ATTACHMENT APR

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM ACCOUNTABLE CARE ORGANIZATION (ACO) PY1 ANNUAL PROGRESS REPORT RESPONSE FORM

General Information

Full ACO Name:	Atrius Health, Inc.
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Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The Atrius Health/Tufts Health Public Plans (THPP) Accountable Care Partnership Plan (ACPP) is leveraging the Delivery System Reform Incentive Payments (DSRIP) to meet the following goals:

1. Address Patient and Community Social Determinants of Health
2. Enhance Care Coordination and Utilization of Care in Right Setting to Improve Health
3. Manage Mental Health & Substance Abuse
4. Develop Effective Community Partnerships
5. Address home-based issues affecting chronic disease
6. Increase reliability of chronic disease management to improve outcomes
7. Increase effectiveness of population health management for patients with gaps in care
8. Establish and maintain infrastructure to support clinical programs
9. Ensure compliance of ACPP programs

These goals are a priority for the ACO because they address the barriers to care faced by the MassHealth population. The socioeconomic and behavioral health factors which affect access to care must be systematically identified and addressed; this may include individual attention through intensive care coordination and additional support both in the practice and in the patients' communities. It is not possible to address the physical needs of some members of this population without first addressing their behavioral health needs. Atrius Health recognized that its prior resources were insufficient to fully address these concerns and has made these barriers a focus of DSRIP investment.

1.2 PY1 Investments Overview and Progress toward Goals

Atrius Health's DSRIP investment strategy emphasizes both existing infrastructure and targeted, incremental investments in personnel and resources that support the MassHealth patient population. In this first performance year, DSRIP investments have advanced the goals set forth in the ACO's Participation Plan by maintaining and expanding the programs and infrastructure that form the backbone of Atrius Health's approach to delivering high value care.

The following four examples illustrate Atrius Health's progress in advancing the initiatives supported by the DSRIP funding in PY1. Atrius Health used DSRIP funding to:

1. Support the analytics and reporting department to develop reporting logic for a Medicaid registry and associated performance dashboard, leveraging risk stratification algorithms to identify and tier our highest risk MassHealth population so that the individual care needs of these highest risk patients could be reviewed and addressed by the care team and cost and utilization performance segmented by risk stratum.

2. Address MassHealth quality measures by identifying key quality priorities; producing internal reporting for priority quality measures to manage performance and drive local improvement work, including internally-transparent, provider-level reporting; facilitating workflow development to address care gaps; and ensuring readiness for timely and accurate reporting of quality measures at contract settlement.

3. Launch health-related social needs screening in primary care. A multi-disciplinary team including medical leadership, pediatrics, internal medicine, behavioral health, and information technology (including clinical applications, project management, and Epic support) selected, tested, implemented, piloted, and is spreading health-related social needs screening among pediatric and internal medicine departments.

4. Support care facilitators, community health workers, case managers, and social workers. These resources are an essential part of the care team, providing high-touch assistance to patients and their families with medical, behavioral, and social risks. Critical activities of these roles include identifying and addressing social barriers, making connections to community based resources, and supporting care integration with specialty providers. This year, these resources advanced program implementation, including integrated transitions of care telephonic rounds with THPP, a longitudinal social work enrollment pilot, Community Partners integration, and response to health-related social needs for patients and families screening positive.

1.3 Success and Challenges of PY1

Key ACO successes in PY1 include the following:

1. The support of robust infrastructure around quality measurement and analytics has permitted the ACO to leverage actionable data to manage performance, address care gaps, and drive local improvement efforts. Patient registries support proactive and reactive outreach to the ACO population, and are available to all members of the care team within the electronic health record. Routine quality reporting allows care gaps to be addressed, enables local leadership to solve problems at the front line, and provides transparency into variation in provider performance. The ACO performance dashboard allows leadership to monitor ACO performance and establish countermeasures as necessary.

2. Through case management and care facilitation staff, the ACO provides the personalized care required to coordinate the complex care needs of MassHealth patients. Behavioral health care

facilitators routinely communicate and collaborate closely with inpatient providers during psychiatric admissions to ensure the patient's transition from the hospital to the outpatient setting is well-supported, improving patient care and reducing unnecessary utilization. Case managers for pediatric and adult patients routinely collaborate with Long Term Services and Supports Community Partners to jointly manage shared patients, enabling patients' whole-person needs to be met: medical, behavioral, functional, and social.

There are several challenges yet to be overcome:

1. Spreading health-related social needs screening was a challenge in PY1. Competing ACO priorities and hiring challenges delayed screening launch. Any effective implementation plan requires a thoughtful change management strategy to ensure meaningful clinician and staff buy-in, both in terms of workflow acceptance and regarding the larger aims of the initiative, and it took longer than anticipated to develop and deploy this strategy. There is variation in front-line clinician and staff focus on social determinants of health. There is also variation in the accessibility of local resources depending on the specific community-based organizations available in patients' communities. Despite these challenges, the ACO has established an aggressive deployment plan for PY2.

2. Communicating patient information and care plans across organizations remains a challenge. Historically, Atrius Health has used IT interoperability to support the care management of patients at preferred institutions. Atrius Health is actively working with its assigned Community Partners and THPP to improve and optimize workflows to advance the effective and efficient sharing of relevant medical information. For example, in PY2, Atrius Health intends to explore alternative ways to share care plans and care plan approvals with one Community Partner by piloting care plan exchange using the Mass HIway in the second half of the year. Should the pilot prove successful, the ACO can consider spreading to additional preferred Community Partners.