

ATTACHMENT APR

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

General Information

Full ACO Name:	Merrimack Valley Accountable Care Organization
ACO Address:	15 Union St., Suite 555, Lawrence, MA 01841

Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The Merrimack Valley ACO is composed of Greater Lawrence Family Health Center (GLFHC) and Lawrence General Hospital (LGH) that joined with Neighborhood Health Plan (NHP) (now Allways Health Partners) to form the Merrimack Valley Health Partnership (MVHP). The ACO is known to Mass Health members as My Care Family. My Care Family served an average of 32,500 members in PY1 in the service areas of greater Lawrence, Haverhill and Lowell.

Vision of the MVACO

Members of the MVACO will experience improvement in overcoming adverse effects of social determinants of health, in access to an integrated continuum of care including behavioral health and LTSS services, in active participation in their health care, in the flow of health information across the continuum of care, and in health status and outcomes of care.

The MVACO is utilizing DSRIP funds to develop, implement, continually evaluate and redesign integrated structures, functions, and processes of care to help achieve this vision and success in our risk-based contract with EOHHS. Below are the goals by category that MVACO seeks to accomplish through investments funded by the DSRIP program over the five-year period.

Cost and Utilization Management

- Goal 1: Reduce total cost of care with a focus on areas where our patient population appears to have higher cost relative to benchmarks, such as home health care expense and emergency room use. This is expected to be addressed by our care team-based approach to care that will include provider education on appropriate home care use and patient education on appropriate emergency room use.

Integration of Physical Health, BH, LTSS, and Health-Related Social Services

- Goal 2: Integrate providers and their services across the continuum of care for MVHP members. We are making investments in care team members and support personnel and leaders who will provide organizational integration across the continuum including with Community Partners and serve to integrate physical health, behavioral health, LTSS and health-related social services.
- Goal 3: Integrate information systems across the continuum of care in the MVHP. We are making significant investment in a data warehouse that will aggregate data from various provider and health plan sources and provide the basis for operational and quality reporting and we plan to develop an interoperable care plan to assist care team members in integrating physical health, behavioral health, LTSS and health-related social services.

Member Engagement

- Goal 4: Increase patients' active involvement in their care, including goal-setting for their personal health. The care team has a role in achieving this goal, but we are also providing some funding for innovative programs to engage patients including those with food insecurity, offering wellness program grants for clinicians and exploring telehealth opportunities.

Quality

- Goal 5: Develop a new system to manage the measurement, reporting and tracking of quality measures across the continuum of care in order to set focused quality improvement targets based on gaps compared to benchmarks and improve patient outcomes. We are investing in systems and personnel to ensure timely and accurate quality reporting to achieve 100% of all quality metrics.

Other

- Goal 6: Establish and maintain a new MVACO office, including human, physical, material, and fiscal resources which will provide the means to co-locate the care management teams and lead the local ACO organization in its collaboration with NHP to achieve the goals of the EOHHS contract.

During PY0 our initial focus was on infrastructure development for our newly formed organization, building data integration functionality for improved information and reporting across the organizations as well as a system for supporting the care model for care management and care coordination. In PY1 we progressed to implementing our care management model as the program kicked off on March 1, 2018, added data sources to our data warehouse and began report production, implemented integration with our community partner organizations in the summer and later in PY1 began to explore and implement telehealth opportunities. We also added to our leadership team, developed our capabilities as an ACO and achieved ACO certification with the Massachusetts Health Policy Commission.

1.2 PY1 Investments Overview and Progress toward Goals

During PY1 we continued the investment in our data warehouse and analytics resources to achieve goal 3. We were challenged in PY0 to hire a business intelligence director and finally hired this position in June of 2018, having utilized consultants in the interim. Since then we have trained users across our three

organizations, rolled out web-based access to several dashboards and interactive reporting based on claims in the areas to date of inpatient utilization and readmissions, emergency room utilization, pharmacy expense, care retention, home health, referrals to specialists, membership and an executive dashboard. These tools are helping us identify opportunities to target interventions for improving care access and reducing cost. Additionally, we added data from our independent community primary care practices for quality metrics to the data warehouse along with data from Patient Ping, the event notification system we utilize to be able to make transition of care calls to patients and better coordinate care following emergency room visits and inpatient admissions.

