ATTACHMENT APR

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

General Information

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Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

During PY1, our goals remained focused on our original plans as outlined in the PY1 Full Participation Plan, mainly to establish a strong ACO foundation on which to build programs that will bend our cost curve while maintaining high quality of care for our patients, which include goals of Cost & Utilization Management, Quality, Member Experience and Engagement, and Integration of Physical Health, BH, LTSS and Health-Related Social Services (see section 2.2 in the PY1 Full Participation Plan).

In PY1, the ACO leveraged DSRIP funding to achieve the goals as outlined in this section by newly implementing or expanding Complex Care Management, Transitions of Care (ED), Pharmacy Care Management, SUD and BH Management, Chronic Disease Management, Advanced Technology and Quality Management. We were able to begin the process of operationalizing programs using DSRIP funding. These programs each aim from a different perspective, to achieve our strategic goals. The first served as a foundation year where our organization, in partnership with our MCO, learned many lessons. Though these lessons seemed painful at the time, they directed us to adjust accordingly as we laid out plans. Many areas experienced these types of "growing pains," from sharing information between the ACO and the MCO, to how best to use data at the ACO level proved challenging but very fruitful in the first year. Knowing who our beginning population was became obviously very important very early on. The first year also saw us making great strides in setting up teams, hiring individuals, and moving the programs to the practice-level of care for our population. We developed a cadence of data sharing, and saw good strides with providers and patients becoming engaged in understanding the ACO and its goals. All of the above were fundamental to a strong start for a new program.

These programs were critical to the success of the ACO as we began to manage this very challenging population. In order to simultaneously maintain high-quality care and bend the cost curve, these programs will have to be successful, and will be the foundation for a strong ACO in the future.

As we continue to build out these programs, we know that there will be challenges. As we work to address not only the clinical conditions for this population but also the social determinants of health, we may find that resource ratios may need adjustments. We have begun to learn the population's baseline which will be important to tailor these programs in order to meet the specific needs that the population demands moving forward.

1.2 PY1 Investments Overview and Progress toward Goals

Our investment approach supports our ACO's overall performance and strategy in several important ways. A central component of this strategy is executing on our population health management program. This program is overseen and managed by the VP of Population Medicine, ACO Medical Director, Clinical Director of Population Health Management, as well as the Chiefs of Internal Medicine and Family Practice. This team is responsible for implementing the ACO strategy, population health management programs which includes primary-care based Complex Care Management team focusing on the top 2-3% of members, and the Transitions of Care (ED) care team programs.
These programs are complemented by local programs overseen by the ACO, and which each practice site has identified as important to addressing local member needs. To prevent duplication with local programs, local program leaders provided lists of patients enrolled in primary care complex care management.

Our DSRIP investment strategy is to make targeted investments in high-impact programs (supported by either research or our collective experience) aimed at fulfilling our overall goals, most importantly TCOC reduction and increased quality for our members. Our focus has been on clinical and financial integration of the programs, while at the same time increasing quality for our members and moving toward total cost of care reduction. During PY1, the ACO made great progress in standing up many initiatives and implementing strategic investments, as outlined below:

1. **Transitions of Care ED/Hospital**: Our team of a care manager and CHW based at the hospital, have already made great strides in assuring almost all patients admitted are discharged with a follow up appointment, as well as being connected to appropriate resources in our community.

2. **Pharmacy Care Management**: Despite some turnover in staffing in this part of our investment, we saw all of our ACO patients being discharged from the hospital having a pharmacist-driven medication reconciliation done. This then triggered a notification to the PCP who would see the patient after the hospitalization, thereby maintaining a truly up to date medication list for our ACO patients.

3. **Quality Management:** We have made significant strides during PY1 in hiring appropriate individuals to help in managing our quality metrics, in combination with our partner MCO. During PY1 we were able to see where our quality metrics were hitting targets and where we needed to focus our efforts for particular metrics.

