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:	Merrimack Valley Accountable Care Organization
ACO Address:	15 Union Street, Suite 555, Lawrence, MA 01840

Part 1. PY2 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 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 33,000 members in PY2 in the service areas of greater Lawrence, Haverhill and Lowell.

Our vision is that members of M y Care Family 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 high-level goals that MVACO seeks to accomplish through investments funded by the DSRIP program over the five-year period as defined in our PY2 Full Participation Plan.

Goal #	Goal Category & Description
1	**Cost & Utilization Management**: Keep TCOC below 93% of premium for 1% margin for PY 2-5
2	**Quality:** Attain goals as set by the state and develop quality improvement processes to meet those goals in years 2-5. Achieve 100% of quality opportunity each year.

3	**Member Experience and Engagement:** Increase member enrollment in the care management program by 40% over year 1 baseline by year 5
4	**Care Retention (Other):** Keep 70% of inpatient admissions locally by year
5	**Integration of Physical Health, Behavioral Health, LTSS and Health-Related Social Needs:** Increase the number of patients screened for social determinants of health by 25% over year 2 baseline by year 4

Cost and utilization management are necessary to achieve the aim of the ACO initiative and to generate savings to invest back into the program in later years. We set a modest goal of a 1% margin starting in PY2. Many of our other goals, if achieved, would contribute to cost management. We focused on quality improvement in PY2, knowing that improving health outcomes leads to reduced cost. Providing high quality care as measured by the ACO quality metrics aligns with our mission of caring for vulnerable patients in our service area through our federally qualified health center and non-profit safety net hospital in Lawrence. Our care team-based approach to care contributes to reduced emergency room use and inpatient readmissions while connecting patients to primary care and addressing social care needs. Our goal is to increase the impact by growing enrollment in the care management program, which improves members' experience and engagement in their care. Additionally, patients are best served by keeping care local. We are measuring the percent of inpatient admissions to our local hospitals each year. For patients in the emergency room or admitted to Lawrence General Hospital we have systems of alerts such that we can reach out to patients who may have been difficult to find and connect them with the appropriate care manager--medical, LTSS or Behavioral Health, and to assist with transitions of care back to the community and primary care support. Finally, we are working to expand screening for social determinants of health (SDOH) in the primary care setting and create more efficient ways to connect patients with need to the appropriate resources. There is clear evidence that understanding the true drivers of utilization and addressing social needs of patients are critical to improving health outcomes . The greater Lawrence community has rich resources to address social needs through its community services agencies with whom we can collaborate to improve whole-person care for our members.

1.2 PY2 Investments Overview and Progress toward Goals

During PY2 we moved into process improvement, expansion of impact of the care teams, quality improvement, exploring SDOH and began to plan flexible services, to have resources for patients at our fingertips. We engaged with additional physician leaders from our organizations to drive us forward. As a relatively new ACO organization, we also used consultant expertise and DSRIP Technical Assistance funding to help move us into this next phase of our learning and growth. Below are examples of four areas of investments in PY2 that helped us in these efforts.

The care management program is a critical investment that we expect to have the greatest impact on reducing cost, goal 1. It is a comprehensive program to work with high and rising risk patients through multiple teams: YCC team for highest risk patients with behavioral health and SUD resources (AllWays); Mano a Mano multi-disciplinary care team (MVACO) that includes clinical pharmacist resources; disease management programs and more. Early in PY2 we launched a redesign effort to ensure that we made the most efficient use of resources since we still had care manager vacancies we could not fill, and to meet goal 3. We wanted to improve patient outreach and engagement rates, optimize caseloads, optimize use

of Patient Ping (event notification system we invest in), improve PCP engagement by decentralizing and spending time meeting patients in the primary care setting, and coordinate better with the CPs. We hired an inpatient navigator who is a social worker, to build on the success of the ED navigator, to connect with ACO inpatients at LGH to improve transitions and linkages to care. This redesign effort took several months working collaboratively across organizations including GLFHC and LGH and we did exceed the targets in most of the program-related goals for this investment, as described under successes.

The medical director for quality and practicing family medicine physician coordinated data analytics and clinical resources to ramp up our efforts to improve quality of care and performance on ACO quality metrics, goal 2. Data analytics investments allowed us to build patient outreach reports that the population health coordinators use to call target population patients, schedule PCP appointments and ensure they are getting their medications. We purchased the HEDIS specifications and began an intensive effort to build quality outreach and management level reporting that we will utilize going forward since our vendor, Nagnoi, became prohibitively expensive to move to the 2020 NCQA HEDIS specifications. This reporting will be utilized in PY3 with AllWays maintaining reporting for behavioral health-based measures due to data sharing restrictions.

