

## 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

<b>Full CP Name:</b>	Community Care Partners, LLC
<b>CP Address:</b>	66 Canal Street, Boston, MA 02114

#### Part 1. BP3 Annual Report Executive Summary

CCP maximized on DSRIP investments in BP3, allocating funding to several critical initiatives. With the onset of the public health crisis, CCP successfully adapted to remote work, including access to cell phones and tablets for Enrollees to promote ongoing care coordination via video conferencing and boost telehealth with other healthcare providers during this critical time. The amount of donated PPE Care Teams secured was heartwarming, the lengths Care Teams went to fill and deliver prescriptions and deliver groceries was extraordinary, and the time Care Teams spent supporting Enrollees around SNAP benefits, unemployment claims, rental relief, utility protection, fuel assistance and phone discounts was remarkable.

CCP's Intake Team continued to evolve and adapt over the course of BP3, particularly in relation to the launch of MassHealth's Daily Enrollment in March 2020 and the launch of the CP portal in September 2020. Despite the complexities of Daily Enrollment, CCP's Intake Team was successful in adapting workflows and systems in place to manage both enrollment and disenrollment effectively and timely.

CCP engaged Milliman for the purposes of uploading MassHealth historical claims data into its MedInsight platform to produce a variety of Population Health reports, many aligned with CP Quality Metrics. In October 2020, CCP began providing Population Health reports specific to inpatient stays, ED visits, and risk scores to Care Teams. CCP has also pulled preliminary utilization data specific to IP stays, ED visits, Psych Hospital Days and Wellness visits. For members enrolled with CCP for at least 18 months (N=1384), the intervention reduced hospital admissions by 20%, Psychiatric hospitalization days by 46%, ED visits by 13%, while increasing PCP wellness visits by 13%.

In January 2020, recognizing the process metric of Average Days to Care Plan Complete needed to improve, CCP Central Team began to work directly with ACO Central Teams to escalate care plans. New workflows and communication channels began to gain traction and by September 2020, CCP saw the average number of days from "care plan sent to the PCP" to "care plan returned by PCP" drop by 50%. Per Mathematica data, CCP's Average Days to Care Plan Complete metric had dropped by 105 days from March 2020 to September 2020. Building on this success, CCP is developing new initiatives to launch in BP4 to continue to improve on this metric.

BP3 proved to be a pivotal year for enhanced integration with CCP's ACO/MCO partners, despite the pandemic's impact on our ACO/MCO partners and their provider practices. To date, CCP has access to Tiger Connect with Wellforce, and EPIC with CHA. CCP participates in monthly High Utilization Reviews / Case Reviews with Tufts Medical Center, Everett Hospital, BIDCO Plymouth and HCA, and Lawrence General Hospital, and Collaborative Care meetings with Bowdoin Street and Manet. And CCP anticipates launching Integrated Care Team meetings with several ACO/MCO partners in the first quarter of BP4. At the end of BP3, CCP partnered with Beth Israel Lahey Health in a joint TA project with Collaborative Healthcare Strategies. We are in the pre-planning phase of launching an MVP program (Multiple Visit Patient program) at BIDMC. The program aims to identify high utilizers of Inpatient stays, determine root cause(s) of utilization, and in turn impact the root cause(s) in partnership with a multidisciplinary team inclusive of the hospital system and the supports and networks in the community at large.