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

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Part 1. PY3 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

During PY3, our goals remained focused on our original plans as outlined in the PY3 Full Participation Plan, mainly to establish a strong ACO foundation on which to build programs that will bend our cost curve, while maintaining high quality of care for our patients, which included goals of Cost & Utilization Management, Quality, Member Experience and Engagement, and Integration of Physical Health, BH, LTSS and Health-Related Social Services (see section 2 in the PY3 Full Participation Plan).

In PY3, the ACO leveraged DSRIP funding to achieve the goals as outlined in this section by newly implementing, expanding and operationalizing Complex Care Management, Pharmacy Management, Quality Management, SUD and BH Management, Advanced Technology, Patient Engagement and Enrollment, and Risk Coding.

These programs were critical to the success of the ACO, as we began to manage this very challenging population. In order to simultaneously maintain high-quality care and bend the cost curve, these programs have to be successful, and will be the foundation for a strong ACO for the future. As we continue to build out these programs, we know that there will still be challenges. As we work to address not only the clinical conditions for this population but also the social determinants of health, we may find that resource ratios may need adjustments.

1.2 PY3 Investments Overview and Progress toward Goals

Our investment approach supports our ACO's overall performance and strategy in several important ways. A central component of this strategy is executing on our population health management program. This program is overseen and managed by the President of Signature Medical Group, ACO Medical Director, Vice President of Clinical Quality, Clinical Director of Population Health, as well as the Chiefs of Internal Medicine and Family Practice. This team is responsible for implementing the ACO strategy, population health management programs which includes primary-care based Complex Care Management team focusing on the top 5% of members. These programs are complimented by local programs overseen

by the ACO, in which each practice site has been identified as important to addressing local member needs. To prevent duplication with local programs, local program leaders are provided lists of patients enrolled in primary care complex care management.

Our DSRIP investment strategy is to make targeted investments in high-impact programs (supported by either research or our collective experience) aimed at fulfilling our overall goals, most importantly Total Cost of Care (TCOC) reduction and increased quality for our members. Our focus has been on clinical and financial integration of the programs, while at the same time increasing quality for our members and moving toward total cost of care reduction. During PY3, the ACO made great progress in continuing to stand up many initiatives and implementing strategic investments, as outlined below:

1. **Complex Care Management:** The Complex Care Management (CCM) team continued to reach out and engage our "high risk" identified patients (we utilized the analytical program Arcadia). We have seen a positive return on investment with a decrease in emergency department visits and inpatient hospital admissions. As mentioned in our semi-annual progress report, this investment was impacted by COVID, but was back on track by the end of the year.

2. **Pharmacy Management**: We saw all of our ACO patients being discharged from the hospital having a pharmacist-driven medication reconciliation done. This then triggered a notification to the PCP who would see the patient after the hospitalization, thereby maintaining a truly up to date medication list for our ACO patients. The team was also involved is disease specific programs, such as asthma and diabetes. The team also worked closely at the end of the year on MassHealth formulary changes and changes to BMCHP pharmacy benefits manager, to ensure minimal impact to our patients. This investment was impacted by COVID, but was back on track by the end of the year.

3. **Quality Management:** We have made significant strides during PY3 in launching a robust dashboard to track all quality measures among our patient populations. Prior to COVID, we were able to see where our quality metrics were hitting targets and where we needed to focus our efforts for particular metrics that were under goal. As we began reopening in the second half of the year, our CM teams supported outreach to patients with HTN and patients and diabetes to improve primary care reengagement post pandemic

4. **Risk Coding:** We continued our coding efforts to ensure that we were assigning the appropriate diagnoses for the ACO population. The benefits of appropriate coding include improved opportunity for patients to be identified for care management programs and/or disease intervention programs. The ACO Risk Coding Specialists ensured that we were assigning the appropriate diagnosis for the ACO population, as well as using systematic approaches to leverage a robust data model to easily integrate with our existing EMR. During Q42020, we had an extensive EMR system conversion to Meditech, which halted POC coding initiatives until such time as the system was back online. The new system was successfully converted and we are ramping up operations within the new Meditech system in Q12021.

1.3 Success and Challenges of PY3

The ACO had several successes in PY3, as we continued to launch and manage the ACO toward our investment strategy to make targeted investments in high-impact which were aimed at fulfilling our overall goals, most importantly TCOC reduction and increased quality for our members.

