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:	Community Care Partners, LLC
CP Address:	66 Canal Street, Boston, MA 02114

Part 1. PY2 Annual Report Executive Summary

CCP maximized on DSRIP investments in BP2, allocating funding to several critical initiatives including workforce development, enhanced technology and various operational improvements. These investments served to further build and strengthen CCP's capacity to advance its focus on integration with ACO/MCO partners and on its Quality Management program.

While CCP and its Member Organizations continued to prioritize recruitment in BP2, new focus was placed on staff retention and staff development. CCP streamlined its New Hire Orientation from a four day to three-day event. And several Learning Collaboratives were implemented in this budget period, including an ongoing series specific to RN Clinical Care Managers. CCP also sponsored a professional development session with Phillipe Copeland, Clinical Assistant Professor of Boston University's School of Social Work. Dr. Copeland presented a half day session on Social Justice, Social Determinants of Health, and Health Disparities to rave reviews.

CCP navigated a critical transition from its initial CCIT platform to a new, more intuitive platform at the beginning of this Budget Period. The new eHana system has promoted easier workflows and greater efficiencies for Care Teams and enhanced reporting functions for CCP.

CCP's Intake Team evolved considerably over the course of BP2. As the complexities of CP enrollment came to light, including challenges as related to multiple types and formats of ACO files, ACCS referrals, and MH eligibility, CCP's Intake Team adapted and developed more advanced skillsets to manage both enrollment and disenrollment as effectively/timely as possible.

CCP hired a Data Analyst at the beginning of BP2 who worked diligently to develop a comprehensive report based on data/reports within eHana. This audit report serves as a one stop Supervision Tool for Teams Leaders with regards to Quality. It flags concerns in relation to enrollee engagements milestones, including any documentation that appears to be missing. It flags errors as related to coding an activity, thereby giving Care Teams the opportunity to make corrections in advance of billing. The report serves as a Quality tool for CCP as well, as errors and trends can then be analyzed to improve training for Care Teams, ensure that workflows are consistent across both Member Organizations, and improve overall quality of care of Enrollees.

CCP is dedicated to promoting enhanced integration with many of its ACO/MCO partners. To date, CCP has access to Tiger Connect with Wellforce, and EPIC with CHA. CCP participates in

monthly clinical / case reviews with Atrius, Tufts MCO, BIDCO, CHA, and Wellforce. And the Team Leader of CCP's Lawrence Care Team is a member of MVACO's Multiple Visit Patient (MVP) team that focuses on reducing ED visits by identifying and mitigating the specific factors that drive patients to the ED. CCP has initiated and implemented monthly Admin check-ins with several ACO/MCO partners, including C3, Atrius, BIDCO, and CHA. CCP's Care Teams have had great success in further developing relationships with their counterparts within the ACO or PCP practices, including BMC, Steward, PHACO, and CHA. And lastly, CCP is in the process of exploring opportunities for embedding a CP Care Coordinator either within a PCP practice (Wellforce – Tufts Medical Center; BIDCO – Plymouth and HCA practices) or Hospital ED (CHA – Cambridge Hospital and Everett Hospital; Steward- Cape Cod Hospital). CCP hopes to see this level of integration be implemented in Spring of 2020.