MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

ACO Report:

Atrius Health in partnership with Tufts Health Public Plans

(THPP Atrius)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

DSRIP Midpoint Assessment Highlights & Key Findings

Atrius Health in partnership with Tufts Health Public Plans (THPP Atrius)

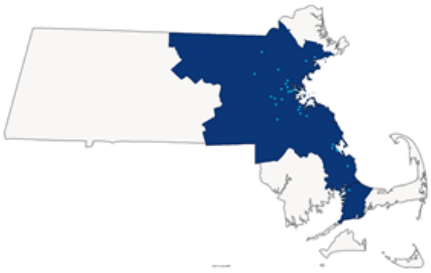
PUBLIC CONSULTING GROUP

Model A ACO

THPP Atrius is a MassHealth Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as Tufts Health together with Atrius Health.

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)	**28K members**	**$3.2M**
2018	**28K members**	**$5.5M**
2019	**32K members**	**$5.0M**

POPULATIONS SERVED

- Behavioral health (BH) diagnoses are common in members, particularly depression, anxiety, and substance use disorder (SUD).
- Chronic condition in the population include diabetes, hypertension, obesity, and chronic obstructive pulmonary disease (COPD)
- Roughly one in seven members are asthmatic.

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

IMPLEMENTATION HIGHLIGHTS

- The Performance Excellence team sets population health management (PHM) goals, monitors and analyzes quality data, and provides PHM consultation, project management assistance, and electronic health record support (EHR). A majority of sampled Atrius practice sites reported that the vast majority of providers receive quality performance measure results regularly and the ACO uses one on one review and feedback as a key mechanism for performance management.
- All Atrius practices utilize the same EHR platform, facilitating integrated data sharing between providers and allowing for electronic referral requests. A majority of Atrius practice sites agree or strongly agree that EHR and population and case management platforms improve their ability to coordinate care for MassHealth members.
- The ACO also has a dedicated Navigator Center for coordinating referrals outside of the Atrius Health system and a 24/7 Telecom Center to redirect low-acuity emergency department use. Patient Navigators conduct appointment scheduling and member outreach work, along with coordinating follow-up, documentation transfers, and confirmation of care following appointments.

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

LIST OF SOURCES FOR INFOGRAPHIC

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

NOTES

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

INTRODUCTION

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

Progress was defined by the ACO actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[2] (IE) to tie together the implementation steps and the short- and long-term outcomes and goals of the program. It was summarized into a high-level logic model which is described in the CMS approved Massachusetts 1115 MassHealth Demonstration Evaluation Design document (https://www.mass.gov/doc/ma-independent-evaluation-design-1-31-19-0/download).

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1. Framework for Organizational Assessment of ACOs

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

METHODOLOGY

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

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

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

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

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

ACO BACKGROUND[3]

Atrius Health in partnership with Tufts Health Public Plans (THPP Atrius) is an Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as Tufts Health Together with Atrius Health. An ACPP is a partnership between a single health plan and a provider-led ACO that receives monthly capitated payments from MassHealth based on enrollment and member risk scores, and takes on full insurance risk[4] for the population.

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

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

Tufts Health Public Plans provides a wide range of administrative functions including network management, member services, claims adjudication and compliance. THPP Atrius is one of four Model A ACOs for which THPP holds a contract with EOHHS.

Atrius Health's service area includes various portions of eastern Massachusetts. Atrius is represented in the following locales: Attleboro, Beverly, Boston, Brockton, Falmouth, Framingham, Gardner-Fitchburg, Lawrence, Lowell, Lynn, Malden, Plymouth, Quincy, Revere, Salem, Somerville, Waltham, Wareham, and Woburn.

THPP Atrius' MassHealth member attribution and allocated non-at risk DSRIP funding are summarized below.

Table 2. THPP Atrius MassHealth Members and DSRIP Funding 2017-2019[5]

Year	Members	DSRIP Funding
2017 (partial year, Jul-Dec)	28,097	$3,209,113
2018	28,097	$5,461,642
2019	31,867	$5,022,867

THPP Atrius reports a high level of behavioral health (BH) diagnoses in members, particularly depression, anxiety, and substance use disorder (SUD). Chronic conditions found in the Atrius Health Medicaid population include diabetes, hypertension, obesity, and chronic obstructive pulmonary disease (COPD). Roughly one in seven Atrius Health Medicaid members are asthmatic.

SUMMARY OF FINDINGS

The IA finds that THPP Atrius is On track or On track with limited recommendations in all six focus areas.

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

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

[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.

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 THPP Atrius is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

Established governance structures

THPP Atrius has established appropriate governance structures. THPP Atrius has a Joint Operating Committee (JOC) with membership evenly divided between THPP and Atrius. The JOC determines the ACO's DSRIP budgets and sets priorities for financial investments. THPP Atrius also has a Governing Board comprised of practicing providers, members of the ACO's Analytics and Performance Excellence Department and a consumer advocate. The Governing Board reports directly to the JOC on a regular basis on care delivery strategy and performance on key indicators. Atrius Heath's practice site and specialty PFACs provide patient feedback and serve as Governing Board PFACs for the purpose of MassHealth ACO participation. The Quality Committee manages quality initiatives and oversees performance analytics. The Quality Committee also incorporates reports and inputs from the ACO's Performance Excellence department which oversees the ACO's population health managers.

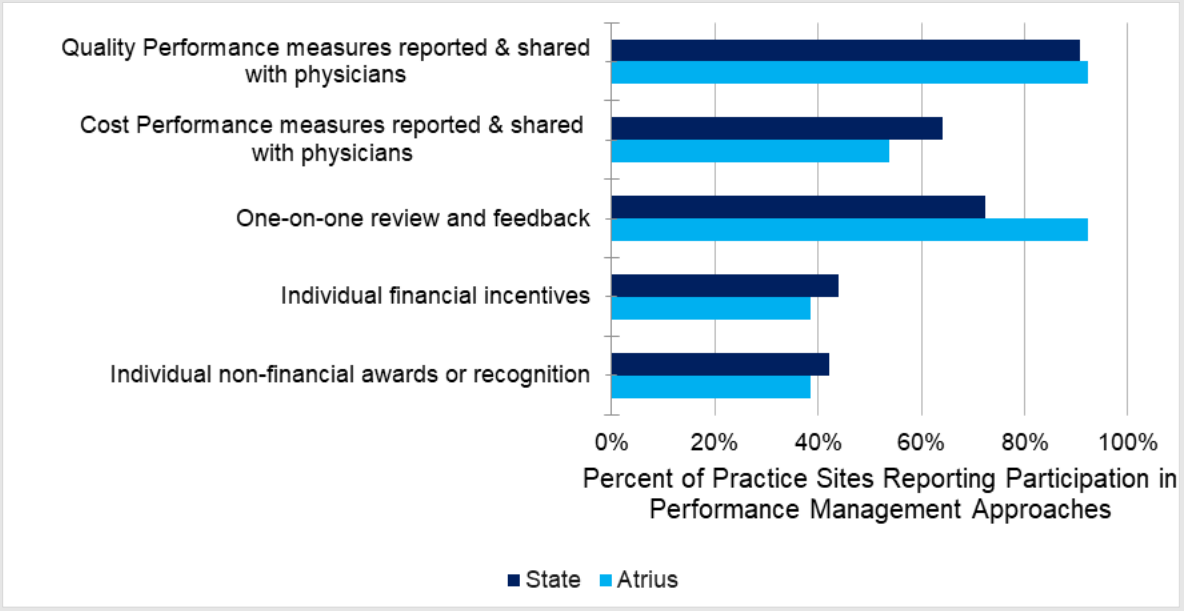
Provider engagement in delivery system change

Atrius Health's Performance Excellence Department includes medical directors of quality and medical management who help set targets and goals, track performance, promote workflows to improve quality metrics, and coordinate the role of population managers to help physicians achieve their targets. This same group also oversees a system-wide weekly two-hour Population Health Management (PHM) dedicated timeslot where providers are asked to focus on PHM related activities and workflows.

