

# MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

## **ACO Report:**

Boston Children's Accountable Care Organization in  
partnership with Tufts Health Public Plans  
(THPP BCHACO)

Report prepared by The Public Consulting Group: December 2020



**PUBLIC**  
CONSULTING GROUP

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## DSRIP Midpoint Assessment Highlights & Key Findings

Boston Children's Health Accountable Care Organization in partnership with Tufts Health Public Plans (THPP BCHACO)

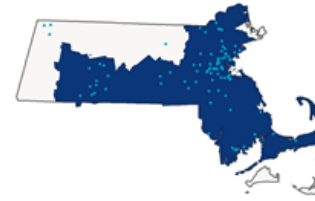


Model A ACO

THPP BCHACO is a MassHealth Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as Tufts Health Together with Boston Children's ACO. THPP BCHACO is a pediatric and young adult ACO.

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

<b>2017</b> (Jul to Dec)	<b>83K members</b>	<b>\$10.9M</b>
<b>2018</b>	<b>83K members</b>	<b>\$19.9M</b>
<b>2019</b>	<b>97K members</b>	<b>\$17.5M</b>

### POPULATIONS SERVED

- ▶ Common health concerns for the children and families THPP BCHACO serves include asthma, obesity, mental health, alcohol/drug abuse, community violence and trauma, and early childhood development.
- ▶ Roughly 1 in 3 members has a behavioral health condition.
- ▶ An estimated 1 in 10 members has at least one chronic medical condition; asthma is the most common.

### 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	● Limited Recommendations

### IMPLEMENTATION HIGHLIGHTS

- THPP BCHACO offers wellness programs for all eligible members. These supports include health coaching, a Healthy Baby Program, and member incentives including car seats, bike helmets, child safety kits, and immunization gift cards.
- All THPP BCHACO practice sites responding to the ACO Practice Site Administrator Survey indicated that they conduct screening for housing instability and transportation needs. A majority of THPP BCHACO practice sites responding to the survey indicated that they also screen for a range of needs including tobacco use, polypharmacy, opioid use, utility needs, interpersonal violence, Medicaid eligibility, depression, and need for financial assistance with medical bills
- THPP BCHACO analyzes cost and quality data at the aggregate and individual provider level, reports quality and utilization performance metrics at multiple levels, and promotes decision making primarily at the provider group level regarding shifts in care delivery models and ongoing quality improvement efforts.

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

## LIST OF SOURCES FOR INFOGRAPHIC

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

### NOTES

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

## INTRODUCTION

Centers for Medicare and Medicaid Services' (CMS') requirements for the MassHealth Section 1115 Demonstration specify that an independent assessment of progress of the Delivery System Reform Incentive Payment (DSRIP) Program must be conducted at the Demonstration midpoint. In satisfaction of this requirement, MassHealth has contracted with the Public Consulting Group to serve as the Independent Assessor (IA) and conduct the Midpoint Assessment (MPA). The IA used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations<sup>1</sup> (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<sup>2</sup> (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.

<sup>1</sup> 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.

<sup>2</sup> 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
<b>Organizational Structure and Governance</b>	<ul style="list-style-type: none"> <li>• ACOs established with specific governance, scope, scale, &amp; leadership</li> <li>• 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)</li> </ul>
<b>Integration of Systems and Processes</b>	<ul style="list-style-type: none"> <li>• ACOs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)</li> <li>• ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)</li> <li>• ACOs establish structures and processes for joint management of performance and quality, and conflict resolution</li> <li>• Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the Demonstration</li> </ul>
<b>Workforce Development</b>	<ul style="list-style-type: none"> <li>• 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)</li> </ul>
<b>Health Information Technology and Exchange</b>	<ul style="list-style-type: none"> <li>• 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)</li> </ul>
<b>Care Coordination and Care Management</b>	<ul style="list-style-type: none"> <li>• 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))</li> </ul>
<b>Population Health Management</b>	<ul style="list-style-type: none"> <li>• 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)</li> <li>• 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</li> <li>• 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)</li> </ul>

## METHODOLOGY

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

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

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

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

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

## ACO BACKGROUND<sup>3</sup>

Boston Children's Health Accountable Care Organization (THPP BCHACO) in partnership with Tufts Health Public Plans (THPP BCHACO) is a MassHealth Accountable Care Partnership Plan (ACPP), a "Model A" ACO, and is also known as Tufts Health Together with Boston Children's ACO. 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<sup>4</sup> for the population.

<sup>3</sup> Background information is summarized from the organization's Full Participation Plan.

<sup>4</sup> 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.



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

THPP BCHACO's service area includes the following MassHealth service areas: Adams, Attleboro, Barnstable, Beverly, Boston, Brockton, Fall River, Falmouth, Framingham, Gardner-Fitchburg, Haverhill, Holyoke, Lawrence, Lowell, Lynn, Malden, New Bedford, Northampton, Oak Bluffs, Orleans, Plymouth, Quincy, Revere, Salem, Somerville, Southbridge, Springfield, Taunton, Waltham, Wareham, Westfield, Woburn, and Worcester.

In addition, THPP BCHACO has entered into a management services agreement with the Children's Hospital Corporation (CHC), under which the Department of Accountable Care and Clinical Integration of CHC (DACCI) provides the THPP BCHACO with an executive management team, care management resources, and operational support.

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

Table 2. THPP BCHACO MassHealth Members and DSRIP Funding 2017-2019<sup>5</sup>

Year	Members	DSRIP Funding
2017 (partial year, Jul-Dec)	83,403	\$10,886,760
2018	83,403	\$19,899,760
2019	97,353	\$17,461,758

THPP BCHACO is a pediatric and young adult ACO. Chronic conditions among THPP BCHACO's members include asthma, obesity, mental health and substance use disorders, and community violence and trauma.. Roughly one in three members has a behavioral health condition. An estimated one in ten members has at least one chronic medical condition. Asthma is the most common chronic condition.

## SUMMARY OF FINDINGS

The IA finds that THPP BCHACO is On track or On track with limited recommendations 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 with limited recommendations

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

## FOCUS AREA LEVEL PROGRESS

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

### 1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

#### *On Track Description*

Characteristics of ACOs considered On track:

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

#### *Results*

The IA finds that THPP BCHACO is **On track with no recommendations** in the Organizational Structure and Engagement focus area.

#### **Established governance structures**

The ACO has established appropriate governance structures. The ACPP is overseen by a Joint Operating Committee (JOC) that determines the overall operating strategy, approves DSRIP budgets, conducts periodic progress reviews and manages all reporting to MassHealth and EOHHS. The JOC, which includes an equal number of representatives from Boston Children's Hospital (BCH) and Tufts Health Public Plans (THPP), is supported by a Finance Committee, a Compliance Committee, a Quality Committee and the ACO's Patient and Family Advisory Council (PFAC). BCH also provides an executive management team, care management resources and provides the majority of operational support across key clinical and care management functions. BCH also provides

primary oversight over the ACO's provider networks across its primary care practices as well as several affiliated physician organizations.

The JOC's Finance and Quality committees establish and monitor the ACP's overall performance on quality and cost measures. The ACO's governing board, which reports to the JOC and is composed primarily of providers, social workers and some administrative personnel regularly reviews and makes recommendations on the management of the ACO's approaches to care delivery including recommending quality improvement strategies for adoption by the Quality Committee and JOC. The Governing Board is comprised of 75% representatives from BCH and 25% from THPP.

