

ATTACHMENT APR

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM ACCOUNTABLE CARE ORGANIZATION (ACO) PY3 ANNUAL PROGRESS REPORT RESPONSE FORM

PART 1: PY3 PROGRESS REPORT EXECUTIVE SUMMARY

- **General Information**

Full ACO Name:	Tufts Together with CHA
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1.1 ACO Goals from its Full Participation Plan

CHA and its MCO partner Tufts Health Public Plans have a shared vision of driving strong outcomes in quality, member experience and value for members who entrust our organizations with their healthcare. As the ACPP program moved into PY3, we continued to place greater focus on broader long-term outcome measures in addition to the programmatic and infrastructure investments that were described in earlier participation plans. Our goal is to achieve the sustained success of the program. We believe we were making progress on our goals when the covid 19 pandemic materialized and overwhelmed CHA and every other delivery system in Massachusetts. CHA was hit particularly hard due to the underserved and blue-collar populations that make up large portions of its service area. Our ability to achieve PY 4 goals must be considered in this context. Substantial numbers of CHA accountable care staff were redeployed to Covid 19 coverage. Our PY3 goals are summarized below. In our PY4 Participation Plan, we have updated targets and timelines to reflect the exceptional year that 2020 was. CHA believes that 2020 (PY3), due to the COVID pandemic, should not be considered a stable performance year or as a stable base year for future performance measurement, and we have adjusted the timing of our goals of our PY4 performance plan accordingly.

Our PY 3 full participation plan outlined four broad goals, summarized in the table below.: Given that 2020 was an exceptional year, we believe it would be helpful to look at the last three years of our experience on some of our broader measures:

- In 2020 CHA/THPP achieved a 2% surplus on its adjusted core medical budget prior to the application of corridor adjustments, based on current estimates. In 2019, we were 8.1% unfavorable on our core medical budget, but this was less than the 8.8% market change that Medicaid has estimated, thus suggesting that CHA/THPP met its budget goals on an adjusted basis.
- Through October of 2020, medical surgical admissions per thousand were in total below 2019 levels, with three rating categories exhibiting higher utilization and three rating categories showing lower utilization when compared to 2019. Between 2018 and 2019,

aggregate medical surgical admissions per thousand decrease slightly in an environment where the total risk in the population increased, as measured by ACG risk scores.

- Through October of 2020, behavioral health admissions per thousand were in total below 2019 levels by 9%. However, this was offset by a 30% increase in length of stay. We believe that this was due to the case mix, severity of illness and difficulty placing patients in the community during the COVID pandemic. Between 2018 and 2019, we saw a 4% and 3% reduction in behavioral health admissions per thousand and ALOS, respectively.
- Through October of 2020, emergency room visits per thousand were 31% below 2019 levels. 2019 ED utilization decreased 4% from 2018 levels.
- Between 2018 and 2019 we saw a 33% decrease in aggregate SNF days per thousand. This decreased further in 2020 but was likely highly influenced by covid 19.

As we have stated, 2020 was an exceptional year due to the Covid 19 pandemic. It is likely that the broad outcome measures for 2020 were highly influenced by the unique dynamics of the pandemic. Our 2018 to 2019 outcome measures indicate that we were making progress on our goals.

Even through the pandemic, CHA and THPP continued to implement and refine activities related to achieving our stated goals. These are outlined in section 1.2 below:

PY 3 ACO program goals	
Goal #	Goal Category & Description
1	Cost and Utilization Mgmt. (Medical Trend): For PY 3, manage core medical cost of care to 1% below the MassHealth adjusted core medical budget. By PY 5, manage core medical cost of care to 2% below the MassHealth adjusted core medical budget.
1.a	<u>Sub goal #1:</u> Reduce inpatient Medical Surgical admissions per thousand by 4% (from June 2019 base) in 2020 and an additional 2% by 2022, adjusted for rating category mix and case mix.
1.b	<u>Sub goal #2:</u> Reduce behavioral health days per thousand by 5.5% (from June 2019 base) in 2020 and an additional 4.0% by 2022, adjusted for rating category mix and case mix.
1.c	<u>Sub goal #3:</u> Reduce emergency room visits per thousand by 11% (from June 2019 base) in 2020 and an additional 5.0% by 2022, adjusted for rating category and case mix.
	Cost and Utilization Mgmt. (Operational efficiency):
1.d	Assess the need to establish preferred provider networks for services not served by the current network and expand the network based on need and opportunity for improving care management and improving quality.