THPP Atrius produces monthly quality metric dashboards which are distributed to providers as well as quarterly member experience reports. THPP Atrius reports relying on insights gleaned from an abundance of surveying of frontline staff to assist in identifying quality improvement initiatives geared both toward member care and provider support. THPP Atrius also reports that their reliance on rapid cycle continuous improvement methodologies at the practice level is the basis for much of the continuous learning and improvement seen throughout the system.

A majority of sampled Atrius practice sites reported that the vast majority of providers receive quality performance measure results regularly and the ACO uses one-on-one review and feedback as a primary method for performance management. Just over half of practice sites indicated that their providers receive performance information related to cost.

Figure 1. Provider Engagement and Physician Performance Management Approaches



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in Atrius, N = 14
Figure displays responses to Q37. *Which of the following approaches are used to manage the performance of individual physicians who practice at your site? Select all that apply.*
Statistical significance testing was not done due to small sample size.

Recommendations

The IA has no recommendations for the Organizational Structure and Engagement focus area.

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

Administrative coordination among ACO member organizations and with CPs

Administrative integration is achieved in part through the JOC and ACPP Governing Board, which facilitate coordination between Atrius and THPP in care management, risk stratification, and financial investments. THPP provides Atrius with reports including information on care management, risk stratification, quality, and utilization. The ACO Director appears to be a role dedicated to administrative integration as well. Additionally, THPP has promoted two care managers to Relationship Managers, who will assist with administrative coordination to avoid duplication of services between THPP and Atrius.

THPP has also hired a Community Partner (CP) Program Manager who will oversee CP program operations and activities. The practice manager serves as a single point of contact for routine activities. In order to streamline CP communications, THPP Atrius utilizes a single point of contact telephone line to minimize confusion for CP staff who need to reach someone within the ACO for questions. THPP Atrius and CP staff also participate in meetings on topics such as risk-stratification and care management and engage in frequent communication to build strong working relationships. PHM staff are involved in the daily operations of the CP program, and care managers and BH facilitators distribute CP member lists regularly to designated CP staff. CP enrollment is also included in the EHR.

Results from the ACO Practice Site Administrator Survey indicate that a majority of Atrius practice sites “usually or always” felt that members receiving care coordination and management services from multiple programs felt that these resources operated together efficiently.

Clinical integration across ACO member organizations and with CPs

Multidisciplinary teams including nurses, licensed social workers, BH care managers, and non-clinical staff, and warm handoffs between these teams, are the foundation of the ACO’s clinical integration

strategy. ACO and CP staff collaborate in the reporting and analysis of performance data for Program-Specific Metrics, which are part of the organization's PHM strategy.

THPP Atrius has integrated BH case conferences with THPP, along with monthly high-risk case reviews with CPs. Regular care management meetings are also held for front-line staff and organizational leaders to address organizational challenges, discuss specific cases, find collaborative solutions, and examine care management reports generated by THPP. These reports from THPP are distributed to practice sites and are accessible in the EHR platform. Additionally, ambulatory care managers perform monthly follow-up on each member receiving care at a LTSS CP.

THPP Atrius' EHR allows care managers and clinical care teams to view member records and collaborate on member care. They use standardized documentation tools across sites and make care plans available to CPs. THPP Atrius and practice sites share Continuity of Care documentation using an interoperability platform across practice sites which integrate with their EHRs. Practice sites also have access to bi-directional web portals with preferred hospitals to share member care plans. THPP Atrius continues to assess opportunities to improve interoperability and integration with preferred Community Partners.

> THPP Atrius Administrator Perspective*: "We're a really highly integrated practice. We meet twice a month together, we're on the same platform, and we decide our priorities together. I think we develop our strategy together jointly, and I think that's different from [other] provider networks. I think we benefit from the fact that our alignment is strong across our practice."*

In the ACO Practice Site Administrator Survey, a majority of Atrius practice sites reported that "any type of care coordinator/manager to address health-related social needs" is co-located at the practice site (Figure 2).

Figure 2. Co-Location of Behavioral Health Resources

Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in Atrius, N = 14
Figure displays responses to Q8b. *For the Behavioral Health entities you selected in the previous question, how often are they located within your practice site? For those entities to which you never refer, please select Don't Know/Not Applicable.*
Statistical significance testing was not done due to small sample size.

Joint management of performance and quality

THPP Atrius has an established performance monitoring plan. THPP Atrius has a Performance Excellence team which implements and oversees PHM program performance. The Performance Excellence team sets PHM goals, monitors and analyzes quality data, and provides PHM consultation services, project management assistance, and EHR support.

Atrius and THPP leadership, together with clinical leaders at ACO practice sites, monitor performance through regular reporting and data-sharing in financial, clinical, and quality domains. Cost dashboards and member experience reports are shared quarterly, while member registries and quality performance data are shared monthly.

Each service line at each provider site has a "site chief" responsible for the implementation of PHM strategy for their team. Site chiefs review quality, cost, and performance data with individual physicians through a recurring meeting structure. It is not clear if the ACO reviews quality performance with CPs through similar structures.

Additionally, the Atrius Health Infection Control program conducted daily monitoring in 2019 for suspected contagious diseases at the ACO, including pertussis, measles, mumps, and rubella. The team then relayed information to staff to ensure that potentially exposed members and staff were tested and treated, if necessary.

ACO/MCO coordination (at Accountable Care Partnership Plans)

THPP and Atrius are represented equally in the JOC. THPP and Atrius are able to share member contact information, comprehensive needs assessments, and care plans.

Recommendations

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

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

- ✓ **Administrative coordination among ACO member organizations and with CPs**
  - Establishing weekly meetings to discuss newly engaged members.
  - Establishing monthly meetings with practices sites and CPs to discuss member care plans.
  - Creating a case review process including care coordination, service gaps and service duplication.
  - Sharing member risk stratification reports including results of predictive modeling.
- ✓ **Clinical Integration among ACO member organizations and with CPs**
  - Designating a practice site champion responsible for integrating Care Coordination and Care Management (CCCM) and clinical care plans.
  - Embedding CCCM staff at practice sites to participate in shared model for care management.
  - Providing resiliency training to CCCM staff to improve team cohesion and offer emotional support.
  - Developing a centralized care management office to support member care teams in conducting needs assessment, follow-up, disease management and transitions of care.
  - Following members for at least 30 days post-discharge from the hospital.
  - Providing laptops or other devices that enable EHR access by off-site providers during visits with members.
  - Holding monthly meetings of CCCM teams to share best practices, develop solutions to recent challenges and provide collegial support.

- ✓ **Joint management of performance and quality**
    - Developing practice site specific quality scorecards and reviewing them at monthly or quarterly meetings.
    - Having the Joint Operating Committee (JOC) review scorecards of clinical, quality, and financial measures.
    - Sharing individual performance reports containing benchmarks or practice wide comparisons with providers.
- ✓ **ACO/MCO coordination** (at Accountable Care Partnership Plans)
    - Reviewing performance and quality outcomes at regular governance meetings.
    - Developing coordinated goals related to operations, budget decisions and clinical quality outcomes

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of ACOs considered On track:

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

Results

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

Recruitment and retention

THPP Atrius has implemented recruiting and retention strategies that appear to be mitigating persistent vacancies. THPP Atrius reported success in recruiting CHWs through a partnership with a community organization already familiar with the Medicaid population that provides contracted CHWs to the ACO on an as-needed basis. THPP Atrius also reports success in fulfilling roles through internal promotion.

