

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:	Riverside Community Partners
CP Address:	270 Bridge Street Ste. 301 Dedham, MA 02026

Part 1. BP3 Annual Report Executive Summary

BP3 (CY2020) was a time of significant growth and progress at Riverside Community Partners (RCP). Just two weeks before Massachusetts released a “Stay at Home” order, the program onboarded an independently licensed social worker, as a full time Assistant Program Director. The addition of an LICSW to the central leadership team has allowed the program to enhance ongoing performance and operations improvement by expanding clinical support and oversight of our Affiliated Partners (APs). During the early days of the pandemic, the CP was able to pivot quickly to remote care coordination, modifying approaches to intervention and documentation while EOHHS also navigated the implications of COVID-19 on CP programs and their members.

ACO referrals grew substantially over the course of 2020, and teams expanded in various ways to meet this increased demand. Most teams added staff (with one of our smaller APs doubling staff size), one team hired a full-time team lead to support program management, and another expanded their nursing capacity to provide coordination for the most medically complex cases. Data showed that these staffing changes have directly resulted in dramatically improved performance.

While managing an increased roster size and ongoing challenges related to COVID-19, RCP was able to develop and implement several initiatives over the course of BP3:

- 1) Utilized DSRIP Technical Assistance funds to create a standardized and trackable training infrastructure, ensuring completion of all required initial and annual trainings, as well as ongoing professional development and skills building.
- 2) Partnered with Aunt Bertha to allow staff to efficiently identify community resources and refer members where appropriate. The platform also provides reports that assess staff adoption of Aunt Bertha and trends pertaining to service/need areas.
- 3) Continued work with Hexplora to expand and enhance a data warehouse that merges claims data and members records from eHana, our care coordination platform. Our Hexplora platform provides both member-level data to enhance clinical care, as well as long-term population-level trends that support

ongoing quality improvement initiatives. Data analysis is shared with internal stakeholders as well as external partners such as ACOs, DMH, and MassHealth.

- 4) Enhanced integration with ACO partners, increasing meeting cadence between administrative leads as well as developing ongoing case review and outreach collaboration meetings between clinical leads. With TA consultation on Population Health data analysis, our Program Analyst developed quarterly dashboards to support collaboration on mutually-agreed-upon quality and performance metrics. The program also established change team relationships with 3 of our ACO partners (Partners, CCC, and BIDCO) to enhance care planning collaboration and exchange.
- 5) Established monthly meetings with each AP for ongoing performance and roster management, using multiple data points and quality benchmarks to monitor and improve member care. During the year, we completed an audit of each of our APs to identify strengths challenges; these results were incorporated into ongoing process improvement efforts.
- 6) The APD and the team leads collaborated on process manuals to supplement the eHana training and workflow guide. This process promoted in-depth reviews of CP activities such as care planning, ongoing care coordination, and outreach.