Clinical pharmacist resources are an integral part of our care team and quality improvement efforts, funded through DSRIP. Clinical pharmacists provided 1100 consults with members through the GLFHC pharmacy locations and the telehealth program in PY2. See Appendix A for program details. One KEPRO Performance Improvement Program focused on better care for asthma patients, a large patient population in our ACO, measured by the asthma medication ratio. We invested in a medication reconciliation technician to expand the telehealth program and a pharmacy delivery driver to expand home delivery for medications, an identified need in the community. Nurses, Clinical pharmacists and CHWs completed DPH asthma home visit training. Education for asthma patients and their families included proper inhaler technique, use of spacer, and videos shown in person. We supplied hypoallergenic pillows and pillowcases, cleaning supplies and an air purifier if needed to help reduce triggers. We targeted a 10% gap to goal improvement each year in the asthma medication ratio (AMR) starting in year 2 over year 1. Our PY1 AMR rate was 65.3% which was above the 57.2% attainment threshold. With the Mass Health ACO benchmark of 67.5% our PY2 goal was 65.52%. We believe we are on track to exceed this goal but will not have the quality results until late in PY3.

Our evolution in PY2 included planning for the new funding in PY3 for flexible services and expanding SDOH screening in the primary care setting, goal 5. Our investments supported a project manager to coordinate the screening workflow at GLFHC once a revised screening tool was approved by Mass Health. The flexible services planning investment was for a consultant who helped develop our approach to the program with research of evidence, interviewing local community services agencies, assessing target populations and service options and contract development for the CP partnership with MVCP, one of our LTSS CPs. We submitted an application and gained Mass Health's approval for our program plan starting March 2020. Because of this consultant's prior ACO experience, we expanded the scope of her engagement to include assisting us in recommending, planning and managing vendors for multiple TA projects. The consultant helped us coalesce our efforts to screen for SDOH, identify patients with needs for flexible services, and develop a team-based approach to address social needs in real-time for multiple visit patients. This laid the groundwork for further work on addressing SDOH needs in PY3.

1.3 Successes and Challenges of PY2

Successes:

The MVACO continued to evolve its organization and infrastructure in PY2. Quality improvement was one important area of development. We succeeded in achieving 100% for pay for reporting on quality for PY1. We began early in PY2 with an enormous effort and resources to build out the quality program for the organization to succeed under pay for performance. The ACO prepared to transition away from reliance on a vendor and build the necessary quality data reporting tools and requirements for its own Data Warehouse. A focused approach to managing quality metrics, identifying gaps and putting solutions into place were created under the leadership of a quality medical director. Emphasis was placed on outreach and closing gaps with all clinicians. The clinical pharmacy program supported quality improvement as described above and in Appendix A. In addition, population health coordinators were utilized to support non-health center community practices and conduct patient outreach. The population health data created for quality improvement is also being leveraged to develop our target population lists for the new flexible services program for PY3. This work was made possible through multiple DSRIP investments in our data analytics team, clinical leaders, population health coordinators, clinical pharmacists, data warehouse support and the flexible services consultant. Overall, a more focused and aligned approach to addressing quality was put into place to serve as a foundation for the subsequent years for quality performance.

Another major effort early in PY2 was the formation of a multi-organizational and multi-disciplinary task force to identify opportunities to improve the care management program, one of our largest investments, to better serve patients and meet our goals. The care management program was redesigned to be a more effective and hands on program by deploying the care managers to the PCP sites to provide more in-person assessments to complement telephonic outreach. This helped raise awareness among the primary care clinicians to be able to identify and refer more appropriate cases for care management rather than just relying on a risk stratification program using historical claims data for referrals. We worked to optimize the use of Patient Ping by the care teams to know when patients were presenting at the emergency room or discharged from the inpatient setting, so the care manager could connect and improve the transition of care. We began to host more multidisciplinary team meetings for complex patients and engage the entire care team including the primary care clinician, LTSS or BH CP care manager, home health nurse, and in some cases the recovery coach, dialysis center nurse, HIV care manager, and anyone involved in the patient's care, for very impactful case conferences yielding better care plans and coordination. We also planned to implement Karuna Health in PY3 for secure patient texting and a centralized communications platform as a strategy to increase patient engagement and coordination for certain patients. Through all these efforts, we succeeded in improving our patient engagement rate of assigned patients from 28% in PY1 to 38% during PY2. We also increased the percent of patients enrolled in care management who met their care plan goals from 57% to 84% which was very rewarding for the team.