	Establish preferred providers use baselines and increase use of preferred providers by 2.5% by 12/31/2020.
1.e	Increase referrals to Preferred SUD Providers by establishing a baseline in 2020 and increasing this volume by 20% by 2022.
1.f	Reduce the proportional share of inpatient admissions out migrating from CHA by 1%.
2.a	Quality: By end of PY 3, decrease by 1% for comprehensive diabetes care; A1C- Poor control over 2018 baseline
2.b	Quality: By end of PY 3, improve immunization rates for adolescents by 5% over 2018 baseline
2.c	Quality: (Behavioral Health) By end of PY 3, improve metabolic monitoring for children and adolescent on antipsychotics by 2% over 2018 baseline

3.a	Member experience: Increase the percentage of new and/or inactive Medicaid ACO panel population who have primary care utilization in the measurement year compared to the initial baseline year by one percent each year.
3.b	Member experience: 5% improvement in year 2020 over 2019 in the "Willingness to Recommend" measure for adult and child as measures on the Tufts Together with CHA MassHealth Quality Measures Results Report.
4	Integration of physical health, BH, LTSS, and health related social needs: For PY 3, optimize the use of LTSS and BH community partners by increasing engagement with both BH and LTSS CPs as follows: Sub goal #1: Increase engagement to LTSS CPs by 50% in 2020 and an additional 25% by 2022. Sub goal #2: Increase engagement of high-risk patients with BH CP by 50% over 2019 totals in 2020 and an additional 25% by 2022. Sub goal #3: Integrate new software program "CHA Connect" to enable its use for patients screening positive for one or more social determinant of health needs requiring referral to community-based services.
5	Other

1.2 PY3 Investments Overview and Progress toward Goals

CHA has made strong progress within each of its broad goals. The following summarizes this progress.

Goal 1 Cost and Utilization Management:

CHA has four programmatic areas under cost and utilization management: individual care management, behavioral health, medical management, and post-acute care. The following summarizes key accomplishments in each of these areas.

Complex Care Management

- Redeployed CCM staff to inpatient behavioral health and med/surg inpatient settings during the Covid19 surge initiated in April and ending in June. This strengthened both teams' understanding of each other's roles, the relationships between inpatient and ambulatory staff and thereby increasing cross-continuum collaboration and integration in the wake of the redeployment;
- Maintained and supported patients enrolled in complex care management during the Covid surge by conducting regular outreach calls to check on patient health status and provide covid prevention and self-care strategies;
- Conducted a CCM performance improvement initiative to improve several process and outcome metrics, namely 1) optimizing enrollment and increasing annual rates of engaged patients; 2) achieving a 4-6-month LOS target in care management; 3) improving rates of community partner referrals and enrollment 4) Monitoring and improving access to all populations to ensure health equity;
- Revised risk stratification criteria to facilitate achievement of stated goals;
- Maintained the Hospital-to-Home care transitions program, staffed by community health workers to support high- and rising-risk patients post-inpatient discharge with the goal of promoting continued home-based recovery and avoiding readmission;
- Maintained the clinical social worker under CHA's Healthcare for the Homeless program to provide care management to homeless patients to access necessary healthcare services as well as in helping to address long standing addiction issues in this challenging population;
- Engaged Emergency Department physicians and care managers to identify high utilizing patients and develop patient specific care plans to provide ED staff with tactics to educate and support appropriate use of ED services, exceeding annual targets care plan completions; and
- Consistent with the recommendations provided via the technical assistance process, hired a manager for the Patient Resource Coordinator workforce to help navigate patients to community-based supports and establish consistency in service delivery across settings.

