ATTACHMENT APR

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

General Information

Full ACO Name:	Tufts Health Together with Beth Israel Deaconess Care Organization (BIDCO)
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Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The *Tufts Health Together with BIDCO* ACO strives to improve the health outcomes of our diverse members, their families, and their communities by providing access to integrated health care services that promote health, well-being, independence, and quality of life. As an Accountable Care Partnership Plan, BIDCO and Tufts Health Plan have leveraged the strengths of each organization to create a multidisciplinary, data-directed and 'whole person' care approach. We target interventions with the promise to deliver to MassHealth members fully-integrated population health management programs that meet Massachusetts Executive Office of Health and Human Services (EOHHS) and accreditation requirements for care management, disease management, wellness, and prevention to achieve our goal of high-quality, cost-effective care and improved health outcomes.

Goals from the PY1 Full Participation Plan: *Tufts Health Together with BIDCO* built the PY1 full participation plan based on a joint assessment of the strengths and gaps of the partnership programs as well a data-directed evaluation of the ACO members, which were identified at the outset of its new partnership. Mapping these system attributes, *Tufts Health Together with BIDCO* developed the following goals for the DSRIP plan:

Goal 1. Cost and Utilization Management: Decrease avoidable inpatient admissions and adverse outcomes by resourcing personnel to expand and improve engagement in care management and disease management programs.

Goal 2. Quality: *Tufts Health Together with BIDCO* ACO programs are implemented according to MassHealth program requirements and priorities and internal program design.

Goal 3. Member Experience and Engagement: All high risk and complex members are connected to a primary care provider.

Goal 4. Integration of Physical Health, BH, LTSS, and Health-Related Social Services: Social service needs and social determinants of health for MassHealth members are documented and addressed as a part of the care plan.

1.2 PY1 Investments Overview and Progress toward Goals

To deliver value to our members, EOHHS and CMS, *Tufts Health Together with BIDCO* has leveraged existing infrastructure and made targeted investments to improve the health and outcomes for MassHealth members and bend the total cost of care for this population across our diverse network.

To this end, specific investments priorities in PY1 include:

1. Care Management and Population Health Management Services to manage individual risk: *Tufts Health Together with BIDCO* invested in clinical and non-clinical staff to provide direct care management, population health outreach and care coordination services to our members with high-risk and emerging risk needs. This investment assured that our MassHealth members experience unified and coordinated care episodes, with robust communication across settings to reduce avoidable utilization as well as reduce missed opportunities and improve outcomes. These FTE investments that were made to expand existing programs or create new programs at both the Health Plan and provider groups and are now at full capacity with plans for delegation of some of these services from the health plans to the providers occurring in PY2.

2. Targeted Investments in Information Technology to Enable Optimal Care for MassHealth Members: To build capacity for the management of MassHealth members, the BIDCO made targeted investments in a population health management platform to provider point of care dashboards and reports on utilization and quality gaps to guide evidence-based care and facilitate efficient integration of the system for member care. In PY1, the ACO population health platform successfully integrated MassHealth and health plan claims data to build corresponding reports and dashboards with provider and staff training beginning in Q4 of the PY1 year. In PY1 the platform completed its new risk stratification model including claims, clinical and census data. The implementation of this model will occur in PY 2 for the delegated provider entities. In PY 1 the platform care management tool was completed and has been in use since the inception of the program with enhancements continuing in PY2. The increased engagement related to this tool is evidenced by the significant increase in patient engagement and follow up after inpatient hospitalization with the PCP. THPP and BIDCO also collaborated to integrate MCO data with the ACO to support care management activities. These include but are not limited to day of admission, adult and pediatric stratification, high-cost claimant, gaps in care, leakage, eligibility, and high-level pharmacy reports. In PY2, these reports will continue to expand and develop to provide insight to the ACO and direct care management activities.

3. Targeted investments in Workforce Development to Enable Optimal Care for MassHealth Members: The ACO made investments in several workforce development programs. Noted is the Screening, Brief Intervention and Referral Treatment (SBIRT) and motivational interviewing training of the care management staff as well as Medical Assistant training program completed in PY1. The latter trained all the office staff and population health specialists in the ACO employed community physician practices in population health management which included closing identified gaps in knowledge and skill sets to meet the needs of MassHealth members.

4. Investments in tools and pilot programs to address social, medical and behavioral needs in order to improve care of the MassHealth members. In PY1 investments were made to successfully build the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) social determinant of health screening tool in the 3 main ACO EMRs. Investments were also made in integrating these data into the data warehouse to help enhance the risk stratification model in PY2-3. In PY2, pilots will begin to implement the workflows for this screening process. In addition, in PY1, we invested in building pilot programs to enhance access to behavioral health in primary care (the ACO Behavioral health collaborative) as well as the vendor diabetes program for insulin dependent diabetics. These investments will help the ACO improve health outcomes of our MassHealth members.

Specific examples of PY1 investments that reflect these investment priorities meant to achieve FPP goals include:

BIDCO community staffing for Complex Care Management and Transitions of Care: Community resource specialists, nurse care nurse managers, medical directors, pharmacists (Goals 1-4)
Our strategy in 2018 was to coordinate between the THPP and BIDCO programs, with THPP providing the risk stratification models as well as complex care management in the initial non-delegated years, while transitions of care was provisioned by both BIDCO and THPP. During this same time, the BIDCO providers developed, trained, and increased capacity of care programs across the BIDCO network with a focus on South Cove Community Health Center, Bowdoin Street Health Center, and Health Care Associates. These three sites worked to create or refine policies and procedures to follow NCQA standards and workflows for complex care management, transitions of care, and disease management. The plan will be to achieve delegation for these provider sites from the health plan.

