITE ADMINISTRATOR SURVEY RESULTS

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

- 30 practice sites were sampled; 25 responded (83% response rate)
- Survey questions are organized by focus area.
- The table provides the survey question, answer choices, and percent of respondents that selected each available answer. Some questions included a list of items, each of which the respondent rated. For these questions (i.e., Q# 12), the items rated appear in the answer choices column.
- NA indicates an answer choice that is not applicable to the survey question.

FOCUS AREA: ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
12	In the past year, to what degree have the following practices in your clinic become more standardized, less standardized or not changed? <i>A lot less, a little less, no change, a little more, a lot more standardized (1-5), I Don't Know</i>	a. Physician compensation	8%	4%	28%	12%	12%	N/A	N/A	36%
		b. Performance management of physicians	8%	0%	24%	28%	16%	N/A	N/A	24%
		c. Care processes and team structure	4%	4%	20%	24%	24%	N/A	N/A	24%
		d. Hospital discharge planning and follow-up	4%	0%	20%	40%	24%	N/A	N/A	12%
		e. Recruiting and performance review	4%	4%	32%	16%	12%	N/A	N/A	32%
		f. Data elements in the electronic health record	4%	0%	24%	32%	24%	N/A	N/A	16%
21	To the best of your knowledge, in the past, has your practice participated in payment contract(s) together with the other clinical providers and practices that are now participating in the [ACO Name]? Select one.	a. Yes, with most of the clinical providers and practices that now compose this ACO (1) b. Yes, with some of the clinical providers and practices that now compose this ACO (2) c. No, this is our first time participating in a payment contract with the clinical providers and practices that compose this ACO (3) d. Don't know	30%	26%	9%	N/A	N/A	N/A	N/A	35%
22	Has your practice received any financial distributions (DSRIP dollars) as part of its engagement with the MassHealth Accountable Care Organization?	Yes (1) No (2) Don't know	9%	18%	N/A	N/A	N/A	N/A	N/A	73%
23	Is a representative from your practice site engaged in ACO governance?	Yes (1) No (2) Don't know	17%	30%	N/A	N/A	N/A	N/A	N/A	52%
24	To what extent do you feel your practice has had a say in important aspects of planning and decision making within the MassHealth Accountable Care Organization that affect your practice site?	Almost never had a say (1) Rarely had a say (2) Sometimes had a say (3) Usually had a say (4) Almost always had a say (5) Don't Know/Not Applicable	32%	9%	32%	9%	0%	N/A	N/A	18%
25	Please indicate the extent to which you agree or disagree with the following statement: ACO leaders have communicated to this practice site a vision for the MassHealth ACO and the care it delivers.	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5) Don't know/ Not applicable	23%	9%	32%	36%	0%	N/A	N/A	0%

26	To what extent do you agree or disagree with each of the following statements? <i>Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know/Not Applicable</i>	a. The MassHealth ACO is a resource and partner in problem-solving for our practice.	0%	26%	22%	35%	4%	N/A	N/A	13%
		b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions.	0%	9%	30%	22%	4%	N/A	N/A	35%
		c. All entities in this MassHealth ACO work together to solve problems when needed.	0%	5%	32%	27%	5%	N/A	N/A	32%
28	Overall, how satisfied are you with your practice's experience as part of this MassHealth ACO?	Highly dissatisfied (1) Somewhat dissatisfied (2) Neither satisfied nor dissatisfied (3) Somewhat satisfied (4) Highly satisfied (5)	13%	26%	30%	26%	4%	N/A	N/A	N/A
34	In the past year, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	a. Massive change - completely redesigned their care (1) b. A lot of change (2) c. Some change (3) d. Very little change (4) e. No change (5)	0%	27%	36%	23%	14%	N/A	N/A	N/A
35	In the past year, to what extent has your practice's ability to deliver high quality care to MassHealth members gotten better, gotten worse, or stayed the same?	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	9%	23%	41%	27%	0%	N/A	N/A	N/A
37	Which of the following approaches are used to manage the performance of individual physicians who practice at your site? Select all that apply.	a. Performance measures on quality are reported and shared with physicians (1) b. Performance measures on cost are reported and shared with physicians (2) c. One-on-one review and feedback is used (3) d. Individual financial incentives are used (4) e. Individual non-financial awards or recognition is used (5)	86%	77%	64%	32%	36%	N/A	N/A	N/A
38	To the best of your knowledge, has your practice ever participated in any of the following, either directly or through participation in a physician group or other organization authorized to enter into such an agreement on behalf of the practice? Select all that apply.	a. Bundled or episode-based payments (1) b. Primary care improvement and support programs (e.g. Comprehensive Primary Care Initiative, Patient Centered Medical Home, Primary Care Payment Reform etc.) (2) c. Pay for performance programs in which part of payment is contingent on quality measure performance (3) d. Capitated contracts with commercial health plans (e.g. Blue Cross Blue Shield Alternative Quality Contract), etc.) (4) e. Medicare ACO upside-only risk bearing contracts (Medicare Shared Savings Program tracks one and two) (5) f. Medicare ACO risk bearing contracts (Pioneer ACO, Next Generation ACO, Medicare Shared Savings Program track three) (6) g. Commercial ACO contracts (7)	0%	68%	68%	63%	21%	37%	32%	N/A

