MassHealth Delivery System Reform Incentive Payment Program Midpoint Assessment

ACO Report:

Cambridge Health Alliance in partnership with Tufts Health Public Plans

(THPP CHA)

Report prepared by The Public Consulting Group: December 2020

PUBLIC CONSULTING GROUP

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Cambridge Health Alliance in partnership with Tufts Health Public Plans (THPP CHA)

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Model A ACO

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

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

SERVICE AREA

DSRIP ATTRIBUTION AND FUNDING

2017 (Jul-Dec)	32k members	$4.7M
2018	32k members	$9.1M
2019	26k members	$5.3M

POPULATIONS SERVED

- Approximately one in three members is of Brazilian, Haitian, or Salvadorian descent. CHA serves unique sub-groups including persons of Indian, Asian, Nepalese, Dominican, Bangladeshi, Ethiopian, Pakistani, Cape Verdean, Honduran, and Somali descent.
- Over 40% of the active MassHealth member's primary language is not English.
- Prevalent conditions include asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, obesity, severe mental illness and substance use.

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

IMPLEMENTATION HIGHLIGHTS

- The ACO has implemented locally-grouped pods of providers. Each Pod monitors performance on PHM strategies and manages performance metrics. Pods meet monthly and include standing agenda items related to performance review as well as time for educational opportunities for various supportive programs focused on care management, disease management, coding and documentation.
- The ACO co-locates behavioral health services at primary care locations through their Primary Care Behavioral Health (BH) Integration program. Members receive self-management support, outreach, psychiatry consultation, medication management and brief therapy according to a stepped care model. Primary care embedded BH providers refer members requiring more intensive treatment to specialty providers. THPP CHA also runs a Behavioral Health Home which co-locates medical and behavioral health with comprehensive care management at an outpatient mental health clinic.

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

LIST OF SOURCES FOR INFOGRAPHIC

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

NOTES

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

INTRODUCTION

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

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

The question addressed by this assessment is:

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

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

MPA FRAMEWORK

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

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

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

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

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

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

Table 1. Framework for Organizational Assessment of ACOs

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

METHODOLOGY

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

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

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

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

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

ACO BACKGROUND[3]

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

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

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

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

THPP CHA's service area is the Boston metropolitan area. THPP CHA covers Boston, Cambridge, Somerville, Medford, Malden, Everett, Chelsea, Lynn, Revere, Woburn, Salem, Winthrop, and the surrounding communities.

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

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

Year	Members	DSRIP Funding
2017 (partial year, Jul-Dec)	32,201	$4,728,668
2018	32,201	$9,100,097
2019	26,158	$5,260,663

CHA serves a culturally diverse population; approximately one in three members is of Brazilian, Haitian, or Salvadorian descent. CHA serves many unique sub-populations including Indian, Asian, Nepalese, Dominican, Bangladeshi, Ethiopian, Pakistani, Cape Verdean, Honduran, and Somali. Over 40% of the active MassHealth members' primary language is not English.

The most prevalent conditions for CHA's primary care members include asthma, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, obesity, severe mental illness and substance use. Poverty, racial and ethnic disparities, violence, and mental health/substance use are other salient characteristics of the population. Roughly one in ten persons in the CHA service area has a disability.

SUMMARY OF FINDINGS

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

Focus Area	IA Findings
Organizational Structure and Engagement	On track
Integration of Systems and Processes	On track with limited recommendations
Workforce Development	On track
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

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

FOCUS AREA LEVEL PROGRESS

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

1. ORGANIZATIONAL STRUCTURE AND ENGAGEMENT

On Track Description

Characteristics of ACOs considered On track:

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

Results

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

Established governance structures

THPP CHA has established appropriate governance structures. THPP CHA is overseen by a six-person Joint Operating Committee (JOC) with equal representation from the MCO and the ACO Partner. A Finance Committee and a Compliance Committee report directly to the JOC. The ACO's Governing Board, which is represented by at least 75% providers and includes a MassHealth member representative, oversees all operational aspects of THPP CHA including provider and care delivery strategy and performance.

THPP CHA's Patient and Family Advisory Committee (PFAC) and its Quality Committee report directly to the Governing Board. The PFAC appears to be used in several capacities across the ACO's governance including providing informal review and approval of proposed quality measurement and management strategies as well as designs for care coordination and care management. The Governing Board's Quality Committee is responsible for identifying the major decisions around how THPP and CHA exchange data, which quality metrics will be prioritized for reporting and how quality management is executed throughout CHA.

CHA also maintains a Population Health Management Committee (PHMC) that recommends overall strategic PHM priorities to the ACO's Senior Executive Team which includes CHA's SVP and Senior Medical Director. Recommendations for PHM strategies are then communicated throughout CHA in various forums including Chiefs Council meetings, Nursing Leadership, Physician Practice meetings and Regional Medical Director Meetings. The ACO's JOC, Governing Board and Quality Committees are then used to establish and coordinate PHM recommendations between CHA and THPP.

Provider engagement in delivery system change

THPP CHA centrally identifies and disseminates its population health management model through locally grouped pods of providers. Each Pod then monitors performance toward implementing PHM strategies and managing performance metrics on patient quality and total costs of care. Pod meetings appear to be the primary setting through which provider groups review performance reports and identify areas where performance could be improved upon. Pods meet monthly and include standing agenda items related to performance review as well as time for educational opportunities for various supportive programs focused on care management, disease management, coding and documentation.

THPP CHA provides some limited incentive dollars primarily to its primary care providers for managing certain aspects of patient care like referral management. Overall however, THPP CHA reports that its orientation is not overly directed toward any pay-for-performance basis and instead attempts to incentivize local practice sites to establish and pursue their own quality improvement initiatives informed by their own experience of patient care and patient need. THPP CHA attempts to support this local autonomy by enticing providers and staff through financial payments and other non-monetary incentives to attend pod meetings and take leadership positions overseeing quality improvement efforts.

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

Administrative coordination among ACO member organizations and with CPs

THPP CHA's EHR displays member enrollment and members that have been identified as appropriate for CP referral. THPP CHA's analytics team sends providers performance reports and circulates cost and utilization reports through online dashboards. Additionally, providers have access to member care plans through the EHR.

Care management teams and care advisors from CHA and THPP collaborate to serve high utilization members. The teams work closely and assign distinct functions to each organization to avoid duplication of effort while best serving the member.

