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

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

Part 1. PY3 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), a large FQHC, and Lawrence General Hospital (LGH), a safety net hospital, 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 36,000 members in PY3 in the service areas of greater Lawrence, Haverhill and Lowell. Our vision is that members of My 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 PY3 Full Participation Plan.

Goal #	Goal Category & Description
1	**Cost & Utilization Management**: Hold medical trend to a 3.1% increase year over year, based on the Health Policy Commission state cost growth benchmark.
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. PY3 focus is on improving Comprehensive diabetes care, Asthma medication ratio, and the Rate of initiation and engagement of treatment for alcohol or other substance use disorder (IET).
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 65% of inpatient admissions locally each 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 in the primary care setting and screen 25% of ACO members by the end of PY5.

Cost and utilization management (Goal 1) are necessary to achieve the aim of the ACO initiative, but we have found it challenging to achieve savings despite success holding medical trend to a reasonable level. Programs such as care management, improving transitions of care and implementing the new flexible services program are our focus to impact medical trend by reducing key spend categories such as inpatient and emergency room utilization. We focused on quality improvement (Goal 2) in PY2, knowing that improving health outcomes leads to reduced cost and realized significant improvement in 7 of 9 pay for performance measures. For PY3 we expected to focus on diabetes, asthma and treatment for substance use disorder, that impact many of our ACO members. We had a supporting Performance Improvement Project with KEPRO for both asthma and IET and received a score of 99% on each for our multi-disciplinary approach to improvement. The onset of the COVID-19 pandemic disrupted many of our intended quality improvement strategies.

Our care team-based approach to care has demonstrated reduced emergency room use and inpatient readmissions while connecting patients to primary care and addressing social care needs. Goal 3 is to increase the impact by continuing to grow enrollment in the care management program, which improves members' experience and engagement in their care. Additionally, patients are best served by keeping care local where we collaborate best. For Goal 4 we are measuring the percent of inpatient admissions to our local hospitals each year. More care coordination resources are available locally such as the Multiple Visit Patient (MVP) Program at Lawrence General Hospital where we work to understand the true drivers of utilization and address the social needs of patients, critical to improving health outcomes. Finally, we are working to expand screening for social determinants of health (SDOH) in the primary care setting (Goal 5) and create more efficient ways to connect patients with need to the appropriate resources. This work complements the Flexible Services program, funded by Mass Health separately, launched in March 2020 and providing certain housing and nutrition supports to members with health-related social needs.

1.2 PY3 Investments Overview and Progress toward Goals

The evolution of our ACO continued in PY3 with investments supporting enhanced collaboration of care management teams and addressing social determinants of health along with continued quality improvement. However, PY3, 2020, was a year like no other, with the onset of the COVID-19 pandemic in March. Lawrence rapidly became a hot spot. Below are examples of four areas of investments in PY3 that helped us continue to serve our members and move our ACO forward towards achieving our goals.

At the time of developing our PY3 budget, the coronavirus had not yet taken hold, but we found that several of our investments were particularly relevant to continue our programs in the pandemic environment. Consultants from Blue Cirrus helped develop policies and workflows at GLFHC to utilize their behavioral health clinicians via telehealth, to provide care to more members during COVID. Our MAVEN incentives investment meant PCPs could virtually consult with specialists and increase their expertise to care for patients as access to specialists became more limited during COVID. We supported the call center at GLFHC which became busier as patients began calling for COVID testing results and

needed more support with the move to telehealth. We utilized Docusign for electronic PCP signatures on care plans and expanded its use to members, completing 96 member consents and care plan signatures. We provided COVID care packages to members who needed monitoring at home to avoid an emergency room visit. The care packages included a pulse oximeter, thermometer, hand sanitizer, gloves and other personal supplies. We provided pulse oximeters and bilingual instruction sheets to primary care practices, GLFHC pharmacy and the emergency room at LGH where doctors could feel more comfortable sending patients home rather than admitting them when they could be monitored remotely. We gave out 246 devices across all locations and arranged telehealth follow-up. The GLFHC pharmacy delivered an average of 1677 prescriptions per month from May – Oct with 656 stops each month with the pharmacy delivery driver we supported, a critically important resource for members who could not travel.