THPP Atrius also reports relying on a hiring strategy that emphasizes career development and promotion to motivate and retain staff members. THPP Atrius reported additional retention efforts including the regular use of targeted team building and resiliency trainings.

THPP Atrius did not report the use of educational assistance, loan forgiveness programs, ongoing licensing and credentialing, or performance bonuses in its retention strategies.

Training

All staff are provided onboarding training and continue to attend regular skill-building trainings throughout their tenure at THPP Atrius. Onboarding training focuses on providing ACO educational material on the model of care and general organizational assets available to staff. In addition, staff also begin additional role-specific training upon hire. The ACO also provides shadowing and mentoring program to link experienced individuals with newly onboarded staff.

THPP Atrius also reports having conducted ad-hoc trainings to assist staff develop capabilities in population health management strategies, EHR use, HRSN screenings and related referral management as well as pre-visit planning.

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

Attempts to deliver patient-centered care are reflected in THPP Atrius's inclusion of resource navigators, licensed social workers, and other non-clinical staff on care management teams. These non-clinical staff are embedded in clinical settings and focus on assisting members obtain HRSN services and get connected to additional resources.

Similarly, clinical staff are also engaged in population health and quality roles in accordance with MassHealth guidance.

Recommendations

The IA encourages THPP Atrius 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:

- developing additional programs to assist staff recruitment and retention like educational assistance, loan forgiveness programs, ongoing licensing and credentialing, or performance bonuses.

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

Infrastructure for care coordination and population health

All Atrius practices utilize the same EHR platform, facilitating integrated data sharing between providers and allowing for electronic referral requests. The EHR platform integrates several data sources including claims, clinical data, and health-related social needs (HRSNs) screenings. The EHR also includes care management features, such as a chart flag for adult members requiring complex care, and a clinical decision support tool.

Risk stratification reports are also built into the EHR system. Risk scores use utilization, cost, diagnostic, and clinical data to determine a member's likelihood of being hospitalized. THPP Atrius also generates condition-specific registries of members, along with a registry of all members who are Medicaid beneficiaries (regardless of condition). Additionally, Atrius is planning technical platform enhancements intended to support workflow improvements for disease-specific members and improved quality initiatives.

Atrius uses their EHR's capacities for generating registries and developing dashboards as tools to engage and manage their member population, particularly those with complex care needs.

> THPP Atrius Administrator Perspective: "*I think there's a lot of alignment that we benefit from, from the way that we're organized, that really supports outcomes. And the fact that we're all on the same electronic platform is a critical component of that*."

Systems for collaboration across organizations

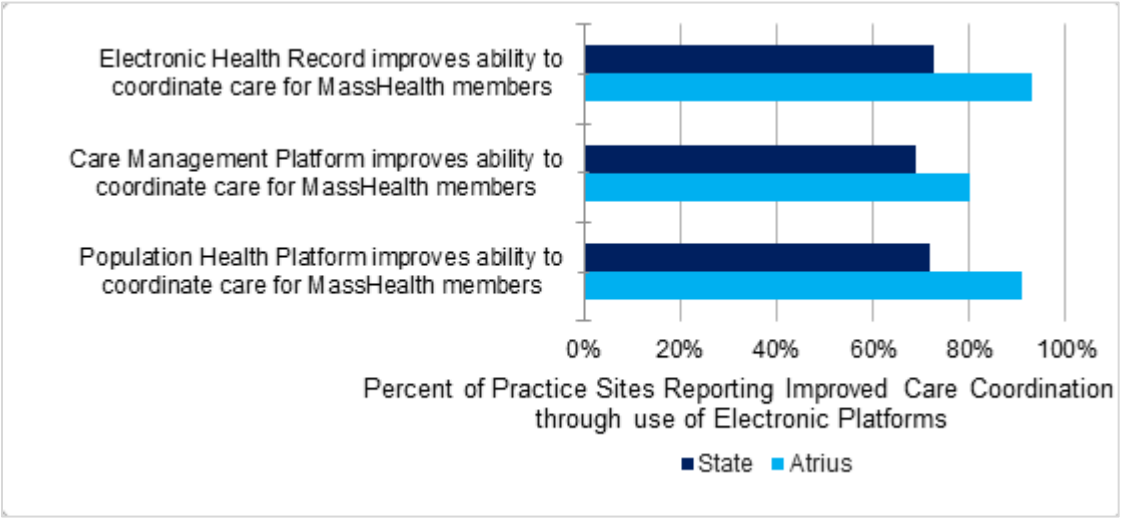
THPP Atrius and all their participating PCP sites have full access to ADT feeds and real-time event notification, although the ACO is only partially able to incorporate this data into their population health analytics technology.

THPP Atrius has also constructed real-time EHR interfaces with 14 participating hospitals. These interfaces also include event notifications for member admissions, transfers, and discharges and can include more comprehensive summary of care documents. For partnered hospitals that do not utilize these real-time interfaces, bi-directional web portals are in place so that providers can still access member care plans. THPP Atrius providers also have access to a total cost of care (TCOC) dashboard that is updated quarterly with ACO cost data.

THPP Atrius is able to share and/or receive electronic Member contact information, comprehensive needs assessments and care plans through secure and compliant means with all or the majority of their participating PCP sites, participating specialists, community partners and managed care plan; but very few of their non-affiliated providers.

Results from the ACO Practice Site Administrator Survey indicate that a majority of Atrius practice sites agree or strongly agree that EHR and population and care management platforms improve their ability to coordinate care for MassHealth members (Figure 3).

Figure 3. Perceptions of HIT Platforms for Care Coordination



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in Atrius, N = 14
Figure displays responses to Q13_EHR, Q13_CMP, Q13_PHP. *To what extent do you agree that the Electronic Health Record/ Care Management Platform/Population Health Platform improves your ability to coordinate care for your MassHealth members?*
Statistical significance testing was not done due to small sample size.

Recommendations

The IA encourages THPP Atrius 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:

- developing system integration which allows for the electronic transmission of Member contact information, comprehensive needs assessments and care plans to/from their non-affiliated providers; and
- further integrating ADT feeds and other data directly into EHR and Care Coordination platforms to increase utilization by PCPs.

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

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

- Leveraging EHR integrated care management and population health platforms.
- Automating risk stratification to identify high-risk, high-need members.
- Developing HIT training for all providers as part of an on-boarding plan.
- Incorporating meta-data tagging into care management platforms to allow supervisors to monitor workflow progress.
- Conducting ongoing review and evaluation of risk stratification algorithms to improve algorithms and refine the ACO's approach to identifying members at risk who could benefit from PHM programs.

✓ **Systems for collaboration across organizations**

- Establishing EHR portals that allow members to engage with their chart and their care teams.
- Providing EHR access through a web portal for affiliated providers, CPs or other entities whose EHR platforms are not integrated with the ACOs EHR.
- Developing methods to aggregate data from practice sites across the ACO; particularly if sites use different EHRs.
- Pushing ADT feeds to care managers in real time to mitigate avoidable ED visits and/or admissions.
- Developing continuously refreshing dashboards to share real-time program eligibility and performance data.

