

ATTACHMENT B

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM COMMUNITY PARTNER (CP) BP3 ANNUAL REPORT RESPONSE FORM

PART 1: BP3 ANNUAL REPORT EXECUTIVE SUMMARY

General Information

Full CP Name:	Boston Coordinated Care Hub
CP Address:	780 Albany Street, Boston, MA 02118

Part 1. BP3 Annual Report Executive Summary

The Boston Coordinated Care Hub began 2020 with overarching goals that included scaling our program to greater than 1000 enrollees and improving the quality of care provided to our Behavioral Health Community Partner enrollees. BP3 saw significant swings in operations due to the COVID pandemic. By mid-March, we shifted our care model that relied heavily on face-to-face outreach with numerous encounters per enrollee per month, to a model that relied mostly on telephonic engagement and collateral contacts. For several months, we needed to redeploy nearly half of our BCCH staff (RNs, care coordinators, managers) to care for/provide operational support for homeless individuals diagnosed with COVID at emergency facilities such as the BCEC and isolation and quarantine tents in shelter parking lots. This resulted in greatly increasing caseloads for some of the BCCH staff and adding extra hours to their workweek. We stopped taking new referrals from April-July 2020 to reduce the stress on staff caseloads.

By mid-June, COVID emergency facilities closed, and we were able to have BCCH front line staff resume their panels and provide mostly remote work. By September, when the COVID cases began to taper, we began resuming face-to-face outreach and care coordination. November saw new surges in infections, and we responded by reducing face-to-face outreach to only as necessary with heavier emphasis on telephonic care management.

Shifting to a mostly telephonic, remote model required new technology expenses to support our team and our enrollees. We were fortunate to receive federal grant funding to purchase extra laptops and Wi-Fi devices to support BH CP staff working remotely. We increased our BH CP spend to purchase more cell phones/data plans for patients who did not have phones and added Zoom accounts for managers to stay in touch with their teams and to support virtual team conferencing/learning. By fall, we shifted to a hybrid model of some outreach and some remote work and have been able to resume focus on our original BP3 goals which include:

- *Goal: Stabilize enrollment at 1200.* At the end of BP3, we were at 1126. There were several months in BP3 that we deferred new assignments due to redeploying a significant number of BCCH staff to care for homeless individuals being cared for in COVID emergency shelters.

- *Goal: Continue to accelerate efforts that focus on Enrollee Engagement to help advance person-centered goals and stabilize revenue streams.* At the end of BP3, our enrollee engagement rate was 77%. Our ability to find and engage our assigned population within 90 days was more than twice the state average (14.5% vs. 6.1% (Mathematica)). The pandemic made it more difficult to get PCTPs completed in person with the enrollee, our ideal mode of engaging hard-to-engage individuals who often do not have phones. In addition, many PCPs worked remote during the pandemic and were hard to connect with to get PCTPs signed. Finally, many PCPs were not scheduling appointments to see new enrollees and consequently would not sign the PCTPs until there was a face to face appointment (telehealth appointments were not available for new patient intakes.).
- *Goal: Focus on Quality Improvement.* *Goal: Focus on Quality Improvement.* We were successful in securing a TA contract in late summer to help us augment the data we have from our EHR, care management platform, and ENS system. By the end of 2020, the data was being refined to pull in our care management dashboard to ensure staff have access to timely, informative, actionable data using the quality metric state set forth by MassHealth.