The care management program is a critical investment that we expect to have the greatest impact on reducing cost, goal 1. In PY3 we continued the new MVP program at LGH where the ACO social worker uses systems of alerts through Collective Medical Technologies (CMT) and Patient Ping event notifications to identify patients presenting in the ED or inpatient setting, reach out to those patients who may have been difficult to find, and connect them with the appropriate care manager—medical or behavioral health, and assist with transitions of care back to the community and ongoing supports. We found a key aspect of this work are the weekly "lightning rounds". A multi-disciplinary group including PCPs, BH CPs, social worker, clinical pharmacist, home health, other ACO personnel, focus on one or two MVPs and work on a joint care plan. These rounds leverage the expertise of each organization to improve patient care and wellbeing. We have many stories of MVPs who have gone from multiple ED visits weekly to months without an ED visit or admission. This case conference technique has also been used during COVID to successfully care for the homeless members who were temporarily housed at the Days Inn, staffed by a home health agency, supported by the mobile van healthcare team from GLFHC and with weekly collaboration across all parties, including AllWays Health Partners. Despite the move in March to have staff work remotely from home, the ACO hired and successfully onboarded new nurse care managers and community health workers, eliminating vacancies for a full complement of staff. This allowed us to grow caseloads and enrollment during this time of need. We filled the vacant ED Navigator position with a CHW late in the year, to connect with ACO patients in the LGH emergency room to improve transitions to primary care, screen for SDOH and provide linkages to care. Despite interruptions from normal workflows, we did exceed the targets for most of the program goals for this investment, as described under successes.

A third set of investments were investments in tools, training and processes to support care management teams and collaboration with our Community Partners to improve outcomes for members. We completed a TA project to improve CP engagement rates (quality metric) and have been holding monthly joint meetings with the CPs, sharing best practices and progress made, led by our external partner relationship manager and our medical director for quality. Our CP and data teams implemented the new assignment process early in the year and have successfully identified more patients eligible for CP assistance than under the Mass Health process, with monthly reporting to CPs and Mass Health. More case conferences have been initiated with the BH CPs this year in order to promote collaboration and achieving improved outcomes. We invested in Karuna Health, a secure texting platform to augment how we communicate with members. Using texting for low risk patients' transitions of care outreach, we have a 42% response rate from over 3000 patients in six months. Forty-nine percent of members interacting with the MVACO Mano a Mano care management team have consented to texting and sent at least one SMS text, with

24,080 texts sent via Karuna overall. This is the preferred method of communication for a subset of members and is now being piloted by the AllWays Your Care Circle team. We reached our highest rate of engagement in Q2, 53%. We enhanced data feeds to our data warehouse, for care manager identification and care plan information from CCA, the care management system, that will then flow to Patient Ping, Karuna and the GLFHC EMR. This will enable better care coordination and efficiencies. Education and training for staff in PY3 focused on cultural competency and diversity, equity and inclusion training. As we consider health equity more, we need to assure equitable care for our members and overcome implicit bias for example. We recognized the great stresses on staff of COVID disruption, working from home in a community at high risk for COVID, with patients with many needs, while caring for children out of school, all of which made employee wellness a priority concern. We have provided a self-care and wellness program for staff which has been well received and appreciated.

Finally, we invested more in addressing Social Determinants of Health (SDOH), completing the planning and implementation of the Flexible Services Program (FSP) and expanding SDOH screening in primary care, goal 5. Our investments support a project manager to coordinate expanded screening workflows and referrals to flexible services. The greater Lawrence community has rich resources to address social needs through its community services agencies, but previously it was not easy for PCPs or CHWs to know what is available and how to refer someone. To reduce that barrier, we made a key investment in the Unite Us platform for closed loop referrals from primary care and ACO staff to ten community agencies initially. Through community engagement, we will grow the participating agencies and use of the platform in PY4.

1.3 Successes and Challenges of PY3

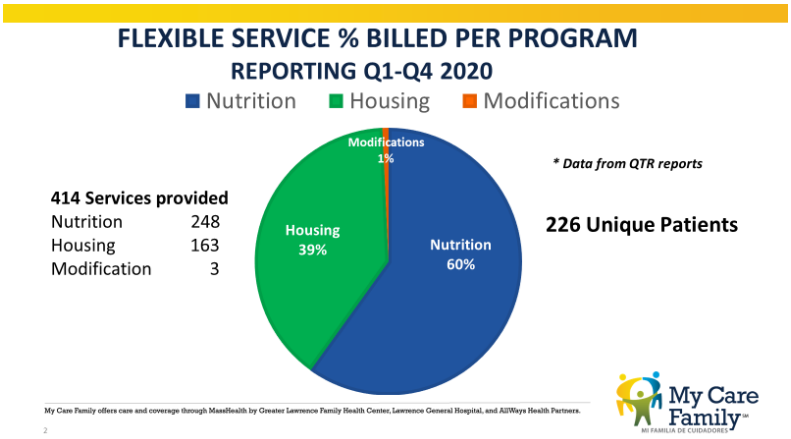
Care management remains a major investment and we have seen more successes in PY3 following the program optimization work done in PY2. As described above, we grew to fully staffed despite COVID challenges and exceeded most of our program goals for the year as listed below.

