# Attachment APR

# Delivery System Reform Incentive Payment (DSRIP) Program

# Accountable Care Organization (ACO) PY1 Annual Progress Report Response Form

## General Information

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| **Full ACO Name:** | Boston Accountable Care Organization, Inc. (BACO) |
| **ACO Address:** | 720 Harrison Avenue, Boston, MA 02118 |

## Part 1. PY1 Progress Report Executive Summary

## 1.1 ACO Goals from its Full Participation Plan

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| **Goal Category** | **Goals** | **Why a Priority for ACO** |
| Cost and Utilization Management | 1. Reduce total cost of care relative to FY17 present state 2. Reduce fragmentation between primary care, acute care and long-term care 3. Develop a holistic, targeted and high-touch care management model for the top 3% of our members 4. Reduce avoidable readmissions to lower inpatient cost 5. Reduce avoidable ED visits to reduce emergency room costs 6. Develop integrated behavioral health programs and protocols to address siloed behavioral health care and pervasive need by members and manage BH spend 7. Develop best-in-class analytic infrastructure and enhance analytic capabilities to give providers expanded access to meaningful data to inform treatment decisions and patient care and to manage TCOC 8. Identify actionable opportunities for performance improvement and work collaboratively toward achieving value-based care and provider accountability 9. Address social determinants, which impact health outcomes and TCOC 10. Deliver care in a culturally and linguistically competent manner 11. Provide appropriate performance feedback to providers and staff | We believe that fragmentation is a driver of TCOC, therefore, a relatively large portion of inpatient and emergency room spend can be impacted through these goals. Collectively, these goals will allow us to reduce TCOC by approximately 5% over five years, reduce avoidable readmissions (which contributes 20% to TCOC for BACO), integrate services for our members, and address underlying social issues that are often drivers of adverse patient behavior, especially among our high risk population. |
| Integration of Physical Health, Behavioral Health, LTSS, and Health-related Social Services | 1. Develop workflows and protocols with local social service organizations 2. Develop workflows and protocols with community partners | These goals reflect our overall vision to improve the health of our members. They allow us to reduce fragmentation and develop an integrated delivery system that provides the right care, in the right setting, at the right time, while linking members to critically need support services |
| Member Engagement | 1. Develop educational programs/ materials for members with chronic diseases | We believe that through carefully designed member education programs, we can improve engagement with outpatient care, specifically primary care, minimize use of unnecessary, higher cost settings like the ED and inpatient care, and reduce overall utilization while effectively managing medical expense. |
| Quality | 1. Improve upon quality for patients overall and specifically on MassHealth’s metrics 2. Actively monitor quality outcomes and intervene proactively where there is deficiency 3. Provide physicians with information on quality outcomes and the tools to improve performance | These goals reflect our focus on delivering high quality services to our members as part of our overall vision to improve their health by addressing patient gaps in care, We believe that these goals will help reduce total cost of care. |