We implemented our care management model with care teams working both out of NHP (now Allways Health Partners), our health plan partner, and our ACO, based locally. The work of these teams helps us achieve goals 1, 2 and 4. We were focused on improving appropriate use of the emergency room in PY1 as we knew this was an area of spend above benchmark and patients often use it for symptoms that could be treated by their primary care provider. One strategy was that we added an ACO social worker located at the hospital to engage with patients both in the inpatient setting and emergency room. Using Patient Ping to identify when ACO patients arrive in the emergency room, she can check to see if the patient is in care management and reach out to the care manager, whether an ACO care manager or a behavioral health care manager from a community partner organization. This has helped us locate patients who maybe were previously unable to reach and attempt to engage them in care management and educate the patient to try to prevent future unnecessary visits. We hired a community partner relationship manager during the summer who assists with this integration effort. We also used DSRIP funding to produce flyers to educate patients on when to call their primary care doctor and what symptoms are truly appropriate for the emergency room. These were emailed to patients and put on TVs in the GLFHC clinics and handed out in the community PCP practices. We have an English and Spanish version for both the adult and pediatric version for greater understanding by the patients. The bilingual population health coordinators and transitions of care nurse (who joined the care teams in the summer) call every patient who visited an emergency room to ensure they understand their discharge instructions, try to set up a follow-up primary care visit for them and educate them on appropriate use of the emergency room as well. These investments and efforts have been successful in reducing our rate of emergency room utilization during PY1 compared to historical data.

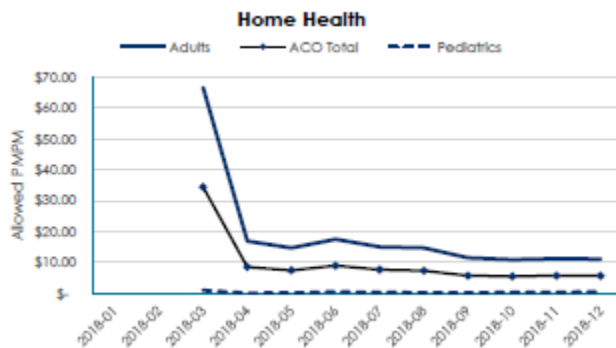
A third investment that is helping achieve our quality goal 5 was for a third-party vendor, Nagnoi, to build the quality measure specifications and produce provider-facing reports for each primary care provider for each ACO quality measure and rolled up for the ACO performance overall. Nagnoi is accumulating both claims data from NHP and EHR data from the data warehouse for the hybrid measures. These reports show both compliant and non-compliant patients, so they can be utilized for patient outreach to improve the measure performance as well. The PY1 information will help us determine gaps and opportunities to improve for PY2, when many measures become pay for performance measures.

Finally, during PY1 we began to invest in preparing for innovation in telehealth to help achieve our goals in patient engagement (goal 4). We utilized an RFP process to hire consultants experienced in telehealth to produce an assessment of opportunities for our organization in the current environment and make a recommendation on programs we could consider implementing to help us achieve our goals. We also began a pilot program for telehealth with clinical pharmacists from the patient's home for a complete

medication review and reconciliation for patients referred from the care management teams. This is facilitated by a bilingual medication reconciliation technician in the home with the patient who uses an iPad to visually connect the remote bilingual clinical pharmacist with the patient who then interviews and provides advice to the patient. This helps improve the patient’s compliance with medications for better outcomes, assure that they are on correct doses of medication, remove medications or over the counter drugs that are counter-indicated, and clear out expired or unused medications (sometimes bags full of these). The pharmacist follows-up with the PCP as necessary to make any changes. This has been very well received by patients and clinicians alike and we will be expanding the program in PY2.