4. **Patient Engagement and Enrollment:** During the first half of PY1, it became necessary for the ACO to build new processes around redeterminations, open enrollment, and patient engagement. For patients without future appointments or those with gaps in care, we had to develop processes to create outreach opportunities to schedule appointments. Strong PCP engagement impacts a number of ACO performance drivers: maintaining enrollment, ensuring appropriate risk

adjustment, providing opportunities to meet quality metrics, and the management of overall utilization and medical expense. Therefore, we shifted DSRIP priorities to adjust for this new program.

1.3 Success and Challenges of PY1

The ACO had several successes in PY1, as we launched the ACO toward our investment strategy to make targeted investments in high-impact programs (supported by either research or our collective experience) aimed at fulfilling our overall goals, most importantly TCOC reduction and increased quality for our members.

1. **Complex Care Management:** At the very foundation of our ACO are medical management and Complex Care Management, which are vital to our success. During PY1, we built a solid Complex Care Management team who worked on quality measures by outreaching patients and assisting them with scheduling appointments, coordinating appropriate referrals to specialists, completed assessments within 72 hours after an ED visit, engaged patients identified as high risk, and offered assistance to help patients achieve overall their healthcare goals. Our teams are fully staffed and preliminary data is already showing a positive ROI, where we are reducing ED visits and hospital admissions for patients enrolled in our complex care management program for the ACO.

2. **Risk Coding:** It became apparent in PY1 that Risk Coding and IT solutions would need to be developed to ensure that we were assigning the appropriate diagnoses for the ACO population. The benefits of appropriate coding include improved opportunity for patients to be identified for care management programs and/or disease intervention programs. As such, we launched two coding initiatives, we have seen some positive benefits as a result:

   a. **Obesity:** The ACO developed a focused process around Obesity coding and rolled this initiative out to the all the practices in which all patients are weighed at each visit and heights entered to automatically calculate a BMI (Body Mass Index). When a patient fell outside of the normal ranges- including overweight, obesity, or morbid obesity, the clinician was triggered to both address and document a plan. Within the EMR, the clinician has the ability to select items such as "referral to nutritionist, dietician, endocrinology, discuss exercise and healthier eating choices". Our population is not immune to the epidemic of overweight/obesity currently affecting our country, and by addressing obesity during visits with their PCPs, we are able to offer them the tools necessary to best help them succeed. Also important is the added benefit of accurately coding our population for overall population risk management and tracking.

   b. **Homelessness:** The ACO developed a process to aid in identifying if a patient is homelessness in an effort to aid patients with their housing needs. Early results indicate that we have seen a steady improvement in identifying our homeless population. Patients who have been identified as having insecure housing or are homeless are given information regarding our monthly "Housing 101 Workshop" where a Social Worker and Community Health Worker from the ACO are there to assist patients with their housing needs and will refer to CCM or other community resources as needed.

The ACO did face some challenges in PY1, of which two were particularly formidable:

1. **<u>Behavioral Health Management Team:</u>** During PY1, we were not able to fill the position of Chief of Psychiatry. This combined with our organization's lack of experience in directly managing behavioral health, led to a slow start to mapping out the details of our approach in this area. There is a shortage of behavioral health providers across the country, and our immediate community is no exception, and finding psychiatrists and NP's (with specific training/expertise in BH) has been a challenge. At the end of 2019, we eventually recruited the Chief of Psychiatry who began in early 2019. The ACO will work with this leader to develop and implement a BH program for our ACO.

2. **<u>Advance Technology and Analytics:</u>** During PY1, this became a challenge right from the start. The initial plan we had for ZeOmega as a platform for care management did not work for our organization. Our care teams quickly realized that they would have to be very inefficient in their documentation of care for our ACO patients. Therefore, we had to develop, in partnership with our MCO, a different tool to directly manage our CCM's within our electronic medical record. Another challenge within this initiative remains that we are planning a transition to another EMR system in 2019, and the workaround developed in our current EMR in 2018 will have to be redesigned with the new EMR in mind. This will continue to be a challenge going forward.