Clinical Integration among ACO member organizations and with CPs

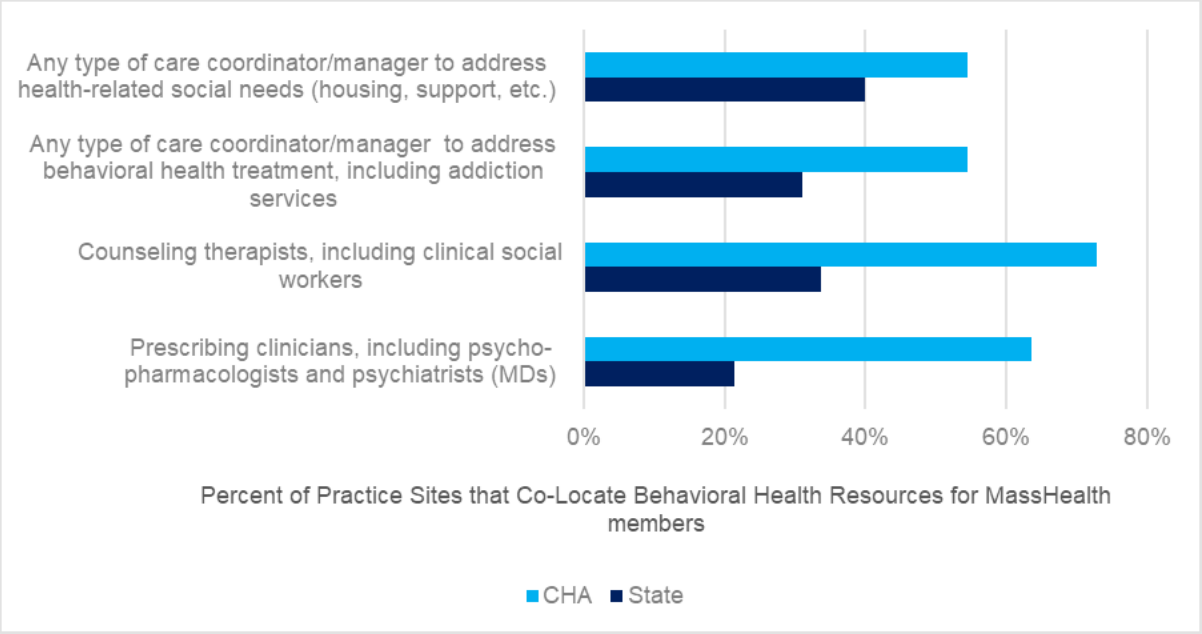
CHA earned NCQA accreditation for their care management program. THPP CHA hired a Care Integration Officer to oversee clinical services integration and promoted a nurse to manage the primary care ambulatory care management team and lead care management education. THPP CHA's care management teams utilize warm handoffs between providers and hold weekly meetings to review cases. The ACO also holds quarterly meetings with CPs to ensure patient management workflows run smoothly. In addition to nurse care managers, social workers and community health workers, THPP CHA's care management program includes staff roles that augment care for special populations or address social needs such as women's health social workers, patient resource coordinators, BH care management teams, and social workers specializing in homelessness. CHA offers programmatic training to care management staff, most recently focusing on LTSS and BH CP engagement and collaboration in addition to care management of high-risk patients.

THPP CHA providers have access to member clinical information in an EHR. THPP CHA integrated claims data and CP care plans into the EHR as well.

THPP CHA co-locates behavioral health services at primary care locations through their Primary Care Behavioral Health Integration program. This program provides members with self-management support, outreach, psychiatry consultation, medication management and brief therapy according to a stepped care model. Primary Care embedded BH providers refer members requiring more intensive treatment to specialty providers. THPP CHA also runs a Behavioral Health Home which co-locates medical and behavioral health with comprehensive care management at an outpatient mental health clinic.

A majority of THPP CHA practice sites responding to the ACO Practice Site Administrator Survey report that care coordinators to address health related social needs and/or behavioral health treatment, counseling therapists, and prescribing clinicians are co-located at the practice site.

Figure 1. Co-Location of Behavioral Health Resources



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in THPP CHA, N = 11
Figure displays responses to Q8b. *For the Behavioral Health entities you selected in the previous question, how often are they located within your practice site? For those entities to which you never refer, please select Don't Know/Not Applicable.*
Statistical significance testing was not done due to small sample size.

Joint management of performance and quality

THPP CHA has a Quality Committee that meets to address challenges and opportunities for improvement. THPP CHA also has several workgroups to address quality improvement. The ACO added a quality project improvement advisor and a project manager to their quality team to support the existing metrics managers implement the ACO's quality initiatives. The improvement advisor collaborates with the population health management team to improve behavioral healthcare performance, access, workflows, staffing models, and communication tools. Organizational leadership created dashboards containing real-time performance data set against performance targets to flag concerning trends that lead to improvement interventions.

CHA shares individual performance reports with providers, but these reports are not necessarily limited to MassHealth members. Some providers participate in an upside and down-side financial risk structure based on their performance outcomes. The ACO supports provider engagement in quality initiatives through regular performance reporting, on-going performance review meetings, and training. The ACO shares performance at most team meetings including care and disease management meetings.

ACO/MCO coordination (at Accountable Care Partnership Plans)

THPP CHA has a Joint Operating Committee that meets to identify and address challenges and opportunities in the program. The governing structure also includes workgroups with THPP and CHA membership to focus on member engagement and disease management.

Recommendations

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

- sharing population health and cost-of-care reports between the ACO and MCO entities.
- reviewing their strategy for members who receive care coordination and management from multiple programs to ensure that practice site staff and the members they serve feel that these services operate together efficiently

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

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

- establishing weekly meetings to discuss newly engaged members.
- establishing monthly meetings with practices sites and CPs to discuss member care plans.
- creating a case review process including care coordination, service gaps and service duplication.
- sharing member risk stratification reports including results of predictive modeling.

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

- designating a practice site champion responsible for integrating Care Coordination and Care Management (CCCM) and clinical care plans.
- embedding CCCM staff at practice sites to participate in shared model for care management.
- providing resiliency training to CCCM staff to improve team cohesion and offer emotional support.
- developing a centralized care management office to support member care teams in conducting needs assessment, follow-up, disease management and transitions of care.
- following members for at least 30 days post-discharge from the hospital.
- providing laptops or other devices that enable EHR access by off-site providers during visits with members.
- holding monthly meetings of CCCM teams to share best practices, develop solutions to recent challenges and provide collegial support.

