

ATTACHMENT APR

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

General Information

Full ACO Name:	Baystate Healthcare Alliance in Partnership with Health New England
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Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

The BeHealthy Partnership includes four community health centers of Baystate Health, Caring Health Center and Health New England.

Our many specific goals fall under several overarching goals. We seek to transform the delivery system for primary care in our health centers from provider centered care to team based care centered on patient needs. We integrate behavioral health and substance abuse care into our primary care work. We collect information on our patient's unmet social needs and address those needs to the maximum extent that community resources allow.

Our goal is to continuously use clinical, utilization and financial data to design, measure and modify our investments and interventions.

We are working to develop payment models that support our integrated team based work.

Our practice transformation activities and pilots are shared by teams from all of our health centers coming together regularly to share pilots, successes, challenges and mid-course corrections. We seek to balance site specific innovation with development and sharing of best practices, allowing for the work to constantly move forward.

These goals are the priorities of the BeHealthy Partnership because we recognize that our patients bring a complex combination of medical, behavioral health and social needs into our health centers and we cannot improve quality and reduce costs without meeting more of those needs. Traditional 15 or 20 minute provider visits alone leave many needs unmet. The results in patient and provider dissatisfaction, unnecessary utilization of emergency departments and in some cases specialty care, and poor health outcomes. This widespread poor health drags down our vulnerable disadvantaged communities. In addition, without culturally and linguistically sensitive team members contributing to care, health disparities grow unchecked. At the same time, we know that some ideas to address these

issues will not work, so we have invested heavily in the resources necessary to measure everything we try. We want to promote a healthy environment where our staff can innovate, measure, adjust, capture successes in best practices and share those practices across health centers to be used where they make sense.

Our investment strategy supports these goals. We invested very significantly in multidisciplinary care teams in our health centers to provide care management and care coordination. We also invested in teams to focus on specific populations across health centers, such as patients at risk for readmission. The geographic proximity of our health centers allows us to share resources in this way.

We support the work of our teams by investments in data and financial analysts, interoperability work that will allow us to share care plans and activities with community partners, consultants in data systems, and upgrades to telephone systems.

Finally, we invested in leadership and training. We support clinical team leaders' time to work on practice transformation. We support leadership across our three organizations to focus on BeHealthy Partnership work. We provide financial support for training to enhance our work, from community health worker trainings to conference attendance for clinical leaders. We supported recruitment activities as we hired for positions that were new to our health system.

1.2 PY1 Investments Overview and Progress toward Goals

We have many examples of investments that have allowed us to make progress toward our goals. Here are several:

We hired teams consisting of nurses, care coordinators and community health workers at each site to work on care management and care coordination activities for high risk members. When the need to do comprehensive assessments and care plans for our LTSS Community Partner assigned patients – of which we had over 1,100 – arose, we had teams in place to do this work. Initially we allowed each team to choose how they would approach the work. Some teams used care coordinators to collect information from the medical record before the nurse met with the patient to speed up the assessment process. Others used community health workers in the home to collect as much information as possible and then had the CHW call the nurse to complete the assessment over the phone with the patient. Others had a more nurse focused approach. We brought all the teams together monthly. We transparently shared their progress in terms of numbers of assessments and plans completed. They then shared their approaches and more successful approaches were adopted by other teams. We believe that having teams in the health centers made the care plans better by allowing for easy interactions between the care teams and primary care providers. The work was very demanding and distracted from other care team activities, but this intensity did force teams to work as teams and to maximize the skills of each team member. When they were able to refocus on non-CP assigned high need patients, they worked more effectively as teams.

Our goal of moving toward team based care has also been addressed by our multidisciplinary transitions of care team. The development of this team has also helped us work on our goal of data informed care.

Before we hired any team members, we analyzed our admissions and readmissions, looking at diagnoses. We got together a practice team to review some cases to better understand factors leading to readmission. We then hired a team with members best equipped to handle those factors, such as having recovery coaches to address substance use issues. Once the team was hired, we gave them access to daily reports of admissions and a risk stratification of our patients to help them choose which inpatients were at high risk of readmission. They then assign team members to assess and work with a patient based on needs. For example, a homeless person with mental illness might be assigned to a social worker and community health worker. A person with three chronic diseases and significant alcohol use would be assigned to a nurse, pharmacist and recovery coach. It has taken some time to hire the team and work out efficient work flows, but we are now seeing significant reductions in readmissions for patients cared for by this team.