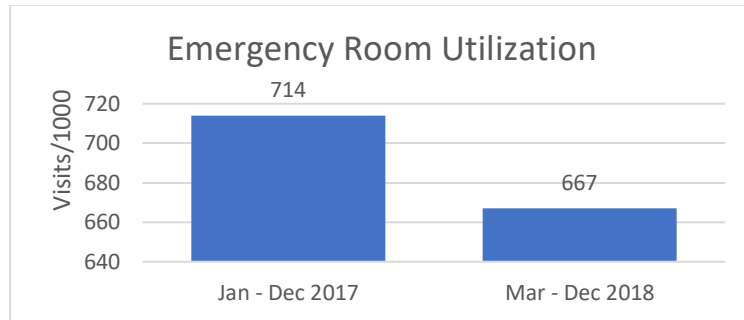
1.3 Successes and Challenges of PY1

One of our major successes in PY1 was to reduce home health utilization and spend, which had been identified in historical data from Mass Health for our region as being the highest in the state, for a non-managed patient population. We used several strategies to tackle home health. One of our primary care clinicians and medical directors, well-versed in home health services, took charge of this effort. She led the RFP process for convening a preferred network of 11 home health agencies covering all needed services, spent time hands-on with the utilization management nurses at NHP reviewing authorization requests for appropriateness, redirected patients with longer term needs to PCA services rather than ongoing skilled nursing visits (as appropriate), held joint meetings with the home health agencies and community partners organizations to better integrate care and educated the primary care clinicians on appropriate home health services for patients. After the first month of the continuity of care period, March 2018, we implemented utilization management and began to see an immediate improvement per the figure below. By August we were successful in directing over 90% of services to our preferred agencies and overall, reduced utilization by 80% over the historical level which exceeded our goal of a 25% reduction. The home health spend for CY17 was \$46.00 per member per month (pmpm) and as shown below, for March – December 2018 overall it was reduced to \$9.40 pmpm. Utilization has remained consistent for several months at a more appropriate level and we have not heard of any negative impact on patient outcomes. We have created reporting to monitor emergency room and inpatient utilization for patients who have had their home care reduced to make sure we catch any of these patients whose health may be worsening and could benefit once again from home care or additional services.



A similar effort to reduce unnecessary emergency room use, prevalent in our patient population, was described in the progress toward goals section above. We utilized a variety of strategies and alerts, both

through Patient Ping and built into the hospital’s EMR, to notify ACO personnel when a high utilizer presented at the emergency room so we could interact with the patient, provide additional education, connect them with primary care and a care manager as appropriate. We also educated the population in general with our flyers, email and waiting room TV campaign on appropriate use and the GLFHC urgent care hours on evenings and weekends. The results were a 9% increase in urgent care visits at GLFHC during November – January following the education campaign, and a 6.6% reduction in emergency room visits/1000 for March – December 2018 compared to the historical period of January – December 2017. ER utilization decreased from 714 visits/1000 in CY2017 to 667 visits/1000 for March – December 2018 as shown below. This exceeded our goal of a 5% reduction from CY2017.



The care management program provided both successes and challenges during PY1. We succeeded in enrolling 3% of our patient population or 1060 patients during the year, including the initial ramp-up period, but fell short of our target of 5% of the population. We have many patient success stories of how our care team interventions in addressing both medical and social care needs of these patients improved our patients’ health and lives. We were challenged however, by unexpected turnover in our care management staff during the year. One care manager moved out of state in July, one took another higher-paying job elsewhere in September, and one passed away unexpectedly in October. We have had difficulty finding nurse and social worker care managers (bilingual Spanish is preferred but not required) so we had reduced capacity for several months during the year. We believe there is competition for these personnel from health plans for dual-eligible patients as well as community partner organizations in the area. We were able to draw on resources at NHP to help fill the gap, but the vacancies did have an impact. We have not had trouble with our community health worker staffing. Another challenge was enrolling patients in the care management program. We found that 33% of patients were unable to be reached, 17% declined participation in care management, about 20% were in progress at a given time and overall, we enrolled 28% of assigned patients. We originally had expected closer to 50% of patients identified would participate. We are currently re-evaluating all aspects of our model to determine how to optimize the teams and patient engagement efforts for greatest impact in PY2.

Finally, we have had some challenges aggregating data to build the provider-facing reports for managing our quality metrics. There have been some mis-communications between our data warehouse team and the vendor as we started to provide files with data from the EHR and delays in production of the quality measure files. Also, there was some mis-understanding of how it takes time for the data to “develop” with the claims lags before it becomes most useful. As a result, we have not had the tools in our hands as quickly as we thought we would that enables us to work to improve the quality measures. Once we

realized that, we have worked to fill the void by creating reports from the health center's EHR on the patient populations that are targeted in these measures such as childhood and adolescent immunizations, asthma, diabetes, pregnant members, etc. We will be using these reports early in PY2 to perform outreach to these patients and ensure they get the required care to improve outcomes, until the vendor's reports are more robust. We are using population health coordinators, health center medical assistants and nurses, and clinical pharmacists as key contributors to our quality program in support of the primary care clinicians.