✓ **Joint management of performance and quality**

- developing practice site specific quality scorecards and reviewing them at monthly or quarterly meetings.
- having the Joint Operating Committee (JOC) review scorecards of clinical, quality, and financial measures.
- sharing individual performance reports containing benchmarks or practice wide comparisons with providers.

- ✓ **ACO/MCO coordination** (at Accountable Care Partnership Plans)
    - reviewing performance and quality outcomes at regular governance meetings.
    - developing coordinated goals related to operations, budget decisions and clinical quality outcomes

3. WORKFORCE DEVELOPMENT

On Track Description

Characteristics of ACOs considered On track:

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

Results

The IA finds that THPP CHA is **On track with no recommendations** in the Workforce Development focus area.

Recruitment and retention

THPP CHA has pursued a recruitment and retention strategy that appears to have mitigated any major or persistent gaps in staffing. Senior staff within CHA were responsible for the ACO's primary efforts in recruiting frontline and extended health care staff during the ACO's initial launch period. THPP CHA reported some challenges in recruiting staff given the highly competitive marketplace within which they operate. Additional difficulties were reported related to filing positions with individuals capable of providing the cultural and linguistically appropriate level of services THPP CHA requires of staff. THPP CHA did however counter that although this dynamic does create difficulties in

finding large numbers of qualified candidates, it does increase the likelihood that staff will pursue positions at THPP CHA specifically because of this service-delivery orientation.

THPP CHA's performance evaluation process encourages managers and staff to define career goals and plan for appropriate supports to enhance professional development opportunities. THPP CHA also supports a tuition reimbursement program which it reports attracts candidates who may be pursing part time education while working at THPP CHA. Mentorship programs and peer learning retreats are also systems THPP CHA uses to derive professional development and reduce staff attrition.

Training

THPP CHA uses DSRIP funds to enable members of the care management team to pursue CCP (Chronic Care Professional) and CCM (Certified Case Manager) certification. THPP CHA also reports actively sending community health workers and staff with similar qualifications to training offered through the Boston Public Health Commission's Community Health Education Center (CHEC). "Train the trainer" models are also in use across THPP CHA, where a clinical staff member may receive specialized training, and then perform trainings for other staff across the ACO. THPP CHA has had success using this model to, for example, provide insight into the American Society of Addiction Medicine (ASAM) placement, stay, transfer or discharge criteria.

THPP CHA also reports conducting trainings this way alongside educators from community partners.

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

THPP CHA has oriented its care model around person-centered and population health delivery concepts through multi-disciplinary teams. During the initial program years, THPP oversaw most complex patient care management activities through their existing care manager systems. Across ensuing years of the demonstration however care management functions shifted to CHA resources as well as responsibilities related to coordination with Community Partners.

Multi-disciplinary teams located inside of CHA then implemented and managed day-to-day tasks across the ACO's PHM programs. Medical matters continued to be managed by RN care managers. Clinical BH matters continued to be handled by masters-level BH clinicians with Community Health Workers, and outreach coordinators involved in various capacities across most programs. Additional staff involved in care teams as needed include registered dieticians, respiratory therapists, pharmacists and pharmacy technicians as well as certified doulas. Individual sites and practices have the ability to make local operational changes so long as they align and satisfy THPP CHA's larger PHM strategic goals. Feedback from staff and performance improvement teams are considered and integrated into these larger PHM strategies where appropriate.

Recommendations

The IA has no recommendations for the Workforce Development focus area.

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

Infrastructure for care coordination and population health

THPP CHA utilizes an EHR to aggregate and share information among providers across the ACO. An EHR based care management platform facilitates collaborative member care across disciplines and providers.

The EHR provided population health platform integrates member data, generates registries and provides predictive models, utilization patterns and financial metrics to identify patients eligible for programs or in need of additional care coordination. This includes an automated risk stratification process to identify members for additional care management assessments and a social determinants of health web-based platform that results in referrals to appropriate community agencies.

Results from the ACO Practice Site Administrator Survey indicate that a majority of CHA practice sites agree or strongly agree that EHR population health, and care management platforms improve their ability to coordinate care for MassHealth members (Figure 2).

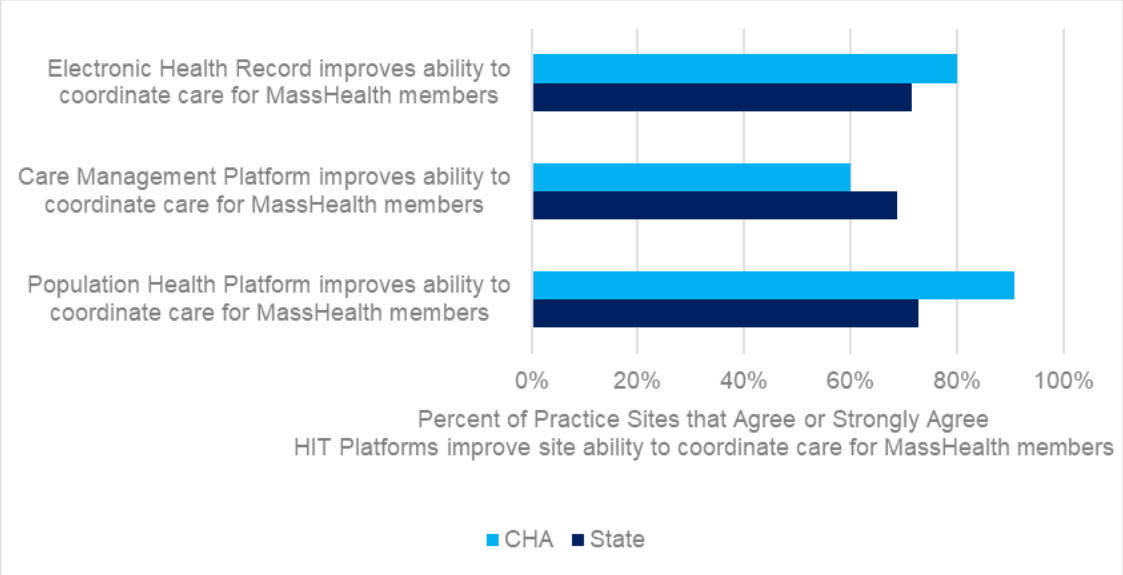
Systems for collaboration across organizations

THPP CHA has taken steps to improve EHR interoperability. While care sites are on a universal EHR, the ACO still requires work arounds to ensure data exchange with community partners who utilize a different EHR.

