

## 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>	Mercy Health Accountable Care Organization
<b>ACO Address:</b>	271 Carew Street <sup>[1]</sup> <sub>[SEP]</sub> Springfield, MA 01104

#### Part 1. PY3 Progress Report Executive Summary

##### 1.1 ACO Goals from its Full Participation Plan

Our goals for this participation plan are broadly aligned with (a) the goals of the MassHealth program and (b) the strategic plans of Mercy Health as we look to lead in accountable care and continue to improve both our core operations and the experience of our members.

##### Cost and Utilization Management:

- Develop a Primary Care Based Complex Care Management (CCM) Program that targets high utilizer members (top 3%) in order to decrease costs.
- Develop an Emergency Department (ED) Care Management Program to reduce avoidable ED visits and admissions and lower costs.
- Develop a Transitions of Care Program to improve transitions after acute hospitalization.
- Create a Specialty Pharmacy Program in order to support CCM, Transitions of Care, and ED CM Programs; conduct medication reconciliation and improve medication management in order to improve health outcomes.
- Improve data and analytics capabilities to deliver actionable information that drives interventions influencing quality outcomes and TCOC.
- Ensure reliable reporting on quality and TCOC performance across ACO in order to improve quality outcomes and lower TCOC.
- Integration of Physical Health, BH, LTSS, and Health Related Social Services
- Incorporate BH providers into primary care practices to expand services and close gap between physical health services
- Develop in-person resources and online portal linking members with local social services in order to improve health outcomes.
- Provide digital visits (tele-health) for patients with SMI/SUD in order to improve health outcomes and lower costs.

- Create an inpatient addiction consult service in order to coordinate care for patients admitted as a result of SUD and improve quality outcomes.

### Member Engagement

- Utilize novel electronic applications to better engage members at the point of care and improve patient satisfaction with their provider visits. Engage patients in primary care visits annually, in order to improve connections with primary care practitioners, establish central management of care, and improve access to care when needed

### Quality

- Develop a Quality Improvement Program to enhance overall quality performance and MassHealth ACO P4P quality metrics for PY 3 – PY5.

## 1.2 PY3 Investments Overview and Progress toward Goals

Overview of Investment	Advancement of Goals	Implementation Status	Examples of Progress
Invest in a <b>Primary Care Based Complex Care Management Workforce</b> to be embedded in MercyHealth ACO primary care sites	Embedded CCM staff in the practices provide a seamless approach for our members and integrates the care team.	Fully implemented and operational	Through PCP referral and identification of high risk members utilizing the CCM algorithm, 490 members are under management with an approximate program LOE of 7 months. 96% completion rate of assessments (76% in 72 hours).
Expand existing <b>Specialty Pharmacy Program</b> to better support medication reconciliation and management for highest risk and highest utilizing members	This program outreach has provided education and support for high risk members	Fully implemented and operational	Oversaw 145 patient visits for disease management (diabetes), comprehensive medication reviews, or targeted medication reviews from PCP referrals  Assisted with the outreach and conversion of 2,773 medication for the MH partial formulary and PBM conversion

Investment to help <b>Embed BH Workforce in Primary Care Practices</b>	Embedding BHS as part of the care team has closed gaps in care for members	Fully implemented and operational	3.5 BH Specialists participate as part of the CCM team, quickly assess and intervene with at risk members and warm transfer to CPs as available. At the end of PY3, we focused on building out BH specific caseloads for the team to further enhance their impact.
<b>Disease management and education program workforce</b>	Reduces ED and inpatient utilization for patients with disease specific needs	Fully implemented and operational	This program is operational through the hospital and is no longer funded through DSRIP.
Invest in <b>Quality Improvement Program Workforce</b> to help improve quality performance and outcomes	Investment in quality resources has improved capture and performance on all measures	Fully implemented and operational	Fully implemented with internal reporting on quality measures to drive on-going performance
Invest in a <b>Care Management System</b> that allows care managers to communicate with broader care teams	Improves documentation of member engagement, improves efficiency of case management	Fully implemented and operational	We have implemented a new case management system with management tools to track productivity, case assignment, and completion of tasks. These tools allow us to support performance management of staff.
Expand existing <b>ED Care Management Program</b> by embedding RN care managers in Mercy ED and other local hospitals	Embedded staff have reduced ED utilization and costs and perform SDOH screening on all ACO members not just CCM members	Fully implemented and operational	Mercy ED CM and CHW is implemented. The ACO has collaborated with Baystate Medical Center, where our highest ED volume seeks care and BSMC has implemented the same approach and hired an ED CM and CHW for their ED. Mercy ED CM staff are