5. CARE COORDINATION AND CARE MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

✓ **Full continuum collaboration**

- collaborates with state agencies such as DMH;

- has established processes for identifying members eligible for BH or LTSS services and collaborating with CPs, including exchanging member information, and collaborating for care coordination when CP has primary care management responsibility;
- designates a point of contact for CPs to facilitate communication;
- incorporates social workers into care management teams and integrates BH services, including Office-Based Addiction Treatment (OBAT), into primary care.

✓ **Member outreach and engagement**

- uses both IT solutions and manual outreach to improve accuracy of member contact information;
- uses a variety of methods to contact assigned members who cannot be reached telephonically by going to members' homes or to community locations where they might locate the individual (e.g. a congregate meal site);
- addresses language barriers through steps such as translating member-facing materials, providing translators for appointments, and recruiting CCCM staff who speak members' languages;
- supports members who lack reliable transportation by providing rides or vouchers[6], and/or providing services in homes or other convenient community settings;

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

- locates CCCM staff in or near EDs;
- enables staff to build 1:1 relationships with high-need members, and uses telemedicine, secure messaging, and regular telephone calls for ongoing follow-up with members;
- provides members with 24/7 access to health education and nurse coaching, through a hotline or live chat;
- implements best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;
- implements processes to direct members to the most appropriate care setting, including processes to re-direct members to primary care to reduce avoidable emergency department visits;

✓ **Referrals and follow-up**

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

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

Results

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

Full continuum collaboration

THPP Atrius aims for full continuum collaboration through the inclusion of social workers and CHWs in addition to physicians and nurses on care management teams. Care facilitators are scattered throughout ACO sites. BH is addressed through co-located psychiatrists, psychiatric nurse practitioners, social workers, and BH Care Managers.

THPP Atrius also drives care coordination through strategic relationships BH and LTSS CPs. THPP Atrius established clear documentation processes with CPs to specify CP responsibilities in care coordination and has hired additional staff to support integration of the CP program. The Director of Care Management and the Chair of Behavioral Health build linkages and design workflow strategies with LTSS CPs and BH CPs, respectively. The newly-hired CP Program Manager serves as a single point of contact for all day-to-day CP-related matters, while Care Managers work with members assigned to CPs to complete needs assessments and to help members begin their CP relationship.

THPP Atrius includes clinical information extracted from the EHR in the enhanced Assignment File process and uploads care plans to the EHR. The ACO and CP also share information through care planning meetings with CCM and CP staff. Member CP enrollment is included in the EHR, which is beneficial to both providers and the Analytics and Reporting Department, which compares EHR data to State registries of CP enrollees for accurate updates.

Members with complex needs are assigned to care facilitators for intensive review with the PCP and other members of the care management team. For instance, pediatric admissions to BH facilities are discussed on weekly discharge planning calls with the CCCM team. The ACO also conducts regular pediatric roster reviews to ensure a smooth referral process (discussed below).

The IA did not find documentation of collaboration with state agencies.

Member outreach and engagement

THPP Atrius utilizes several traditional methods of member outreach, such as telephone calls and mailings. The ACO's Telecom Center offers a 24/7 hotline that members can call to speak with clinicians and is actively working to expand telehealth offerings. Additionally, CHWs outreach to "harder to engage" members in their communities if they are unable to engage these members in office. THPP Atrius has also hired Community Care Outreach Workers and invested in motivational interviewing training to bolster engagement efforts.

THPP Atrius offers member health education through disease management workshops and one-on-one sessions with care managers for members with chronic conditions such as diabetes.

THPP Atrius staff receive cross-cultural communication training to improve members' interaction with ACO staff. THPP Atrius sites also utilize medical interpreter services, including services for American Sign Language.

Connection with navigation and care management services

THPP Atrius begins the navigation process by screening members for depression and HRSNs, although the HRSN screening initiative is still being integrated into some sites. THPP Atrius is in the process of incorporating HRSN screening data into the EHR, and members enrolled in the complex care program are marked in the EHR platform with an identifying flag. When these members call or visit an ACO site, they are automatically rerouted to a trained care management nurse, who will assess the member for exacerbation of existing problems or development of new problems. Following care encounters, CCM staff emphasize warm handoffs to care management and social services using the EHR.

THPP Atrius also has a Navigator Center dedicated to coordinating referrals outside of the Atrius Health system. For internal referrals, Patient Navigators conduct appointment scheduling and member outreach work, along with coordinating follow-up, documentation transfers, and confirmation of care following appointments. Along with the 24/7 Telecom Center, these resources are major strategies used by the ACO to redirect low-acuity ED use. Care Facilitators and CHWs also assist with navigation and work to connect members and their families with community resources.

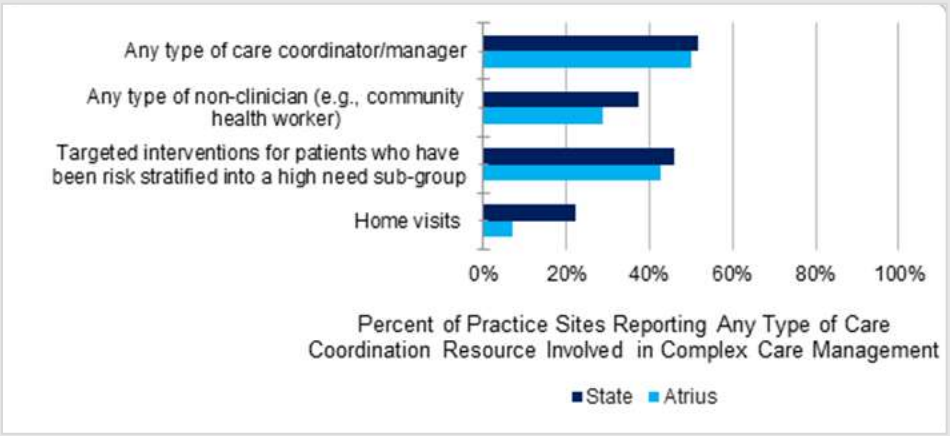
Referrals and follow-up

THPP Atrius has detailed referral process workflows to document referrals into each department, to specific staff, and back to primary care providers, although a standardized process for HRSN referrals is still under development. For members in the psychiatric target program, care management teams triage each referral request to determine the necessary complexity of care. Members with highly complex care needs are referred to BH providers within the Atrius Health system, while members needing less complex care may be referred to external BH providers (such as BH CPs). THPP Atrius providers can send electronic referral requests to other providers in the Atrius Health system, while external referrals are completed through the Navigator Center. Patient Navigators are primarily responsible for member follow-up and confirmation of completed care. CCM teams also have regular case conferences and roster reviews to discuss complex care members and schedule follow-ups as necessary.

> THPP Atrius Administrator Perspective*: "We had been engaged in trying to understand the key drivers of utilization for our socioeconomically vulnerable population. We recognized that there were unique challenges where we weren't successfully engaging those folks, so we recognized that our usual ways were not nearly sufficient. I think we [realized] that we needed to do things differently, [like] investing in spread of care facilitation, navigator services, investing in community health workers, and really engaging members in new ways that we just hadn't been doing thus far."*

Results from the ACO Practice Site Administrator Survey indicate that about half of Atrius sites report that any type of care coordinator is involved in helping complex high-need MassHealth members adhere to the care plan.

Figure 4. Care Coordination Resources Involved in Helping High-Need Members Adhere to the Care Plan



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in Atrius, N = 14
Figure displays responses to Q6. *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?*
Statistical significance testing was not done due to small sample size.