FOCUS AREA: INTEGRATION OF SYSTEMS AND PROCESSES

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1b	For the care coordination and management resources used by your practice, how many of these resources are MANAGED by people at the following organizations (e.g., overseen, supervised)? <i>None, Some, Most, or All of the Resources (1-4)</i>	a. An ACO/MCO	7%	40%	24%	32%				
		b. The physical location and department where you work	24%	32%	20%	24%				
		c. A community-based organization	40%	32%	20%	8%				
		d. A different practice site, department, or location in your organization	56%	36%	4%	4%				
		e. Other organization, entity, or location	44%	40%	8%	8%				
1c	For the care coordination and management resources used by your practice, how many of these resources are HOUSED at the following locations (by housed we mean the place where these resources primarily provide patient services)? <i>None, Some, Most, or All of the Resources (1-4)</i>	a. An ACO/MCO	20%	28%	24%	28%				
		b. The physical location and department where you work	20%	24%	24%	32%				
		c. A community-based organization	56%	16%	24%	4%				
		d. A different practice site, department, or location in your organization	48%	28%	4%	20%				
		e. Other organization, entity, or location	48%	36%	8%	8%				
3	For your MassHealth members who receive care coordination and management services from more than one program or person, how often do these resources operate together efficiently?	Never (1) Rarely (2) Sometimes (3) Usually (4) Always (5) Don't Know/Not Applicable	0%	20%	28%	24%	12%			16%
8b	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? <i>Almost Never, Rarely, Sometimes, Often, Almost Always (1-5), I Don't Know</i>	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	72%	8%	4%	0%	4%			12%
		b. counseling therapists, including clinical social workers	36%	12%	40%	0%	0%			12%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	60%	4%	16%	8%	0%			12%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	40%	4%	40%	0%	4%			12%
10	How difficult is it for your practice to obtain treatment for your MassHealth members with opioid use disorders?	Nearly impossible (1) Very difficult (2) Somewhat difficult (3) A little difficult (4) Not at all difficult (5) Don't Know/Not Applicable	8%	32%	20%	12%	4%			24%
15	If screening for the needs in the previous question is performed at a level other than the practice (e.g., by an accountable care organization), how often does your practice have access to the results?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	25%	4%	4%	17%	8%			42%
31	Currently which of the following best describes how many MassHealth members in your practice are receiving care coordination services from a MassHealth designated Community Partner?	Very few (1) More than very few, but not many (2) About half (3) A majority (4) Nearly all (5) I don't know/I'm not aware)	35%	22%	9%	0%	0%			35%
32	How frequently have clinicians, staff and/or administrators interacted with Community Partner organization staff in coordinating these patients' care?	Almost Never (1) Rarely (2) Sometimes (3) Often (4) Almost Always (5) Don't know	0%	33%	40%	13%	7%			7%

33	To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members?	Has made it harder almost all of the time (1) Has made it harder some of the time (2) Has made little or no change (3) Has made it easier some of the time (4) Has made it easier almost all of the time (5) Don't know	0%	7%	20%	47%	7%			20%
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FOCUS AREA: WORKFORCE DEVELOPMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
27	In the past year, which of the following resources has your practice accessed as part of its involvement in this MassHealth ACO? Select all that apply.	(1) The MassHealth ACO has provided resources and/or assistance to help recruit providers and/or staff (2) The MassHealth ACO has provided resources and/or assistance to help train providers and/or staff (3) Providers and/or staff have taken part in trainings made available directly by MassHealth (4) Providers and/or staff have received training focused on behavioral health and long-term services and supports. (5) DSRIP Statewide Investments (e.g. Student Loan Repayment Program) have been provided to help in training and/or recruiting.	0%	67%	0%	33%	0%	N/A	N/A	N/A

