

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:	Berkshire Fallon Health Collaborative
ACO Address:	725 North St. Pittsfield, MA 01201

Part 1. PY3 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

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.

1.2 PY3 Investments Overview and Progress toward Goals

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.

- The ACO has already begun evaluating DSRIP funded programs for their ability to achieve clinical quality targets, lower unnecessary utilization, and reduce total cost of care. Those programs which achieve the above-mentioned targets will be maintained. Those that do not meet intended targets will be discontinued. The Berkshire Fallon ACO discontinued programs in PY2 that did not meet the expectations for patient engagement or utilization. The ACO will use the specific metrics for each funded program as outlined in the performance management plan to evaluate effectiveness for long term sustainability.

PY3 Investments:

- Investment in Care Management Pods:
 - In PY3 the Care Management Pod Team staff in collaboration with Fallon Health worked to optimize member outreach utilizing enhanced risk stratification tools. The ACO Care Pod teams were able to successfully pivot during the Covid-19 pandemic and offer additional support to members through increased outreach and engagement in Covid focused Flexible services programs including Grocery Delivery. Utilizing outside grant funds the care pod teams also participated in an initiative to provide members with a Covid-19 care package upon discharge from the hospital. The target population included members at risk for Covid-19, Covid-19 positive, and/or Covid-19 recovery. In June 2020, the pods began a new initiative of Post Ed Contact record in collaboration with the hospital based CHW team. Preliminary results are promising in reduction in inpatient admissions, ED utilization, and improvement in PCP and specialty visits.
- Investment to Support BH/SUD Needs – SUD Medical Home:
 - Expanding its patient panel to 139 patients by the end of PY3 The Primary Care based SUD Medical home offered services to engaged patients including MAT, brief drug and alcohol counseling and links to key supportive services such as clinical therapy, AA, NA, and support for housing and other SDOH related needs. This program continues to expand and support the needs of our most vulnerable population with SUD and BH care needs.
- Investment to Support the Medical Needs of Members:
 - ACO staffed hospital based CHW program 7 days/week. The CHWs who staff this program see members who are in the ED and hospital inpatient units providing a chance to engage emergent and high-risk members in real-time. The goal of this program is to provide intervention in the form of care coordination and prevent future ED utilization and hospitalizations. The ACO implemented a new “Post ED Contact” workflow in Q2 of 2020 that proved an effect tool in care coordination and follow up for ED events. Preliminary metrics for members receiving the Post ED Contact reflected a decrease in future utilization for some of our members.
- Investment to Create Automated Systems:
 - After transitioning our clinicians in early PY3 (February 2020) from Allscripts to Meditech Expanse some progress was lost in the creation of our automated system. Unfortunately, due to the Covid-19 pandemic we did not recover this fully until late PY3. At the close of PY3 these reports have been rebuilt and validated for accurate reporting to

our clinicians. In addition, increased functionality gained through the “BCA” or Business Care Analytics features of Expanse should prove a more effective way of communicating appendix q measure results in a to our clinicians, timely. These reports previously provided monthly performance measure calculations and allowed providers to monitor performance, review patient lists, and make ongoing quality improvement. The new reports from BCA should serve the same purpose to our providers.

1.3 Success and Challenges of PY3

The ACO saw some successes in PY3. The most important Clinical success was in the form of the SUD Medical Home Program. 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. The data for PY3 continues to reflect the efficacy of the program so much so that it has been officially adopted by Berkshire Health Systems and will continue to operate without the support of DSRIP funding.

Both Care Pod Teams and Hospital Based CHWs were required to pivot their roles dramatically in the wake of the Covid-19 PHE. Care Pod Teams and hospital based CHW staff were shifted into engagement with the Flexible Service Covid Care Package Program. They participated in preparation and delivery of over 250 boxes to BFHC members. Although CHW staff were not allowed to see members face to face in the ED for a large portion of PY3, the CHW staff did call members and engage in a new “Post ED” contact workflow which began at the beginning of Q3 of 2020. This assessment proved an effective tool in care coordination and follow up post ED events. Preliminary metrics for patient’s receiving the Post ED Assessment reflected a decrease in future utilization for many members.

