

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:	Health Collaborative of the Berkshires
ACO Address:	725 North Street, Pittsfield MA 01201

Part 1. PY2 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The vision of the Berkshire Fallon Health Collaborative ACO is to deliver integrated, person-centered care at the right time, right place, and at the right level of intensity using best practices. To this end, we have developed several priorities that will guide our use of DSRIP funds and our alignment with EOHHS' goals for Delivery System.

Priority 1. Create high-value, integrated provider partnerships that address Members' medical, behavioral and psychosocial needs in a person-centered, culturally and linguistically appropriate manner. We will develop and implement Care Coordination and Care Management programs, consistent with Model A Contract requirement, that include support services to manage Members with Special Health Care Needs and those who are Behavioral Health (BH) Community Partner (CP) and Long-Term Services and Supports (LTSS)-CP eligible. We will prioritize Transitional Care Management initiatives and invest in developing the necessary infrastructure as well as flexible services that target specific health-related social needs that help Members remain in the community with the help of services and supports.

We are committed to investing in new Information Technology (IT) and infrastructure that supports primary care integration with Behavioral Health (BH), LTSS and other services across the continuum. We seek to create the ability to share data and employ decision support tools that facilitate Care Management, Care Coordination and sharing of service utilization data (e.g., real-time Emergency Department [ED] utilization) across the network. We will also invest in workforce capacity and skill sets that will be needed across our network for re-deployment of staff, as well as new and expanded roles.

Priority 2. Increase BH/LTSS integration through partnerships with PCPs, Community Partners (CPs) and Care Management staff. As both an initial implementation priority and an ongoing part of our strategic vision, we plan to invest in developing strategies to maximize the collaboration with, and contribution of, newly selected EOHHS certified BH- and LTSS-Community Partners (CPs) to meet Members' LTSS and BH needs in an integrated manner. We will prioritize the development of work flows, best practice protocols, trainings and supports to create this integrated vision. We also plan to

invest in expanding community linkages between the ACO-PP and additional providers, CPs, and social services across our service area.

Priority 3. Fund “flexible services” that address social determinants of health. The MassHealth program establishes clear expectations that ACO-PPs make investments that address Members’ social determinants of health. We will support this requirement by investing in programs that ensure that Members’ social service needs are adequately assessed through our Comprehensive Assessment and, that linkages with social service organizations are established. Based upon funding authorization by EOHHS, we will invest in services such as housing stabilization, utility assistance, nutritional counseling, and counseling and supports around instability and violence.

Priority 4. Build a foundation to expand our role in accountable care delivery. We are committed to investing in incentives that promote quality outcomes and the integration of primary care with BH, LTSS, and Care Management services at the practice level. As a provider organization that has not participated in Value-based purchasing, this is a key priority.

We will invest in activities that will help partners embrace a transition to working to achieve value-based incentives. Some steps that we see as being essential to this process include, but are not limited to: developing data infrastructure to measure and share information regarding performance; developing clinical, operational and data workflows that support value-based incentives; educating providers regarding workflows, data and value-based opportunities; and, obtaining baseline data.

We also wish to fund a learning collaborative to jointly define Care Management processes, protocols and workflows among our HCB ACO partners to develop best practices. By moving toward these activities, Health Collaborative of the Berkshires will create a strong foundation for high quality, accountable care delivery.

Priority 5. Materially improve Member experience and relationships with PCPs. We plan to invest in initiatives that increase Member awareness of available health care services and education materials that increase Member understanding of health care needs and services. We will promote Member access to services and Member awareness of PCP choice, thereby strengthening critical primary care relationships, which we believe will lead to improved clinical outcomes and the reduction of avoidable medical costs.

BFHC aims to accomplish through investments funded by the DSRIP program over the five-year period the below outlined goals and objectives.