Recommendations

The IA encourages THPP Atrius 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:

- developing collaborative relationships with state agencies such as DMH;
- locating CCCM staff in or near EDs; and
- creating a standardized process for HRSN referrals and a standardized process to track all referrals.

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

✓ **Full continuum collaboration**

- Establishing a systematic documentation process to track members receiving care coordination from CPs.
- Matching members based on their needs to interdisciplinary care coordination teams that include representatives from primary care, nursing, social work, pharmacy, community health workers and behavioral health.
- Expanding BH integration through multiple strategies, including embedding staff in primary care sites, reverse integration of physical health care at BH sites, and telehealth.
- Increasing two-way sharing of information between ACOs and CPs.
- Leveraging EHR-integrated tools to flag members requiring a higher level of care coordination.
- Coordinating with government agencies and community organizations to enhance care coordination and avoid duplication for members receiving other services.

- Supporting families of pediatric members by offering to have care managers work with school-based personnel to address health or disability related needs identified in the Individualized Education Program.

✓ **Member outreach and engagement**

- Developing a high-intensity program for extremely high-need, high-risk members with strategically low case load.
- Establishing trust between members and CCCM staff by building and maintaining a 1:1 consistent relationship.
- Creating a mobile phone lending program for hard-to-reach members, particularly those experiencing housing instability.[7]
- Embedding CCCM staff in EDs.
- Creating a "Navigation Center" to manage referrals outside the ACO, handle appointment scheduling, and coordinate testing, follow-up, and documentation transfers.
- Developing an assistance fund to support transportation vouchers[8] and low-cost cell phones.[9]

✓ **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;

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

- Builds mature partnerships with community-based organizations to whom they can refer members for services
- has a plan approved for provision of flexible services;

✓ **Population health analysis**

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

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

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

Results

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

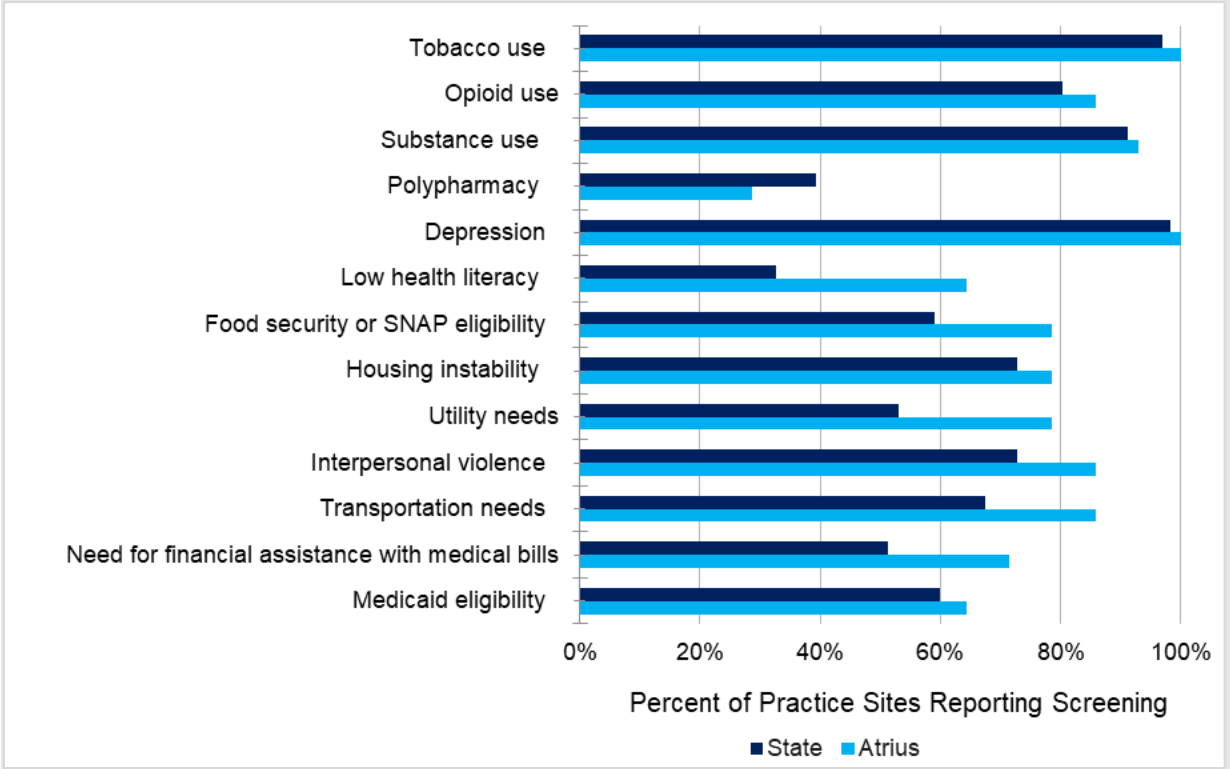
Integration of health-related social needs

THPP Atrius staff conduct HRSN screenings in primary care, internal medicine, and pediatric settings. THPP Atrius has provided a modest stipend for two physicians serving as champions, identified to sponsor and support health-related social needs screening throughout the practices. The results of these screenings are included in the EHR and incorporated into risk stratification reports, which also include clinical and pharmacy claims.

All Atrius practice sites responding to the ACO Practice Site Administrator Survey indicated screening for tobacco use and depression, and most also indicated that they conduct screening for a range of needs including housing instability, transportation needs, food insecurity or SNAP eligibility, and need for financial assistance with medical bills (Figure 5).

THPP Atrius incorporates HRSNs in targeting members for more intensive services, such as through the various CCCM programs. THPP Atrius has received approval for their plan for provision of flexible services.

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



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in Atrius, N = 14
Figure displays responses to Q14. *For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)*
Statistical significance testing was not done due to small sample size.

Population health analysis

THPP Atrius has devised a risk stratification model that sorts members according to risk of future hospitalization and by condition based on clinical data, medical and pharmacy claims, prior utilization, BH information, demographic data, and HRSN screening results. Care planning and ACO support is tailored to members based on their risk stratification category.

THPP Atrius also develops registries of members with complex care needs and of members receiving Medicaid benefits.

In addition to the utilization cost analyses completed in the risk stratification process, THPP Atrius tracks various financial metrics and uses predictive models to identify opportunities for both clinical intervention, such as CCCM program and CP referrals, and reduction in TCOC. THPP Atrius employs data analysts dedicated specifically to this work and to identifying drivers of TCOC. The ACO also provides clinicians with access to a cost dashboard, which is updated quarterly.

THPP Atrius produces quarterly reports on utilization and TCOC. The utilization report examines costs associated with services provided on specific dates, while the TCOC report covers utilization costs associated with deliveries, prescription drugs, and various inpatient, ambulatory, and BH services.

Program development informed by population health analysis

THPP Atrius offers several population health programs catered to particular medical diagnoses such as BH and diabetes. For instance, the diabetes program includes one-on-one diabetes education and nutritional counseling with care managers and nutritionists, respectively. THPP Atrius's Innovation Center, which is dedicated to developing creative new programming, has initiated a program providing same-day home visits by a registered nurse, along with a "hospital at home" program that is still growing.

> THPP Atrius Administrator Perspective: "*With social determinant screening, every patient is given the opportunity at every annual physical to complete the social determinants of health screening that we integrated, and they can do so electronically from home before the appointment... Anyone under 13 can complete it at home before their visit, then it's assessed by the clinician at the time of their visit. We've tried to make as many easy connections to resources as possible, based on a positive screen [for health-related social needs.]*"

Recommendations

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

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

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

- Implementing single sign-on and query capability into the online Prescription Monitoring Program, so that providers can quickly access and monitor past opioid prescriptions to promote safe opioid prescribing.