THPP CHA and all their participating PCP sites have full access to ADT feeds and real-time event notification and but THPP CHA is only somewhat able to incorporate this data into their population health analytics technology. While data is available to CPs, it is done through a monthly extract, and not available in real-time.

THPP CHA is able to share and/or receive electronic member contact information, comprehensive needs assessments and care plans through secure and compliant means with ***all or the majority*** of their participating PCP sites, participating specialists, CPs, non-affiliated providers and the managed care plan.

Figure 2. Perceptions of HIT Platforms for Care Coordination



Number of Practices Reporting in the State, N = 225
Number of Practices Reporting in THPP CHA, N = 11
Figure displays responses to Q13_EHR, Q13_CMP, Q13_PHP. *To what extent do you agree that the Electronic Health Record/ Care Management Platform/Population Health Platform improves your ability to coordinate care for your MassHealth members?*
Statistical significance testing was not done due to small sample size.

Recommendations

The IA encourages THPP CHA 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:

- automating the process for exchanging information with CPs;
- ensuring timely data exchange capacity with all EHRs utilized by ACO partners as opposed to relying on monthly data exchanges; and
- developing continuously refreshing dashboards to share real-time program eligibility and performance data.

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

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

5. CARE COORDINATION AND CARE MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Full continuum collaboration**
    - collaborates with state agencies such as DMH;
    - has established processes for identifying members eligible for BH or LTSS services and collaborating with CPs, including exchanging member information, and collaborating for care coordination when CP has primary care management responsibility;
    - designates a point of contact for CPs to facilitate communication;
    - incorporates social workers into care management teams and integrates BH services, including Office-Based Addiction Treatment (OBAT), into primary care.
- ✓ **Member outreach and engagement**
    - uses both IT solutions and manual outreach to improve accuracy of member contact information;

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

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

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

✓ **Referrals and follow up**

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

Results

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

Full continuum collaboration

THPP CHA established formal collaborative relationships with state agencies, including DMH. Utilizing EHR platforms, THPP CHA established a process to identify members appropriate for referral for BH and LTSS services and also to exchange this information with the collaborating CPs through a monthly data exchange.

Care managers serve as the point of contact to facilitate communication with the CPs. They are also members of THPP CHA's care team (comprised of a RN care manager, social worker (LICSW) and CHW), who screen members to assess risk and direct them to eligible services. The IA was unable to find sufficient documentation to assess the integration of BH services, including Office-Based Addiction Treatment Program (OBAT), into primary care.

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

Member outreach and engagement

THPP CHA utilizes both IT solutions and manual outreach to improve the accuracy of member contact data. This includes electronic updates when members engage any member of the care team, as well as manual methods such as telephone and mailings for harder to reach members. THPP CHA leverages its EHR capabilities to reach members via secure messaging and other IT solutions, as well as traditional telephonic outreach and visiting members in their homes and community settings.

THPP CHA addresses language barriers through its staff hiring practices, to include staff fluent in member language needs.

Connection with navigation and care management services

THPP CHA locates Care Coordination and Care Management (CCCM) staff in the ED to assist members seeking urgent care. THPP CHA also implemented processes to help redirect members to appropriate care settings and/or primary care to reduce avoidable future emergency department visits.

THPP CHA enables staff to build 1:1 relationships with high-need members and utilizes EHR based messaging and telephone calls to support members with their ongoing follow-up. The nurse line also provides members with 24/7 access to health education and nurse coaching. This support includes the implementation of best practices for transitions of care, to include warm handoffs as members transition between care teams.

Referrals and follow up

THPP CHA's care team utilizes EHR platforms to standardize processes for referrals for BH, LTSS and HRSN services, and has the ability to systematically track referrals, enabling PCPs and care coordinators to confirm members receive services and incorporate the results into the EHR and care plans. The care team conducts regular case conferences to coordinate services when a member is referred and to mitigate service gaps and/or duplication.

Recommendations

The IA encourages THPP CHA 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:

- integrating BH services, including OBAT, into primary care; and
- supporting members who lack reliable transportation by providing rides or vouchers.[7]

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.

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

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

✓ **Member outreach and engagement**

- developing a high-intensity program for extremely high-need, high-risk members with strategically low case load.
- establishing trust between members and CCCM staff by building and maintaining a 1:1 consistent relationship.
- creating a mobile phone lending program for hard-to-reach members, particularly those experiencing housing instability.[8]
- embedding CCCM staff in EDs.
- creating a "Navigation Center" to manage referrals outside the ACO, handle appointment scheduling, and coordinate testing, follow-up, and documentation transfers.
- developing an assistance fund to support transportation vouchers[9] and low-cost cell phones.[10]

✓ **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.

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

6. POPULATION HEALTH MANAGEMENT

On Track Description

Characteristics of ACOs considered On track:

- ✓ **Integration of health-related social needs**
  - standardizes screening for health-related social needs (HRSN) that includes housing, food, and transportation;
  - incorporates HRSN with other factors to target members for more intensive services;
  - Builds mature partnerships with community-based organizations to whom they can refer members for services
  - has a plan approved for provision of flexible services;
- ✓ **Population health analysis**
  - articulates a coherent strategy for stratifying members to service intensity and use of a population health analysis platform to combine varied data sources, develop registries of high-risk members, and stratify members at the ACO level.
  - integrates cost data into reports given regularly to providers to facilitate cost-of-care management.
- ✓ **Program development informed by population health analysis**
  - offers PHM programs that target all eligible members (not just facility-specific), and target members by medical diagnosis, BH needs (including non-CP eligible), HRSNs, care transitions;
  - offer interactive wellness programs such as smoking cessation, diet/weight management.