Medical Management

- CHA developed evidenced based clinical practice guidelines for COPD, CHF, Diabetes and Alcohol Use Disorder, which were approved by the Nursing and Medical Executive

Committees. A hypertension guideline was approved in May 2020 and an Opioid Use Disorder Guideline in November 2020. These guidelines were delayed due to the national coronavirus emergency;

- CHA embedded care pathways for selected diseases into clinic practice across the care continuum, including EMR decision supports and training for practice teams in primary care, care management, ambulatory specialty care, the hospital, emergency department and post-acute partners. Development includes patient education materials where applicable and available;
- Developed condition-specific dashboard reports for performance monitoring for the identified chronic conditions, showing ED and hospital utilization, and total medical expense;
- CHA continues to create or review existing chronic condition guidelines. In this reporting period, the Chronic Obstructive Pulmonary Disease (COPD) was reviewed for possible clinical updates. OUD Guideline approved by MEC November 2020;
- CHA partnered with an advanced automated patient outreach system to assist CHA in outreaching to patients who have care gaps for chronic conditions or wellness appointments. The first five protocols were developed for 4 chronic conditions: uncontrolled diabetes, hypertension, COPD, and depression and for wellness checks for patients age 17 and under and follow up for an abnormal pap smear. Patients who did not have an appointment scheduled in the prior months according to the protocol requirement or in the next 30 days, the patients were contacted by their preferred contact mode: text, email or a recorded telephone call asking the patient to contact their primary care site providing a telephone number to call;
- CHA also provided outreach to patients with 2 or more comorbidities through the electronic medical record (EMR) patient email portal, through a recorded message on each of the primary care clinic telephone numbers, and on the CHA website to notify patients when they were eligible for a COVID vaccination. Patients were also outreached by a CHA centralized scheduling department. During this reporting period, the CHA Nursing Home program implemented a Congestive Heart Failure (CHF) protocol which was piloted at one of the CHA preferred nursing facilities. This pilot was started on October 19. As of March 5, with an average of 14 patients per month who had this protocol added to their nursing home orders, the protocol was initiated on five different occasions. The review of these patients revealed there were no readmissions for CHF;
- CHA Pharmacotherapy team collaborated with the inpatient respiratory therapists to identify patients with COPD who receive the COPD patient education to schedule an outpatient appointment with a pharmacist for a rescue pack, medication optimization and inhaler teaching before the patient is discharged;
- CHA has also added a diabetes nurse educator to work in collaboration with primary care, endocrinology, and pharmacotherapy to provide diabetes education to patients on an inpatient or outpatient basis; and
- Progress for Core Components

✓ *Identify key evidence-based practices from review of the literature and formalize a clinical guideline*

Progress Update: CHA continues to create new guidelines and update existing guidelines for chronic conditions. During this reporting period, the previously approved COPD guidelines were reviewed for possible clinical updates. The guideline was updated to ensure it incorporates the recommendations from the 2020 GOLD guidelines.

- ✓ *Develop and use a registry database for risk stratification, for use in identifying and closing gaps in care, and for use in monitoring adherence to best practices*

Progress Update: CHA has partnered with an advanced automated patient outreach system to assist CHA in outreaching to patients who have care gaps for chronic conditions, require follow up for abnormal tests and for wellness care. The patients who will be targeted are those who have not been seen or have an appointment scheduled with their primary care or specialty provider in the appropriate amount of time. For example, patients with hypertension who have not had a visit related to their condition in the previous 6 months or do not have an upcoming appointment in the following 30 days will be targeted by this outreach system. The outreach will place a recorded telephone call, text or email to the patient according to the patient's contact preference reminding the patient to contact their provider for follow-up.

This system will integrate two software systems, the CHA electronic medical record (EMR) and the outreach system and will share internal documentation practices to select appropriate protocols identified for each specific condition or wellness care gaps. The provider will be notified if there has been successful contact. If an appointment has not been scheduled, a follow up contact will be completed.

During this reporting period, the initial pilot for this process started by creating protocols for the outreach system to close care gaps for 4 chronic health conditions: uncontrolled diabetes, hypertension, COPD, and depression. In addition, a protocol for wellness visits for patients through the age of 17 and a protocol for patients with an abnormal pap smear have also been created. This outreach pilot will be reviewed for effectiveness in the next reporting period before adding additional health care gap protocols. The outreach pilot is scheduled to begin during the next reporting period.