The ACO's Governing board meets with its 11-member PFAC quarterly. The PFAC is comprised entirely of parents of BCH members including those with severe behavioral health issues and is consulted regularly on clinical protocols as well as topics like flexible services program design.

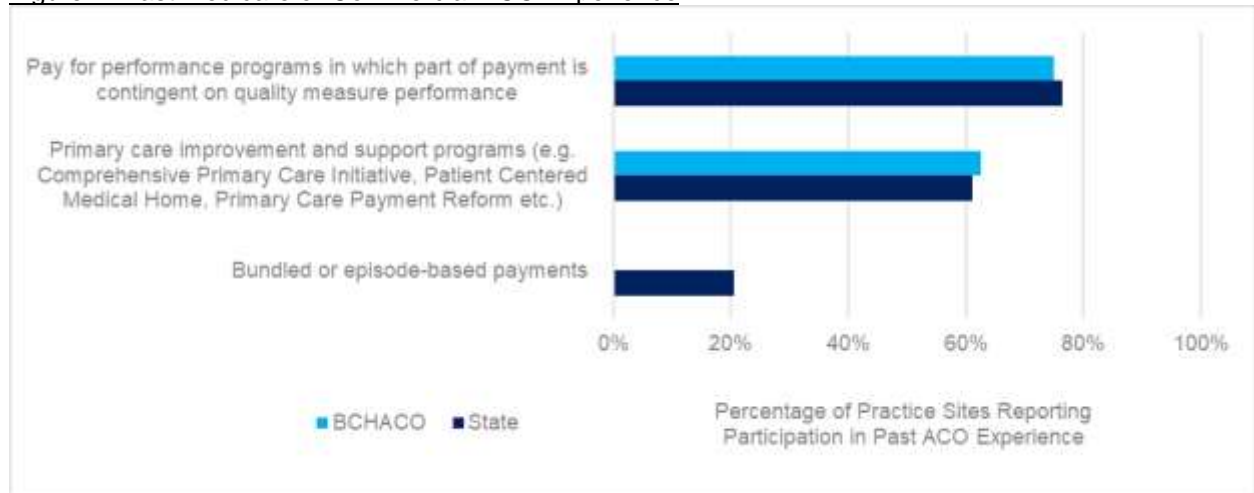
### **Provider engagement in delivery system change**

The quality committee establishes the key performance indicators across cost and quality metrics. Annual progress reports and some interim reports are then generated through a combination of data sources taken from BCH's clinical information systems which also contain information related to health-related social needs and THPP's claims data. Although the Value-Based Payment (VBP) strategy is set centrally by the Quality Committee, Finance Committee and the JOC annually, individual practice sites are granted flexibility in implementing care models and pursuing quality improvement initiatives using ongoing performance reports.

Feedback from front line staff is received through regular care management staff meetings overseen by THPP. These meetings typically explore all aspects of the PHM strategy and how models for care coordination and care management can be improved. Additionally, the Vice President of PHM hosts biweekly management meetings and regular staff meetings to collect provider feedback on program design changes and input on care management operations and strategy.

THPP BCHACO reports improvements in its ability to generate interim performance reports for providers following early program year setbacks based on shifting quality metric priorities through MassHealth. THPP BCHACO appears to report cost and quality data at the individual provider level, but promotes decision making primarily at the provider group level regarding shifts in care delivery models and ongoing quality improvement efforts. Results from the practice site survey indicate a majority of sampled THPP BCHACO practice sites reported participation in pay for performance programs and primary care improvement and support programs (Figure 1).

Figure 1. Past Medicare or Commercial ACO Experience



Number of Practices Reporting in the State, N = 225

Number of Practices Reporting from THPP BCHACO, N = 17

Figure displays responses to Q38: 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. Statistical significance testing was not done due to a limited 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 BCHACO is **On track with no recommendations** in the Integration of Systems and Processes focus area.

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

BCHACO, THPP, and LTSS CPs exchange member care plan, new referral, follow-up encounter, and social program enrollment data. THPP provides care management, risk stratification, quality and utilization reports to THPP BCHACO to assist with member management. The Children's Behavioral Health Initiative (CBHI) manages members who require behavioral health (BH) services with assistance from THPP BCHACO to coordinate care plans and follow-up services. THPP BCHACO assisted CBHI integration by hiring a new project leader to facilitate this collaboration and a long-term services and supports (LTSS) CP Program Manager to oversee the LTSS care program.

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

Care management for members is organized by clinical programs who serve members. Warm handoffs and collaboration across multidisciplinary teams of nurses, licensed social workers, and non-clinical staff are the foundation of THPP BCHACO's care management strategy. THPP BCHACO also hired a complex care manager to document program activities and monitor a set of operational process metrics to enhance their medical home program. THPP BCHACO runs frequent care management meetings for front-line staff and organizational leaders to address organizational challenges, discuss specific cases, find collaborative solutions, and examine care management reports generated by the MCO. Providers can view member clinical information through an EHR. In survey results, 42% of THPP BCHACO practice sites reported that their Care processes and team structures had become more standardized in the last year, and all other respondents said it was unchanged.

Additionally, THPP BCHACO's clinical integration plan emphasizes measurability to improve primary care providers' ability to address member social and behavioral health needs. The plan includes objective metrics such as increasing provider site participation and building PCP knowledge, experience, and comfort in caring for members requiring BH services. Additionally, in a pilot aimed at increasing integration of primary care and BH services, THPP BCHACO formed four partnerships between primary care practices and CBHI to improve access to low acuity BH services and to further integrate primary care and community based BH entities. An ACO senior project manager oversees these partnerships.

### **Joint management of performance and quality**

THPP BCHACO's quality assurance plan jointly engages providers and ACO staff. ACO leadership determines quality initiatives and calls on regional medical directors, clinical providers and administrative staff to adopt ACO-wide quality standards at practice sites. The ACO reported success in improving process or outcome metrics in HPV vaccination, depression screening, health-related social needs screening, and metabolic monitoring for children and adolescents with antipsychotics. Practice sites are currently working to improve a variety of performance and process metrics related to outreach calls, follow-up, immunization status, screening and low-acuity ED utilization.

THPP BCHACO's Quality Committee meets regularly to discuss performance metrics and the VBP program. These meetings form the basis for payment recommendations sent to the JOC as committee members assess various sites' progress on integration plan measures. The ACO embedded Medical Home Care Coordinators (MHCC) in all practice sites to assist providers with quality improvement initiatives, such as reducing low-acuity ED utilization and reducing disparities in public versus privately insured patients. The Coordinators use EHR and other data-based platforms to drive improvement projects.

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

THPP BCHACO's Joint Operating Committee (JOC) oversees enrollee risk stratification and administrative coordination in care management between THPP BCHACO and THPP. THPP provides THPP BCHACO with reports including information on care management, risk stratification, quality, and utilization.

## 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 BCHACO is **On track with limited recommendations** in the Workforce Development focus area.

##### **Recruitment and retention**

THPP BCHACO has pursued a recruitment and retention strategy that appears to have mitigated any major or persistent gaps in staffing. THPP BCHACO relies on local practice clinical leaders primarily to decide on their staffing needs across its major provider groups. THPP BCHACO then uses partnerships with colleges, community service resources and agencies, as well as providers, to assist in recruiting candidates at practice sites.

Practice sites across the ACO use regularly scheduled huddles, individual and group coaching, ongoing participation in peer networking as a way of supporting staff and increasing retention levels. THPP BCHACO reports as well offering various opportunities for both on-line and in-person professional development opportunities though the IA was unable to identify specific examples.