Source: ACO Care Pod Team/Fallon Health

Data Reviewed: ACO Patients who completed a Post ED Contact Record.

Dates Reviewed: A snapshot in time*. July 2020 through October 2020.

Total Unique Patients:	380
Total Events:	497
Total Patients with 2 or more Events:	68
% attempted within 48 business hrs.:	100%
% completed contact record:	43.85%

PRE "ED Post Contact Record Completion" - Total PCP Visits	POST " ED Post Contact Record Completion " - Total PCP Visits	% Change in PCP Visits
1121	1174	5%
PRE " ED Post Contact Record Completion " - Total SPECIALIST_EVENTS	POST " ED Post Contact Record Completion " Total SPECIALIST_EVENTS	% Change Specialty Visits

506	615	22%
PRE " ED Post Contact Record Completion " - Total ED Visits	POST " ED Post Contact Record Completion " - Total ED Visits	% Change In ED Events
693	631	-9%
PRE " ED Post Contact Record Completion " - Total ACUTE_IP_EVENTS	POST " ED Post Contact Record Completion " Total ACUTE_IP_EVENTS	% Change Acute IP Events
58	28	-52%
PRE " ED Post Contact Record Completion " - Total BH/SUD IP Events	POST " ED Post Contact Record Completion " Total BH/SUD IP Events	% Change in BH/SUD Events
57	61	7%

Challenges:

Anticipated Challenges:

The primary challenge that concerns the ACO is the rural geography of the region and the impact it has on access to services as well as utilization rates of specific health care service lines. It is noteworthy to mention that the characteristics make recruitment of primary care and specialty physicians extremely challenging. From a contract perspective, continuous modifications in state-wide timelines for deliverables and delays in critical information required for operation make it challenging to meet the needs of state deliverables. In addition, as we continue to understand the BH/SUDs needs of our population, it is clear that there is a critical need for increased access to outpatient BH/SUDs treatment in the Berkshires.

The Pods Teams will continue to struggle with balancing requirements of 42 CFR and providing quality care management services to a member population with high SUDs needs.

Unanticipated Challenges:

Certainly, the challenge none of us were expecting the effects of which are still unknown relate to the Covid-19 PHE. Many of our programs were stalled and or suspended in the wake of this crisis and did not achieve our targeted outcomes. One such program was the RN triage line effective late March was reallocated to be a Covid-19 support line for the community. At the time of reallocation it was determined that the funds for this program would originate within operations and would continue throughout the Covid-19 crisis using other funding sources.

Our Get Cuffed Program was unfortunately disbanded by Q4 of PY3. This program focused on engaging patient's with elevated blood pressure or diagnosed hypertension with an at-home monitoring system for Blood Pressure with results reported into an RN and CHW staff member for review and dissemination to clinical teams. Ultimately, Get Cuffed needed to be put on pause in order to redetermine the goals of the program to better align with HEDIS measure and telemonitoring. There may be a restart of this program in the future which would be operationalized by BHS using other funding sources.

Some areas, where small progress was made in PY2 was lost because of the PHE. In PY3 (February 2020) we transitioned from Allscripts to Expanse. In PY2 we had established a data pull from ACO participants into a data warehouse to allow for reporting capabilities for all participating practices on Appendix q measures. These reports provided monthly performance measure calculations and allowed providers to monitor performance, review patient lists, and make ongoing quality improvement. After our transition in February 2020 the infrastructure team at Berkshire were unable to rebuild the appendix q measure reports for provider distribution prior to the start of the PHE. This important Quality initiative like many others was side-lined due to the need to increase reporting capabilities for Covid-19 hospital patients. In recent months there have been many advancements in the creation of Provider and practice dashboards within the Business Care Analytics module of Expanse.