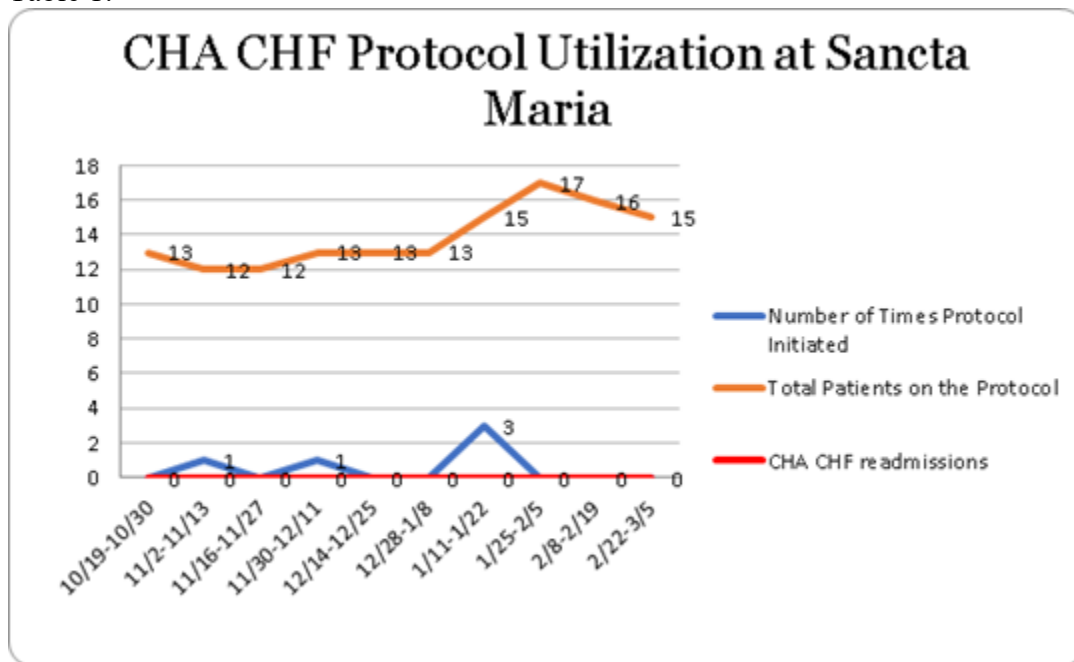
CHA also provided outreach to patients with two comorbidities, including diabetes, the CHA EMR sent email messages to these patients through the patient email communication portal. In addition, CHA created a recorded vaccine message which patients could listen to when calling their primary care site and provided updates on the CHA website when COVID vaccines would be available to this at-risk population. In addition, a centralized scheduling department called these identified at-risk patients to schedule a vaccination appointment.

- ✓ *Develop roles and responsibilities for collaborative practice across the care continuum and design strategies for embedding best practices into clinical workflows*

Progress Update: CHA Nursing Home Program developed a CHF protocol, which has been piloted since October 2020 at one of the CHA preferred nursing facilities. This pilot has been reviewed for effectiveness by reviewing patient records for initiation of protocol, compliance, and hospital readmissions.

On average per month from October 19, 2020 through March 5, 2021, 14 patients have had the CHF protocol added to their nursing home orders. During that same time-period, the CHF protocol was initiated 5 times. Each of the patients in the protocol were reviewed for CHF readmissions. The review indicated that there were no CHF readmissions reported. CHA will continue to review this pilot for needed updates and will plan to initiate this work in other CHA preferred nursing facilities soon.

Table 1:



CHA Pharmacotherapy has also created a workflow for identifying patients admitted to the inpatient department who have COPD. This workflow coordinates an outpatient appointment with a pharmacist for a rescue pack, medication optimization and inhaler teaching. This process is in collaboration with inpatient respiratory therapists who provide patient education to patients admitted with COPD. In addition, a standing order was created in the EMR to refer the patient to the pharmacist as part of the inpatient discharge planning. CHA Pharmacotherapy has also developed teaching tools for all inhaler types for patient education and has had these tools translated into multiple languages.

CHA Primary Care and Pharmacotherapy teams collaborated to start a pilot as of October 29, 2020, to provide in-home visits for patients with hypertension and diabetes who are at risk and not part of the CHA House Calls and PACE programs. This pilot provides a CHA staff member with monitoring equipment, screening instruments such as depression screening, equipment to obtain and safely store specimens, appropriate personal

protective equipment, and an iPad to conduct a video visit with the provider during the appointment.