## Training

All staff receive onboarding training that addresses primary topics around the ACO as well as specific content areas like electronic health record use. Care Managers also receive regular training and coaching in motivational interviewing to improve membership engagement. Additional trainings are managed by major provider groups, reportedly targeting for all staff specific to their role and populations they serve. Training takes place at practice sites though ongoing web-based trainings and occur at least quarterly.

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

THPP BCHACO has pursued a person-centered care delivery and population health model through the development of multi-disciplinary teams. Care management teams include Registered Nurse Care Managers (RNCM), Behavioral Health Care Managers (BHCM), Licensed Independent Clinical Social Workers (LICSW), Public Health Workers (PHW), and Community Care Outreach workers (COO).

Various iterations of care management team structures exist across the ACO's major provider groups and are primarily determined, measured and adjusted by provider groups themselves. THPP BCHACO reports one region inside of a provider group operating care management teams with a nurse care manager supported by a CHW. Another regional group has several CHWs supporting a pilot asthma program. All PHM programs are overseen by either an RN, if the program is clinical, or an MSW, if the program addresses behavioral and/or social topics.

## Recommendations

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

- exploring opportunities for career development, educational assistance, ongoing licensing and credentialing or loan forgiveness for staff.

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

### ✓ Promoting diversity in the workplace

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

- Recruiting in other geographic areas with high concentrations of Spanish speakers or other needed language skills, and then helping qualified recruits with relocation expenses.

✓ **Recruitment and retention**

- Contracting with a local social services agency capable of providing the ACO with short term CHWs, enabling the ACO to rapidly increase staff on an as-needed basis.
- Onboarding cohorts of new CCCM staff with common start dates, enabling shared learning.
- Implementing mentorship programs that pair newly onboarded staff with senior members to expedite training, especially amongst CCCM teams with complex labor divisions.
- Providing opportunities for a staff voice in governance through regularly scheduled leadership town halls at individual practice sites.
- Recruiting staff from professional associations, such as the Case Management Society of America, and from targeted colleges and universities.
- Offering staff tuition reimbursement for advanced degrees and programs.
- Using employee referral bonuses to boost recruitment.

**Training**

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

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

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

## 4. HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

### *On Track Description*

Characteristics of ACOs considered On track:

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

### *Results*

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

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

THPP BCHACO continues to demonstrate progress toward enterprise-wide technical interoperability. All of the Pediatric Physicians' Organization of Children's Hospital (PPOC) practices utilize the same EHR platform facilitating integrated data sharing between providers. BCH runs BCHACO primary care sites, and though it differs from the PPOC sites, it does allow for electronic referral requests to be sent between the two systems.

THPP BCHACO is finalizing a system-wide EHR upgrade focused on improving handoffs and clinician communication. The upgrade will enhance handoff notifications and enable the sharing of more information, including the purpose of a specialty consultation request, and the expectation of whether future care will be handled by a specialist or returned to a primary care provider. Additionally, BCH and the PPOC have launched bi-directional portals to view members' medical records from their respective platforms to facilitate collaborative care. These portals match on shared members only and feed directly into member medical records.

THPP produces risk stratification reports using a proprietary THPP risk stratification model designed to identify members most likely to benefit from care and disease management programs. The model incorporates data from claims, admissions, ED use (number of visits and amount paid), pharmacy including number of prescribed medications, Health Needs Assessment results, state agency involvement, as well as various public records for use as HRSNs proxies. To tailor the model to various PHM programs, each variable's weight can be adjusted as needed. THPP provides the risk stratification report to BCH ACO on a regular basis. PPOC providers and clinic staff access population management reports (e.g., practice-wide immunization rates compared to network, health-related

social needs screening data) via the EHR. Primary care providers at BCH sites also use population health reports generated using clinical and claims data. All BCHACO practice sites agreed or strongly agreed with 'Population Health Platform improves your ability to coordinate care for your MassHealth members.

### **Systems for collaboration across organizations**

THPP BCHACO utilizes the BCH PPOC reverse portal to transfer specialty consult notes and discharge summaries from BCH to PPOC sites, and uses additional secure and compliant means between BCHACO practices and all health systems in Massachusetts. Other real-time event notifications (including BH events) are processed through the Massachusetts eHealth Collaborative (MAeHC) dashboard.

THPP BCHACO reported that it is exploring options with CPs, CBHI, and other relevant social service organizations but currently has no data exchange platform in place. THPP BCHACO has no data exchange plan for members receiving Substance Use Disorder (SUD) treatment, as very few of their pediatric members use these services.

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

THPP BCHACO is able to share and/or receive electronic comprehensive needs assessments through secure and compliant means with all or the majority managed care plan; but none or very few of their of their participating PCP sites, participating specialists, community partners and non-affiliated providers.

THPP BCHACO is able to share and/or receive electronic care plans through secure and compliant means with most of their participating PCP sites, community partners and managed care plan; but none or very few of their participating specialists and non-affiliated providers.

### **Recommendations**

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

- continuing efforts to improve interoperability through a third-party platform and other workarounds;
- utilizing a platform (or updating platform so that it) integrates THPP risk reports, and automatically generates flags when members meet multidimensional criteria for program enrollment or graduation, or are in need of additional care coordination; and
- developing a strategy to include CPs, CBHI, and relevant social services organizations in the ACO's data exchange platform.

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<sup>6</sup>, and/or providing services in homes or other convenient community settings;
- ✓ **Connection with navigation and care management services**
  - locates CCCM staff in or near EDs;
  - enables staff to build 1:1 relationships with high-need members, and uses telemedicine, secure messaging, and regular telephone calls for ongoing follow-up with members;
  - provides members with 24/7 access to health education and nurse coaching, through a hotline or live chat;
  - implements best practices for transitions of care, including warm handoffs between transition of care teams and ACO team;
  - implements processes to direct members to the most appropriate care setting, including processes to re-direct members to primary care to reduce avoidable emergency department visits;
- ✓ **Referrals and follow-up**
  - standardizes processes for referrals for BH, LTSS, and health-related social needs (HRSN), and ability to systematically track referrals, enabling PCPs and care coordinators to confirm that a member received a service, incorporate results into the EHR and care plan;
  - conducts regular case conferences to coordinate services when a member has been referred.

## Results

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

### Full continuum collaboration

THPP BCHACO includes social workers, CHWs, and complex care coordinators in addition to physicians and nurses on care management teams. Behavioral health is addressed through embedded social workers and BH providers at ACO sites.

THPP BCHACO collaborates with LTSS CPs and the Children's Behavioral Health Initiative for care coordination. THPP BCHACO has established clear documentation processes for CP responsibilities in care coordination and has hired additional staff to support integration of the CP program. A senior staff member from THPP oversees the LTSS CP program, while another THPP senior staffer directs the CBHI. Other THPP staffers manage day-to-day operations and communications between the CPs, CBHI, THPP, and BCH.

THPP uses screening and assessments from the risk stratification process to identify members who are appropriate for CP referral but have not yet been assigned to a CP. THPP BCHACO then works with THPP to identify other eligible members and to educate providers about the purpose and value of CPs. So far, THPP BCHACO has no plans to engage CP sites in two-way sharing of clinical information or electronic data exchange. There also does not appear to be any protocol for quickly

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

determining if THPP BCHACO or CP has primary care responsibility for a member, such as through a clear indicator in the EHR.

