

ATTACHMENT B

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM COMMUNITY PARTNER (CP) BP2 ANNUAL REPORT RESPONSE FORM

PART 1: PY2 ANNUAL REPORT EXECUTIVE SUMMARY

General Information

Full CP Name:	Greater Lowell Behavioral Health Community Partner
CP Address:	161 Jackson St, Lowell, MA 01852

Part 1. PY2 Annual Report Executive Summary

The Greater Lowell BH CP was able to accomplish the goals set out for Budget Period 2 (BP2), by leveraging the continued growth in skills and development of expertise in our diverse workforce hired during BP1. DSRIP funds assisted in further strengthen outreach, technology, and care coordination approaches and activities that were found to be effective in reaching and engaging members. Data collected in eHana validated many of the processes developed were successful, such as; having a designated outreach team was more effective then Care Coordinators and Community Health Workers (CHWs) attempting to provide care coordination and follow up with engaged members, while attempting to outreach to those that were more challenging. This approach to service delivery is more efficient and lent to increased staff satisfaction, aiding in staff recruitment and retention efforts. As a result, 78% of the assigned members, were located and agreed to participate in some degree in care coordination services, 28% of those individuals have been assessed and have had a care plan completed, leaving only 22% either still in outreach, declining participation or staff identifying that the member falls into another stop category, such as moved out of the service area or is incarcerated. At the same time, leadership and staff evaluated, re-strategized and planned to transform programming that data demonstrated was not as successful as anticipated.

Our multi-disciplinary, multi-cultural care teams continue to develop and hone outreach and engagement skills through training and education as a group and as individuals. During case conferencing, interdisciplinary care team meetings and staff meetings, staff have opportunities to learn from one another as content experts, as well as from external community partners and ACO/MCO partners coming to the table to share their knowledge, experience and opportunities for collaboration to serve this unique and challenging population. Through these collaborative sessions, stronger relationships have been formed creating more opportunity for staff to successfully connect members to needed services.

Data trends collected, extracted and analyzed have continued to drive decision making, for operational process improvement and strategic priorities. An example; as a result of data provided from a partnering ACO regarding ED and In-patient utilization, data collected during assessment with the members and through receiving event notifications in our EMR, the GL BH CP recognized the need for a deliberate strategy related to outreach, engagement and care coordination of the high-risk, high-utilizing, homeless population in Greater Lowell. This resulted in a BH CP staff member rounding at the local ED's Monday through Saturday, to connect with members while they are there and potentially willing to engage in services.

The program leadership strives to utilize effective, evidence based approaches, leveraging our strengths, historical knowledge, experience within our community as well as feedback from our members and staff to continue to grow and develop the GL BH CP program to best meet the members where they are, with services they need at the time they are ready.