FOCUS AREA: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
13	Which of the following technologies are in use at your practice? Select all that apply.	(1) Electronic health record (2) Care management platform (3) Population health management platform (4) Other technology	100%	40%	40%	12%	N/A	N/A	N/A	N/A
13_EHR	To what extent do you agree that the Electronic Health Record improves your ability to coordinate care for your MassHealth members?	<i>Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know</i>	4%	4%	24%	40%	28%	N/A	N/A	0%
13_CMP	To what extent do you agree that the Care Management Platform improves your ability to coordinate care for your MassHealth members?	<i>Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know</i>	0%	0%	50%	30%	10%	N/A	N/A	10%
Q13_PHP	To what extent do you agree that the Population Health Platform improves your ability to coordinate care for your MassHealth members?	<i>Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know</i>	0%	0%	20%	80%	0%	N/A	N/A	0%

FOCUS AREA: CARE COORDINATION AND CARE MANAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1a	Which of the following care coordination and management resources has your practice used in the past 12 months for your MassHealth members? Select all.	Community Health Workers (1) Patient Navigators/Referral Navigators (2) Nurse Manager/Care Coordinator (3) Any other (non-nurse) Care Coordinator/Manager (4) Social Worker (5) Other title (6)	7	44%	80%	16%	68%	4%	N/A	N/A

2	In the past 12 months to what extent have these coordination and management resources helped your practice's efforts to deliver high quality care to your MassHealth members?	<i>Not at all, A little, Somewhat, Mostly, A great deal (1-5)</i>	0%	12%	40%	28%	20%	N/A	N/A	N/A
4	In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members? <i>Always, Usually, Sometimes, Rarely, Never Difficult (1-5) Don't Know</i>	a. Learn the result of a test your practice site ordered	4%	4%	12%	28%	48%	N/A	N/A	4%
		b. Know that a patient referred by your practice site was seen by the consulting clinician	8%	8%	36%	24%	20%	N/A	N/A	4%
		c. Learn what the consulting clinician recommends for your practice site's patient	0%	4%	44%	20%	28%	N/A	N/A	4%
		d. Transmit relevant information about a patient who your practice site refers to a consulting clinician	0%	16%	16%	40%	24%	N/A	N/A	4%
		e. Reach the consulting clinician caring for a patient when your staff need to	0%	4%	40%	28%	20%	N/A	N/A	8%
5	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following? <i>There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable</i>	a. Arranging eye care from an ophthalmologist or optometrist	0%	0%	4%	8%	44%	40%	N/A	4%
		b. Confirming that a diabetic eye exam was performed	0%	0%	8%	8%	44%	32%	N/A	8%
		c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note	0%	0%	20%	8%	40%	20%	N/A	12%
6	For your complex high-need MassHealth patients, how often is any type of care coordination or management resource involved in helping the patient adhere to the care plan? <i>Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)</i>	a. Any type of care coordinator/manager	12%	12%	40%	32%	4%	N/A	N/A	N/A
		b. Any type of non-clinician (e.g., community health worker)	12%	20%	40%	28%	0%	N/A	N/A	N/A
		c. Targeted interventions for patients who have been risk stratified into a high need sub-group	8%	24%	32%	36%	0%	N/A	N/A	N/A
		d. Home visits	16%	20%	44%	16%	4%	N/A	N/A	N/A
7	For complex, high-need MassHealth members, how often does your practice use each of the following resources to help the patient adhere to the care plan? <i>Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)</i>	a. Referral to community-based services for health-related social needs	12%	0%	32%	36%	20%	N/A	N/A	N/A
		b. Communication with the patient within 72 hours of discharge	8%	4%	8%	24%	56%	N/A	N/A	N/A
		c. Home visit after discharge	36%	20%	36%	4%	4%	N/A	N/A	N/A
		d. Discharge summaries sent to primary care clinician within 72 hours of discharge	8%	12%	28%	28%	24%	N/A	N/A	N/A
		e. Standardized process to reconcile multiple medications	8%	8%	12%	20%	52%	N/A	N/A	N/A
8a	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? <i>Almost Never, Rarely, Sometimes, Usually, Almost Always within the practice site (1-5), Don't Know/Not Applicable</i>	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	0%	0%	20%	32%	36%	N/A	N/A	12%
		b. counseling therapists, including clinical social workers	0%	0%	24%	20%	48%	N/A	N/A	8%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	0%	4%	20%	20%	48%	N/A	N/A	8%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	4%	4%	24%	20%	32%	N/A	N/A	16%