### **Member outreach and engagement**

THPP BCHACO utilizes several traditional methods of member outreach, such as telephone calls, mailings, and outreach in community settings. For members who are more difficult to engage, staff attempt to identify most recent contact information via the member's PCP office or pharmacy. In-person outreach is also performed should a member be admitted to one of THPP BCHACO's inpatient facilities.

THPP BCHACO also has a Super-Care Management Program designed to engage members who are difficult to reach and are in severe need of assistance. Care managers in the program have strategically low caseloads in order to allow time to build rapport and trust. Additionally, THPP care managers complete training in motivational interviewing to enhance their member engagement, and ACO staff receive cross-cultural communication training aimed at improving a members' interaction with THPP BCHACO.

THPP BCHACO sites utilize medical interpreter services and are incorporating multi-lingual documents and communications. Other outreach efforts include a mobile phone loaning program to members who are in a care management program but experiencing homelessness or otherwise cannot be contacted through traditional methods.<sup>7</sup>

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

THPP BCHACO screens members for behavioral health and health-related social needs in primary care settings to identify the need for referrals to services. CHWs and other clinic staff (e.g., Resource Specialists) navigate members to community resources such as housing, transportation, nutrition, and legal assistance.<sup>8</sup> Following care, THPP BCHACO's CCCM staff emphasize warm handoffs to case management and social services using the system's EHR.

### **Referrals and follow-up**

Most referrals are completed telephonically by MHCCs. PPOC providers can send electronic referrals to BCH specialty providers. A referral and handoff request tool built into the EHR allows PCPs to include a message about the purpose of the specialty consult and whether the provider expects the member to be returned following specialty care or if the specialist will continue care.

As a part of transitions of care work, THPP BCHACO ensures that members in the CCCM program receive a nurse video visit following inpatient admission or a telephone follow-up. For BH-related admissions or ED visits, THPP BCHACO uses social workers and CHWs to provide follow-up and care coordination.

The PPOC has regional support teams that together with PCPs and MHCCs, follow-up with complex members who were hospitalized at BCH or who were not hospitalized but still have significant care coordination needs, in which case these activities occur at BCH primary care sites without RST involvement. These teams develop registries of high-risk members, strive to improve triage services, expand access to telehealth services, coordinate specialty care, facilitate transitions of care from inpatient to outpatient settings, and work with member families and ACO providers in pre-procedural planning, discharge planning, and post-discharge monitoring.

<sup>7</sup> ACOs should first utilize Lifeline program for members as appropriate.

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

## Recommendations

The IA encourages THPP BCHACO 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;
- establishing a single point of contact for CPs;
- implementing a 24/7 hotline or live chat for health education and nurse coaching;
- providing services to overcome transportation barriers to access, such as taxi or ride-share vouchers, public transit passes, or shuttle pick-up and drop-off;<sup>9</sup>
- locating CCCM staff in or near EDs;
- standardizing the referral process to social services organizations, including creating a process flow chart and institutionalizing relationships with social services; and
- conducting case conferences to coordinate services following a member's referral.

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.

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<sup>9</sup> ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.



- Creating a mobile phone lending program for hard-to-reach members, particularly those experiencing housing instability.<sup>10</sup>
- 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<sup>11</sup> and low-cost cell phones.<sup>12</sup>
- ✓ **Connection with navigation and care management services**
  - Utilizing EHR-based documentation transfer during warm handoffs.
  - Establishing daily or weekly care management huddles that connect PCPs and CCCM teams and streamline care transitions.
- ✓ **Referrals and follow-up**
  - Utilizing EHR messaging tools to better describe the purpose of specialty consults and a plan for follow-up communication.
  - Automating referral tracking and management, using flags to prompt referrals, linked directories to suggest appropriate providers and services, notifications to care managers when referral results are available, and databases allowing care teams to easily identify follow-up needs.

## 6. POPULATION HEALTH MANAGEMENT

### *On Track Description*

Characteristics of ACOs considered On track:

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

<sup>10</sup> ACOs should first utilize Lifeline program for members as appropriate

<sup>11</sup> ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

<sup>12</sup> ACOs should first utilize Lifeline program for members as appropriate.

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

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

## **Results**

The IA finds that THPP BCHACO is **On track with limited recommendations** in the Population Health Management focus area.

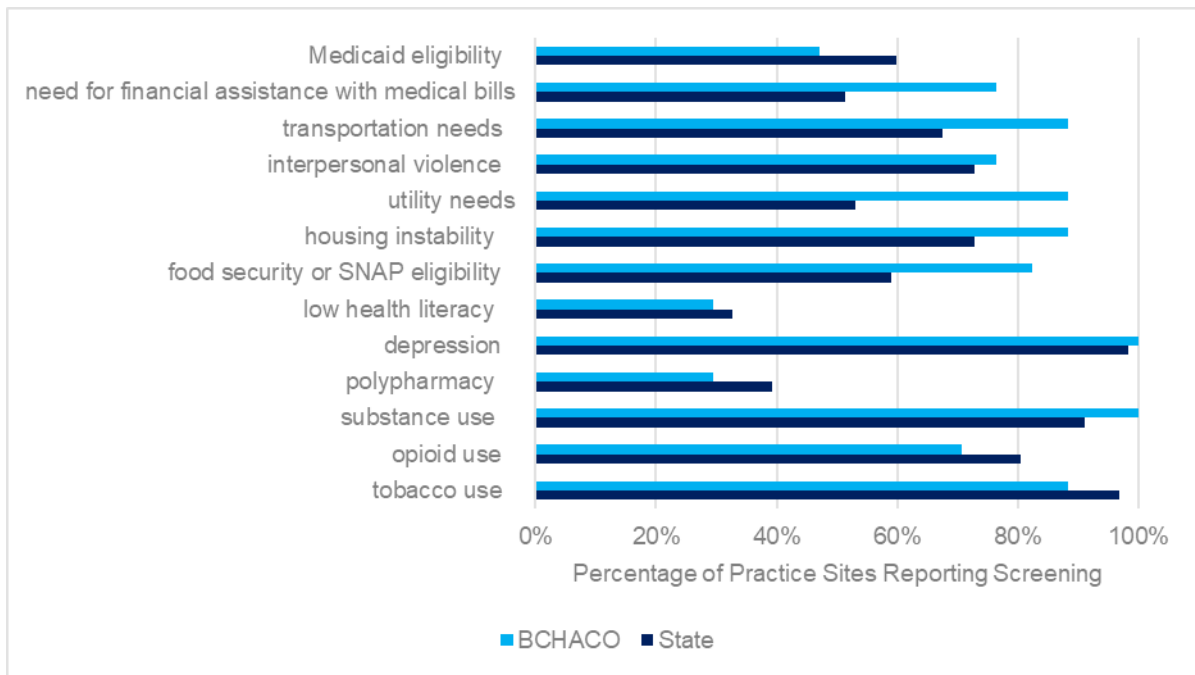
### **Integration of health-related social needs**

All THPP BCHACO practice sites responding to the ACO Practice Site Administrator Survey indicated that they conduct screening for housing instability and transportation needs. The ACO utilizes a MassHealth approved HRSN screening tool to identify members with additional needs. This screening information is examined to determine how the ACO can best help to address these needs. A majority of THPP BCHACO practice sites responding to the survey indicated that they also screen for a range of needs including tobacco use, polypharmacy, opioid use, utility needs, interpersonal violence, Medicaid eligibility, depression, and need for financial assistance with medical bills (Figure 2).

THPP BCHACO staff conduct HRSN screenings in primary care settings, and results of these screenings are incorporated into the EHR, which feeds into the population health platform for risk stratification.

