

ATTACHMENT APR

**DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM
ACCOUNTABLE CARE ORGANIZATION (ACO) PY2 ANNUAL PROGRESS REPORT RESPONSE FORM**

PART 1: PY2 PROGRESS REPORT EXECUTIVE SUMMARY

General Information

Full ACO Name:	Tufts Health Together with Beth Israel Deaconess Care Organization (BIDCO)
ACO Address:	247 Station Drive, Suite Northwest 1, Westwood, MA

Part 1. PY2 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.

ACO Program Goals	
Goal #	Goal Category & Description
1	Cost and Utilization Mgmt (Medical Trend): Maintain the ACO medical expense trend below 3.1% compared to PY2
1.a	<i>Sub goal #1: Engage acutely hospitalized MassHealth patients in the ACO transitions of care program to reduce inappropriate 30 day readmissions by 2% compared to PY2.</i>
1.b	<i>Sub goal #2: Reduce total behavioral health inpatient admissions by 2% compared to PY2.</i>
1.c	<i>Sub goal #3: Engage complex MassHealth patients in care management to stabilize health conditions and reduce 12-month post-CCM engagement total medical expense by 5% as compared to the 12-month pre-engagement TME.</i>
2a	Cost and Utilization Mgmt (Operational efficiency): Maintain aging claims (> 30 days) levels no more than 10% of total inventory by 2020 and throughout program duration.

2.b	Cost and Utilization Mgmt (Operational efficiency): Achieve total claims accuracy rates of 95% or higher by 2020 and throughout program duration.
3	Quality: Improve depression screening and follow-up plan results by 3% compared to PY2 and 5% compared to PY1.
4	Quality: Improve health related social needs screening by 3% in PY3 compared to PY2 and 5% compared PY1.
5	Quality: Improve rate of patients with A1c<9 by 3% compared to PY2 and 5% compared to PY1.
6	Member experience: All high risk and complex members are connected to a primary care provider.
7	Integration of physical health, BH, LTSS, and health related social needs: Improve health related social needs screening by 3% in PY3 compared to PY2 and 5% compared PY1.

1.2 PY2 Investments Overview and Progress toward Goals

To deliver value to our members, EOHHS and CMS, *Tufts Health Together with BIDCO* has continued to leverage existing infrastructure and make 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 PY2 included:

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 assures 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 workforce investments support programs at both the Health Plan and provider groups.
2. Targeted Investments in Information Technology to Enable Optimal Care for MassHealth Members: BIDCO has made targeted investments in a population health management platform to support ACO-wide efforts at improving patient care and bending the cost curve. These technology investments have facilitated successful integration of clinical and claims data to allow the ACO platform to provide accurate point of care dashboards, utilization and quality reports, all with the goal of facilitating high value, evidence-based care to members. In PY2, BIDCO continued implementation of the risk stratification model that incorporates claims, clinical, and census data. In addition, BIDCO has enhanced the ACO care management platform, which has especially benefited the BIDCO transitions of care program that supports members discharged from network acute care hospitals.

3. Addressing Social Determinants of Health: In PY2, BIDCO successfully integrated into the population health platform patient-level social determinants of health data collected by practices. These data are collected using a standardized health-related social needs screening assessment that is fed into one of the ACO electronic health records, which then feeds into the population health platform. BIDCO has also started working with our population health platform vendor to leverage these data to more accurately identify high risk and rising risk members and neighborhoods for intervention.
4. Integration of medical and behavioral health programs: In PY2, BIDCO continued to prioritize investments that focus on integrating care for patients with complex behavioral and medical conditions. We invested in a collaborative care program to support primary care based management of patients with complex behavioral health needs. In addition, we invested in a pilot program to support a remote monitoring insulin dependent diabetes program. These efforts, undertaken at overlapping primary care practices, support and improve health outcomes for MassHealth members with complex comorbid conditions and put at the center of the care team both the patient and the primary care team.