Lastly, to address the high number of potentially preventable ED visits and admissions, the ACO took advantage of the Technical Assistance DSRIP funding and engaged a vendor to assist the hospital and ACO in developing a robust care pathway to address the multiple visit patient (MVP) and the underlying drivers of overutilization. This framework will be embedded in hospital workflow going forward and

provides an opportunity to partner with the entire health care community in addressing these patients and their non-medical needs. We have succeeded in helping many patients improve their lives and some who have been able to use this aid are proud that they have stayed out of the emergency room for months, when they had been going there multiple times a week. We don't expect to start seeing a financial impact of this program until later in PY3 as we grow our skills in this model of care. With the continuation of the ED navigator in PY2 we have kept ED visits per 1000 below the CY17 rate by 3.3%, at 690 visits/1000 compared to 714 visits/1000 in CY17. We missed the 5% reduction target of 678 visits/1000. The MVP program was implemented late in PY2 and training continued into PY3 so we expect to see a decrease in ED visits/1000 in PY3.

Challenges:

The significant Behavioral Health and Substance Use Disorder population unduly burdens our health system and the need for tighter coordination and placement has been challenging . In addition, the BH program is very siloed with multiple organizations having oversight or responsibility for certain program elements and lack of aligned care processes between behavioral health and primary care. We utilized TA funds for a consultant group to assess opportunities for improved processes and coordination for the Community Partner program in PY2. After interviews with ACO and CP constituents and working sessions, we now have a roadmap and timeline for a variety of projects that will yield improvements. Through our DSRIP investment in an external partner relationship manager and operations director, we plan to prioritize these efforts and challenge ourselves to optimize these CP resources in PY3 through multi-organizational collaboration. Utilizing all our resources becomes more critical as our DSRIP funding declines and we have still been challenged to maintain a full complement of care managers on our teams with some persistent vacancies. The result of those vacancies is that we did not meet our care management enrollment target for PY2. We enrolled 1137 patients in care management across all our care management resources, which was 3.6% below our target of 1179 members. Restated, we grew the program by 16% rather than the target of 20% growth. One strategy for growing enrollment despite limited resources, is to implement Karuna Health in PY3 as a shared communications platform to help drive efficiencies between and among care team members as well as increase patient engagement in a variety of ways, including via secure texting and patient outreach campaigns.

Managing the cost of care has been an ongoing challenge. Despite saving millions of dollars in home health expense, we posted a loss overall for PY1 and are trending larger losses for PY2. Medical expenses are trending up 4% with increases in inpatient, behavioral health and pharmacy expenses. The revenue shortfalls in premium have been significant for this ACO and that, coupled with the significant member churn in this market makes for tremendous instability. Additionally, the Columbia Gas explosions in September 2018 hit three cities/towns in our service area—Lawrence, Andover and North Andover--home to nearly 75% of our membership. The collateral impact to the health and finances of the community well into 2019 was a significant challenge and now it is coupled with the advent of a pandemic in the community. Despite these hurdles, we continue to work to strengthen our organization and meet the goals of accountable care. Our medical director for quality has been extremely proactive in marshalling resources and has been data-driven, creative and thorough in his approach to driving improvement. We know that over time, improving health outcomes for patients will also reduce costs of care so this is a key strategy for us. Another strategy is to keep the patients in our local care system and in our ACO. We utilize certified application counselors and CHWs to reach out to patients up for

redetermination to keep them enrolled with our ACO. With our new senior data analyst who started late in PY2, we are developing more robust reporting in concert with the chief medical officer to more systematically identify opportunities to reduce cost. We are expanding use of MAVEN in PY3 as well that allows primary care clinicians to have a peer to peer consult with a specialist, available in many specialties, to be able to treat more patients in the primary care setting, reduce the need for expensive specialist consults, improve access and patient experience.

Our teams remain energized to improve the lives of our members both through innovations in medical care delivery and care coordination and through convening new resources like the flexible services program, to address social determinants of health. The DSRIP program has allowed us to foster greater collaboration on new models of care among caregivers and make a difference for patients. We look forward to data-driven initiatives to reduce cost and greater ability to connect patients with SDOH resources as we move forward in PY3 and continue to create value with our ACO program.