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

- Engaging top level ACO leadership in design and oversight of PHM strategy.
- Developing methods to assess members' impactibility as well as their risk, so that programs can be tailored for and targeted to the members most likely to benefit.
- Developing services that increase access to real-time BH care, such as an 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 THPP Atrius is On track or On track with limited recommendations across all six focus areas of progress under assessment at the midpoint of the DSRIP Demonstration. No recommendations are provided in the following focus areas:

- Organizational Structure and Engagement
- Integration of Systems and Processes
- Population Health Management

The IA encourages THPP Atrius 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:

Workforce Development

- developing additional programs to assist staff recruitment and retention like educational assistance, loan forgiveness programs, ongoing licensing and credentialing, or performance bonuses.

Health Information Technology and Exchange

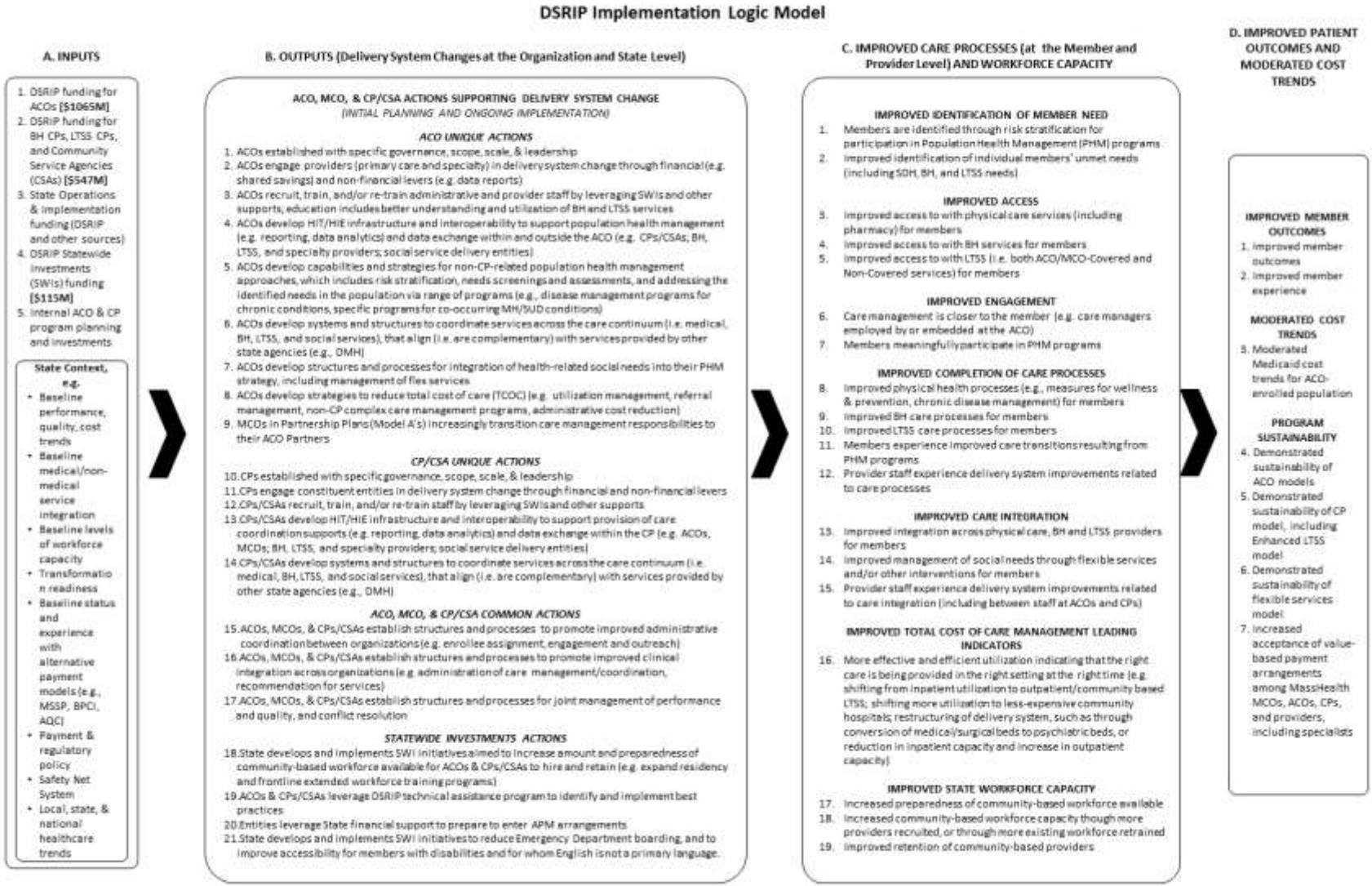
- developing system integration which allows for the electronic transmission of Member contact information, comprehensive needs assessments and care plans to/from their non-affiliated providers; and
- further integrating ADT feeds and other data directly into EHR and Care Coordination platforms to increase utilization by PCPs.

Care Coordination and Care Management

- developing collaborative relationships with state agencies such as DMH;
- locating CCCM staff in or near EDs; and
- creating a standardized process for HRSN referrals and a standardized process to track all referrals.

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations[10] (ACOs) towards the goals of DSRIP during the time period covered by the MPA, July 1, 2017 through December 31, 2019.

Progress was defined by the ACO actions listed in the detailed MassHealth DSRIP Logic Model (Appendix I), organized into a framework of six focus areas which are outlined below. This model was developed by MassHealth and the Independent Evaluator[11] (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

[10] 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).
[11] The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

FOCUS AREA FRAMEWORK

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

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

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

Table 1. Framework for Organizational Assessment of ACOs

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

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

ANALYTIC APPROACH

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

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

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

DATA COLLECTION

ACO Practice Site Administrator Survey Methodology

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

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

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

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

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

Table 1. Distribution of Practice Site Types

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

Table 2. Distribution of Practices Across Geography

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

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

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

Key Informant Interviews

Key Informant Interviews (KII) of ACO Administrators were conducted in order to understand the degree to which participating entities are adopting core ACO competencies, the barriers to transformation, and the organization's experience with state support for transformation.[12] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[12] 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: THPP ATRIUS 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.

- 25 practice sites were sampled; 14 responded (56% 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.
- Gray fill indicates an answer choice that is not applicable to the survey question.

FOCUS AREA: ORGANIZATIONAL STRUCTURE AND GOVERNANCE

Q#	Question	Answer Choices	1	2	3	4	5	6	7	Don't Know
12	In the past year, to what degree have the following practices in your clinic become more standardized, less standardized or not changed? *A lot less, a little less, no change, a little more, a lot more standardized (1-5), I Don't Know*	a. Physician compensation	0%	0%	29%	7%	7%	N/A	N/A	57%
		b. Performance management of physicians	0%	0%	7%	21%	7%	N/A	N/A	64%
		c. Care processes and team structure	0%	0%	14%	43%	43%	N/A	N/A	0%
		d. Hospital discharge planning and follow-up	0%	0%	7%	21%	64%	N/A	N/A	7%
		e. Recruiting and performance review	0%	7%	36%	21%	7%	N/A	N/A	29%
		f. Data elements in the electronic health record	0%	0%	7%	21%	64%	N/A	N/A	7%
21	To the best of your knowledge, in the past, has your practice participated in payment contract(s) together with the other clinical providers and practices that are now participating in the [ACO Name]? Select one.	a. Yes, with most of the clinical providers and practices that now compose this ACO (1) b. Yes, with some of the clinical providers and practices that now compose this ACO (2) c. No, this is our first time participating in a payment contract with the clinical providers and practices that compose this ACO (3) d. Don't know	21%	0%	0%	N/A	N/A	N/A	N/A	79%
22	Has your practice received any financial distributions (DSRIP dollars) as part of its engagement with the MassHealth Accountable Care Organization?	Yes (1) No (2) Don't know	0%	7%	N/A	N/A	N/A	N/A	N/A	93%
23	Is a representative from your practice site engaged in ACO governance?	Yes (1) No (2) Don't know	7%	21%	N/A	N/A	N/A	N/A	N/A	71%
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	7%	29%	7%	7%	14%	N/A	N/A	36%
25	Please indicate the extent to which you agree or disagree with the following statement: ACO leaders have communicated to this practice site a vision for the MassHealth ACO and the care it delivers.	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5) Don't know/ Not applicable	0%	29%	14%	29%	7%	N/A	N/A	21%

