

## 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

<b>Full ACO Name:</b>	Be Healthy Partnership
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#### Part 1. PY2 Progress Report Executive Summary

##### 1.1 ACO Goals from its Full Participation Plan

The BeHealthy Partnership seeks to improve the quality of care and control costs for our members by employing team based care management within primary care, integrating behavioral health into primary care, screening for and addressing health related social needs and implementing alternative payment models to support our delivery system redesign.

In Year 2 we have had three specific areas of focus related to cost control. We are taking a close look at our home care spend. Our care management teams connect with patients and with home care agencies to be sure that services meet medical necessity, address needs articulated by our patients and do not duplicate other services. In some cases this results in reducing services, in some cases in increasing services, in some cases redirecting services to more appropriate long term social support services.

Our multidisciplinary transitions of care team focuses on patients with frequent admissions. Our nurse, pharmacist, social worker, community health workers and recovery coach address the barriers to successful care in the community. In one case this might involve complex medication reconciliation involving the team, primary care and community pharmacies. In another it may consist of a community health worker connecting a patient to housing resources. In yet another, our recovery coach may step in to help connect a patient to community recovery supports. This team continues to successfully reduce admissions for a complex population of patients.

Our primary care based care management teams, consisting of a nurse, care coordinator and community health workers, work over extended periods of time with some of our more complex patients with chronic medical, behavioral health and social needs. We measure their impact in many ways, but have had a special focus this year on reducing emergency room utilization. Our teams are connected to an event notification system that lets them know by text when one of their patients is in the emergency room. Team members can follow up with a patient or, in some cases, will head directly to the emergency room

to connect with a patient who has not been coming to primary care. Slowly, they are impacting our high emergency room utilization.

An important goal for sustaining our work is our goal of adopting new payment methodologies. Specifically, we hoped to develop a capitated payment for integrated behavioral health within primary care to allow for services which meet patient needs but do not meet fee for services billing requirements such as brief interventions, co-visits with behavioral health and primary care, or wellness focused group visits. We also have the lofty goal of Primary care capitation to support delivery system redesign.

In order to design appropriate interventions for our patient population and best support and guide care management, BeHealthy seeks a deep understanding of our population. We are working hard to add social need data to more traditional health plan diagnoses and utilization data. Initially we focused on obtaining very detailed information from a comprehensive Care Needs Screen for over 30% of our population, then shifted to a more sustainable short screen embedded in the electronic health record and visit work flow. Using this data, a social needs score is calculated and included in our risk stratification model to help guide care management. We are also taking a deep dive into accumulating race ethnicity and language data from all available sources and comparing and analyzing results to understand best practices in gathering this vital data. We are anxious to identify and address health disparities.

The BeHealthy flexible spend program is being designed to address areas of need as they emerge from this population health analysis. For example, our Transitions of Care team identified chronic homelessness in members with mental illness as a cause of frequent readmissions and we have designed a flexible spend program to help this very challenging and vulnerable population.

BeHealthy has also been working hard to align our care management work with Community Partners work to avoid duplication of efforts. Our Interoperability Committee has pulled together our clinical partners, our Community Partners and Health New England to address all the complexities and challenges of sharing information on an ongoing way to allow each partner to work as efficiently as possible.

We are also using our embedded care management to drive quality improvement. One example is our goal to improve seven day follow up to behavioral health hospitalizations by using our Transitions of Care team and our integrated behavioral health model to connect admitted patients with follow up visits, address transportation and other barriers, and to stay connected with patients until the follow up is completed.

Finally, we have a goal of engaging all of our members and connecting those who have never been seen in primary care with a primary care provider and an appointment for care. We developed a process between Health New England and our provider partners to assign all members to a health center, to identify members in need of care for the health centers and to create a culture within the health centers of seeing all assigned patients as “their” patients even if the member has not yet been seen or consistently misses primary care appointments.

## **1.2 PY2 Investments Overview and Progress toward Goals**

BeHealthy Partnership DSRIP investments can be grouped into categories.