1. **Complex Care Management:** At the very foundation of our ACO are medical management and Complex Care Management, which are vital to our success. During PY3, we continued with a solid Complex Care Management team who worked on ensuring quality of care during the COVID pandemic outreaching patients and assisting them with scheduling appointments, coordinating appropriate referrals to specialists, completed assessments within 72 hours after an ED visit, engaged patients identified as high risk. Our teams are fully staffed and preliminary data continues to how a positive ROI, where we are reducing ED visits and hospital admissions for patients enrolled in our complex care management program for the ACO.

2. **Quality Management:** In PY3, we were challenged with the pandemic and managing re-opening while ensuring the safety of our members. We instituted expanded hours, and parking lot texting for patients to wait in their car for a text to be called directly into the exam room. Our primary focus was to bring in our pediatric population to catch them up on Childhood and Adolescent immunizations missed while our office was closed and converted to telehealth. Our Community Health workers (CHW) used the gap reports in Arcadia to call patients to schedule in person visits. Additionally, we prioritized our diabetics who needed labs and vital signs. The CHW's outreached the diabetic and hypertension members to schedule visits. Patients were also mailed blood pressure monitors for at home surveillance. Our performance for Childhood and Adolescent immunizations met goal. We did identify a data issue that aligned with our EMR conversion and point of care testing mapping to Arcadia. Our internal data has us at attainment to goal for hemoglobin A1C and below attainment for hypertension.

The ACO did face challenges during PY3 related to COVID-19 and our EMR Conversion.

1. **COVID-19 Pandemic**
   We had several challenges around the COVID-19 pandemic with our patient's ability to access care and get tested. Early on, we like most health systems had to close our offices and quickly transition our patients to telehealth visits. We stood up our newly established Telehealth service line within a matter of weeks, but found that telehealth visits presented significant challenges to our patients and our providers at first. We found that some of our patient's did not have the appropriate technology to access video conferencing, and some preferred in-person care. Our providers had to learn a new way of caring for their patients through this new electronic process and the system was complicated at first. Additionally, we saw big challenges in terms of accessing appropriate medication reconciliation, dealing with the psychosocial stresses of COVID, and obtaining point of care testing for our quality metrics that was needed to provide the best care for our patients during telehealth visits. Furthermore, we instituted multiple safety measures to ensure the public's confidence in re-opening. We purchased temperature devices for all of our offices, and hired staff to monitor screening questions for all on site appointments. We opened an offsite clinic for patients with any respiratory or COVID related symptoms so they

could be seen in a remote area. We instituted a drive through testing site for all Signature patients, installed barriers and secured PPE to ensure the staff safety. We converted to Telehealth visits enabling providers to maintain patient contact.

COVID testing was another challenge during the pandemic, with significant limitations and availability of test materials early on; and the fact that our community (Brockton) was hit hard. Brockton had the fourth highest COVID positive rate during both surges in the pandemic. The state did allocate higher volumes of testing supplies and equipment to our community, and we were able to stand up a testing site in conjunction with Brockton Neighborhood Health Center at the Brockton High School. This gave us greater access to test our patients, but was limited in that, it was a drive up testing site and did not avail itself to patients without transportation. Due to our limited ability to reach our patients, it made it much more difficult to identify patients with COVID especially those who were at high risk, and to appropriately diagnose and educate patients on quarantining. We believe this potentially added to the increased spread to the high risk population; as most were patients who needed to continue to work because they were either essential workers, or lived in multigenerational housing which potentially increased the transmission of the disease in the younger population.

2. **EMR Conversion**

As has been outlined in our Full Participation Plan; Budget and Budget narratives, we were supposed to upgrade our EMR to Meditech Expanse in the fall of 2019. However, due to system readiness, we delayed the conversion until April 2020, but as COVID-19 took precedence in Q1 2020, we were once again forced to delay our EMR conversion. In the fall, we converted to Meditech Expanse Ambulatory EMR to align with the Hospital to enable one record across the system. Upon conversion, we were presented with a couple of challenges in caring for patients; the acquisition and monitoring of quality data was significantly limited initially; as data integrity caused issues.

In addition, there were difficulties in caring for our patients; as the new systems was more cumbersome than what they were using before; so seeing patients in our office, new workflows, documenting, completing medication reconciliations, and prescription refills, all presented significant challenges to our providers at first. At this point many, most of these challenges with the conversion have been addressed, and our IT department has helped us with our maximizing our workflows, and has made sure that we have the data available that we need to populate clinical actions. Lastly, our providers are gaining confidence with navigating through the system; and are actually able to see more patients now than they were prior to the conversion.