

ATTACHMENT APR

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

General Information

Full ACO Name:	Wellforce Care Plan in partnership with Fallon Community Health Plan
ACO Address:	10 Chestnut Street, Worcester, MA 01608

Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

Cost and Utilization Management

1. Bend the cost curve. Achieve 2.5% reduction in expected spending over 5 years
2. Create an ACO program that is financially viable. Achieve surplus and share in savings
3. Reduce avoidable ED visits by facilitating outpatient care
4. Reduce avoidable inpatient admissions by strengthening outpatient and community based programs
5. Achieve clinical improvement savings at a rate that is sufficient to cover operating expenses as DSRIP funding decreases

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

6. Support BH needs of patients with multi-disciplinary care teams
7. Integrate behavioral health social workers in PCP practices with psychiatrist support
8. Integrate the behavioral health, medical, and social needs of the patient via the RN lead to prioritize resolution of issues and barriers
9. Expand community linkages between the ACO-PP, Providers, Community Partners, and social services
10. Develop and implement plan for workforce capacity and professional development to support ACO-PP needs
11. Partner with local organizations to address social determinants of health for our patients

Member Engagement

12. Streamline transition of care for patients and their caregivers during the first months and year of the program
13. Achieve targets for high-risk member enrollment in care management for SHCN, BH, and LTSS services
14. Improve patient experience with providers and care team through performance improvement initiatives, workforce training and the development of culturally and linguistically appropriate programs

15. Provide members with educational tools to understand and manage their health, including resources to promote shared decision making and access to information that addresses those with limited health literacy
16. Develop community-based health navigation services

Quality

17. Meet or exceed MassHealth Quality goals (Meet reporting requirements in Year 1 and meet or exceed targets in Years 2 and beyond)
18. Improve quality through education of providers, access to specialized resources, quality improvement initiatives, and patient outreach
19. Support implementation of evidence-based best practices for disease management in medical practice, leveraging technology and system-wide expertise
20. Support PCPs with Primary Care Redesign by facilitating cross-functional teams to improve access, throughput, quality, and provider satisfaction with primary care
21. Implement patient and family-centered approaches to engage and support members' achievement of their health goals, and to promote self-management and integrate primary and preventive services

Other

22. Develop infrastructure and policies to support ACO clinical goals
23. Develop programs to recruit and maintain competitive roles (e.g., PCPs, LICSWs)
24. Successfully manage, measure and report overall population health initiatives and outcomes by developing and implementing a data, analytics, and IT strategy
25. Build a foundation to ensure success and expand our role in accountable care delivery (e.g., solid infrastructure)
26. Increase PCMH recognition and adoption of PCMH workflows among participating providers

1.2 PY1 Investments Overview and Progress toward Goals

In PY1, Wellforce Care Plan made a significant investment in staffing to support care management, clinical integration and behavioral health initiatives. We hired, trained and deployed fifteen (15) adult and pediatric regional care teams, each comprised of a registered nurse lead, a behavioral health social worker, and one-two community health workers. These care teams integrate with our primary care physicians in a patient-centric model which integrates the physical, behavioral and social needs of our members. We have enrolled approximately 3,900 patients into our care management programs, and approximately 2,500 of those patients are also enrolled with Community Partner programs. Our care teams have been instrumental in executing the model of care requirements in the Model A contract, including but not limited to: transitions of care, completion of comprehensive assessments, and interfacing with our Community Partners. We have many examples of successful execution of this investment, as evidenced by member stories highlighting the difference the teams are making in members' lives each and every day. As we progress to PY2, we need to continuously refine the role of these care teams to ensure that we continue to utilize them for the innovative, population health strategies warranted by this significant investment. Additional investments in the care management and clinical integration categories include chronic disease registries and staff, registered nurses located in the emergency departments at our ACO hospitals, and regional pharmacists who assist with medication reconciliation and transitions of care. Our behavioral health and substance use investments are comprised of psychiatric and substance use consultative services, as well as Medication Assisted Therapy (MAT) training for PCPs. The integration of behavioral health in primary care has been a significant goal for our ACO. As we progress to PY2, we are recognizing the need to focus not only on integrating behavioral health and substance use treatment in the primary care setting, but also on transitions of care from the emergency department and inpatient settings. We have also made significant investments in data and analytics across the ACO, creating a central data repository and producing reports of key performance indicators on a monthly basis.

1.3 Success and Challenges of PY1

Challenge 1: Identifying, reaching and engaging our highest risk and most vulnerable members, our “rising-risk” members, and our members who will benefit from additional care management services, and building the infrastructure and financial support to sustain these investments as DSRIP funding declines in the coming years.

Related Successes: We have hired and deployed fifteen (15) regional care teams (focused on adult and pediatric patients). Each team is comprised of a registered nurse (RN) care manager, a behavioral health social worker, and two community health workers. We have also hired pharmacists who work at the regional level and assist with medication reconciliations and transitions of care. The Lowell region has designated one community health worker (CHW) to work with the homeless population and build relationships with local shelters and tent encampments. We have a psychiatric nurse practitioner who is meeting patients where they live in order to promote continuity of care and medication adherence in the community.

Challenge 2: Culture shift in managing financial risk for Medicaid.

Related Successes: Our providers have built efficient operations for patient care, but those did not initially account for the extra time and consideration necessary for our new population health approach using care teams, communicating with outside partners, reviewing and approving care plans, etc. To help manage this transition, we launched a robust communications plan for provider education that will extend beyond the first year of the program. We have also ensured that providers have appropriate supports for quality reporting, care management, and the administrative tasks associated with participating in an ACO. Our ACO medical directors work with participating providers to review key performance indicators and utilization data to help track performance and continue to provide the best quality of care to our patients.

Challenge 3: Hiring challenges, due to the competition for talent by all participating ACOs and CPs.

Related Successes: Completed hiring and filled all targeted positions. One successful strategy was the sharing of applicant information across our ACO.

Challenge 4: Information Sharing & Implementation of a robust analytics program.

Related Successes: While the ACO member organizations each had strong analytics capabilities, scaling-up to begin receiving and analyzing Medicaid data for the various participating entities participating required significant effort. The ACO created a Data, Reporting, and Analytics workgroup staffed with talented individuals from each organization. This group created a data warehouse using an existing vendor such that our Medicaid ACO data extracts flow from a central location to each individual entity. Additionally, the ACO and health plan use the same case management documentation system, and we have developed data-sharing workflows with our community partners to work around different documentation systems. Some of these partners are in the process of developing technical solutions to bridge between their system and ours. We have built a data warehouse through Athenahealth, which is used for information sharing and analytics among the entities in the ACO.

Challenge 5: Limited networks and referral management.

Related Successes: Some of our patients were initially confused about their more limited options for care, potentially causing frustration and disengagement with the ACO. The initial continuity of care period, along with the ability to retroactively process referrals for a limited time period, are strategies that have proven to assist providers and patients in dealing with these new requirements.