THPP BCHACO has a plan approved for providing 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 THPP BCHACO, N = 17

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 has devised a proprietary risk stratification model that sorts members into High Risk and Emerging Risk categories based on claims data, clinical data, HRSN screening results, pharmacy data, utilization statistics, data from state agency utilization, and proxy data for HRSNs found in public records. Variables can be assigned different weights to allow the model the flexibility to be used for various purposes. Care and ACO support is tailored to members based on their risk stratification category.

PPOC regional support teams also develop registries of members with complex care needs.

However, it is unclear if registries are produced on the larger ACO level.

Additionally, THPP BCHACO does not appear to have a separate HRSN stratification, which could improve targeting efforts and help identify the appropriate intensity of intervention.

Quarterly reports on utilization and TCOC for members are shared with providers.

### Program development informed by population health analysis

THPP BCHACO offers wellness programs for all eligible members. These supports include health coaching, a Healthy Baby Program, and member incentives including car seats, bike helmets, child safety kits, and immunization gift cards.

THPP BCHACO also provides chronic disease management programs tailored to particular medical diagnoses such as BH and asthma. For instance, the asthma program includes relevant asthma supplies, work with respiratory therapists, and visits by complex care managers.

In addition to the cost analyses completed in the risk stratification process, THPP BCHACO uses predictive analytics to identify opportunities for both clinical intervention and reduction in TCOC. The ACO employs data analysts to complete this work and to investigate various drivers of TCOC, while THPP's utilization management team manages this work on the health plan side.

## **Recommendations**

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

- building partnerships with state agencies and community-based organizations where members may be referred for services;
- integrating cost data into dashboards or reports given monthly to providers to facilitate cost-of-care management; and
- developing programs that target members with unmet HRSNs.

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

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

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

### **Population health analysis**

- Developing and utilizing condition-specific dashboard reports for performance monitoring that include ED and hospital utilization and total medical expense.
- Developing key performance indicator (KPI) dashboards, viewable by providers, that track financial and operational metrics and provide insights into patient demographics and how the population utilizes services.
- Developing a registry or roster that includes cost and utilization information from primary care and specialty services for primary care teams and ACO leadership to better serve MassHealth ACO members.

- Implementing single sign-on and query capability into the online Prescription Monitoring Program, so that providers can quickly access and monitor past opioid prescriptions to promote safe opioid prescribing.
- ✓ **Program development informed by population health analysis**
  - Engaging top level ACO leadership in design and oversight of PHM strategy.
  - Developing methods to assess members' impactability as well as their risk, so that programs can be tailored for and targeted to the members most likely to benefit.
  - Developing services that increase access to real-time BH care, such as a SUD urgent care center.
  - Developing programs that address BH needs and housing instability concurrently.
  - Offering SUD programs tailored to subgroups such as pregnant members, LGBT members, and members involved with the criminal justice system allowing the care team to specialize in helping these vulnerable populations.
  - Providing education at practice sites or community locations such as:
    - Medication workshops that cover over-the-counter and prescription medication side effects, how to take medications, knowing what a medication is for, and identifying concerns to share with the doctor.
    - Expectant parenting classes that cover preparation for childbirth, breastfeeding, siblings, newborn care, and child safety.
    - Cooking classes that offer recipes for healthy and cost-effective meals.
  - Offering items that support family health such as:
    - Free diapers for members who have delivered a baby as an incentive to keep a postpartum appointment within 1-12 weeks after delivery.
    - Car seats, booster seats, and bike helmets.
    - Dental kits.

## OVERALL FINDINGS AND RECOMMENDATIONS

The IA finds that THPP BCHACO is On track or On track with limited recommendations in 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

The IA recommends that THPP BCHACO 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***

- exploring opportunities for career development, educational assistance, ongoing licensing and credentialing or loan forgiveness for staff.

***Health Information Technology and Exchange***

- continuing efforts to improve interoperability through a third-party platform and other workarounds;
- utilizing a platform (or updating platform so that it) integrates THPP risk reports, and automatically generates flags when members meet multidimensional criteria for program enrollment or graduation, or are in need of additional care coordination; and
- developing a strategy to include CPs, CBHI, and relevant social services organizations in the ACO's data exchange platform.

***Care Coordination and Care Management***

- developing collaborative relationships with state agencies such as DMH;
- establishing a single point of contact for CPs;
- implementing a 24/7 hotline or live chat for health education and nurse coaching;
- providing services to overcome transportation barriers to access, such as taxi or ride-share vouchers, public transit passes, or shuttle pick-up and drop-off;<sup>13</sup>
- locating CCCM staff in or near EDs;
- standardizing the referral process to social services organizations, including creating a process flow chart and institutionalizing relationships with social services; and
- conducting case conferences to coordinate services following a member's referral.

***Population Health Management***

- building partnerships with state agencies and community-based organizations where members may be referred for services;
- integrating cost data into dashboards or reports given monthly to providers to facilitate cost-of-care management; and
- developing programs that target members with unmet HRSNs.

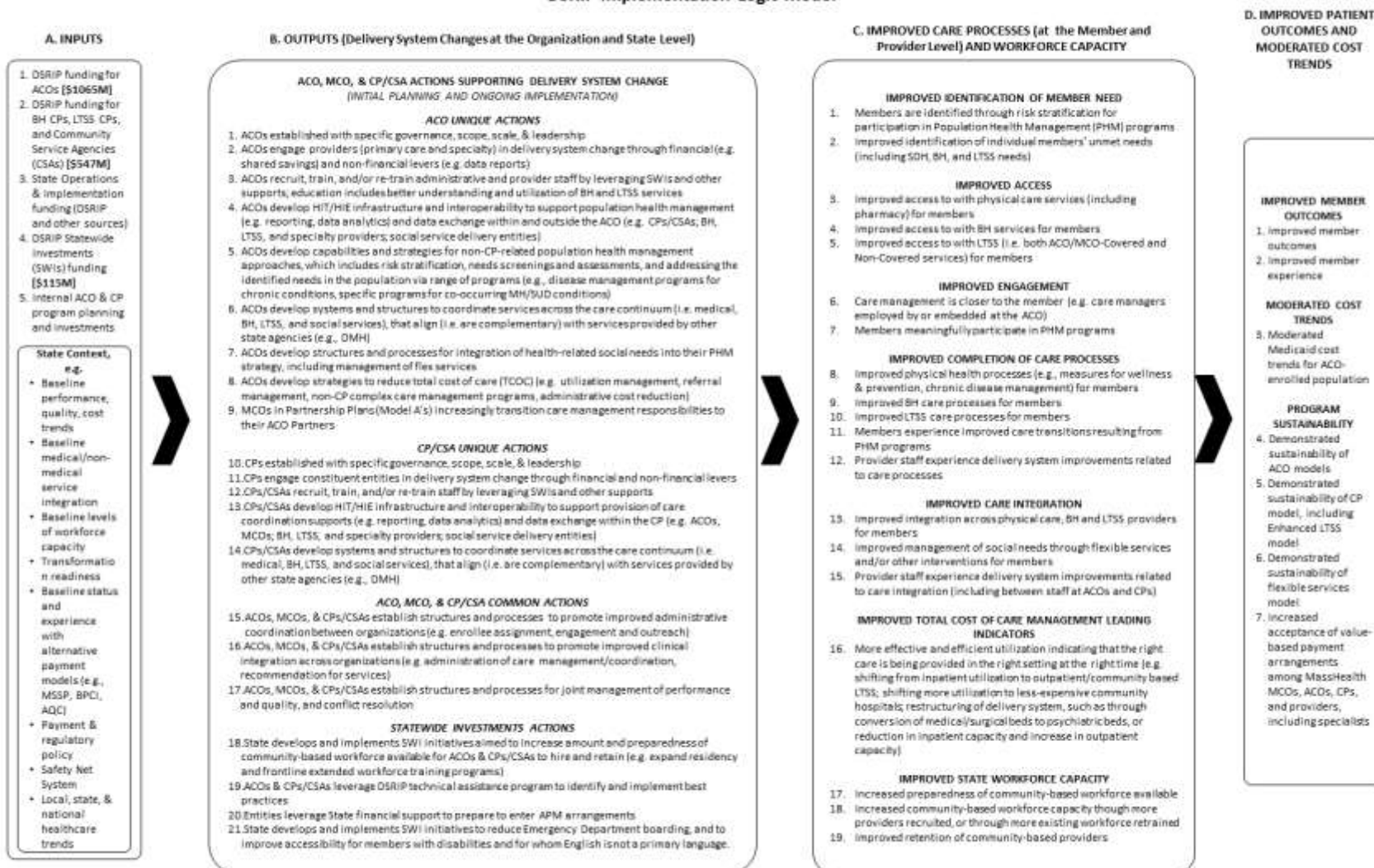
THPP BCHACO should carefully self-assess the areas noted above, and consider the corresponding promising practices identified by the IA for each focus area. Any action taken in response to the recommendations must comply with contractual requirements and programmatic guidance.

