

ATTACHMENT APR

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

General Information

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| Full ACO Name: | Partners HealthCare Choice |
| ACO Address: | 399 Revolution Drive, Somerville, MA 02145 |

Part 1. PY1 Progress Report Executive Summary

1.1 ACO Goals from its Full Participation Plan

- **Cost and Utilization Management**
 - Goal #1 (Cost and Utilization Management) Reduce ED visits
 - Goal #2 (Cost and Utilization Management) Reduce IP admits
 - Goal #3 (Cost and Utilization Management) Reduce TCOC by greater than 2% from benchmark)
 - Goal #4 (Cost and Utilization Management) Expand iCMP to enroll appropriate percentage of MassHealth ACO patients, and specifically address the needs of those patients.

- **Integration of Physical Health, BH, LTSS, and Health-Related Social Services**
 - Goal #5 (Integration) Expand Collaborative Care Program and other necessary resources to serve an appropriate percentage of ACO patients with behavioral health needs.
 - Goal #6 (Integration) Expand SUDs Recovery Coach Program and other necessary resources to serve an appropriate percentage of ACO patients with SUDs related needs.
 - Goal #7 (Integration) Screen ACO patients for SDOH needs in outpatient primary care setting
 - Goal #8 (Integration) Increase SDOH support capacity for patients screened positive for SDOH needs through both internal and community-based resources.

- **Member Engagement**
 - Goal #9 (Engagement) Engage highest-risk, unengaged, homebound and challenging patients, including with mobile primary care where necessary.
 - Goal #10 (Engagement) Engage patients outside of traditional care settings through the use of Community Health Workers and SUDs Recovery Coaches
 - Goal#11 Reach out to patients and provide materials and education in multiple languages and in a culturally appropriate manner.

- **Quality**

- Goal #12 (Quality) achieve benchmark performance on all quality measures, but with particular focus on clinical improvement on the depression screening measure (#17).
- **Other**
 - Goal #13 (Other) Coordinate and enact program development across Partners Healthcare, and within each member institution.
 - Goal #14 (Other) Promote system wide IT integration and analytic capabilities to gather relevant information to support care management.

1.2 PY1 Investments Overview and Progress toward Goals

Partners is excited about the progress the MassHealth ACO has made towards achieving the goals outlined in the Full Participation Plan. The support and resources that went towards existing Partners Population Health programs allowed these programs to expand throughout the year. Additionally, the strategic investments that generated the new Population Health programs and initiatives are already demonstrating success in some areas. The investments in year one of the program focused on building up the care management teams at local institutions to support the meaningful work that would be necessary to integrate BH, LTSS, and Health-Related social services into our primary care settings. Although hiring and onboarding both central and local resources took longer than expected, Partners is proud of the progress both teams have made towards achieving the ACO's goals. The expansion of existing high-risk care management and behavioral health programs in combination with new Population Health initiatives such as the iCMP PLUS and the ED Navigator program position the ACO for success in meeting goals related to cost and utilization management, primary care integration, member engagement, quality, and system-wide integration and coordination.

1.3 Success and Challenges of PY1

The Partners MassHealth ACO overcame many of the challenges associated with implementation and is proud of the progress it has made in accomplishing goals for PY1.

Hiring and onboarding resources was one of the biggest challenges throughout PY1. Many of the programs such as iCMP, Collaborative Care, and SUDs Recovery Coach, experienced delays in filling the social worker and community health worker care management positions. Additionally, central program management required more resources than initially expected. Despite the delays early on, most of the programs became fully or close to fully staffed by the end of the year. However, we do anticipate hiring to continue into PY2.

Behavioral Health integration and expansion was somewhat challenging throughout the year. The integration of behavioral health treatment into primary care proved difficult with many of our local institutions. Program enrollment began to slow towards the latter part of the year which forced central

teams to reevaluate current strategies and techniques. Transferring the work that had previously been done in the community into the primary care setting is still a work in progress. The ACO will be working on creating new recruitment and engagement techniques for members in addition to educating both patients and care teams about the importance integrating behavioral health into primary care.

The challenges in staffing and onboarding care management resources did not prevent program enrollment from increasing. Both Partners core and new Population Health programs demonstrated increased enrollment throughout the first year. Member enrollment in the ACO's core programs, iCMP, Collaborative Care, and SUDs Recovery Coach, grew over the course of the year. The ACO team was also pleased with the successful roll out of the new Population Health programs: iCMP PLUS, ED Navigator, and Social Determinants of Health screening and referral workflows.

Implementation of the Social Determinants of Health (SDOH) Screening and Referral process at the local institutions was a major success. This work required a large amount of coordination from central and partnering teams to not only carry out system-wide IT integration, but also engage members and physicians around the benefits of integrating health-related social services into primary care. Partners is excited about the progress in the first year of implementation and will be working towards refining processes and improving care in the coming years.

Partners is also excited about the successful implementation of the ED Navigator pilot program that was developed with the goal of engaging members in non-traditional settings, connecting them to primary care, and addressing health-related social needs. By the end of PY1, the program had three ED navigators working to connect with patients in the ED setting at MGH, BWH, and NSHS. Due to the successful number of encounters and referrals in the first year of the program, Partners will be expanding the ED Navigator program by doubling the ED navigators at the BWH and MGH locations.

The Partners ACO also experienced success with the rollout of the iCMP PLUS program which was designed to engage and address the needs of the highest-risk, unengaged, homebound and challenging patients. The program was extremely close to hitting target enrollment numbers and was able to successfully carryout an evaluation of the program impact to date.