9	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for MassHealth members obtaining the following behavioral health services? <i>There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable</i>	a. Scheduling the appropriate behavioral health services	12%	4%	16%	12%	28%	28%	N/A	0%
		b. Confirming that behavioral health services were received	4%	4%	24%	16%	20%	28%	N/A	4%
		c. Ensuring that your practice site receives the prescribing clinician, counseling therapist, or any type of care coordinator/manager's consult note, as appropriate	4%	8%	24%	20%	28%	8%	N/A	8%
		d. Establishing when a prescribing clinician, counseling therapist, or any type of care coordinator/manager will share responsibility for co-managing the patient's care	8%	8%	24%	20%	24%	8%	N/A	8%
11	To what extent do you agree or disagree that providers follow a clear, established process for the following activities? <i>There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable</i>	a. Screening for service needs at home that are important for the patient's health?	8%	12%	4%	12%	24%	24%	N/A	16%
		b. Choosing among LTSS providers?	8%	12%	4%	16%	24%	12%	N/A	24%
		c. Referring patients to specific LTSS providers with which your office has a relationship?	8%	12%	8%	24%	16%	12%	N/A	20%
		d. Confirming that the recommended LTSS have been provided?	8%	12%	0%	24%	24%	12%	N/A	20%
		e. Establishing relationships with LTSS providers who serve your patients?	8%	12%	4%	20%	28%	8%	N/A	20%
		f. Getting updates about a patient's condition from the LTSS providers?	8%	20%	0%	12%	28%	12%	N/A	20%
17	When MassHealth members receive referrals to social service organizations, how often is your practice aware that those patients have received support from those organizations?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	24%	8%	36%	8%	4%	N/A	N/A	20%
18	Does your practice regularly provide any of the following? Select all that apply.	Scheduling to enable same day appointments (1) Appointments on weekdays before 8 am or after 5 pm (2) Appointments on weekends (3) Home visits carried out by practice staff or a clinician (4) Clinical pharmacy services provided after discharge at the practice site (5) Care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology) (6)	100%	40%	32%	4%	8%	40%	N/A	N/A

FOCUS AREA: POPULATION HEALTH MANAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
14	For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)	a. tobacco use	96%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		b. opioid use	72%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		c. substance use	72%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		d. polypharmacy	28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		e. depression	96%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		f. low health literacy	36%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		g. food security or SNAP eligibility	28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		h. housing instability	48%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		i. utility needs	24%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		j. interpersonal violence	60%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		k. transportation needs	48%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		l. need for financial assistance with medical bills	28%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		m. Medicaid eligibility	32%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		n. none of the above	4%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	How often are MassHealth members referred from your practice to social service organizations to address health-related social needs (e.g., housing, food security)?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	4%	16%	52%	8%	0%	N/A	N/A	20%
19	What is the main source of information that your practice uses to identify which of your MassHealth members are complex, high need patients? Select one.	a. We perform an ad hoc review of information from our own practice's system(s) (e.g., EHR) when we think it is relevant (1) b. We regularly apply systematic risk stratification algorithms in our practice using our patient data (2) c. We receive risk stratification information from a managed care organization or accountable care organization (3) d. We do not have a way of knowing which patients are complex/high need (4) e. Don't know	20%	12%	32%	0%	N/A	N/A	N/A	36%
29	Please select the option below that best describes the change in the past year in your practice site's ability to tailor delivery of care to meet the needs of patients affected by health inequities (e.g., by using culturally and linguistically appropriate services):	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	22%	35%	35%	9%	0%	N/A	N/A	N/A
30	How often does your practice site use site-specific data to identify health inequities within its served population? For example, data might include EHR charts or ACO reports.	Annually (1) Bi-annually (2) Quarterly (3) Monthly (4) On an ad hoc basis (5) We do not have access to this type of data. (6) We have access to this type of data but do not analyze it for health inequities. (7)	0%	0%	13%	13%	9%	35%	30%	N/A

