The following appendix is supplemental to a Commonwealth Fund report, Kristen A. Peck et al., *How ACOs Are Caring for People with Complex Needs* (Commonwealth Fund, Dec. 2018), https://www.commonwealthfund.org/publications/fund-reports/2018/dec/how-acos-are-caring-people-complex-needs.

Appendix Table 1. NSACO Questions and Response Frequencies by Care Management Capability

Question		Response category	All (n=394)	Comprehensive care management capabilities (n=250)	Less comprehensive care management capabilities (n=144)
To what extent are chronic care management processes and programs in place to manage patients with high-need, high-cost chronic illnesses? [9-point Likert scale] Number (%)		1–3: Few or no chronic care management processes or programs in place	15 (4)		
		4–6: Some chronic care management processes or programs in place	129 (33)		
		7–9: Comprehensive chronic care management processes or programs in place	250 (63)		
For patients attributed to the ACO, to what extent is a system in place for predictive risk stratification? Number (%)		Advanced	173 (44)	131 (52)	42 (29)
		No/Little/Some	221 (56)	119 (48)	102 (71)
Do you segment high-risk patients into subgroups based on common needs (e.g., frailty, mental illness, similar combinations of chronic conditions)? Number (%)		Yes	261 (66)	171 (68)	90 (63)
		No	133 (34)	79 (32)	54 (38)
To what extent are clinicians trained in patient activation and engagement methods and techniques (e.g., two-way communication, motivational interviewing, etc.)? Number (%)		Advanced	117 (30)	94 (38)	23 (16)
		No/Few/Some	277 (70)	156 (62)	121 (84)
To what extent are processes in place for clinicians to encourage ACO patients to be actively involved in decisions involving their care and self–management of their conditions? Number (%)		Advanced	117 (30)	95 (38)	22 (15)
		No/Few/Some	277 (70)	155 (62)	122 (85)
For how many of your ACO-attributed hospitalized patients undergoing a care transition to home or a post-acute care facility receive the following services to reduce the risk of readmission? Number (%)	Medication reconciliation	Most/All	303 (77)	194 (78)	109 (76)
		None/Some	91 (23)	56 (22)	35 (24)
	Telephone follow-up (within 72 hours of discharge)	Most/All	300 (76)	208 (83)	92 (64)
		None/Some	94 (24)	42 (17)	52 (36)
	In-home follow-up (within 72 hours of discharge)	Most/All	68 (17)	52 (21)	16 (11)
		None/Some	326 (83)	198 (79)	128 (89)
	Standardized process in place to ensure timely follow-up with primary/specialty care	Most/All	288 (73)	198 (79)	90 (63)
		None/Some	106 (27)	52 (21)	54 (38)
	Discharge summaries are transmitted to clinicians accepting care of the patient	Most/All	283 (72)	189 (76)	94 (65)
		None/Some	111 (28)	61 (24)	50 (35)
	Use of a patient navigator or care manager while patient is in the hospital	Most/All	187 (47)	130 (52)	57 (40)
		None/Some	207 (53)	120 (48)	87 (60)
	Use of a care manager or health coach post-discharge	Most/All	201 (51)	156 (62)	45 (31)
		None/Some	193 (49)	94 (38)	99 (69)

Question		Response category	All (n=394)	Comprehensive care management capabilities (n=250)	Less comprehensive care management capabilities (n=144)
Medicare contract (based on screeners) Number (%)		Yes	328 (83)	205 (82)	123 (85)
		No	66 (17)	45 (18)	21 (15)
Medicaid contract (based on screeners) Number (%)		Yes	91 (23)	62 (25)	29 (20)
		No	303 (77)	188 (75)	115 (80)
Commercial contract (based on screeners Number (%)		Yes	284 (72)	188 (75)	96 (67)
		No	110 (28)	62 (25)	48 (33)
Which of the following best describes the leadership structure of your ACO? Number (%)		Physician-led	210 (53)	130 (52)	80 (56)
		Hospital-led	35 (9)	22 (9)	13 (9)
		Jointly led by physicians and hospital	115 (29)	79 (32)	36 (25)
		Other	34 (9)	19 (8)	15 (10)
Do any providers in your ACO use the following strategies to integrate primary care and treatment for depression and/or anxiety? Number (%)	Care manager to primarily address mental health treatment coordination*	Yes	43 (55)	22 (54)	21 (57)
		No	35 (45)	19 (46)	16 (43)
	Care manager to address nonmedical needs (e.g., job support, housing)	Yes	265 (67)	188 (75)	77 (53)
		No	129 (33)	62 (25)	67 (47)
	Mental health clinician (not colocated) consulting primary care clinicians	Yes	226 (57)	152 (61)	74 (51)
		No	168 (43)	98 (39)	70 (49)
	Patient registries to track mental health symptoms	Yes	103 (26)	71 (28)	32 (22)
		No	291 (74)	179 (72)	112 (78)
	Telemedicine to treat a patient by phone or video	Yes	118 (30)	75 (30)	43 (30)
		No	276 (70)	175 (70)	101 (70)
	Peer support specialist	Yes	74 (19)	49 (20)	25 (17)
		No	320 (81)	201 (80)	119 (83)
To what extent are systems in place to assure smooth transitions of care across all practice settings including hospitals, long–term care, home care, adult day care, and community–based health and social services as needed? Number (%)		Advanced	175 (44)	147 (59)	28 (19)
		No/Few/Some	219 (56)	103 (41)	116 (81)
Number of advanced care approaches		0	122 (31)	43 (17)	79 (55)
		1	136 (35)	94 (38)	42 (29)
		2	79 (20)	60 (24)	19 (13)
		3	57 (14)	53 (21)	4 (3)

Table shows number (%) of ACO respondents reporting a given response.