BIDCO community staffing for care coordination, social service management and quality programs-Community health workers and Population Health specialists (Goals 1-4)
BIDCO expanded community health workers and population health specialists' capacity in 2018. These staff work as care coordinators for practices to provide care coordination, health related social needs screening and referral, health coaching, and disease and quality gap closure services to the ACO members that is culturally and linguistically sensitive. The population health staff at BIDCO and THPP works closely to identify high-risk and rising risk patients with the shared goal of optimizing patient engagement, medical care, and community resource access. THPP also expanded care management support, both through staffing and expanded policies and care plans, to work closely with Community Partners for Behavioral Health and Long Term Services and Supports. By involving and working closely with Community Partners, members have been able to receive optimal care at the local level, in a manner that works with their specific health and cultural needs. THPP coordination of this work has also prevented duplication of resources or members being missed for potential support services.

BIDCO Investment in Arcadia Software Solution for Care Management (Goal 1, 2, 3)
Arcadia development of the care management platform began in PY0 with first phase completion in early PY1 for use of transition of care managers. The following progress has been made year to date:

- Complex care and disease management assessments have been enhanced in Arcadia with goals, tasks, interventions and patient education (**Goal 1, 2**)
- The tool was accompanied by building enhanced policies, procedures and care paths to NCQA standards in preparation of obtaining delegation for some provider groups in PY2 (**Goal 2**)

BIDCO Data and Population Health Analytics
Arcadia data warehouse and population health tool (Goals 1, 2, 4): Arcadia data warehouse began integration of claims, clinical, scheduling and ADT data for MassHealth members while building corresponding cost, use and quality dashboards and reports. This increased functionality allows the ACO to close care and quality gaps existing within the current EHR encounter-based data feeds. Through ongoing integration of BIDCO hospital ADT data, MassHealth and THPP data, and EMR clinical data, the BIDCO Arcadia population health platform will allow care teams and practices to better coordinate care, reduce utilization, close quality gaps, and lower total medical expense. BIDCO made significant strides in Arcadia-related data integration and population health development in PY1, and work in this space will continue in PY 2.

Health Information Technology
Enhance Patient Identification in the Electronic Health Record (**Goals 1-2**)
In 2018, BIDCO enhanced EHR functionality by implementing a flagging system for *Tufts Health Together with BIDCO* MassHealth members. This flagging system allows the entire care team including clinicians, care managers, community health workers, social workers, or population health specialists to capture appropriate data elements critical for the MassHealth quality measure slate as well optimizing members' care through appropriate identification and linkage to MassHealth ACO-related resources.

Medical Assistant Training (Goal 4): BIDCO providers developed a training program with the assistance of a consultant group to integrate the discipline of health coaching into the medical assistant skillset. Development and several training sessions were held in 2018 and were so well received that BIDCO plans to expand this opportunity to the entire care team across the BIDCO network.

1.3 Success and Challenges of PY1

Successes
As noted above, *Tufts Health Together with BIDCO* achieved a number of important milestones in 2018.

Overall PY1 was very successful with implementation of all the state deliverables, hiring most FTEs, building and implementing program pilots, training the staff in population health management, and most importantly, building the technology and data analytics for future program success and performance management.

1. Arcadia Population health tool: In keeping with BIDCO population health philosophy of data-directed strategy and care, BIDCO began to build and enhance its population health platform tool for the MassHealth members. This included integration, validation and normalization of the claims, clinical, ADT and scheduling data, which involved building several interfaces with the tool. We were also able to build reports such as the high utilization emergency room report as well as the MassHealth quality metric gap report which will allow the ACO population health staff to address care gaps at the point of care for the

MassHealth members. In addition, a new risk stratification tool was built with an 'Impactablility score' for complex care management to enroll the right members in their programs. Other reports built include the 'upcoming visit report' which allows for pre-visit planning as well as the post- discharge report allowing care managers to assess for member follow up with the primary care physician. All of these tools will be implemented in PY 2 and should be key in reducing avoidable utilization, closing prevention and disease specific quality gaps in MassHealth members(Goal 1 and 2) to improve their health outcomes and achieve our goals. This will also allow delegation from the health plan to the ACO for the analytics related to the population health management.

2. Second success in PY1 was hiring, training and onboarding the DSRIP funded ACO staff in order to begin the population health management for the MassHealth members. This included care management and care coordination. It also included staffing the new clinical program pilots. In Q 4 of PYI BIDCO began to see some of the program performance metrics. One of the major successes was the embedded adult inpatient transitions of care team, which successfully managed post- discharge patients for 30 days with significant improvement of member engagement (84 % between 3/18-12/31/18) and follow up with PCP for appointment post discharge- 80.8 % at 30 days for the BIDCO transition of care team, versus 62 % for the members who were not managed by the BIDCO team in the non- BIDCO hospitals.

Challenges

PY1 challenges were largely operational with most of these related to lack of updated member demographics, a poor attribution algorithm, and difficulty with hiring causing vacancies for multiple positions. There were also technology investment delays along with delays in implementation of vendor programs in order to ensure compliance with state regulations.

The first major challenge was related to member attribution. With significant influx of new members and lack of updated demographics, the ACO had difficulty maintaining a stable member roster. This operational issue had subsequent operational issues in the community partner assignment as well as assignment for several of the clinical programs such as complex care management. BIDCO and THPP have worked extensively on a process improvement model for PY2 in order to enhance the existing algorithm.

The second major challenge was related to multiple operational issues during the implementation of the community partner program. This included hiring staff with expertise in this space along with the development of processes due to the multiple stakeholders and finally implementing the program with significant variation and lack of standardization amongst the community partners. The state has helped the stakeholders in PY1 by developing standard care plans as well as removing some of the complexities of the program (such as the participation agreements) we have also streamlined some of our processes such as post transition allowing better engagement through the end of PY1.