Results

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

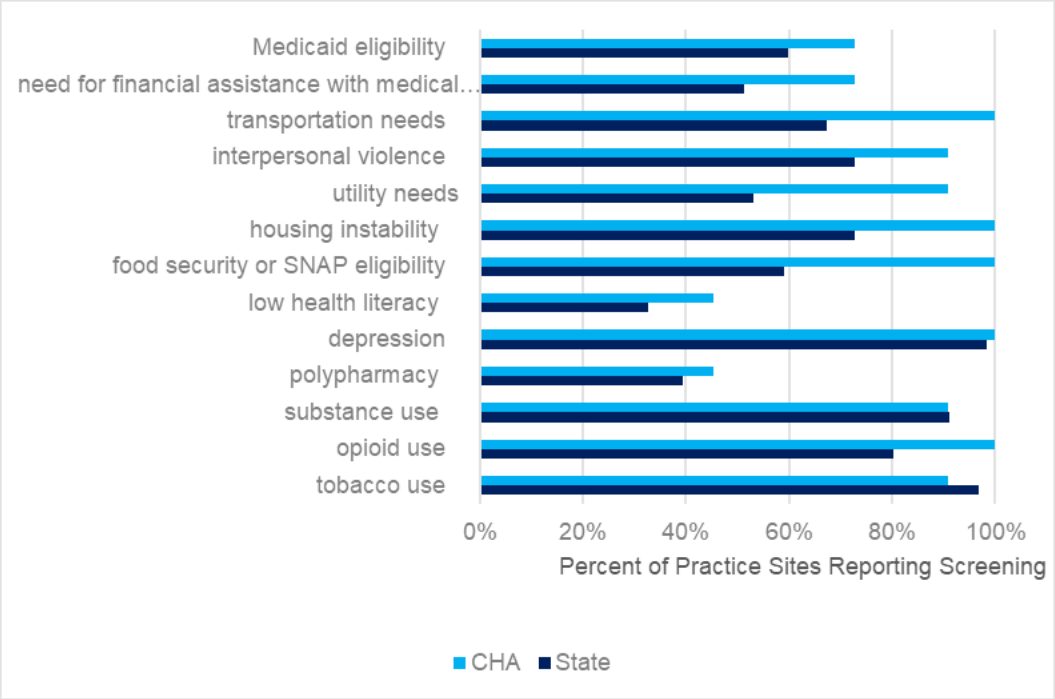
Integration of health-related social needs

THPP CHA conducts HRSN screening in all primary care and BH provider sites and documents the results in the EHR. An EHR-integrated platform provides an inventory of and access to community-based social services. A majority of CHA practice sites indicated they conduct screening for tobacco use, opioid use, substance use, depression, food insecurity, housing instability, utility needs, interpersonal violence, transportation needs, need for financial assistance with medical bills, and Medicaid eligibility.

THPP CHA employs clinical social workers who support specific populations. One assists persons experiencing homelessness in accessing health care and SUD treatment, and other services promoting housing stabilization. Another supports the CHA women's health program in addressing HRSN. In addition, PCP-embedded staff known as Patient Resource Coordinators work with community based organizations to connect members with social services.

CHA has a plan approved for providing flexible services.

Figure 3. 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 CHA, N = 11
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 CHA uses a stratification model that considers three axes – Medical risk, social risk, and behavioral risk. Medical risk encompasses physical and BH conditions, while behavioral risk is defined as "behaviors that drive health complications" such as smoking and substance use. HRSNs such as housing instability are incorporated into the model as social risk. An EHR-integrated population health platform integrates claims data, EHR data, and screening results for stratification. The top 5% of risk includes members enrolled in BH or LTSS CP services, and members with end-of-life care needs as well as others with uncontrolled conditions, history of high utilization, and social risk factors. The second tier, designated rising risk, includes about 15% of members. Nurse care managers are provided with monthly registries in order to reach out to members, conduct full needs assessments, and offer a service intensity appropriate for their risk stratum. Members identified as high risk are eligible for the Complex Care Management program, providing the highest intensity of services, and moderate risk members are offered Care Management – Rising Risk and Special Care Needs.

Total cost of care analysis is updated on a monthly basis by the MCO and is available to providers through cost and utilization dashboards.

Program development informed by population health analysis

THPP CHA offers disease management programs tailored for members with chronic medical or BH conditions. Additional programs serve members who require LTSS supports or are experiencing

transitions of care. Attention to HRSN is integrated into care coordination programs including the Women's Health program, and also targeted by specific programs for members with unmet social needs. CHA's Healthcare for the Homeless team provides primary care and care coordination for members experiencing housing instability. The ED Care Management program, embedded at Everett Hospital and Cambridge Hospital, works with members who are frequent utilizers of the ED.

All members are eligible for health maintenance activities and wellness programs.

Recommendations

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

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

- ✓ **Integration of health-related social needs**
    - implementing universal HRSN screening in all primary care sites and behavioral health outpatient sites.
    - using screening tools designed to identify members with high BH and LTSS needs.
    - using root-cause analysis to identify underlying HRSNs or unmet BH needs that may be driving frequent ED utilization or readmissions.
    - partnering with local fresh produce vendors, mobile grocery markets, and food banks to provide members with access to healthy meals.
    - providing a meal delivery service, including medically tailored meals, for members who are not able to shop for or prepare meals.
    - organizing a cross-functional committee to understand and address the impact of homelessness on members' health care needs and utilization.
    - enabling members and CCCM field staff to document HRSN screenings in the EHR using tablet devices with a secure web-based electronic platform.
    - automating referrals to community agencies in the EHR/care management platform.
- ✓ **Population health analysis**
    - developing and utilizing condition-specific dashboard reports for performance monitoring that include ED and hospital utilization and total medical expense.
    - developing key performance indicator (KPI) dashboards, viewable by providers, that track financial and operational metrics and provide insights into patient demographics and how the population utilizes services.
    - developing a registry or roster that includes cost and utilization information from primary care and specialty services for primary care teams and ACO leadership to better serve MassHealth ACO members.
    - implementing single sign-on and query capability into the online Prescription Monitoring Program, so that providers can quickly access and monitor past opioid prescriptions to promote safe opioid prescribing.
- ✓ **Program development informed by population health analysis**
    - engaging top level ACO leadership in design and oversight of PHM strategy.

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

- Organizational Structure and Engagement
- Workforce Development
- Population Health Management

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

Integration of Systems and Processes

- sharing population health and cost-of-care reports between the ACO and MCO entities.
- reviewing their strategy for members who receive care coordination and management from multiple programs to ensure that practice site staff and the members they serve feel that these services operate together efficiently

Health Information Technology and Exchange

- automating the process for exchanging information with CPs;

- ensuring timely data exchange capacity with all EHRs utilized by ACO partners as opposed to relying on monthly data exchanges; and
- developing continuously refreshing dashboards to share real-time program eligibility and performance data.

