Q1 Please provide your contact information below.

Name	**Amy Vreeland**
Title and Organization	**Chief Commercial Officer, ACT.md**
Address	**200 State Street**
Address 2	**12th Floor**
City/Town	**Boston**
State/Province	**MA**
ZIP/Postal Code	**02109**
Email Address	**amy@act.md**
Phone Number	**(781) 367-3650**

Q2 Please describe your company or organizations overall goals and mission.

ACT.md is a cloud-based care coordination platform that helps connect patients, their families, medical and behavioral healthcare providers, and the community, home-based, and social services that support them on their journey to health and well-being. A simple concept is gaining momentum in healthcare: how can we effectively care for a patient if we are not caring for the whole patient? The health and financial burdens of chronic health conditions and disability are straining families and communities.

For many patients, a single medical encounter with a healthcare provider is not a sufficient intervention because it does not begin to tackle the behavioral, mental health or socioeconomic issues in their life that have an impact on the effectiveness of costly medical interventions. ACT.md's community health collaboration hub integrates data, people, and workflows from healthcare organizations and community-based groups to create a real-time, central view of each patient's multidisciplinary plan of care.

Together, using this platform, teams can conduct assessments, create plans and measure patient-centered care goals, and collaborate to complete tasks assigned and scheduled for the patient and each team member. It is a secure, shared space where care coordinators can interact with patients, families, and care teams wherever they may be, and members can see up-to-the minute status and ownership responsibility for all of these activities, across all the determinants of health.

Q3 Please indicate which category your organization falls under.

Technology Solutions

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility,

evidence based support for innovation, relevance to the Medicaid population and speed to market).

ACT.md is a community health collaboration hub designed for comprehensive workflow management. The platform is uniquely suited to and proven to support the care coordination workflows involved in SDOH interventions. Key steps in the workflow, supported by ACT.md:

1. Data connection and integration: Working with SDOH intervention leaders, identify the required patient data, process configuration, data flow, and structure for care plans to be created dynamically based on ACT.md's rules engine. Design care plans to grow organically and longitudinally, following a patient through the continuum of care. Plan for analytics and reports to auto-populate with data as a consequence of work that happens within ACT.md, rather than as a separate step.
2. Comprehensive, collaborative and goal centered patient care plans: Initial patient care plans are created by ACT.md upon program kick-off, and then new patient care plans are added manually by care coordinators or automatically through a data-driven trigger. Care plans contain all required patient information and areas for care coordinators to add additional information manually.
3. Patient assessments and goal elicitation: Care plans include SDOH assessments that are selected and defined by our clients. They may include emerging SDOH assessment standards, such as Prapare or SEEK, or any assessments defined by our clients. These assessments are completed within the application. Care coordinators can also elicit and capture patient and family goals within the application.
4. Care team assignments: Care teams, including medical, non-medical, and community resource partners, are automatically assigned based on assessment results, or are manually assigned by care coordinators. Community service partners are selected within ACT.md or from an integrated community resource directory.
5. Closed-loop community services referrals: Community service partners accept new assignments within ACT.md, confirming they have received a referral and then confirming they have begun work with a patient. Care teams and supervisors have visibility into real-time status of referrals, and can see what remain open, and which have been successfully closed, and where patients are at every step in every process. This can be done within the ACT.md platform, through integration with available social service directories, or most likely, through a mix of both.
6. Comprehensive workflow management: Community service referrals are the beginning of the SDOH care coordination process. All of the care delivery that follows is initiated, tracked, and completed via ACT.md, with input from all members of the care team, all involved community service partners, and patients and families.
7. Reporting and analytics: As a comprehensive workflow management tool, ACT.md offers access to all patient, team, and workflow data. This data is indispensable for rigorous research and analysis, management insights, and contractual reporting.

ACT.md address the six innovation criteria in the following ways:

1. ROI: ACT.md helps care teams achieve patient and family engagement rates of up to 70 percent. Families have experienced 16 percent fewer ER visits, 40 percent fewer inpatient visits, and a 29 percent shorter length of stay, and improved quality of life. 59 percent of ACT.md users say the platform noticeably increases team accountability, and 48 percent of users say ACT.md has significantly reduced email and other forms of external communication.
2. Scalability: Our platform is designed for rapid growth and for large-scale user and beneficiary volume. From our experience in care redesign research, incremental approaches are more effective. The implementation of our community health collaboration hub highlights broken or missed processes and communication gaps. Starting with a limited implementation provides the chance to review and understand current state, then develop, test, and manage the evolution of the right future state, and transition to appropriate governance at the enterprise and population levels.
3. Feasibility: We regularly conduct field research with patients, caregivers, and practitioners across the medical, social, and behavioral spectrum. We are also committed to meeting everyday consumer expectations for usability and aesthetics. Altogether, this has led to an average onboarding time for a new user of under 30 minutes. By integrating with other platforms and data sources, and providing features and experiences that people love to use in their daily work, ACT.md becomes an essential tool in the community health and social care workflows of our customers.

4 and 5. Evidence-based support for innovation, and speed to market: Since 2012, ACT.md has partnered with innovative healthcare providers who have embarked on demonstrations of new models of care. Over the years, we have amassed significant evidence that a simplifying technology platform such as ACT.md, when implemented in combination with the right collection of people and the right set of processes, can have a dramatic impact on patient, family, and caregiver experience, as well as clinical and social outcomes and costs

of care.

6. Relevance to Medicaid: The Center for Health Care Strategies is a thought leader in the field of complex care and has partnered with nearly every state in the country to promote innovations in publicly financed health care, especially for individuals with complex, high-cost needs. In 2018, they launched their Digital Health Database for Complex Populations which features ACT.md as a successful tool for improving the health of Medicaid populations. For more information and to see ACT.md's profile in this database, please visit: https://www.chcs.org/digital-health-products/act-md-healthcare-collaboration-hub/

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.

Yes (please specify when and the estimated number of people impacted):

(1) New York City (national health plan and labor union) implemented in 2016 serving several hundred union members. (2) Humboldt, California, implemented in 2016 serving several hundred homeless residents of Humboldt County. (3) Greater Boston, implemented in 2015 serving several hundred families of children with medical complexity, and again in 2018 serving 1,000+ Medicaid beneficiaries with LTSS needs. (4) Marin, California, implemented in 2018 serving several hundred Medicaid beneficiaries who are high-utilizers and housing insecure. (5) Many other examples we would like to share.

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)

Social and Community Context ,

Health and Health Care

Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.

I consent to have my innovation shared