Care Management Program Goal	Target	PY3 Attainment	Status
Increase member enrollment in the care management program by 40% over year 1 baseline by year 5.	1278	1389	
Of patients enrolled in the care management program, increase the % of patients who met their goals.	85%	87%	
Of frequent utilizers of the Emergency Room, defined by patients with 3 or more visits in a month, enroll 30% in care management each year.	30%	41%	

The results for our final goal below were based on an analysis of a cohort of 749 members who received and completed care management for a period ending December 2019 where we found a statistically significant decrease in inpatient admissions and ED visits per member per year for those members after completing care management compared to a period prior to enrolling in care management. The value of these savings is estimated at nearly 3 million dollars. Therefore, we know that care management can result in significant cost savings. We are continuing to target growth in this program for greater impact.

Care Management Program Goal	Target	Attainment	Status
For high risk members who enrolled in and completed care management, reduce inpatient and ED utilization costs by 10% compared to a 1-year period prior to being enrolled in and completing care management.	10% reduction in each	Inpatient admissions reduction: 51% ED visits reduction: 39%	

We were pleased to successfully launch the Flexible Services Program in March 2020, just as the pandemic began, with both nutrition and housing components. Merrimack Valley Community Partner, one of our LTSS CPs, performs the outreach, screening, care plans and arranges service delivery. ACO staff planning time was used to add a program to support members impacted by COVID-19 during the summer, expand to pre-tenancy and transitional housing supports during the fall as we learned more about our members' needs, and work with MVCP to optimize workflows. The pandemic was disruptive as staff moved to working remotely, so program growth was slowed. However, one early result is that of 66 members referred for uncontrolled diabetes, after completing their plan, 18 members (27%) reduced their HbA1C by 1 point and 15 members (23%) reached an HbA1C < 9 (controlled). We did make a difference for 226 members as shown below and are planning to assist many more members next year.



The greatest challenge of PY3 was of course, the COVID-19 pandemic. In primary care, the focus switched from quality improvement to quickly move to telemedicine. Care for chronic disease patients was most impacted by COVID. The City of Lawrence, where 75% of our members reside, experienced the highest incidence of COVID-19 in the state, being a low-income community of essential workers, predominantly Hispanic and living in close quarters. Our care teams moved to remote work from home which made it more difficult to connect with certain patients since we could no longer meet them in the community. Some nurses were redeployed, population health coordinators performed outreach for COVID follow-up and test results, and CHWs assisted the state with contact tracing for several months. The pandemic interrupted programs and caused delays hiring some positions. We did manage to hire and onboard new care team staff remotely mid-year and grew caseloads. As unemployment grew, it became more difficult to address housing insecurity for our members, with long waiting lists and low supply of affordable housing. The flexible services program provided support and the expansion of RAFT helped. Availability of appropriate behavioral health services has been a challenge, but we participate with the

Lawrence Mayor's Health Task Force, who are working on improving BH access locally and we expanded GLFHC BH services via telehealth. Quality improvement efforts were derailed at first with PCPs working remotely. A highlight was improving our rate of childhood immunizations by GLFHC bringing families back in person and holding flu vaccine clinics in the fall. We improved to 43.22% for 2020 versus 29.93% in 2019 and 25.8% in 2018.

It has remained a challenge for our ACO to achieve savings. We had projected a loss for 2020 based on expected premium levels. The decrease in outpatient services due to COVID (lower ER visits/1000, rad/lab, elective surgeries) was offset in our experience by high cost cases, complicated newborns, and especially the high incidence of COVID admissions. Inpatient, behavioral health and pharmacy costs all grew. Despite overall a 0.5% expense increase (achieving Goal 1), our ACO is in deficit for 2020. Mass Health has made changes for PY4 to change the risk profile for ACOs and we are focused on outcomes, but we will see. In March 2021 it's a different, more hopeful, outlook from a year ago, with vaccines increasing in supply. There is a tremendous community collaboration now with all parties engaged in COVID vaccine education and rollout to our ACO members. Our SDOH investments have positioned us well to help our members with those needs and the care teams will return to seeing more of our members in person over the next few months for optimal impact of our accountable care organization.