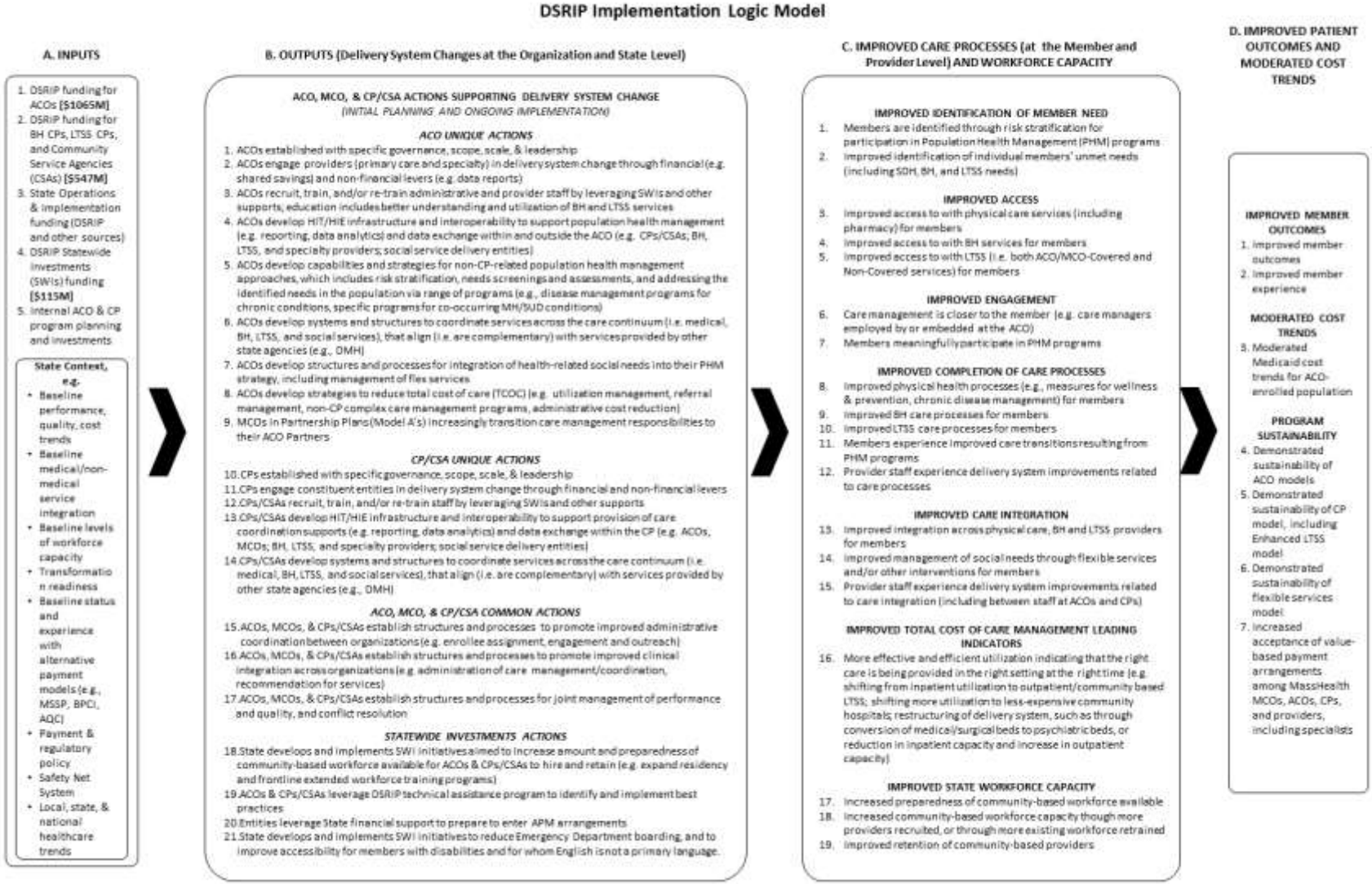
Care Coordination and Care Management

- integrating BH services, including OBAT, into primary care; and
- supporting members who lack reliable transportation by providing rides or vouchers[11].

THPP CHA 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.

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

APPENDIX I: MASSHEALTH DSRIP LOGIC MODEL



APPENDIX II: METHODOLOGY

The Independent Assessor (IA) used participation plans, annual and semi-annual reports, survey responses, and key informant interviews (KIIs) to assess progress of Accountable Care Organizations[12] (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[13] (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

[12] 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).
[13] The Independent Evaluator (IE) – a distinct role separate from the Independent Assessor - is responsible for evaluating the outcomes of the Demonstration.

FOCUS AREA FRAMEWORK

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

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

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

Table 1. Framework for Organizational Assessment of ACOs

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

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

ANALYTIC APPROACH

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

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

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

DATA COLLECTION

ACO Practice Site Administrator Survey Methodology

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

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

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

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

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

Table 1. Distribution of Practice Site Types

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

Table 2. Distribution of Practices Across Geography

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

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

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

Key Informant Interviews

Key Informant Interviews (KII) of ACO Administrators were conducted in order to understand the degree to which participating entities are adopting core ACO competencies, the barriers to transformation, and the organization's experience with state support for transformation.[14] Keyword searches of the KII transcripts were used to fill gaps identified through the desk review process.

[14] 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 CHA 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.