In the last reporting period, CHA Pharmacotherapy created a pilot at four CHA primary care sites for targeted medication reviews to optimize diabetic medications based on comorbidities, the pilot is targeting diabetes patients with CHF, history of atherosclerotic cardiovascular disease (ASCVD), and chronic kidney disease.

A remote home blood pressure monitoring pilot is under development by the CHA pharmacotherapy team working with a CHA primary care site as a pilot. The process includes providing the patient with an AMA validated blood pressure monitor and providing instructions for use and other associated tools at an in-clinic appointment with a pharmacist. During this visit, the patient will be scheduled to complete any outstanding vaccinations or labs that are due. Frequent blood pressure measurements will be recorded either electronically or manually, depending upon equipment and patient comfort. The patient will report blood pressure values to the pharmacist during follow-up visits. Any medication or lifestyle modifications will be adjusted as needed. This pilot is expected to begin in the next reporting period.

In this reporting period, CHA has also added a diabetes nurse educator to work with patients who have uncontrolled diabetes. The diabetes nurse educator is working in collaboration with primary care, endocrinology, and pharmacotherapy to provide diabetes teaching for patients on an inpatient or outpatient basis, depending upon the current patient status. The nurse educator teaches diabetes education to these patients, which is aligned with the diabetes patient education materials.

✓ *Develop process and outcome metrics to evaluate the impact of our efforts in improving clinical quality and reducing total medical expense*

Progress Update: CHA continues to monitor improvement in adherence to guidelines and reductions in healthcare utilization for populations of patients with identified chronic conditions. Due to the current COVID-19 pandemic, many of these performance indicators have seen a decline in performance given these indicators require in person intervention. As of February 28, 2021, CHA's performance in the measures for chronic health conditions are as follows:

- There are three COPD clinical measures that CHA continues to monitor:
 - Providing patients with recently updated education materials during inpatient admissions is currently at 88.14%.
 - For the measure of appropriate use of spirometry for patients with a new or newly active diagnosis of COPD, CHA has seen a decrease in the percentage to 37.32%, which is attributed to COVID.
 - Patients with moderate to severe COPD that were appropriately prescribed a long-acting bronchodilator at 89.52%. CHA Pharmacotherapy Services are identifying patients who meet the criteria for a long-acting bronchodilator, working with Primary Care to prescribe when appropriate.

- CHF education during inpatient admissions is currently at 86.95%. CHA will review the workflow for improvement.
- The measure slate includes three metrics for patients with diabetes:
 - The percent of patients with well controlled diabetes (recent HbA1C <8) is currently at 49.77%.
 - Patients with poor diabetes control who have a documented patient-centered care plan in the electronic medical record is currently at 14.55%.
 - The percent of diabetic patients who have had a retinal eye exam is currently at 51.40%
 - For high-risk patients who have diabetes or hypertension who received enhanced services with nursing, pharmacy and/or nutrition have been impacted by the COVID-19 crisis:
 - For patients with diabetes 28.69%.
 - For patients with hypertension 6.67%.
- Hospitalization follow up contact by telephone or clinic visit for the identified chronic diseases, is currently at 34.87%.
- Emergency Department follow up contact by telephone or clinic visit for the identified chronic diseases, is currently at 33.49%.
- CHA has two measures focusing on patients with depression who have certain chronic medical conditions:
 - The initial depression screening measure is currently at 32.97%.
 - The follow-up depression screening measure is currently at 7.95%.

Behavioral Health

- The ICA behavioral health management program continued to mature and expand in PY3. Under this program, three Intensive Clinical Managers provide clinical input and care coordination for high-risk patients with inpatient BH readmissions or high rates of avoidable BH ED visits. They provide case consultation to CHA BH clinicians working with these patients;
- Claims-based reports suggest that the ICA program may have had some impact on broad measures of behavioral health utilization. CHA adult total behavioral health inpatient events per thousand member months have decreased 13% between March 2018 and Oct 2020;
- We integrated an addictions consultant into the ICA team, as a large percentage of our high-risk patients have a primary or secondary SUD; and
- CHA further integrated preferred SUD providers into our referral system and developed system-wide pathways for the care of SUD patients across the delivery system.