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<sup>13</sup> ACOs should utilize MassHealth Transportation (PT-1) for member needs first as appropriate.

# APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL

## DSRIP Implementation Logic Model



## APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations<sup>14</sup> (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<sup>15</sup> (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

<sup>14</sup> 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).

<sup>15</sup> 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
<b>Organizational Structure and Governance</b>	<ul style="list-style-type: none"> <li>• ACOs established with specific governance, scope, scale, &amp; leadership</li> <li>• 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)</li> </ul>
<b>Integration of Systems and Processes</b>	<ul style="list-style-type: none"> <li>• ACOs establish structures and processes to promote improved administrative coordination between organizations (e.g. enrollee assignment, engagement and outreach)</li> <li>• ACOs establish structures and processes to promote improved clinical integration across organizations (e.g. administration of care management/coordination, recommendation for services)</li> <li>• ACOs establish structures and processes for joint management of performance and quality, and conflict resolution</li> <li>• Accountable Care Partnership Plans (Model A) transition more of the care management responsibilities to their ACO Partners over the course of the Demonstration</li> </ul>
<b>Workforce Development</b>	<ul style="list-style-type: none"> <li>• 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)</li> </ul>
<b>Health Information Technology and Exchange</b>	<ul style="list-style-type: none"> <li>• 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)</li> </ul>
<b>Care Coordination and Care Management</b>	<ul style="list-style-type: none"> <li>• 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))</li> </ul>

### 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 DSRIP 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.<sup>16</sup> Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

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<sup>16</sup> 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 BCHACO PRACTICE SITE ADMINISTRATOR SURVEY RESULTS

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

- 30 practice sites were sampled; 17 responded (57% response rate)
- Survey questions are organized by focus area.
- The table provides the survey question, answer choices, and percent of respondents that selected each available answer. Some questions included a list of items, each of which the respondent rated. For these questions (i.e., Q# 12), the items rated appear in the answer choices column.
- NA indicates an answer choice that is not applicable to the survey question.

### FOCUS AREA: ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
12	In the past year, to what degree have the following practices in your clinic become more standardized, less standardized or not changed?  <i>A lot less, a little less, no change, a little more, a lot more standardized (1-5), I Don't Know</i>	a. Physician compensation	0%	6%	41%	12%	12%	NA	NA	29%
		b. Performance management of physicians	0%	0%	59%	12%	18%	NA	NA	12%
		c. Care processes and team structure	0%	0%	53%	18%	24%	NA	NA	6%
		d. Hospital discharge planning and follow-up	0%	0%	47%	18%	29%	NA	NA	6%
		e. Recruiting and performance review	0%	6%	41%	12%	29%	NA	NA	12%
		f. Data elements in the electronic health record	0%	0%	29%	29%	35%	NA	NA	6%
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	29%	12%	24%	NA	NA	NA	NA	35%
22	Has your practice received any financial distributions (DSRIP dollars) as part of its engagement with the MassHealth Accountable Care Organization?	Yes (1) No (2) Don't know	41%	24%	NA	NA	NA	NA	NA	35%
23	Is a representative from your practice site engaged in ACO governance?	Yes (1) No (2) Don't know	18%	53%	NA	NA	NA	NA	NA	29%
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	35%	29%	18%	6%	0%	NA	NA	12%
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	18%	18%	12%	35%	12%	NA	NA	6%

26	To what extent do you agree or disagree with each of the following statements? <i>Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know/Not Applicable</i>	a. The MassHealth ACO is a resource and partner in problem-solving for our practice.	12%	24%	41%	18%	6%	NA	NA	0%
		b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions.	6%	18%	47%	24%	6%	NA	NA	0%
		c. All entities in this MassHealth ACO work together to solve problems when needed.	6%	24%	35%	29%	6%	NA	NA	0%
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)	12%	18%	24%	41%	6%	NA	NA	NA
34	In the past year, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	a. Massive change - completely redesigned their care (1) b. A lot of change (2) c. Some change (3) d. Very little change (4) e. No change (5)	0%	6%	35%	59%	0%	NA	NA	NA
35	In the past year, to what extent has your practice's ability to deliver high quality care to MassHealth members gotten better, gotten worse, or stayed the same?	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	0%	6%	65%	29%	0%	NA	NA	NA
37	Which of the following approaches are used to manage the performance of individual physicians who practice at your site? Select all that apply.	a. Performance measures on quality are reported and shared with physicians (1) 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)	88%	76%	65%	35%	12%	NA	NA	NA
38	To the best of your knowledge, has your practice ever participated in any of the following, either directly or through participation in a physician group or other organization authorized to enter into such an agreement on behalf of the practice? Select all that apply.	a. Bundled or episode-based payments (1) b. Primary care improvement and support programs (e.g. Comprehensive Primary Care Initiative, Patient Centered Medical Home, Primary Care Payment Reform etc.) (2) c. Pay for performance programs in which part of payment is contingent on quality measure performance (3) d. Capitated contracts with commercial health plans (e.g. Blue Cross Blue Shield Alternative Quality Contract), etc.) (4) e. Medicare ACO upside-only risk bearing contracts (Medicare Shared Savings Program tracks one and two) (5) f. Medicare ACO risk bearing contracts (Pioneer ACO, Next Generation ACO, Medicare Shared Savings Program track three) (6) g. Commercial ACO contracts (7)	0%	63%	75%	38%	0%	0%	13%	NA

