

## 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

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

### Part 1. PY3 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	<b>Cost and Utilization Mgmt (Medical Trend):</b> 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	<b>Cost and Utilization Mgmt (Operational efficiency):</b> Maintain aging claims (> 30 days) levels no more than 10% of total inventory throughout program duration.

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

## 1.2 PY3 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 PY3 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 PY3, BIDCO continued implementation of the risk stratification model that incorporates claims, clinical, and census data. BIDCO continued to implement improvement of the Arcadia EMR platform across the network. 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 PY3, BIDCO through our Flexible Services Program, successfully launched an initiative designed to increase screening of BIDCO patients who may be eligible for one of the Flexible Services programs that are offered. BIDCO practices had the capability of inputting SDOH PRAPARE forms through multiple Electronic Medical Records and developed a SDOH Gap Reporting process which was and is currently being deployed to each practice leadership team.
4. Integration of medical and behavioral health programs: In PY3, 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 PY3 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 2020 was to support Community Health Workers to support patient needs with health related social needs screening and referral, community partners and to conduct health coaching, member outreach and engagement. Community Health Workers (CHWs) provide assistance with resource referral, accompaniment, service coordination, cultural linguistic appropriate education, and health coaching under the direction of and in collaboration with the Clinical Care Manager and/or Behavioral Health Care Manager. CHWs provide longitudinal services to a panel of patients as well as short-term interventions where the latter patients have acute needs identified during routine clinical care.

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

In 2020, BIDCO combined the Population health manager and care management director roles into one manager co-located at Health Care Associates practice site whose focus has been population health, care management, member outreach and engagement, and ACO transition projects. They have supervised population health specialist & outreach teams, and along with Quality Improvement Director coordinate MassHealth ACO process, NCQA standardization process, care coordination and delegation from THPP to the ACO over coming years. They will also coordinate projects for the MassHealth ACO including management for population health outreach integrated with electronic medical record, developing formal protocols for outreaching; upgrading IT population health reports integrated with visit intake forms.

### **BIDCO Collaborative Care**

In PY3, BIDCO supported ACO staff engaged in care management for complex care patients. BIDCO provider-based care management programs provide collaborative medical management and care coordination for members at high risk for hospitalization or other high cost resources and who would benefit from intensive care management to reduce potentially avoidable readmissions by improving the transition of care from hospital, rehab, SNF, and homecare to home. BIDCO leadership will work to ensure that there is no duplication with the telephonic care management provided by THPP.

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

Arcadia population health platform development continued in PY3 with a focus on care management, social determinants of health, clinical and event data integration, and quality across the entirety of the network, specifically BIDMC. Ongoing efforts focused on care management module development continued in 2020, 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 PY3**

### Successes

*Tufts Health Together with BIDCO* achieved a number of important milestones in 2020. 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. Flexible Services Program: Tufts Health Together with BIDCO launched three FS programs in PY3, including one nutrition sustaining support program and two housing support programs of the program year. While in 2020 each of the Flex Services Programs concentrated on building reporting for meaningful quality goals, in 2021 all Flex Programs will be monitoring performance across those goals. Each ACO and SSO partnership has established monthly Performance Meetings in addition to

the ongoing (weekly or bi-weekly) Operational Meetings. These meetings address not only the financial performance, but the performance on referrals, members graduating from the program, and adherence to quality goals. Another function of these meetings is to look at health disparities and inequities from data BIDCO is gathering off of the VPR, inclusive of how to service members who reside out of SSO traditional service areas, individuals with specific health related needs, and all demographic data.

### Challenges

1. Much the same as most other organizations, BIDCO found challenges in 2020 based upon the COVID 19 pandemic where the ACO was forced to make some tough decisions, such as the elimination of the Post Acute Care Team (PACT) due to decreased DSRIP and other budget constraints.
2. Additionally, 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. For example, the ACPP is currently participating in the MassHealth Learning Collaborative with a few of its largest CP partners, to improve collaboration and hopefully improve patient engagement rates.