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:	Boston Accountable Care Organization in partnership with Boston Medical Center Health Plan
ACO Address:	720 Harrison Avenue, Boston MA 02118

Part 1. PY3 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

Goal Category	Goals	Why a Priority for ACO
Cost and Utilization Management	1. Reduce total cost of care relative to 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	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, integrate services for our members, and address underlying social issues that are often drivers of adverse patient behavior, especially among our high risk population.

	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	
Integration of Physical Health, Behavioral Health, LTSS, and Health-related Social Services	12. Develop workflows and protocols with local social service organizations 13. 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	14. 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	15. Improve upon quality for patients overall and specifically on MassHealth's metrics 16. Actively monitor quality outcomes and intervene proactively where there is deficiency 17. 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 PY3 Investments Overview and Progress toward Goals

Overview of Investment	Advancement of Goals	Implementation Status	Examples of Progress
Expand and standardize programs for managing **High Risk** as well as **Complex Case Management for top 3%** of members	Advances goals on development of a holistic, targeted and high-touch care management model for BACO high risk/utilizers. Having a positive impact on reducing TCoC	Fully implemented and operational.	The CCM team engaged in a TA project with Medical Legal Partnerships conducting case consultations for patients with housing related legal concerns. The CCM team also received training from MLP on various SDOH topics- i.e. housing, utility, immigrations, justice involved,etc.
Quality Management Staff to support sites to help improve quality performance and outcomes	Advances quality goals of actively monitoring quality outcomes and providing physicians with information and the tools to improve performance	Implemented with support from existing staff	

Embed staff at provider sites to focus on **Disease Management and Education as well as SDoH**	Advances ACO goals of reducing TCoC and integration of physical health, behavioral health, LTSS, and social services	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	Advances goals reduce avoidable readmissions and ED visits by equipping primary care providers with the appropriate supports	Fully implemented and operational.	
Expand existing **Specialty Pharmacy Program** to better support medication reconciliation and management for highest risk and highest utilizing members	Advances goals of reducing TCoC and equipping our provider sites with resources to support patients with their medication management	Fully implemented and operational.	
Provide **Community Resources Help for Patients** by linking members with social services through in-person resources or online portal	Advances ACO goals on integration of physical health, behavioral health, LTSS, and social services	Fully implemented and operational.	
Expand existing **Practice-based SMI/SUD Program** by embedding BH providers in practices with sufficient numbers of patients	Advances ACO goals of reducing TCoC and integration of physical health, behavioral health, LTSS, and social services	Fully implemented and operational.	
Expand existing **ED Care Management Program** by embedding RN case managers in emergency rooms	Advances goals to reduce avoidable readmissions and ED visits	Fully implemented and operational.	

Expand **EMR Activities** to all BACO sites and integrate EMR platforms	Supports goals of integration amongst provider groups and improved communication and patient care	Fully implemented and operational.	
Invest in a **Care Management System** that allows care managers to communicate with broader care teams	Supports goals of integration amongst provider groups and improved communication and patient care	Fully implemented and operational.	BACO/BMCHS have implemented updates to the existing care management platforms to better track program outcomes for housing.
Invest in an **Analytics System** for generating high-risk lists and other insights related to member health and total cost of care performance	Advances ACO goals of expanding provider access to meaningful data to help inform treatment decisions and patient care and to manage TCOC	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. Through this tool we are able to provide regular, actionable reporting and scorecards on financial, clinical and quality domains to our provider partners.
Invest in **Tele Psychiatry** to provide digital visits for patients with SMI/SUD	Advance ACO goals of BH integration and increasing access to care for patients to telehealth	Fully implemented and operational.	
Centralize administrative costs for ACO members through **Clinical Administrative Activities**	Advances the ACO goals of managing cost and utilization	Fully implemented and operational.	
Invest in **Translators** at sites to assist with member education about ACO programs and services	Advances goals on delivering care in a culturally and linguistically competent manner	Fully implemented and operational.	

Invest in **Call Center Staff** to assist with member transition and education	Supports goals on improved member engagement	Fully implemented and operational.	

1.3 Success and Challenges of PY3

Success Story 1	BACO CCM program continues to see improvements. Based on the program evaluation deliverable measure of the CCM program, 6 measures were identified to show operational efficiencies and patient outcomes. All saw positive improvements from the baseline to the observation period: • Rate of timely completion of CCM assessments increasing by 19% • The rate of completion for 72 hour assessments increasing by 8% • The rate of graduation increasing by 34%. • IP utilization decreasing by 10%, IP spend decreasing by 5%, • ED utilization decreasing by 2%, and ED spend decreasing by 23%.
Success Story 2	Despite the COVID-19 pandemic, BACO/BMCHS was able to launch an initiative focused on transitions of care. The goal is to reduce patient readmission by improving transitions of care post discharge from med/surg and behavioral health hospitalizations. The BACO provider partners have agreed to partner on this initiative and we were successful in implementing reports and tools to make tracking admissions to both medical and behavioral facilities more streamlined and readily available. Tools/reports available are: daily updates to our primary care and CM teams regarding inpatient admissions at both medical and behavioral health facilities. We have developed monthly tracking reports regarding follow-up appointments both on ambulatory and non-ambulatory sensitive conditions. These report track follow-up rates and readmissions by hospitals, in order to identify conditions and/or facilities that could benefit from improved engagement for transitions. Will continue to monitor progress on this initiative in PY4

Challenge	Description	Mitigation Strategy

Challenge 1: Care management documentation	Documentation, and creating a care management continuum of care continues to pose challenges. CPs, CCM and health plan-based care management, document in separate platforms from one another, and clinic sites use separate EMRs. This has created blind spots in care planning for shared patients, patient mobility across the continuum of care, and challenges in coordinating care with patients' care teams in the inpatient and outpatient settings.	In PY4, we will be working on interoperability and integration of documentation platforms, standardization of documentation, and collaborative care planning meetings to build a continuum of care between care management programs.
Challenge 2: Engaging Behavioral Health Facilities	It has been very difficult to engage behavioral health hospitals in quality work, which has made certain measures (e.g. FUH) challenging to improve.	We implemented BH admissions reporting with our BH network, Beacon, to better identify enrolled CCM patients admitted to BH setting. We are in the early stages of collaborating with care management teams at BH facilities and through Beacon to coordinate care for shared members. Second, we have piloted a monthly collaborative care planning meeting between CPs, local clinic care management, and BACO CCM. This has been implemented across 3 clinic sites with good effect.