## FOCUS AREA: INTEGRATION OF SYSTEMS AND PROCESSES

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1b	For the care coordination and management resources used by your practice, how many of these resources are MANAGED by people at the following organizations (e.g., overseen, supervised)? <i>None, Some, Most, or All of the Resources (1-4)</i>	a. An ACO/MCO	41%	41%	18%	0%	NA	NA	NA	NA
		b. The physical location and department where you work	24%	24%	41%	12%	NA	NA	NA	NA
		c. A community-based organization	53%	35%	12%	0%	NA	NA	NA	NA
		d. A different practice site, department, or location in your organization	65%	29%	6%	0%	NA	NA	NA	NA

		e. Other organization, entity, or location	53%	41%	6%	0%	NA	NA	NA	NA
1c	For the care coordination and management resources used by your practice, how many of these resources are HOUSED at the following locations (by housed we mean the place where these resources primarily provide patient services)? <i>None, Some, Most, or All of the Resources (1-4)</i>	a. An ACO/MCO	47%	29%	18%	6%	NA	NA	NA	NA
		b. The physical location and department where you work	29%	24%	29%	18%	NA	NA	NA	NA
		c. A community-based organization	47%	41%	12%	0%	NA	NA	NA	NA
		d. A different practice site, department, or location in your organization	65%	24%	12%	0%	NA	NA	NA	NA
		e. Other organization, entity, or location	53%	24%	24%	0%	NA	NA	NA	NA
3	For your MassHealth members who receive care coordination and management services from more than one program or person, how often do these resources operate together efficiently?	Never (1) Rarely (2) Sometimes (3) Usually (4) Always (5) Don't Know/Not Applicable	6%	18%	29%	29%	6%	NA	NA	12%
8b	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? <i>Almost Never, Rarely, Sometimes, Often, Almost Always (1-5), I Don't Know</i>	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	59%	0%	29%	0%	0%	NA	NA	12%
		b. counseling therapists, including clinical social workers	41%	0%	12%	12%	24%	NA	NA	12%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	35%	6%	24%	12%	18%	NA	NA	6%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	18%	18%	18%	29%	18%	NA	NA	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	6%	6%	12%	6%	0%	NA	NA	71%
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	6%	6%	6%	0%	24%	NA	NA	59%
31	Currently which of the following best describes how many MassHealth members in your practice are receiving care coordination services from a MassHealth designated Community Partner?	Very few (1) More than very few, but not many (2) About half (3) A majority (4) Nearly all (5) I don't know/I'm not aware)	24%	41%	6%	12%	0%	NA	NA	18%
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	7%	50%	29%	0%	7%	NA	NA	7%
33	To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members?	Has made it harder almost all of the time (1) Has made it harder some of the time (2) Has made little or no change (3) Has made it easier some of the time (4) Has made it easier almost all of the time (5) Don't know	0%	7%	50%	36%	0%	NA	NA	7%

## FOCUS AREA: WORKFORCE DEVELOPMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
27	In the past year, which of the following resources has your practice accessed as part of its involvement in this MassHealth ACO? Select all that apply.	(1) The MassHealth ACO has provided resources and/or assistance to help recruit providers and/or staff (2) The MassHealth ACO has provided resources and/or assistance to help train providers and/or staff (3) Providers and/or staff have taken part in trainings made available directly by MassHealth (4) Providers and/or staff have received training focused on behavioral health and long-term services and supports. (5) DSRIP Statewide Investments (e.g. Student Loan Repayment Program) have been provided to help in training and/or recruiting.	0%	57%	14%	29%	0%	NA	NA	NA

## FOCUS AREA: HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
13	Which of the following technologies are in use at your practice? Select all that apply.	(1) Electronic health record (2) Care management platform (3) Population health management platform (4) Other technology	100%	35%	24%	0%	NA	NA	NA	NA
13_EHR	To what extent do you agree that the Electronic Health Record improves your ability to coordinate care for your MassHealth members?	<i>Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) I Don't Know</i>	12%	6%	12%	24%	47%	NA	NA	0%
13_CMP	To what extent do you agree that the Care Management Platform improves your ability to coordinate care for your MassHealth members?	<i>Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) I Don't Know</i>	0%	0%	17%	67%	17%	NA	NA	0%
Q13_PHP	To what extent do you agree that the Population Health Platform improves your ability to coordinate care for your MassHealth members?	<i>Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) I Don't Know</i>	0%	0%	0%	75%	25%	NA	NA	0%

## FOCUS AREA: CARE COORDINATION AND CARE MANAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
1a	Which of the following care coordination and management resources has your practice used in the past 12 months for your MassHealth members? Select all.	Community Health Workers (1) Patient Navigators/Referral Navigators (2) Nurse Manager/Care Coordinator (3) Any other (non-nurse) Care Coordinator/Manager (4) Social Worker (5) Other title (6)	35%	41%	53%	35%	35%	12%	NA	NA
2	In the past 12 months to what extent have these coordination and management resources helped your practice's efforts to deliver high quality care to your MassHealth members?	<i>Not at all, A little, Somewhat, Mostly, A great deal (1-5)</i>	6%	18%	35%	18%	24%	NA	NA	NA
4	In the past 12 months, how often was it difficult for staff in your practice site to do each of the following for your MassHealth members? <i>Always, Usually, Sometimes, Rarely, Never Difficult (1-5) Don't Know</i>	a. Learn the result of a test your practice site ordered	0%	0%	12%	47%	41%	NA	NA	0%
		b. Know that a patient referred by your practice site was seen by the consulting clinician	0%	18%	29%	41%	12%	NA	NA	0%
		c. Learn what the consulting clinician recommends for your practice site's patient	0%	12%	47%	29%	12%	NA	NA	0%



		d. Transmit relevant information about a patient who your practice site refers to a consulting clinician	0%	6%	35%	29%	29%	NA	NA	0%
		e. Reach the consulting clinician caring for a patient when your staff need to	6%	12%	29%	47%	6%	NA	NA	0%
5	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following? <i>There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable</i>	a. Arranging eye care from an ophthalmologist or optometrist	0%	0%	0%	12%	59%	18%	NA	12%
		b. Confirming that a diabetic eye exam was performed	12%	0%	6%	6%	12%	12%	NA	53%
		c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note	12%	0%	0%	18%	47%	6%	NA	18%
6	For your complex high-need MassHealth patients, how often is any type of care coordination or management resource involved in helping the patient adhere to the care plan? <i>Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)</i>	a. Any type of care coordinator/manager	6%	24%	29%	29%	12%	NA	NA	NA
		b. Any type of non-clinician (e.g., community health worker)	12%	12%	53%	24%	0%	NA	NA	NA
		c. Targeted interventions for patients who have been risk stratified into a high need sub-group	24%	18%	29%	24%	6%	NA	NA	NA
		d. Home visits	29%	41%	29%	0%	0%	NA	NA	NA
7	For complex, high-need MassHealth members, how often does your practice use each of the following resources to help the patient adhere to the care plan? <i>Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)</i>	a. Referral to community-based services for health-related social needs	6%	12%	47%	29%	6%	NA	NA	NA
		b. Communication with the patient within 72 hours of discharge	6%	6%	18%	35%	35%	NA	NA	NA
		c. Home visit after discharge	65%	24%	12%	0%	0%	NA	NA	NA
		d. Discharge summaries sent to primary care clinician within 72 hours of discharge	12%	6%	12%	59%	12%	NA	NA	NA
		e. Standardized process to reconcile multiple medications	12%	12%	18%	35%	24%	NA	NA	NA
8a	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? <i>Almost Never, Rarely, Sometimes, Usually, Almost Always within the practice site (1-5), Don't Know/Not Applicable</i>	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	12%	6%	29%	41%	12%	NA	NA	0%
		b. counseling therapists, including clinical social workers	0%	6%	18%	41%	35%	NA	NA	0%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	0%	35%	35%	18%	12%	NA	NA	0%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	0%	35%	35%	18%	12%	NA	NA	0%
9	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for MassHealth members obtaining the following behavioral health services? <i>There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable</i>	a. Scheduling the appropriate behavioral health services	6%	0%	0%	18%	29%	41%	NA	6%
		b. Confirming that behavioral health services were received	6%	0%	6%	29%	24%	29%	NA	6%
		c. Ensuring that your practice site receives the prescribing clinician, counseling therapist, or any type of care coordinator/manager's consult note, as appropriate	6%	0%	18%	24%	35%	12%	NA	6%
		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	12%	0%	12%	24%	29%	18%	NA	6%
11	To what extent do you agree or disagree that providers follow a clear, established process for the following activities? <i>There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable</i>	a. Screening for service needs at home that are important for the patient's health?	18%	0%	0%	12%	41%	18%	NA	12%
		b. Choosing among LTSS providers?	24%	0%	0%	47%	12%	0%	NA	18%
		c. Referring patients to specific LTSS providers with which your office has a relationship?	24%	0%	6%	41%	18%	0%	NA	12%
		d. Confirming that the recommended LTSS have been provided?	24%	0%	6%	24%	35%	0%	NA	12%