			completing the Thrive screener with each ED patient. Moved to tele-support due to COVID in PY3, will move back to in-person support in the middle of PY4.
Implement <b>Patient Ping for Transitions of Care Program</b> to ensure delivery of information to appropriate staff at MercyHealth ACO to support members with out of network hospitalization and ED visits	Assists in identification of CCM members who are hospitalized.	Fully implemented and operational	All patients seen in ED (regardless of hospital) are receiving f/u TOC phone calls from ACO staff.
Invest in an <b>Analytics System</b> for generating high-risk lists and other insights related to member health and total cost of care performance	Improve data and analytics capabilities to deliver actionable information that drives interventions influencing quality outcomes and TCOC.	Fully implemented and operational	Jointly with BMCHP we have stood up the Arcadia platform to review patient utilization, claims and do deep dives on medical needs and complexity consistent with our goal of developing data and analytics capabilities to deliver actionable information that drives interventions influencing quality outcomes and TCOC
Investment to support <b>ACO Program Management</b> , including workforce recruitment, training, protocol development, & consulting	Advances overall ACO goals of improving TCoC, member engagement, and quality	Fully implemented and operational	
Centralize administrative costs for ACO members through <b>Clinical Administrative Activities</b>	Advances overall ACO goals of	Fully implemented and operational	

	improving TCoC		
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### 1.3 Success and Challenges of PY3

<b>Success Story 1</b>	<p>During Covid the CCM team successfully transitioned to remote work with minimal difficulty. They were able to adapt to new way of working and continuously maintained their panels of ~ 75 members. CCM staff worked with members at the beginning of COVID to transition as many members as possible to mail order pharmacy. Members who tested (+) for COVID had frequent check ins and education for symptom monitoring and were connected to tele-health visits. CCM team began doing SDOH and PHQ screenings to capture any members who were facing issues during pandemic.</p> <p>Any member who presented to Mercy ER was called after discharge to be sure appropriate follow is given and being sure to connect to providers</p>
<b>Success Story 2</b>	<p>Due to COVID, Mercy had to rapidly transition from in-person care to tele-health for our primary care practices. This transition rapidly accelerated our tele-health strategy as an organization and has encourage increased uptake in new technologies for our patients. This has led to an increase in patients being able to access their providers and a decrease in our patient no show rates. We will continue to refine how this technology can continue to be leveraged past the pandemic and improve the overall care we provide to our patients.</p>

Challenge	Description	Mitigation Strategy
<b>Challenge 1: COVID impacted POC labs</b>	Patient with chronic conditions such as diabetes and hypertension that require labs and in person visits for care were greatly impacted by COVID as we moved to tele-health in the summer.	In the second half of PY3, we have been prioritizing in-person visits for patients with chronic conditions and working on processes to ensure up to date labs and test for patients. We will continue to reengage these patients in primary care through PY4 to improve chronic conditions maintenance for patients.
<b>Challenge 2: PCP retention loss due to COVID</b>	Due to COVID several of our providers were redeployed for COVID related work. This increased provider burnout leading to a loss of several of our primary care providers due to early retirement or medical conditions.	We are working on a hiring strategy to recruit and backfill primary care providers that will improve overall access in our region and ensure patients with chronic conditions have more integrated care within their primary care office.