Our Medicaid Medical Expense Work Group is an example of how our investments in data analysts, financial analysts and leadership are leading to better understanding of medical costs and where we might focus our clinical teams on opportunities for improvement. Every month, a leadership group gets together to review financial reports and related reports, some of which are generated monthly, some quarterly, some just once to spotlight an issue. Medical costs are broken down by category and then examined by age, health center, etc. For example, now that we have significant social determinants of health data, we are looking at our homeless population to see where we might most effectively intervene with this population.

Finally, our Direct Care Committee is a good example of how our investment in clinical leaders in every health center allows us to move forward with practice transformation. Each health center has two identified practice transformation leaders. Every other week they come together with our medical directors and practice managers and co-CMOs of our Partnership to share small tests of change. Today we had presentations on use of Scribes in primary care piloted with two providers, our new medical legal partnership, and a pilot of nurse visits for straightforward pediatric urgent care walk-ins. For the next meeting, two other health centers have offered to present their own work on nurse visits. Once we have had several presentations on a particular intervention, we spend time reviewing those pilots. We look for common barriers in need of senior management intervention, successes that can be replicated across sites, and areas in need of further pilots and study. This past year, this group did a lot of work on team huddles and case conferences and on group visits. Huddles and case conferences have become well established. Group visits need more work and pilots are ongoing.

1.3 Success and Challenges of PY1

We have faced some significant successes and some large challenges in Year 1 and will share a couple of each.

One success of which we are very proud is our effort to get extensive demographic, medical, behavioral health and social needs screens done on over 13,000 patients in over a dozen languages. We invested in community health workers and additional interpreters at the beginning of our Partnership. Knowing it would take some time to hire nurses and get our care teams fully operational, we used community

health workers to obtain care needs screens on as many patients as possible. However, while our CHWs came from several different cultural communities in our area, we could only cover a few languages with them. By adding interpreters and having them also focus on obtaining care needs screens while we waited to get more fully up to speed with care management, we were able to reach deeply into populations of patients about whom we had limited information. We are still mining this rich data for health disparities, but have already uncovered interesting information.

A related success has been the development of our risk stratification methodology. Our analysts developed a risk stratification pyramid based on diagnoses and utilization. Every health center received a complete list of their patients and the stratification of patients into risk categories. This gave our care teams a place to start finding patients who could benefit from intensive care management. But, we knew that the social needs which were not part of this initial stratification were very important as well. We are now using the social needs information obtained from the care needs screen to give a social risk score to all patients for whom we have this data. Care teams can now look at their high risk patients and find those who have significant social needs so that community health workers can focus first on these patients. During our monthly meetings with all of the care teams we talk about how they use this list, what is helpful and what more – or different – information they would find useful. This is very much a work in progress, but an already rich and rewarding work.

Challenges included some of the following:

Perhaps not surprisingly, hiring so many people all at once proved difficult. Baystate did not have job descriptions or pay grades established for community health workers. Nurses proved particularly challenging to hire, as did social workers, and this delayed the start of some team activities well beyond what we expected. We invested in two leaders from Caring with extensive CHW experience to act as consultants for Baystate, helping to develop job descriptions, assist with recruitment, train and support supervisors new to working with CHWs and helping to coordinate core competency training. To address the issue of hiring nurses and social workers, we reviewed existing hospital job descriptions and requirements and realized they did not meet our needs. We worked with human resources and nursing leadership to make modifications which led to more applicants. We also did a lot of our own recruiting. We are now well staffed, though a couple positions remain open for our newest team.

An additional challenge has been modifying our two electronic health records to meet our needs, including adding social need screening questions, incorporating our comprehensive assessments and care plans, and finding ways to track team activities. All of these cost more money and took more time than we anticipated and not all are accomplished. We have had to bring senior leadership in several times to stress the high priority of this work to move it up the long list of EMR needs within each organization.

Communication has been a big challenge with some much going on with patient care in different sites and in homes. It sometimes proved difficult to prevent duplication of effort. We have addressed this in several ways. The teams, including community partners, now all have access to COR-TEX, a simple communication texting system and this has helped immensely.

Finally, operationalizing community partners into our care management work has been a huge challenge. Because of the tight timeline to get assessments and care plans done on both sides, that work was more often done in parallel rather than in concert. This led to confusion for patients, care teams and community partners. And, because this is a new program, it has often been unclear when an activity can be done by a community partner and when the health center staff needed to perform that activity. File transfers between us, community partners and MassHealth have not always been smooth. All of these issues are being addressed by diligent communication efforts, remembering to cut each other some slack in this new endeavor and time. We are identifying things such as having a community partner attend at least one medical visit with a patient and having community partners invited to multidisciplinary care conferences that have helped to begin to make this work complementary rather than conflicting.

This is an often wild and crazy journey we are taking, but on most days it is an exciting and deeply satisfying endeavor.