Specific examples of PY2 investments that reflect these investment priorities aimed at achieving FPP goals include:

BIDCO Community-based Complex Care Management and Transitions of Care: Community resource specialists, nurse care nurse managers, social workers, medical directors, pharmacists, and pharmacy technicians

The strategy in 2019 was to coordinate care management efforts between THPP and BIDCO programs. Transitions of care management continued to be jointly provisioned based on discharging facility between BIDCO and THPP. Additionally, complex care management for ACO PCMH sites were transitioned to embedded, community based programs, while the health plan continued with telephonic complex care management efforts for non-PCMH sites. These joint efforts continue to evolve as *Tufts Health Together with BIDCO* strives to identify high risk and rising risk members and successfully engage with them to improve patient outcomes and optimize value.

BIDCO Integrated Community Care: Community Health Workers, Community Resource Specialists, and Population Health Specialists

BIDCO continued to invest in staff to support integrated care and community engagement with the goal of providing culturally sensitive care to all members including those at highest risk. BIDCO has continued to support community health worker, community resource specialist, and population health specialists in 2019. CHW and CRS staff help identify and address health related social needs gaps with members in need and are integrated into care teams at multiple levels within the ACO, including at the clinic level, practice group or community health center level, and also within specific clinical programs such as the transitions of care program. Population health specialists to work with practices in identifying and engaging high-risk and rising risk patients with the shared goal of optimizing patient engagement, medical care, and community resource access.

BIDCO Collaborative Care

In PY2, BIDCO prioritized piloting a collaborative model to serve patients with serious mental illness with the goal of supporting members' medical, behavioral health, and social needs in an integrated behavioral health and primary care model. Leveraging prior experience within the network, we transformed an embedded model with a hybrid version that incorporates both face-to-face and telehealth behavioral health support of patients within the primary care setting, with the goal of increasing capacity and scalability.

BIDCO Data and Population Health Analytics: Arcadia Population Health Care Management and Population Health

Arcadia population health platform development continued in PY2 with a focus on care management, social determinants of health, clinical and event data integration, and quality. Ongoing efforts focused on care management module development continued in 2019, while additional enhancements were made with regards to incorporation of social determinants of health and clinical interface of laboratory, radiology, admission/discharge, and ambulatory scheduling data in the platform. These improvements in functionality allow population health teams and practices to better coordinate care, reduce utilization, close quality gaps, and lower total medical expense.

1.3 Success and Challenges of PY2

Successes

Tufts Health Together with BIDCO achieved a number of important milestones in 2019. The ACPP partners continued to collaborate closely in delivering effective and value driven care to our MassHealth patients. Notable successes include:

1. Collaborative Care: BIDCO focused on piloting a model of behavioral health integration that enhances "usual" primary care by adding support from a behavioral health care manager and a consulting psychiatrist in support of patients. This model, leverages a social worker in a hybrid face-to-face and telemedicine approach to patient contact with support from a psychiatrist. In close collaboration with the PCP, an interdisciplinary care plan that includes psychotropic medication management, therapy and other behavioral health services, as well as support for health-related social needs is created and implemented. BIDCO MassHealth Collaborative Care program goals include reduction in behavioral health related inpatient utilization, increased patient engagement, and ultimately successful discharge from the program to the PCP with ongoing management by primary care.
2. Arcadia Population Health Platform: In keeping with a data-driven population health strategy, BIDCO has continued to enhance its population health platform to support MassHealth patients. This includes integration, validation, and normalization of the claims, clinical, event, and scheduling data, while also building out new functionality, such as in social determinants of health, and completing data integration. BIDCO also began implementation of an Arcadia desktop module that pulls from the data warehouse all relevant patient-specific data and displays high impact findings (e.g. quality gaps) for the provider to see while using the native electronic health record for patient care.

Challenges

The first challenge Tufts Health Together with BIDCO faced in 2019 was the Beth Israel Lahey Health merger. This merger, while an opportunity to improve clinical and operational efficiency to better support patients, resulted in some delays as existing programs and investments were evaluated and the larger organizational strategy was developed. The second challenge the ACPP faced in PY2 related to effective community-based care for MassHealth patients. Engagement within the Community Partner program continues to be an obstacle to establishing effective and high value care for all MassHealth patients. THPP and BIDCO continue to work with Community Partners to improve communication and collaboration to improve engagement rates, as well as provide optimal care for engaged members.