- 11 practice sites were sampled; 11 responded (100% 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? *A lot less, a little less, no change, a little more, a lot more standardized (1-5), I Don't Know*	a. Physician compensation	0%	0%	45%	9%	0%	NA	NA	45%
		b. Performance management of physicians	0%	0%	27%	9%	18%	NA	NA	45%
		c. Care processes and team structure	0%	0%	18%	27%	36%	NA	NA	18%
		d. Hospital discharge planning and follow-up	0%	0%	27%	36%	9%	NA	NA	27%
		e. Recruiting and performance review	0%	0%	36%	0%	27%	NA	NA	36%
		f. Data elements in the electronic health record	0%	0%	18%	27%	36%	NA	NA	18%
21	To the best of your knowledge, in the past, has your practice participated in payment contract(s) together with the other clinical providers and practices that are now participating in the [ACO Name]? Select one.	a. Yes, with most of the clinical providers and practices that now compose this ACO (1) b. Yes, with some of the clinical providers and practices that now compose this ACO (2) c. No, this is our first time participating in a payment contract with the clinical providers and practices that compose this ACO (3) d. Don't know	30%	10%	0%	NA	NA	NA	NA	60%
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	50%	10%	NA	NA	NA	NA	NA	40%
23	Is a representative from your practice site engaged in ACO governance?	Yes (1) No (2) Don't know	20%	50%	NA	NA	NA	NA	NA	30%
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	40%	0%	20%	0%	0%	NA	NA	40%
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	20%	10%	10%	30%	0%	NA	NA	30%

26	To what extent do you agree or disagree with each of the following statements? *Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree (1-5) Don't Know/Not Applicable*	a. The MassHealth ACO is a resource and partner in problem-solving for our practice.	10%	30%	0%	20%	0%	NA	NA	40%
		b. When problems arise with other clinical providers in the MassHealth ACO, we are able to work jointly to find solutions.	10%	30%	10%	10%	0%	NA	NA	40%
		c. All entities in this MassHealth ACO work together to solve problems when needed.	10%	10%	20%	10%	0%	NA	NA	50%
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)	30%	0%	50%	20%	0%	NA	NA	NA
34	In the past year, to what extent has your practice changed its processes and approaches to caring for MassHealth members?	a. Massive change - completely redesigned their care (1) b. A lot of change (2) c. Some change (3) d. Very little change (4) e. No change (5)	0%	0%	55%	18%	27%	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%	0%	36%	55%	9%	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)	82%	27%	45%	45%	27%	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)	18%	91%	55%	27%	27%	27%	27%	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)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	27%	73%	0%	0%	NA	NA	NA	NA
		b. The physical location and department where you work	9%	55%	18%	18%	NA	NA	NA	NA
		c. A community-based organization	27%	64%	9%	0%	NA	NA	NA	NA
		d. A different practice site, department, or location in your organization	27%	64%	9%	0%	NA	NA	NA	NA
		e. Other organization, entity, or location	64%	36%	0%	0%	NA	NA	NA	NA
1c	For the care coordination and management resources used by your practice, how many of these resources are HOUSED at the following locations (by housed we mean the place where these resources primarily provide patient services)? *None, Some, Most, or All of the Resources (1-4)*	a. An ACO/MCO	36%	36%	0%	27%	NA	NA	NA	NA
		b. The physical location and department where you work	0%	45%	18%	36%	NA	NA	NA	NA
		c. A community-based organization	36%	45%	0%	18%	NA	NA	NA	NA
		d. A different practice site, department, or location in your organization	36%	45%	0%	18%	NA	NA	NA	NA
		e. Other organization, entity, or location	64%	36%	0%	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	0%	0%	36%	36%	9%	NA	NA	18%
8b	In the last 12 months, how often were your MassHealth members with behavioral health conditions referred to the following entities when needed? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5), I Don't Know*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	0%	0%	27%	27%	36%	NA	NA	9%
		b. counseling therapists, including clinical social workers	0%	0%	9%	18%	55%	NA	NA	18%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	9%	0%	18%	9%	45%	NA	NA	18%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	9%	9%	9%	18%	36%	NA	NA	18%
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	0%	0%	27%	9%	45%	NA	NA	18%
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	9%	0%	27%	27%	9%	NA	NA	27%
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)	9%	45%	9%	18%	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	22%	11%	44%	22%	0%	NA	NA	0%

33	To the best of your knowledge, how has the existence of Community Partners impacted your ability to provide high quality care, for your MassHealth members?	Has made it harder almost all of the time (1) 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%	11%	33%	11%	11%	NA	NA	33%

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%	0%	0%	50%	50%	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%	45%	91%	45%	NA	NA	NA	NA
13_EHR	To what extent do you agree that the Electronic Health Record improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	9%	0%	0%	36%	55%	NA	NA	0%
13_CMP	To what extent do you agree that the Care Management Platform improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	0%	0%	40%	40%	20%	NA	NA	0%
Q13_PHP	To what extent do you agree that the Population Health Platform improves your ability to coordinate care for your MassHealth members?	*Strongly disagree, Disagree, Neither agree nor disagree , Agree, Strongly agree (1-5) I Don't Know*	10%	0%	10%	50%	30%	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)	82%	64%	73%	64%	64%	0%	NA	NA
2	In the past 12 months to what extent have these coordination and management resources helped your practice's efforts to deliver high quality care to your MassHealth members?	*Not at all, A little, Somewhat, Mostly, A great deal (1-5)*	0%	0%	64%	18%	18%	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? *Always, Usually, Sometimes, Rarely, Never Difficult (1-5)* *Don't Know*	a. Learn the result of a test your practice site ordered	0%	0%	0%	36%	45%	NA	NA	18%
		b. Know that a patient referred by your practice site was seen by the consulting clinician	0%	0%	18%	9%	36%	NA	NA	36%
		c. Learn what the consulting clinician recommends for your practice site's patient	0%	0%	36%	9%	36%	NA	NA	18%
		d. Transmit relevant information about a patient who your practice site refers to a consulting clinician	0%	0%	36%	18%	27%	NA	NA	18%
		e. Reach the consulting clinician caring for a patient when your staff need to	0%	0%	27%	27%	27%	NA	NA	18%
5	To what extent do you agree or disagree that providers and/or staff follow a clear, established process for each of the following? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Arranging eye care from an ophthalmologist or optometrist	0%	0%	0%	0%	64%	27%	NA	9%
		b. Confirming that a diabetic eye exam was performed	0%	0%	0%	9%	45%	18%	NA	27%
		c. Ensuring that [Practice Name] receives the ophthalmologist or optometrist consult note	0%	0%	0%	18%	55%	18%	NA	9%
6	For your complex high-need MassHealth patients, how often is any type of care coordination or management resource involved in helping the patient adhere to the care plan? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Any type of care coordinator/manager	9%	0%	45%	36%	9%	NA	NA	NA
		b. Any type of non-clinician (e.g., community health worker)	0%	9%	64%	27%	0%	NA	NA	NA
		c. Targeted interventions for patients who have been risk stratified into a high need sub-group	9%	9%	36%	36%	9%	NA	NA	NA
		d. Home visits	18%	27%	27%	18%	9%	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? *Almost Never, Rarely, Sometimes, Often, Almost Always (1-5)*	a. Referral to community-based services for health-related social needs	0%	0%	36%	64%	0%	NA	NA	NA
		b. Communication with the patient within 72 hours of discharge	0%	9%	27%	27%	36%	NA	NA	NA
		c. Home visit after discharge	18%	9%	55%	9%	9%	NA	NA	NA
		d. Discharge summaries sent to primary care clinician within 72 hours of discharge	0%	0%	36%	36%	27%	NA	NA	NA
		e. Standardized process to reconcile multiple medications	9%	0%	36%	18%	36%	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? *Almost Never, Rarely, Sometimes, Usually, Almost Always within the practice site (1-5), Don't Know/Not Applicable*	a. prescribing clinicians, including psycho-pharmacologists and psychiatrists (MDs)	0%	0%	36%	36%	18%	NA	NA	9%
		b. counseling therapists, including clinical social workers	0%	0%	9%	64%	27%	NA	NA	0%
		c. any type of care coordinator/manager to address behavioral health treatment, including addiction services	9%	0%	18%	36%	36%	NA	NA	0%
		d. any type of care coordinator/manager to address health-related social needs (housing, support, etc.)	9%	9%	9%	36%	36%	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? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Scheduling the appropriate behavioral health services	0%	0%	0%	18%	36%	27%	NA	18%
		b. Confirming that behavioral health services were received	0%	0%	0%	27%	27%	27%	NA	18%
		c. Ensuring that your practice site receives the prescribing clinician, counseling therapist, or any type of care coordinator/manager's consult note, as appropriate	0%	0%	18%	9%	27%	27%	NA	18%
		d. Establishing when a prescribing clinician, counseling therapist, or any type of care coordinator/manager will share responsibility for co-managing the patient's care	0%	0%	18%	0%	36%	18%	NA	27%

