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:	Boston Medical Center HealthNet Plan Southcoast Alliance
ACO Address:	200 Mill Rd., Fairhaven, MA

Part 1. PY2 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The goals for the ACO are focused on several key areas based on previously identified challenges and barriers. Through effective care management strategies and processes, the ACO expects to improve the appropriate utilization of hospital-based services while lowering costs for patients with medical and/or behavioral health needs. Timely access to follow-up care following hospitalization, combined with a thorough medication reconciliation process are instrumental in reducing the risk of hospital readmission. To drive population health management, teams focus on medical record documentation and associated condition coding, with appropriate care plans to manage health status. Focused efforts to close performance gaps for clinical quality measures will also support population health management and improved outcomes for patients.

Cost and Utilization Management

- **Goal #1**: Provide wrap-around medical and behavioral support for Medicaid ACO patients to drive down avoidable admissions and the percentage of 30-day readmissions to 12.8% (all cause, unplanned) over 5 years compared to baseline. This connects with the TCOC management opportunity related to Complex Care Management and the Emergency Department's Clinical Social Workers and Community Health Workers for outreach and support of patients. This will allow the ACO to develop a holistic, targeted and high-touch care management model for the highest-risk and high-risk members; reduce avoidable admissions and readmissions to lower inpatient costs; reduce avoidable ED visits to reduce emergency room costs; develop integrated medical and behavioral health programs and protocols to address siloed health care. Hospital admissions was identified as an area where our ACO was running above market, therefore this goal is a priority for the ACO.

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

- **Goal #2:** Reduce Behavioral Health costs to the ACO system while improving patient satisfaction and communication among various entities involved in the patient's care and to see a reduction in avoidable admissions, the 30-day inpatient readmissions, ED visits and a decrease in TCOC in the

Medicaid ACO population. Hospital admissions and emergency room utilization which were both identified as areas where our ACO was running above market, therefore this goal is a priority for the ACO.

Member Engagement

- **Goal #3:** Ensure that all Medicaid ACO patients leaving an acute or sub-acute facility will have a 5-day post-discharge follow-up (transition of care) appointment with their provider. The goal of this is to engage with the patients, reduce readmissions, ensure the provider is the central hub of the patient's care, conduct medication reconciliation, and provide further reinforcement that the provider is the option-of-choice when a Medicaid ACO patient needs medical, behavioral health or social support. Hospital admissions was identified as an area where our ACO was running above market, therefore this goal is a priority for the ACO.

Quality

- **Goal #4:** Practice Quality Coordinators will engage Primary Care Providers in patient quality metrics and help practice clinics optimize patient satisfaction, primary prevention through appropriate screenings as will be demonstrated through optimized quality scores. This will allow the ACO to identify actionable opportunities for performance improvement and work collaboratively toward achieving value-based care and provider accountability and provide appropriate performance feedback to providers and staff. Achievement of the highest possible quality score as a reflection of clinical and satisfaction patient outcomes is a priority goal for the ACO.

- **Goal #5:** Ensure patient medical record is properly and comprehensively documented and coded appropriately to ensure continuity of care, facilitate quality chart reviews and communicate gaps with providers. The ACO did not have a well-established and comprehensive documentation and associated coding workflow for clinical conditions, thereby making this goal a priority effort for the ACO.

1.2 PY2 Investments Overview and Progress toward Goals

Overview of Investment	Advancement of Goal	Implementation Status	Example of Progress
S/O PC: 1 - Implement team based model of care to meet population health needs	Advance ACO goals of integration of physical health, BH, and social needs to eliminate siloed care and provide more comprehensive care to members	Fully implemented	Daily huddles with multidisciplinary team representation including behavioral health specialties, medical/nursing staff and pharmacists address holistic care needs, identify barriers and ways to remove barriers. This includes access to healthcare appointments, medications and means of transportation. SDOH are reviewed with member and brought to team huddle for designation of appropriate team member to assist member. Team reviews progress at daily huddle to ensure that needs are