26	To what extent do you agree or disagree with each of the following statements? *Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know/Not Applicable (6)*	a. The MassHealth ACO is a resource and partner in problem-solving for our practice. (1)	7%	0%	43%	21%	7%	N/A	N/A	21%
		b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions. (2)	7%	0%	57%	7%	0%	N/A	N/A	29%
		c. All entities in this MassHealth ACO work together to solve problems when needed. (3)	7%	7%	29%	0%	21%	N/A	N/A	36%
28	Overall, how satisfied are you with your practice's experience as part of this MassHealth ACO?	Highly dissatisfied (1) Somewhat dissatisfied (2) Neither satisfied nor dissatisfied (3) Somewhat satisfied (4) Highly satisfied (5)	0%	31%	31%	38%	0%	N/A	N/A	N/A
34	In the past year, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	a. Massive change - completely redesigned their care (1) b. A lot of change (2) c. Some change (3) d. Very little change (4) e. No change (5)	0%	0%	46%	38%	15%	N/A	N/A	N/A
35	In the past year, to what extent has your practice's ability to deliver high quality care to MassHealth members gotten better, gotten worse, or stayed the same?	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	0%	15%	38%	46%	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)	92%	54%	92%	38%	38%	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)	18%	64%	55%	91%	0%	55%	9%	N/A

FOCUS AREA: INTEGRATION OF SYSTEMS AND PROCESSES

Q#	Question	Answer Choices	1	2	3	4	5	6	7	Don't Know
	For the care coordination and management resources used by your practice, how many of these resources are MANAGED by people at the following organizations (e.g., overseen, supervised)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	36%	43%	14%	7%	N/A	N/A	N/A	N/A
		b. The physical location and department where you work	36%	21%	36%	7%	N/A	N/A	N/A	N/A
		c. A community-based organization	14%	79%	7%	0%	N/A	N/A	N/A	N/A
		d. A different practice site, department, or location in your organization	21%	71%	7%	0%	N/A	N/A	N/A	N/A
		e. Other organization, entity, or location	43%	57%	0%	0%	N/A	N/A	N/A	N/A

1c	For the care coordination and management resources used by your practice, how many of these resources are HOUSED at the following locations (by housed we mean the place where these resources primarily provide patient services)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	29%	64%	7%	0%	N/A	N/A	N/A	N/A
		b. The physical location and department where you work	36%	29%	29%	7%	N/A	N/A	N/A	N/A
		c. A community-based organization	14%	79%	7%	0%	N/A	N/A	N/A	N/A
		d. A different practice site, department, or location in your organization	36%	50%	14%	0%	N/A	N/A	N/A	N/A
		e. Other organization, entity, or location	36%	64%	0%	0%	N/A	N/A	N/A	N/A
3	For your MassHealth members who receive care coordination and management services from more than one program or person, how often do these resources operate together efficiently?	Never (1) Rarely (2) Sometimes (3) Usually (4) Always (5) Don't Know/Not Applicable	0%	29%	7%	57%	0%	N/A	N/A	7%
8b	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5), I Don't Know*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	43%	7%	29%	21%	0%	N/A	N/A	0%
		b. counseling therapists, including clinical social workers	36%	7%	36%	7%	14%	N/A	N/A	0%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	29%	14%	36%	14%	7%	N/A	N/A	0%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	36%	0%	14%	7%	43%	N/A	N/A	0%
10	How difficult is it for your practice to obtain treatment for your MassHealth members with opioid use disorders?	Nearly impossible (1) Very difficult (2) Somewhat difficult (3) A little difficult (4) Not at all difficult (5) Don't Know/Not Applicable	7%	29%	7%	14%	14%	N/A	N/A	29%
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	14%	36%	7%	0%	0%	N/A	N/A	43%
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?	a. Very few (1) b. More than very few, but not many (2) c. About half (3) d. A majority (4) e. Nearly all (5) f. I don't know/I'm not aware)	0%	8%	0%	0%	0%	N/A	N/A	92%
32	How frequently have clinicians, staff and/or administrators interacted with Community Partner organization staff in coordinating these patients' care?	Almost Never (1) Rarely (2) Sometimes (3) Often (4) Almost Always (5) Don't know	0%	0%	100%	0%	0%	N/A	N/A	0%
33	To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members?	Has made it harder almost all of the time (1) Has made it harder some of the time (2) Has made little or no change (3) Has made it easier some of the time (4) Has made it easier almost all of the time (5) Don't know	0%	0%	0%	100%	0%	N/A	N/A	0%

FOCUS AREA: WORKFORCE DEVELOPMENT

Q#	Question	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%	57%	14%	29%	0%	N/A	N/A	N/A

FOCUS AREA: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Q#	Question	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%	71%	79%	14%	N/A	N/A	N/A	N/A
13_EHR	To what extent do you agree that the Electronic Health Record improves your ability to coordinate care for your MassHealth members? *Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	7%	0%	0%	21%	71%	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? *Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	0%	0%	0%	60%	20%	N/A	N/A	20%
Q13_PHP	To what extent do you agree that the Population Health Platform improves your ability to coordinate care for your MassHealth members? *Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	0%	0%	0%	27%	64%	N/A	N/A	9%

FOCUS AREA: CARE COORDINATION AND CARE MANAGEMENT

Q#	Question	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)	71%	64%	64%	57%	93%	0%	N/A	N/A
2	In the past 12 months to what extent have these coordination and management resources helped your practice's efforts to deliver high quality care to your MassHealth members?	*Not at all, A little, Somewhat, Mostly, A great deal (1-5)*	7%	0%	29%	21%	43%	N/A	N/A	N/A