One category of investments is administrative, supporting work to create a true partnership of shared responsibilities and oversight. Our goal of becoming a true partnership is being achieved and enhanced every day. Health New England utilization management team members regularly communicate with care management team members in the health centers to jointly manage care. Leadership and staff from all of our health centers regularly come together to share best practices, brainstorm approaches to common challenges and support each other. Information technology professionals from every partner come together to develop improved communication solutions. Most of this work is supported by each partner institution, but DSRIP funds some positions entirely devoted to this BeHealthy work. Our culture of sharing and mutually supporting each other in our work to improve patient care has exceeded our early goals and leads us to reach for ever higher levels of integration.

Another category of investments relates to data gathering and reporting. Only with a combination of health plan data, clinical data, quality data and data from the state can we truly inform clinical programs and measure progress. We have invested in an operational data warehouse, analysts and file sharing capabilities as well as in homegrown solutions in partnership with our technical assistants. We have come a long way and expect to launch a system in early 2020 to better capture all our care management related activities. The exchange of information, especially clinical information between partners is in the very early stages of being realized, but we believe we are on a productive path.

Our largest category of investments is in our clinical multidisciplinary care management programs. We have created new job descriptions such as community health workers which not all partners had. We have fully hired all teams. We have developed care management policies. We have developed, enhanced and refined risk stratification to help inform care management. We have developed and expect to shortly implement a homegrown tracking tool to use with all health centers regardless of their different electronic health records. We have developed a methodology for measuring the impact of the teams on cost and quality. Our next major endeavor will be to pull this information together to assess what factors impact the success of care management. We expect to look at both patient factors such as diagnoses and social needs and care management factors such as types and frequencies of interventions to inform our care management activities going forward. This will be the exciting heart of our endeavor and very challenging and multilayered work has been accomplished to get us to this point in our journey.

### **1.3 Success and Challenges of PY2**

PY2 for BeHealthy has been about building on our early work in establishing a leadership structure that brought all partners fully into our work, establishing an agreed upon model of care which includes team based care with integrated behavioral health and the structure to address health related social needs, and the information sharing needed to inform and measure our progress.

We have had tremendous success in forming a true partnership. This year leadership no longer has to remind partners to think about and include each other. Communication across health centers, between health centers and the health plan, and with our community partners happens constantly and consistently. It has become a natural part of how we all work. This feels like a huge accomplishment.

While it is very much a work in progress, our efforts to achieve a true population health based understanding of our BeHealthy members has an excellent foundation. We have added a social need score to more traditional risk stratification, which has allowed us to better utilize our considerable

investment in community health workers. The next step of adding high quality race, ethnicity and language data is well underway.

Another major success is getting our care management teams and other clinical partners to accept and utilize data such as risk stratification to inform activities. We started from a place of provider referrals which were too often based on the need for a discrete piece of work to be accomplished. Now, our team members understand how to determine which patients may need which level of intervention and we are working to how all clinical staff understand this process as well.

We are particularly proud of our work to find a sustainable approach to tracking care management activities and caseloads. This work was more complex and took much longer than we naively anticipated, but resulting in a true partnership IT/clinical partnership which is paying unexpected dividends moving forward.

Challenges are many. Fully and productively integrating with our community partners has been a major challenge despite best intentions on both sides. The complexities of receiving and sharing information; the need to understand the different cultures between LTSS agencies, behavioral health agencies and primary care; the huge needs of the identified patient populations all made this perhaps our biggest challenge of this past year. We have made great strides, but more is left to do.

Despite our progress in information sharing, this remains a significant challenge. Confidentiality issues, especially related to substance abuse treatment, continually interfere with our work. Placing information in a place accessible to busy providers is another. And there are more. In a world with multiple electronic health record systems, care management platforms and files which don't match each other, this challenge is expected to remain. And we will continue to tackle it, piece by piece.

Addressing health related social needs is, of course, a huge challenge. We do not have the resources to house all those who need shelter, feed all who are hungry, support all who live socially isolated. We continue to screen, utilize community health workers and build connections with community social service agencies. We hope our flexible spend programs will help us make additional progress in PY3.

Finally, time is a challenge. Time to pilot, model and drive practice transformation. Time to design and implement new payment models. Time to measure and refine our programs. Time to educate and involve more fully our patients and our providers. Time to engage with the broader community. Time to complete all required reporting!

The work is deeply challenging, exhilarating, exhausting, never ending and deeply meaningful and gratifying.