Post-Acute

- Sustained the programmatic elements necessary for post-acute care management: 1) Monitoring patients referred to non-preferred SNFs; 2) Ongoing measurement and evaluation of SNF LOS; 3) Ongoing measurement and evaluation of readmission rates

- within 30 days discharge from hospital to SNF; and 4) Ongoing measurement of appropriate SNF transfer to Public Hospital when acute transfer is indicated; and
- Total SNF days per thousand, as measured by CHA using claims data, through September 2020, demonstrate a 39% reduction in total SNF days/1000 for the ACPH population.

Goal 2 Quality:

CHA made significant progress in PY3 including:

- Investments supporting the refinement of quality dashboards, monitoring performance against established targets, assessing and identifying metric risks, and providing support to CHA operations on performance improvement activities;
- CHA assessed and incorporated COVID-19 quality adjustments for all measures;
- CHA was fully compliant with all timeliness, accuracy, and completeness requirements set forth by MassHealth;
- We have preliminary data from our MCO partner that show quality measurements for 2019. CHA is still awaiting final results from MassHealth for CY 2019; and
- Based on this preliminary data, it is estimated that CHA will meet attainments for 4 measures and 5 measures meeting goal benchmark.

Goal 3 Member Experience and Engagement:

- We continued implementation of outreach efforts and on refinement of the outreach plan during the first two and a half months of PY3. After the declaration of the Public Health Emergency, we paused our outreach efforts and shifted attention to establishing telehealth services and reorganizing primary care services to address the immediate needs of our patient population caused by the novel coronavirus. Outreach remained on pause through the remainder of PY3.

Goal 4 Integration:

Key integration accomplishments in PY3 include:

- Continuous management of contracts with 6 behavioral health and 4 LTSS community providers;
- Completed cross training of CHA and community partners staff and incorporated criteria and workflows for integrating community partners; established criteria for coordination of care for individuals receiving social services, behavioral health care, and community-based social services through documented processes;
- Integrated community partner care plans into the electronic medical record.
- Maintained quarterly meetings with community partners to monitor collaboration address issues and smooth workflows;
- CHA fully integrated the web-based platform *Aunt Bertha* known as “CHA Connect” into the electronic medical record for use by all staff. CHA Connect provides an inventory of and access to community programs in particular community programs that

- have the ability to assist patients in addressing social determinants of health. CHA ACO users made referrals to community agencies through the program; and
- Introduced the first phase of the flexible services program specific to nutrition support via a collaboration with Community Servings.

1.3 Successes and Challenges of PY3

The Cambridge Health Alliance (CHA) and the Tufts Public Health Plans (THPP) have come together and continue to work to address the needs of the most vulnerable populations within our community. Our organizations have deep knowledge of the current and evolving medical, behavioral health and social service needs of our members, as well as experience in developing partnerships which leverage the specific strengths of each organization and create efficiencies.

We continue to be confident that this history and early experiences together will position us well to meet the objectives of the Quadruple Aim of increasing quality and patient and provider satisfaction while decreasing cost.

Our strength also comes from our collective understanding of the challenges we see in continuing launching this initiative. We outline below our most salient challenge and plans to mitigate its effects.

Program Sustainability:

Tufts Together with CHA experienced various unanticipated sustainability issues during RYs '18, '19, and '20, resulting in substantial losses. Many of these issues were related to broad market changes beyond our control, many of which have been addressed by Medicaid through the global budget model changes for 2021. The 2020 covid pandemic is the most recent and dramatic example of significant market impact and volatility. We recognize and appreciate MassHealth's important changes to its 2021 budget setting, concurrent risk adjustment, market and individual risk protection and settlement processes. However, we believe it remains to be seen how these changes will appropriately balance managing market change risk versus true performance risk, and we continue to have concerns about the financial model and ongoing support for critical programmatic interventions. We are extremely proud of the care our membership has received since the program's inception in 2018. CHA and Tufts look forward to working with MassHealth on managing successful financial performance in the coming year, which we believe is critical for the long-term viability of the ACP program.