GENERAL QUESTIONS

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
20	Our records show that your practice is participating in the [ACO name] for some or all of its MassHealth Medicaid patients. Is that correct?	Yes (1) I am not aware of this (2)	100%	0%	N/A	N/A	N/A	N/A	N/A	N/A

20_O	Were you able to find a colleague who can help you answer questions about [ACO Name]?	Yes (1) No (2)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
20a	Currently, which of the following best describes how many of your practice's patients are covered by [ACO Name]?	Very few (1) A minority (2) About half (3) A clear majority (4) Nearly all (5)	9%	30%	48%	13%	0%	N/A	N/A	N/A
36	Who owns your practice? (select one)	a. Independently owned (1) b. A larger physician group (2) c. A hospital (3) d. A healthcare system (may include a hospital) (4) e. Other (please specify) (5)	55%	5%	9%	32%	0%	N/A	N/A	N/A
39	Which of the following best describes your practice site?	Adult (1) Pediatric (2) Both (3)	36%	27%	36%	N/A	N/A	N/A	N/A	N/A
40	Currently which of the following best describes how many of your practice's patients are covered by any contracts with cost of care accountability?	Very few (1) A minority (2) About half (3) A majority (4) Nearly all (5)	35%	20%	20%	20%	5%	N/A	N/A	N/A
41	To what extent do providers and staff at your practice site seem to agree that "total cost of care" contracts will become a major and sustained model of payment at your practice in the near-term (i.e., within five years)?	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5)	0%	10%	57%	29%	5%	N/A	N/A	N/A
42	What is your professional discipline? (select one)	a. Primary care physician (1) b. Physician assistant/nurse practitioner (2) c. Registered nurse/nurse care manager/ LVN/LPN (3) d. Professional administrator (e.g., practice manager) (4) e. Other-please specify: (5)	23%	0%	0%	77%	0%	N/A	N/A	N/A
43	How long have you worked at this practice site? (select one)	a. Less than 6 months (1) b. 6-12 months (2) c. 1-2 years (3) d. 3-5 years (4) e. More than 5 years (5)	0%	5%	18%	5%	73%	N/A	N/A	N/A
44	Did you ask a colleague for help in answering questions on the survey?	Yes (1) No (2)	27%	73%	N/A	N/A	N/A	N/A	N/A	N/A

APPENDIX IV: ACRONYM GLOSSARY

ACPP	Accountable Care Partnership Plan
ACO	Accountable Care Organization
ADT	Admission, Discharge, Transfer
BH CP	Behavioral Health Community Partner
CCCM	Care Coordination & Care Management
CCM	Complex Care Management
CHA	Community Health Advocate
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CP	Community Partner
CWA	Community Wellness Advocate
DMH	Department of Mental Health
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
ENS	Event Notification Service
EOHHS	Executive Office of Health and Human Services
FPL	Federal Poverty Level
FPP	Full Participation Plan
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HRSN	Health Related Social Need
IA	Independent Assessor
IE	Independent Evaluator
JOC	Joint Operating Committee
KII	Key Informant Interview
LGBTQ	lesbian, gay, bisexual, transgender, queer, questioning
LCSW	Licensed Independent Clinical Social Worker
LPN	Licensed Practical Nurse
LTSS CP	Long Term Services and Supports Community Partner
MAeHC	Massachusetts eHealth Collaborative
MAT	Medication for Addiction Treatment
MCO	Managed Care Organization
MPA	Midpoint Assessment
OBAT	Office-Based Addiction Treatment
PCP	Primary Care Provider
PFAC	Patient and Family Advisory Committee
PHM	Population Health Management
QI	Quality Improvement
QMC	Quality Management Committee

RN	Registered Nurse
SFTP	Secure File Transfer Protocol
SMI	Serious Mental Illness
SUD	Substance Use Disorder
SVP	Senior Vice President
SWI	Statewide Investments
TCOC	Total Cost of Care
VNA	Visiting Nurse Association

APPENDIX V: ACO COMMENT

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

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

ACO Comment

None submitted.