		e. Establishing relationships with LTSS providers who serve your patients?	18%	0%	12%	24%	35%	0%	NA	12%
		f. Getting updates about a patient's condition from the LTSS providers?	18%	0%	6%	41%	24%	0%	NA	12%
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	12%	0%	71%	12%	0%	NA	NA	6%
18	Does your practice regularly provide any of the following? Select all that apply.	Scheduling to enable same day appointments (1) Appointments on weekdays before 8 am or after 5 pm (2) Appointments on weekends (3) Home visits carried out by practice staff or a clinician (4) Clinical pharmacy services provided after discharge at the practice site (5) Care that is provided in part or in whole by phone or electronic media (e.g., patient portal, e-mail, telemedicine technology) (6)	100%	65%	88%	0%	0%	47%	NA	NA

## FOCUS AREA: POPULATION HEALTH MANAGEMENT

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
14	For which of the following are MassHealth members in your practice systematically screened? Select if screening takes place at any level (Managed Care Organization, Accountable Care Organization, Practice, CP)	a. tobacco use	88%	NA	NA	NA	NA	NA	NA	NA
		b. opioid use	71%	NA	NA	NA	NA	NA	NA	NA
		c. substance use	100%	NA	NA	NA	NA	NA	NA	NA
		d. polypharmacy	29%	NA	NA	NA	NA	NA	NA	NA
		e. depression	100%	NA	NA	NA	NA	NA	NA	NA
		f. low health literacy	29%	NA	NA	NA	NA	NA	NA	NA
		g. food security or SNAP eligibility	82%	NA	NA	NA	NA	NA	NA	NA
		h. housing instability	88%	NA	NA	NA	NA	NA	NA	NA
		i. utility needs	88%	NA	NA	NA	NA	NA	NA	NA
		j. interpersonal violence	76%	NA	NA	NA	NA	NA	NA	NA
		k. transportation needs	88%	NA	NA	NA	NA	NA	NA	NA
		l. need for financial assistance with medical bills	76%	NA	NA	NA	NA	NA	NA	NA
		m. Medicaid eligibility	47%	NA	NA	NA	NA	NA	NA	NA
		n. none of the above	0%	NA	NA	NA	NA	NA	NA	NA
16	How often are MassHealth members referred from your practice to social service organizations to address health-related social needs (e.g., housing, food security)?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	0%	24%	59%	12%	6%	NA	NA	0%
19	What is the main source of information that your practice uses to identify which of your MassHealth members are complex, high need patients? Select one.	a. We perform an ad hoc review of information from our own practice's system(s) (e.g., EHR) when we think it is relevant (1) 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	47%	29%	12%	0%	NA	NA	NA	12%

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)	6%	12%	76%	6%	0%	NA	NA	NA
30	How often does your practice site use site-specific data to identify health inequities within its served population? For example, data might include EHR charts or ACO reports.	Annually (1) Bi-annually (2) Quarterly (3) Monthly (4) On an ad hoc basis (5) We do not have access to this type of data. (6) We have access to this type of data but do not analyze it for health inequities. (7)	6%	12%	35%	0%	24%	18%	6%	NA

## GENERAL QUESTIONS

Q#	Question	Question Components or Answer Choices	1	2	3	4	5	6	7	Don't Know
20	Our records show that your practice is participating in the [ACO name] for some or all of its MassHealth Medicaid patients. Is that correct?	Yes (1) I am not aware of this (2)	88%	12%	NA	NA	NA	NA	NA	NA
20_O	Were you able to find a colleague who can help you answer questions about [ACO Name]?	Yes (1) No (2)	100%	0%	NA	NA	NA	NA	NA	NA
20a	Currently, which of the following best describes how many of your practice's patients are covered by [ACO Name]?	Very few (1) A minority (2) About half (3) A clear majority (4) Nearly all (5)	0%	50%	25%	19%	6%	NA	NA	NA
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)	88%	6%	6%	0%	0%	NA	NA	NA
39	Which of the following best describes your practice site?	Adult (1) Pediatric (2) Both (3)	0%	100%	0%	NA	NA	NA	NA	NA
40	Currently which of the following best describes how many of your practice's patients are covered by any contracts with cost of care accountability?	Very few (1) A minority (2) About half (3) A majority (4) Nearly all (5)	13%	38%	25%	19%	6%	NA	NA	NA
41	To what extent do providers and staff at your practice site seem to agree that "total cost of care" contracts will become a major and sustained model of payment at your practice in the near-term (i.e., within five years)?	Strongly disagree (1) Disagree (2) Neither agree nor disagree (3) Agree (4) Strongly agree (5)	0%	19%	69%	13%	0%	NA	NA	NA
42	What is your professional discipline? (select one)	a. Primary care physician (1) b. Physician assistant/nurse practitioner (2) c. Registered nurse/nurse case manager/ LVN/LPN (3) d. Professional administrator (e.g., practice manager) (4) e. Other-please specify: (5)	6%	0%	18%	59%	18%	NA	NA	NA
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%	6%	0%	12%	82%	NA	NA	NA
44	Did you ask a colleague for help in answering questions on the survey?	Yes (1) No (2)	53%	47%	NA	NA	NA	NA	NA	NA

## APPENDIX IV: ACRONYM GLOSSARY

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

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

## APPENDIX V: ACO COMMENT

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

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

### ACO Request for Change

In reference to the Workforce Development recommendation on p. 16 of “*exploring opportunities for career development, educational assistance, ongoing licensing and credentialing or loan forgiveness for staff*”: BCH ACO has established a workforce development EDI program.

In reference to the Care Coordination and Care Management recommendation on p. 23 of “*establishing a single point of contact for CPs*”: BCH ACO has established a single point of contact for CPs.

In reference to the statement of survey results on p. 25 that “*All THPP BCHACO practice sites responding to the ACO Practice Site Administrator Survey indicated that they conduct screening for housing instability and transportation needs*”: Our screening tool also includes the other required domains (utilities, food) and one or more supplemental domains.

In reference to the population health analysis paragraph on p. 26:

- Registries of members with complex needs are produced across the entire ACO.
- “Additionally, THPP BCHACO does not appear to have a separate HRSN stratification, which could improve targeting efforts and help identify the appropriate intensity of intervention.” BCH ACO uses the results of HRSN screening to identify members in need of support and then respond to needs. This would alter the recommendation on page 27 “developing programs that target members with unmet HRSNs.”