4	In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members? *Always, Usually, Sometimes, Rarely, Never Difficult (1-5)* *Don't Know (6)*	a. Learn the result of a test your practice site ordered	0%	0%	0%	57%	43%	N/A	N/A	0%
		b. Know that a patient referred by your practice site was seen by the consulting clinician	0%	29%	21%	43%	7%	N/A	N/A	0%
		c. Learn what the consulting clinician recommends for your practice site's patient	0%	36%	21%	36%	7%	N/A	N/A	0%
		d. Transmit relevant information about a patient who your practice site refers to a consulting clinician	0%	0%	14%	71%	14%	N/A	N/A	0%
		e. Reach the consulting clinician caring for a patient when your staff need to	0%	0%	43%	21%	7%	N/A	N/A	29%
5	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable (7)*	a. Arranging eye care from an ophthalmologist or optometrist	7%	0%	0%	36%	43%	14%	N/A	0%
		b. Confirming that a diabetic eye exam was performed	7%	0%	0%	43%	21%	7%	N/A	21%
		c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note	0%	0%	0%	43%	50%	7%	N/A	0%
6	For your complex high-need MassHealth patients, how often is any type of care coordination or management resource involved in helping the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Any type of care coordinator/manager	0%	14%	36%	21%	29%	N/A	N/A	N/A
		b. Any type of non-clinician (e.g., community health worker)	0%	21%	50%	21%	7%	N/A	N/A	N/A
		c. Targeted interventions for patients who have been risk stratified into a high need sub-group	0%	7%	50%	29%	14%	N/A	N/A	N/A
		d. Home visits	0%	14%	79%	0%	7%	N/A	N/A	N/A
7	For complex, high-need MassHealth members, how often does your practice use each of the following resources to help the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Referral to community-based services for health-related social needs	7%	0%	43%	43%	7%	N/A	N/A	N/A
		b. Communication with the patient within 72 hours of discharge	7%	0%	29%	21%	43%	N/A	N/A	N/A
		c. Home visit after discharge	14%	29%	57%	0%	0%	N/A	N/A	N/A
		d. Discharge summaries sent to primary care clinician within 72 hours of discharge	7%	0%	36%	36%	21%	N/A	N/A	N/A
		e. Standardized process to reconcile multiple medications	7%	0%	36%	29%	29%	N/A	N/A	N/A
8a	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Usually, Almost Always within the practice site (1-5), Don't Know/Not Applicable (6)*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	0%	0%	14%	21%	57%	N/A	N/A	7%
		b. counseling therapists, including clinical social workers	0%	0%	7%	21%	71%	N/A	N/A	0%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	0%	0%	14%	14%	57%	N/A	N/A	14%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	0%	0%	14%	29%	57%	N/A	N/A	0%
9	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for MassHealth members obtaining the following behavioral health services? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable (7)*	a. Scheduling the appropriate behavioral health services	7%	0%	0%	7%	43%	36%	N/A	7%
		b. Confirming that behavioral health services were received	14%	7%	29%	14%	14%	21%	N/A	0%
		c. Ensuring that your practice site receives the prescribing clinician, counseling therapist, or any type of care coordinator/manager's consult note, as appropriate	7%	0%	36%	7%	29%	21%	N/A	0%
		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	0%	0%	29%	29%	21%	21%	N/A	0%

11	To what extent do you agree or disagree that providers follow a clear, established process for the following activities? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable (7)*	a. Screening for service needs at home that are important for the patient's health?	0%	0%	0%	7%	43%	43%	N/A	7%
		b. Choosing among LTSS providers?	0%	0%	29%	14%	7%	29%	N/A	21%
		c. Referring patients to specific LTSS providers with which your office has a relationship?	0%	0%	29%	14%	14%	21%	N/A	21%
		d. Confirming that the recommended LTSS have been provided?	0%	0%	29%	7%	14%	29%	N/A	21%
		e. Establishing relationships with LTSS providers who serve your patients?	0%	0%	29%	14%	7%	21%	N/A	29%
		f. Getting updates about a patient's condition from the LTSS providers?	0%	0%	29%	14%	21%	29%	N/A	7%
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	0%	29%	36%	14%	7%	N/A	N/A	14%
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)	93%	86%	86%	43%	71%	64%	N/A	N/A

FOCUS AREA: POPULATION HEALTH MANAGEMENT

Q#	Question	Answer Choices	1	2	3	4	5	6	7	Don't Know
14	For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)	a. tobacco use	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		b. opioid use	86%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		c. substance use	93%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		d. polypharmacy	29%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		e. depression	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		f. low health literacy	64%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		g. food security or SNAP eligibility	79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		h. housing instability	79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		i. utility needs	79%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		j. interpersonal violence	86%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		k. transportation needs	86%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		l. need for financial assistance with medical bills	71%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		m. Medicaid eligibility	64%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		n. none of the above	0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A

16	How often are MassHealth members referred from your practice to social service organizations to address health-related social needs (e.g., housing, food security)?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	0%	7%	29%	7%	36%	N/A	N/A	21%
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	29%	50%	0%	0%	N/A	N/A	N/A	21%
29	Please select the option below that best describes the change in the past year in your practice site's ability to tailor delivery of care to meet the needs of patients affected by health inequities (e.g., by using culturally and linguistically appropriate services):	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	0%	0%	62%	31%	8%	N/A	N/A	N/A
30	How often does your practice site use site-specific data to identify health inequities within its served population? For example, data might include EHR charts or ACO reports.	Annually (1) Bi-annually (2) Quarterly (3) Monthly (4) On an ad hoc basis (5) We do not have access to this type of data. (6) We have access to this type of data but do no analyze it for health inequities. (7)	8%	0%	0%	15%	69%	8%	0%	N/A

FOCUS AREA: GENERAL QUESTIONS

Q#	Question	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)	71%	29%	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)	100%	0%	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)	0%	57%	36%	7%	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)	38%	38%	0%	23%	0%	N/A	N/A	N/A
39	Which of the following best describes your practice site?	Adult (1) Pediatric (2) Both (3)	8%	38%	54%	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)	0%	50%	25%	25%	0%	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%	8%	33%	33%	25%	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)	0%	0%	62%	38%	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%	8%	62%	8%	23%	N/A	N/A	N/A
44	Did you ask a colleague for help in answering questions on the survey?	Yes (1) No (2)	62%	38%	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

Atrius Health is an innovative nonprofit healthcare leader delivering a system of effective connected care to more than 730,000 adult and pediatric patients in eastern Massachusetts at 30 clinical locations, with nearly 700 physicians and primary care providers in close collaboration with hospital partners, community specialists and skilled nursing facilities. Our vision is to transform care to improve lives. Atrius Health provides high-quality, patient-centered, coordinated, cost effective care to every patient we serve. By establishing a solid foundation of knowledge, understanding and trust with each of its patients, Atrius Health enriches their health and enhances their lives.

We generally agree with the scope of the report and its areas of focus. We appreciate EOHHS's and the IA's recognition, implicit in this report, that as ACOs vary in their structure, composition, and operations, one size solutions do not fit all.

We think it is important to acknowledge that the methodology and data sources relied on for the report do not capture all of the strategies used, and progress made, by Atrius Health in its efforts to support our patients, communities and workforce in general, and in the focus areas in particular. We agree with and had implemented during the period covered by the report, many suggestions included in the report. For example, with respect to recruitment and retention strategies, Atrius Health currently offers ongoing support for licensing and credentialing and access to loan forgiveness programs. With respect to performance bonuses, quality incentives are included in the compensation model for most primary care providers and overall organization performance included in management and executive incentives.

We also want to highlight the role the rapidly changing market and government regulation play in how ACOs, including Atrius Health, are able to make progress towards certain DSRIP goals. For example, we have been committed to achieving the IA's recommendations in areas of health information technology and exchange, but our success is dependent on similar levels of engagement and effort within and across the provider community, as well as in federal and state agencies.

We agree that there are opportunities to advance activities within Care Coordination and Care Management, and are engaged in efforts to think differently about our social work department, transforming our approach to address patient whole-person needs including crisis intervention, adaptation to illness, and supporting patients and families in addressing health-related social needs. We have greatly benefitted from state agencies participating in training sessions for our paraprofessionals such as DCF offering trainings to our pediatric care facilitators.

In future assessment activities, we encourage EOHHS and the IA to focus on quantitative ACO performance, such as EOHHS' own utilization benchmark reports, in addition to key informant interviews, survey results, and ACO-supplied DSRIP reporting.

We appreciate EOHHS' partnership as we serve our Medicaid patients.