## 1.2 PY1 Investments Overview and Progress toward Goals

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| **Overview of Investment** | **Implementation Status** | **Examples of Progress** |
| Expand and standardize programs for managing **High Risk** as well as **Complex Case Management for top 3%** of members | Fully implemented and operational. | A CCM staff is onboard and we have hired a new team of leaders to support the CCM program and the ACO overall. These are critical steps since the leadership also oversees our CCM onboarding plan, which is already in progress. |
| **Embed Quality Management Staff** in provider sites to help improve quality performance and outcomes | Partially implemented with support from existing staff, further evaluation in PY2 |  |
| Embed staff at provider sites to focus on **Disease Management and Education** | Fully implemented and operational. |  |
| **Expand Inpatient Addiction Consult Services** to reduce hospitalizations and ED use, and to help primary care physicians address substance use disorder | Fully implemented and operational. |  |
| Expand existing **Specialty Pharmacy Program** to better support medication reconciliation and management for highest risk and highest utilizing members | Fully implemented and operational. | Pharmacy staff hired and embedded in practices with a pharmacy team to support medication reconciliation. |
| Provide **Community Resources Help for Patients** by linking members with social services through in-person resources or online portal | Fully implemented and operational. |  |
| Expand existing **Practice-based SMI/SUD Program** by embedding BH providers in practices with sufficient numbers of patients | Partially implemented, continuing program implementation through PY2. |  |
| Expand **BMC Transitions of Care Program** to other sites by deploying RN case manager/ social worker dyads focused on transitions after acute hospitalization | Fully implemented and operational. |  |
| Expand existing **ED Care Management Program** by embedding RN case managers in emergency rooms | Fully implemented and operational. |  |
| Expand **EMR Activities** to all BACO sites and integrate EMR platforms | Fully implemented and operational. | Successful creation of regular, actionable reporting and scorecards in financial, clinical and quality domains. |
| Invest in a **Care Management System** that allows care managers to communicate with broader care teams | Fully implemented and operational. | We have implemented a new case management system with tools to track productivity, case assignment, and share information with primary care teams. These tools allow us to efficiently support performance of CCM teams embedded in primary care practices. |
| Invest in an **Analytics System**  for generating high-risk lists and other insights related to member health and total cost of care performance | Fully implemented and operational. | We have implemented an analytics solution to intake EMR and/or claims data and generate risk-adjusted lists used by our case managers to engage high-risk members. |
| Invest in **Tele Psychiatry** to provide digital visits for patients with SMI/SUD | Partially implemented, continuing program implementation through PY2. |  |
| Centralize administrative costs for ACO members through **Clinical Administrative Activities** | Fully implemented and operational. |  |
| **Miscellaneous Activities and Investments** such as recruiting and training to support programs, as needed | Fully implemented and operational. |  |
| Invest in **IT Upgrades** to support new programs | Fully implemented and operational. |  |
| Invest in **Computer Systems for New Hires**, including care managers and community health workers | Fully implemented and operational. |  |
| **Patient Education and Marketing Materials** in print and electronic format | Fully implemented and operational. | Orientation packet sent to new enrollees which explains the ACO program and includes information about member benefits. |
| Invest in **Additional Translators** at sites to assist with member transition and education about ACO programs and services | Fully implemented and operational. |  |
| Invest in **Additional Call Center Staff** to assist with member transition and education | Fully implemented and operational. |  |

## 1.3 Success and Challenges of PY1

There are a number of successes achieved by BACO’s primary care sites during PY1. DSRIP funding was successful in several key activities related to data, analytics and EMR optimization. In addition, notable progress has been made to advance efforts to improve patient experience and continue to meet high standards in providing care in a culturally and linguistically competent manner. We are also eager to continue to build on the work done in PY1 to develop integrated behavioral health and substance use disorder programs and protocols to address siloed care and/or pervasive need by our patient population.

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| **Success Story 1** | Preliminary review of the BACO CCM program has shown positive outcomes for PY1. We have found that by roughly 3-5 months post enrollment, BACO CCM patients decrease utilization by 20% or more relative to historical benchmark. Specifically, we have seen a 29% decrease in inpatient medical/surgical admissions and a 20% decrease in ED visits relative to historical benchmark for BACO active and graduated CCM enrollees. |
| **Success Story 2** | Successful enhancements and expansion of our data and analytics platform across the BACO sites. This has led to successful creation of regular, actionable reporting and scorecards on financial, clinical and quality domains. |

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| **Challenge** | **Description** | **Mitigation Strategy** |
| **Challenge 1: Determining appropriate length of CCM enrollments** | Some patients require intensive CCM involvement for long periods of time, while other patients benefit from a short, intensive intervention for several months or less. | BMCHS will continue to study overall panel size, details of panel composition, and outcomes for different sub-populations to determine an appropriate graduation strategy. |
| **Challenge 2: Ability to Meet Engagement Goals** | We face a varied level of patient readiness to participate in care management with an inconsistent ability/willingness of patients to adhere to activities in support of reaching care plan goals, especially regarding medication adherence and keeping appointments. | Leverage CWA role to conduct telephonic and in-person outreach to patients  Continue active engagement of top 3% risk patients at ambulatory sites.  Continue practice site-specific screenings for risk, social determinants of health, and need for social services at time of visit  Leverage our partnership with CPs, where appropriate, learn more about the population and how to reach these patients and continue to evolve CCM program from those learnings. |