			being met in a timely manner and determines when situations need escalation to be resolved.
S/O PC: 2 - Embed nurses into the interdisciplinary care management team to improve coordination of care for the ACOs complex members	Supports goals of reducing costs to the ACO system while improving patient satisfaction and communication among various entities involved in the patient's care	Fully implemented	Medical RN Care Navigators are assigned to each practice to work with patients with one or more chronic diseases. RN Care Navigator is responsible for educating patient regarding management of their disease process as well as identifying barriers to learning and compliance with patient's plan of care. Home visits are completed by a team member at the direction of RN, who is the lead team member for medical cases, as member allows, to assist with recognition of SDOH facing the patients. Costs are reduced when patients have access to the appropriate level of care while the focus remains on the reduced need for ED/UC/PCP visits with better management of chronic condition.
S/O PC: 4: Embed community health workers at primary care sites to support patients with behavioral and social needs	Supports goals of reducing costs to the ACO system while improving patient satisfaction and communication among various entities involved in the patient's care	Fully implemented	Our model is universal for behavioral and medical community health workers except for the focus on behavioral health than then on medical needs. CHWs were instrumental in connecting patients with resources and the implementation of Southcoast Resource Connect (aka Aunt Bertha™).
S/O D:1 – Invest in actuarial support to guide development of programs and initiatives	Supports ACO goals of reducing TCOC and improving quality for patients	Fully implemented with parent organization assuming cost.	This activity did not require PY2 funding. We have carried out this function within the overall work of the ACO - a yearly actuarial study to support our Risk Based ACO certification.
S/O D: 2 - Hire social workers to address social	Supports goals of reducing costs to the	Fully implemented staff hired and supporting the	LiCSWs were an instrumental part of the members' care team.

and behavioral needs of complex medical patients and work with community partners	ACO system while improving patient satisfaction and communication among various entities involved in the patient's care	primary care sites, working closely with CPs and liaising with state agencies as appropriate	They aligned with the CP assigned to patient. LiCSWs are aligned with PCP practices and they initiate communications with the CP. LiCSWs continue to build relationships by identifying patients and setting up services through a CP or LTSS service.
S/O D: 3 - Expand support and access to clinical pharmacist for medication mgmt., education, optimization and cost	Supports ACO goals of reducing cost and managing utilization	Two clinical pharmacists hired and supporting provider practices identify and implement drug cost saving opportunity	Through claims analysis, the pharmacists discovered $100,000 in cost-savings opportunities through dosage form and other types of drug product conversions. To assist providers, communications were distributed that advised on optimal generic drug order descriptions to permit a retail pharmacy to select the lowest cost, available drug product. The pharmacists worked extensively with practices, providers through direct outreach and communications to streamline and facilitate the drug formulary changes.
S/O D:4 - Expand ACO based practice quality coordinators to assist meeting quality metrics	Supports ACO goals of achievement of the highest possible quality score as a reflection of clinical and patient satisfaction outcomes	Two FTEs hired and managing the PY2 quality metrics with the provider practices	Based on recently available data for hybrid quality metrics, the ACO performed above goal for two metrics (metabolic monitoring and F/U after hospitalization for mental illness); the ACO performed between attainment and goal for three metrics (asthma medication ratio, initiation and engagement of SUD treatment). Overall, the progress improved during PY2 as issues with patient list discrepancies were largely resolved and access to the measures via the EHR dashboard provides greater efficiency in completing the work.
S/O D: 5 - Expand ACO-based Maternal and Child	Supports ACO goals of reducing TCOC and	The ACO will utilize maternal and child	The ACO is rolling out a new program for expectant mothers

Health program to better engage families in preventive services	improving quality for patients	health management time to develop, implement, and communicate planning and program development support	utilizing electronic technology, such as mobile devices or home computers via the MyChart (patient portal) application. The CareCompanion tool includes educational materials on how to remain healthy during pregnancy and allows a member to reach out at any time to speak with a nurse or physician if they have any concerns. The intent of the program is to provide support to the patient during and after their pregnancy. This model is expected to go live in PY3.
S/O D: 8 - Provide ED-based community health workers to engage patients not using their PCPs and address social issues	Supports goals of reducing TCOC while improving patient satisfaction and outcomes by connecting them with appropriate resources	CHW hired and working with the ED team as well as connecting patients back to the Southcoast team or CPs	Community health workers continue to monitor the ED to identify and communicate with high utilization patients that are assigned to CP. CHWs try to make the connection between the designated CP and member. CHWs engage with patients and support them in identifying reasons they are not attending PCP appointments.
S/O D: 11 - Invest in data analytics and reporting to support program development, monitor results and support clinicians	This advances ACO goals by building an electronic dashboard within the EHR that will allow dedicated quality department staff members to conduct outreach, scheduling and order placement with complete documentation through the EHR in an efficient and standardized workflow	Clinical Analyst hired. We do not anticipate using DSRIP to fund this position in PY3.	The dashboard went into production with an initial set of measures near the end of PY2. The dashboard easily identifies non-compliant patients and provides direct access for staff to access the patient record to conduct outreach, schedule appointments, enter orders for provider approval. The dashboard creates an easy format to monitor interventions for measures like social determinant screening, depression screening and remission, blood pressure control, HbA1c control, immunization compliance status, metabolic monitoring for children on antipsychotics and the asthma medication ratio.

S/O D14 - ACO/Medical Management DSRIP Allocation to MCO	Support ACO goals of managing cost and utilization	A portion of program administration is managed by the MCO to support the ACO.	This activity supports routine Pre-Certification, Case Management, Disease Management, Nurse-based Counseling, Health and Wellness, Quality Components, Medical Informatics, and Utilization Review as needed. These activities are important to maintaining total cost of care management efforts.