1. Cost and Utilization Management

- I. Reduce Emergency Department utilization to statewide market rate
- II. Reduce high cost imaging to statewide market rate

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

- I. Reduce readmission and admission to hospital services to statewide benchmark
- II. Reduce readmission and admission of opioid and substance use disorder cases

3. Member Engagement

- I. By year 5, for patients that trigger a comprehensive assessment, 30% will be completed
- II. By year 5, for patients that complete a comprehensive assessment, 20% complete a care plan

4. Quality

- i. ACO provider level dashboard for performance/Appendix Q measures will be shared monthly by year 1
- ii. ACO performance on at least 8 Appendix Q measures will exceed national average by year 5

5. Information Technology

- i. By year 1 integrate non-BHS primary care EMR data into BHS data warehouse for ACO reporting
- ii. By year 2 integrate TruCare into BHS data warehouse for ACO reporting

1.2 PY2 Investments Overview and Progress toward Goals

The DSRIP Plan is developed and approved by a joint work group reporting to the ACO’s Governing Board. Below highlights the high-level summary of the investment approach:

- ACO Program Strategy: Develop care coordination and care management teams (care management pods) to manage Medicaid members, develop disease management programs to improve cost of care, integration of Behavior Health and Primary Care practices, and connect Medicaid with care management hospital services with primary care practice providers
- DSRIP Goals: HCB and Fallon Health share strategic goals to improve outcomes, reduce costs, and improve the overall quality of care for MassHealth Members. These goals are foundational to the creation of our ACO. Our shared strategic goals are to:
 - Transform and innovate to improve the health status and outcomes for MassHealth Members
 - Design and implement a network of high value providers who offer value over volume
 - Offer quality, patient-centered and cost-effective care that engages patients in their own health care in a culturally and linguistically appropriate manner
 - Deliver integrated care including physical and BH as well as psychosocial supports
 - Provide effective population health management for MassHealth Members in the Berkshire region
- DSRIP Investment Strategy: HCB DSRIP full participation plan allow Fallon Community Health Plan and the ACO to achieve three strategic objectives that align with our Model of Care. Those objectives include:
 - Expand resources and capacity to allow HCB to provide care management service to the ACO population
 - Assist with the creation of HCB population health model to support the unique health care and psychosocial needs of Medicaid members
 - Automate system connections between Fallon, HCB, and other community partners
- **PY2 Investment Updates:**
 - Investment in Care Management Pods
 - In PY2 the care management staff, and Fallon Health plan worked together to optimize member outreach through the utilization of a prioritized list of members to outreach to based on risk stratification.
 - Investments to Support BH needs of Members

- The Primary Care – based SUD Medical Home grew its panel to 107 patients. Services offered to the patients in this program include MAT, brief drug and alcohol counseling, and links to key supportive services such as clinical therapy, AA, NA, support for housing needs and other SDOH needs.
 - Investments to Support Medical needs of Members
 - The ACO fully staffed a hospital based CHW program 7 days per week. The CHWs who staff this program see members who come to the ED and hospital inpatient units. This is a chance for the CHW to engage a high-risk member in ongoing care coordination and prevent future ED utilization and hospitalizations.
 - Investments to Create Automated Systems
 - Progress was made to pull all data from ACO participants into a data warehouse to allow for reporting capabilities for all participating practices on Appendix Q measures. These reports provide monthly performance measure calculations to allow providers to actively monitor performance and make ongoing quality improvement.

1.3 Success and Challenges of PY2

The ACO saw successes in PY2. One success related to the ability to provide data to participating providers on their quality performance. Current, regularly updated data reports which show providers how they are performing on important quality metrics spurs real time improvement rather than retrospective reaction.

The SUD Medical Home was an important clinical success in PY2. A nurse practitioner and a nurse based in a primary care practice treat patients with both alcohol use and opiate use disorder. The program provides medication assisted treatment, supportive counseling and key connections to other services patients need. The SUD Medical home also make connections with and maintains communication and collaboration with the pod care managers. The care pathways of this program, which include frequent visits to the office, have played a major role in the reduced utilization of the patient population, specifically when it comes to ED and inpatient utilization.

Major challenges for the ACO in PY2 included finding additional ways to support members with substance use disorder. The ACO hoped to recruit providers in primary care to become waived to provide MAT, but the ACO was met with resistance to this initiative. Given the time commitment needed to manage this complex disease, many PCPs were apprehensive as to whether they could manage this on top of their busy primary care practices. The ACO also tried to recruit a primary care provider to provide primary care services at the Brien Center, a major provider of mental health services. The ACO struggled to find an engaged provider who was able to see the vision and be flexible to the development of a new program and the challenges that can occur.