11	To what extent do you agree or disagree that providers follow a clear, established process for the following activities? *There is no process in place, Strongly Disagree, Disagree, Neither agree nor disagree, Agree, Strongly Agree (1-6); Don't Know/Not Applicable*	a. Screening for service needs at home that are important for the patient's health?	0%	0%	0%	18%	27%	18%	NA	36%
		b. Choosing among LTSS providers?	9%	0%	0%	9%	18%	9%	NA	55%
		c. Referring patients to specific LTSS providers with which your office has a relationship?	9%	0%	0%	0%	27%	9%	NA	55%
		d. Confirming that the recommended LTSS have been provided?	9%	0%	0%	0%	36%	9%	NA	45%
		e. Establishing relationships with LTSS providers who serve your patients?	0%	0%	18%	0%	18%	9%	NA	55%
		f. Getting updates about a patient's condition from the LTSS providers?	0%	0%	9%	9%	18%	9%	NA	55%
17	When MassHealth members receive referrals to social service organizations, how often is your practice aware that those patients have received support from those organizations?	Almost Never, Rarely, Sometimes, Usually, Almost Always (1-5) Not Applicable	0%	36%	18%	18%	9%	NA	NA	18%
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%	82%	45%	27%	82%	73%	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	91%	NA	NA	NA	NA	NA	NA	NA
		b. opioid use	100%	NA	NA	NA	NA	NA	NA	NA
		c. substance use	91%	NA	NA	NA	NA	NA	NA	NA
		d. polypharmacy	45%	NA	NA	NA	NA	NA	NA	NA
		e. depression	100%	NA	NA	NA	NA	NA	NA	NA
		f. low health literacy	45%	NA	NA	NA	NA	NA	NA	NA
		g. food security or SNAP eligibility	100%	NA	NA	NA	NA	NA	NA	NA
		h. housing instability	100%	NA	NA	NA	NA	NA	NA	NA
		i. utility needs	91%	NA	NA	NA	NA	NA	NA	NA
		j. interpersonal violence	91%	NA	NA	NA	NA	NA	NA	NA
		k. transportation needs	100%	NA	NA	NA	NA	NA	NA	NA
		l. need for financial assistance with medical bills	73%	NA	NA	NA	NA	NA	NA	NA
		m. Medicaid eligibility	73%	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%	0%	45%	27%	18%	NA	NA	9%

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	18%	9%	45%	0%	NA	NA	NA	27%
29	Please select the option below that best describes the change in the past year in your practice site's ability to tailor delivery of care to meet the needs of patients affected by health inequities (e.g., by using culturally and linguistically appropriate services):	Gotten a lot harder (1) Gotten a little harder (2) No change (3) Gotten a little easier (4) Gotten a lot easier (5)	0%	9%	18%	73%	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 no analyze it for health inequities. (7)	0%	0%	0%	36%	36%	27%	0%	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)	91%	9%	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)	0%	100%	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%	0%	60%	40%	0%	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)	0%	0%	18%	82%	0%	NA	NA	NA
39	Which of the following best describes your practice site?	Adult (1) Pediatric (2) Both (3)	0%	18%	82%	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)	10%	10%	30%	40%	10%	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%	10%	50%	40%	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 care manager/ LVN/LPN (3) d. Professional administrator (e.g., practice manager) (4) e. Other-please specify: (5)	9%	0%	27%	64%	0%	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)	9%	27%	0%	27%	36%	NA	NA	NA
44	Did you ask a colleague for help in answering questions on the survey?	Yes (1) No (2)	9%	91%	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

1. Page 27 – Overall Findings and Recommendations, Integration of Systems and Processes Section, First bullet

   CHA and Tufts have shared cost and utilization data regularly since implementation of the program to manage our population. We discuss and analyze data at quarterly governance meetings (Joint Operating Committee, ACPP Governing Board, Finance Meeting – with publicly reported minutes available for review), monthly Population Health Committee meetings, as well as at clinical care management meetings designed to optimize care for patients.

2. Page 28 – Overall Findings and Recommendation, Care Coordination and Care Management, Second bullet

   Our care management department provides many resources to members, including transportation resources.

   We provide the below sheet to patients who screen positive for transportation needs on the social determinants of health (SDOH) screening. It is also available on the CHA website in multiple languages, as well as more tailored resource guide sheets for specific regions.

3. Page 13 Table

   CHA is at 100% with integrating 1) PRCs; 2) care partners and OBAT nurse case managers; 3) therapists; and 4) consultant psychiatrists. We have these staff integrated for each site (with the exception of normal vacancies).