1.3 Success and Challenges of PY2

The ACO enjoyed several successes during PY2 due to the performance management plan's goals combined with the associated investment strategies.

1. **Risk Coding:**
   A. Obesity: An effective workflow was created with physician leadership combined with management and IT support to identify, document and code patients with obesity. The efforts which were launched mid-year in PY2 improved the capture of obesity conditions from a baseline of 9% in PY1 to 17% in PY2. The ACO expects to further improve the capture of obesity conductions by an additional 25% in PY3.
   B. Homelessness: An automated workflow was developed and implemented for hospital registration staff to identify and capture patients who indicate a homelessness status at the time of presentation to an emergency department. The resulting data indicates that patients attributed to the BMC-Southcoast Community Alliance do not have a significant incidence of homelessness, but patients attributed to other Medicaid ACO networks within the region do have a higher incidence of homelessness among their attributed patients. The homelessness status is available for review in the patient's record to assist with any needed housing support activities.
   C. All condition coding: The organization created a broad-based workflow to capture patient conditions in both ambulatory and hospital settings using the CMS HCC coding standards. The expansion of this workflow to Medicaid patients is anticipated to go into production in PY3.
2. **Quality Metrics:** The ACO had a successful year in PY2 with performance gap closure across a number of the PY2 clinical quality metrics. Through the use of a dedicated team of two Practice Quality Coordinators and Care Navigation staff, individual patient outreach and/or interventions arranged through the PCP's practice or with PCPs directly resulted in a strong performance year. Based on recently available data for hybrid quality metrics, the ACO performed above goal for two metrics (metabolic monitoring and F/U after hospitalization for mental illness); the ACO performed between attainment and goal for three metrics (asthma medication ratio, initiation and engagement of SUD treatment).
3. **Care Management:**
   A. Low Acuity Emergency Department (LAED) Utilization: In effort to better manage LAED utilization, a patient campaign called, "Where Should You Go" was launched. The essence of the campaign is the use of a patient flier that promotes access to primary care or urgent care for non-

life-threatening conditions as a patient's first consideration for an acute condition. The emergency department is displayed with a sample list of life-threatening conditions that would appropriately indicate use of 911 transport and/or an emergency department visit. For patients undergoing active cancer treatment at one of the ACO's cancer centers, the cancer center's own urgent care service is explained. The flier includes basic instructions for patients and lists the name, location and contact information for all Southcoast Health urgent care locations. Using reports provided by BMCHP, patients with a history of LAED receive a mailed copy of the flier with a cover letter encouraging the patient to consider a non-ED site of care for any future low acuity condition. Early data indicates a slight decline in LAED utilization, but more importantly, patient reception to the flier has been very positive. The standardization of self-management action plans across the disciplines has resulted in patients speaking of their current view of their chronic conditions by identifying with the color on a stoplight tool. Patients will now call the care navigator to report that they feel they are in the yellow zone which may have begun to favorably affect the LAED utilization rate.

B. The Care Navigation team has been able to identify patients with increased anxiety related to their state of health, primarily among patients with COPD. Care Navigation provided appropriate patients with an SPO2 monitor for self-use by the patient to help decrease their anxiety and reduce the need for seeking emergent care.

C. The ACO successfully established two clinical affiliations with local behavioral clinics that has increased rapid access for behavioral health treatment for our B.H. patients.

The ACO experienced some challenges in PY2. Of particular note:

1. **Behavioral Health:** The organization continues recruitment efforts to fill the position of Chief of Psychiatry. Update: Following a professional search process, a new Chief of Psychiatry was recruited and will start in August 2020.

2. **Patient Transportation:** The Care Navigation team identified numerous needs to provide patient transportation for members to complete scheduled, medical appointments. An external funding source was achieved through a private, grant application process where the funding focuses on patient quality/safety interventions. A structured transportation dispatch system through a third-party vendor was reviewed and piloted by our hospitals group; the system is expected to move into production in PY3 for use by Care Navigation's patients in the Southcoast Health Network. The grant funding will pay for the transportation service to/from medical appointments if a primary funding source is not available to the patient and the patient cannot afford to self-pay for transportation.

3. **Patients have knowledge deficits regarding their medications** which results in medication adherence issues. Using existing clinical pharmacists within the Southcoast Health Network, a provider or care navigation staff member may refer a patient to a pharmacist to review medication profiles and provide recommendations for streamlined medication therapy, or the pharmacist may contact the patient directly to provide education, resource information or helpful hints to improve medication adherence. Telephonic/video access to a pharmacist during a home visit is expected to be available in PY3 to help address medication education between a pharmacist and the patient.