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:	Be Healthy Partnership
ACO Address:	One Monarch Place Suite 1500 Springfield, MA, 01440

Part 1. PY3 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 3 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, even when Covid restrictions forced them to work remotely with patients and families.

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 prior to Covid restrictions, 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 developed 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 contracted with Baystate psychiatry for psychiatric consultations to primary care to further support the integration of behavioral health and physical health management. We also have the lofty goal of Primary care capitation to support delivery system redesign, but have chosen to wait for MassHealth guidance on their tiered approach to this contracting.

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. After building a shorter health related social needs screening tool in the electronic health record, we screened thousands of our members telephonically to understand their ongoing and immediate needs during the Covid-19 pandemic. We used this data to identify potential members appropriate for flexible service referrals as well as additional referrals into various Covid-19 grant programs that offered immediate supply support to families in need. We also use this information to incorporate a social risk score 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. This past year we were able to standardize our REL data set and launch a project to provide an ongoing feed of REL data from our Health Information Exchange into our Care Management System. We are anxious to identify and address health disparities.

BeHealthy launched three Flexible Service programs in 2020. The first, a housing navigation and placement program in partnership with Mental Health Association targeting homeless patients with frequent readmissions that have a co-occurring behavioral health condition. The second, a home modification program in partnership with Revitalize CDC targeting asthmatics with frequent ED visits that have potential home triggers. The third program was a Covid-19 food delivery program, also in partnership with Revitalize CDC that aimed to address food insecurity and social isolation barriers for patients at high risk for contracting the Covid-19 virus. We are looking forward to measuring the outcomes of these programs in the coming year.

In 2020, BeHealthy made significant progress with our systems and technology in order to align our care management work with the Community Partners work to avoid duplication of efforts. Care Plan Manager was the mechanism deployed by which comprehensive assessments and care plans became electronically exchanged between community partners and health centers, while also integrating the Care Plan in the EMR. BeHealthy also deployed a Care Management System in order to capture care management activities, caseloads, community partner assignments, and to manage the Flexible Service Program referrals and services. This solution enabled us to reduce the amount of time care managers spent documenting patient interactions, increase their caseload capacity, manage evolving workloads, and offer insight into the patient's care journey.

We are also using our embedded care management to drive quality improvement. Our care teams will contribute to our two new performance improvement projects to be implemented this year that are focused on improving annual flu vaccination rates among those impacted more by racial disparities and reducing barriers to accessing primary care telehealth services.

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 PY3 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.

One success in this area has been to connect our clinical partners to the Pioneer Valley Information Exchange (PVIX). It was an enormous endeavor to connect our FQHC to this system, involving IT staff from the health center, the health center's electronic medical record provider, PVIX staff, consultants to work on privacy protections and a project manager from Health New England. Having all of our clinical data in a single site will vastly improve our ability to integrate care and report on our progress. One example is that we will be using this site to gather race, ethnicity and language data on our members in usable reports. Work here is helping us meet our population health analysis goal of obtaining and using social needs data in patient management and race, ethnicity and language data in program analysis, among other goals.

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.

We have had tremendous success in this area. We developed and fully launched a care management system to track all care management activity. We track care management activities performed by type of activity (phone call, home visit, etc.), activities performed by each staff member, and activities performed for each patient. We have built in assessment and care plan templates. We also use the system to refer patients to flexible spend programs. We are building quality measure prompts into the system, which can be seen by health center staff. We intend to integrate risk stratification and race, ethnicity and language data into the system as well. This system helps us in achieving all of our goals, but is particularly useful for our goal of identifying patients most likely to benefit from care management.

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 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.

As the heart of our BeHealthy Partnership, our care management teams impact all that we do. However, their largest impact is on helping us achieve our Medical Trend goals.

For our goal of reducing emergency department visits, our primary care based teams reduced these visits by 27% comparing utilization for 90 days before with 90 days after onset of care management and maintained a reduction of 12% over 180 days pre and post care management. Our goal for these teams has been a 10% reduction.

Our goal of our Transitions of Care team and Pediatric Intervention team reducing admissions by 5% in this 90-day and 180-day pre and post comparison has been met and far exceeded. Transitions of Care reduced admissions for those they managed by 62% over 90 days and 45% over 180 days, the Pediatric Intervention Team reduced admissions by 70% and 64% over 90 days and then 180 days comparing utilization before and after onset of care management by the teams.

1.3 Success and Challenges of PY3

PY3 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.

As discussed above, a major success has been the design and launch of our care management activity tracking system. This has gone from tracking a handful of activities to case load tracking, incorporation

of quality prompts, tracking of Flex Spend referrals and more. We can now meet monthly with each team and review detailed data on their activities, caseload size and activities for each patient in care management. We also review with them their impact on reductions in emergency room utilization, inpatient admissions and total cost of care. This has resulted in tighter caseload management, better outreach to patients who could benefit from care management and deeper appreciation within health center management for the value of these non fee for service team members.

Another important success has been our work to collect and incorporate race, ethnicity and language (REL) data into all the work we do. For the past year, our analysts have been pulling together REL data from all possible sources including our care needs screens, electronic health records and health plan sources. We have compared details on what data is collected. We have worked, and continue to work, on bringing this data together with quality data and care management data to begin to understand where we have disparities. At the same time, we have had trainings and presentations on health equity and health disparities for leadership in a variety of settings. We believe we are building a solid foundation for the essential work to come.

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 also now have enough data to begin to analyze where we are most and least successful in terms of patient diagnoses, social needs, types of interventions done. This will help guide the choice of patients for care management as well as program redesign to address areas of weakness.

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.

The Covid pandemic has impacted every clinical activity in our partnership. Almost overnight our teams had to transition to remote work with patients. This was surprisingly successful, but there are patients who could not be reached easily if at all. For these patients team members would sometimes stand outside the patient's home to talk to them through the door. Delivery of supplies had to be contact free and we developed policies and work flows for this. Both team members and patients struggled with home schooling children while trying to keep engaged. Staff were hit with illness or the need to quarantine. These staff reductions impacted the volume of care management that could be achieved. The need to staff Covid testing and then Covid vaccination further strained our health centers. For a time early in the pandemic care management really slowed. While this was understandable, the need for care management was greater than ever. Monthly, and sometimes weekly, meetings with teams by the BeHealthy Partnership Medical Directors and similar meetings with health center management resulted in troubleshooting and problem solving and resumption of full care management. It has certainly been a difficult time for us, but for all of health care.

Working effectively with the Community Partner Program continues to be challenging, particularly in the LTSS Program. The need for both our care managers and the CP teams to do separate assessments and care plans that then need to be integrated and signed too often results in duplicative work, delays, frustrations and confusion on the part of the patient. The shift to remote work on both sides has also been challenging. Patients often decline to spend all the telephone time necessary to complete the assessments and plans. Our health center teams make every effort to meet monthly with each CP for case discussion and task assignment, but staffing shortages and remote work with technical difficulties with remote meetings have had some negative impact of this work. We continue to engage with our CPs to address all these challenges and keep the work moving forward.

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 ongoing flexible spend programs will help us make additional progress in PY4.

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