More specifically, we have the following comments on sustainability:

- Our current assessment is that, at best, CHA and THPP will be very challenged to perform break even on medical budget performance. Non-billable but critical services like care management aimed at integrating a fractured healthcare system or medical management focused on efficient and evidence-based care cannot be directly compensated through FFS revenue and are in jeopardy as DSRIP funding winds down. Thus, funding care management through budget surpluses alone is unlikely, given the volatility of budgets and medical costs, the need to maintain reserves, and a budget setting model which reduces budgets every year if programs are successful in reducing

costs. In addition, medical budget surpluses are shared. This leaves CHA with no long-term dependable funding stream for investments in cost of care or medical management activities. We view appropriate care management funding as critical to the long-term sustainability of the program, particularly as DSRIP funding rapidly decreases in 2021 and 2022.

- CHA is concerned over the direction MassHealth appears to be signaling regarding Model A plans, where the administrative component of funding is decreasing, and unassigned patients are being steered to other models, concerns over value have been voiced and plans to remove administrative responsibility for BH programs and care is contemplated. The reduction in administrative funding and responsibility obscures a path for CHA to be able maintain investments in care management and other cost of care activities. This raises questions over long program sustainability. MassHealth needs to address this issue for Model A programs and broadly clarify its intent.
- CHA has come to understand that there were data issues affecting CHA's medical budget for 2021 were remedied absent CHA's input. While MassHealth has partially addressed this, CHA remains concerned over the downstream impacts of this on its other funding streams, including DSRIP and DSTI withholds and PHTII performance as the remediation is outside of the settlement calculations for other supplemental payment calculations.
- We recommend that MassHealth continue to monitor the impact of the Covid pandemic on medical budgets and in particular the impact on behavioral health utilization patterns. CHA believes that we may be differentially impacted due to our commitment to providing high quality behavioral health services. We have raised this issue with MassHealth and look forward to working with MassHealth on exploring this further.
- CHA's commitment clinically to the care of members with SMI and SUD creates a membership which has higher direct and indirect costs of these conditions. While we have invested in programs which address cost and quality, ongoing rate adjustments for our commitment have not been forthcoming and remain contested by MassHealth due to a confidence in precise and accurate risk adjustment coding methodology. It is clear that, given our role in the community as a center for deep expertise and based on MassHealth's data in the care of adults and children with extremely complex behavioral health issues, a disproportionate share of this population hampers our ability to perform while underfunded. We appreciate MassHealth's willingness to have ongoing conversations as the data unfolds so we may monitor and remedy this issue.

Functional and Organizational Integration:

In previous years, we noted a challenge related to the promotion of functional and organizational integration. Each organization continues to make progress in risk stratifying its populations and assigning the most vulnerable to experienced case managers who get to know them and address their on-going needs in a comprehensive, integrated manner. We have worked closely together over the past year to identify and assign clear functions within the two organizations which avoids duplication, enabling us to work synergistically to support members. It is critical to continue this work moving forward which could be compromised if our concerns outlined above regarding program sustainability are not realized. Below is a summary of our work in discrete categories:

a. Governing Structure / Work Groups:

We created a strong governance structure which includes a Joint Operating Committee, Governing Board, Finance Committee, Quality Committee and Compliance Committee which meet regularly to collaboratively identify and address opportunities for program improvement. In addition, several work groups with representatives from both CHA and THPP convene to address issues of member transition, member engagement, disease management, and quality measurement. These work groups seek to create and adapt joint workflows to avoid duplication and ensure that the member gets the right service, at the right time, and in the right location.

b. Institutional Experience:

In addition, both organizations have significant institutional experience with functional and organizational integration. For example, CHA has achieved over the past several years Prime Certification for each of its primary care locations. The organization has created systems to identify high risk patients, coordinate care, and close care gaps and conducted on-going training for staff at all levels to promote functional integration of medical and behavioral health.

c. IT Upgrades and sharing of information:

Both CHA and THPP worked together to coordinate significant IT upgrades and share critical reports to ensure that members are identified, screened, assessed, coordinated, and managed optimally.

d. Learning Collaborative:

As mentioned above, CHA and THPP have a long history of working collaborating to ensure that its members receive coordinated and integrated care. Both organizations look forward to taking advantage of the State's learning collaboratives to share its experience in identifying and addressing any functional and organizational integration challenges which occur.