One Care Implementation Council Presentation

October 13, 2020

Improving care for people with disabilities and chronic health needs

Primary Care ***is the history*** of CCA

- **CCA began as Urban Medical Group** more than 40 years ago, founded by Drs. Bob Master and Marie Feltin as an option for people not served well by the system
- Even as CCA began as an integrated payor/provider system, **primary care continued to be primary with Boston Community Medical Group** and the development of **Commonwealth Community Care**
- **Close partnerships with FQHCs, Safety Net Hospitals**, and others in the Commonwealth
- **Continued growth and innovation** to serve more dually eligible people in the Commonwealth, while not forgetting our roots

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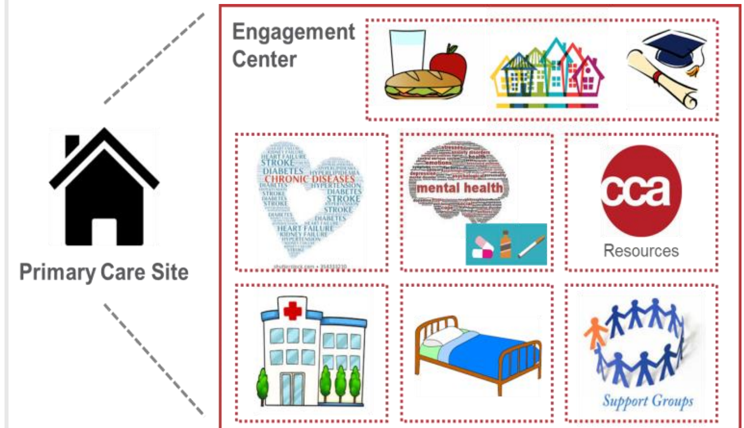
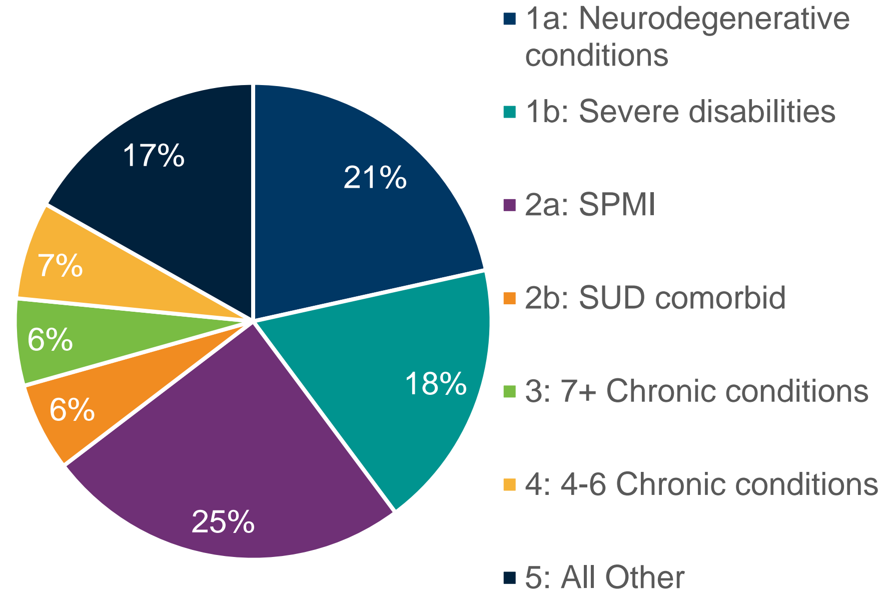
CCA Primary Care: *By the Numbers*

- **1,500 members** at CCA primary care clinics, with projections to grow to **over 2,000 by 2021 EOY**
- **Four clinic locations** in Boston, Lawrence, Framingham, and Springfield
- **30 CCA primary care clinicians**, majority NPs
- Average between **5,000-6,000 encounters** per month, maintained during Covid-19. **1000 clinic visits; 4500 virtual visits;** More than **2000 home visits.**
- **99% of SCO members** and **97% of One Care members** aligned with CCA primary care were **contacted in the last 90 days**
- **2019 revenue was ~$67M,** with 2020 revenue projected to be over **$90M**



CCC Member Snapshot

- Average **HCC score 3.4** (does not include FFS)
- Average **PMPM spend for LTSS** (over past 15 months)
  - One Care: **$621**
  - SCO: **$1,228**
- Average **over five telephone encounters per SCO/OC member per month** from the clinical teams
- Average **number of provider visits per patient per month**:
  - 1.3 since COVID
  - 1.5 pre-COVID



*Data from 2017

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eMOC (evolved Model of Care) Objectives

Why are we doing this?

To prepare for the future and serve more individuals	To obtain the best outcomes for our members	To invest in our teams

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Patient Centered Care: *Challenges*

Goal of 2017 model is to match a member's need(s) to the appropriately skilled care partner, but there are barriers and inefficiencies:

- Members are complex with varying degrees of medical, behavioral, and social needs that *flux over time*
- Care management and care coordination activities have *high administrative burden*

In our current state, we have begun to address some of these challenges:

- Created centralized authorization unit – continues to evolve into a high performing and efficiently operating team
- Implemented Guiding Care (Care Management Platform) takes us to high level standard practice
- Adopted medical policies and standardized UM criteria with InterQual (evidence-based clinical decision support criteria)

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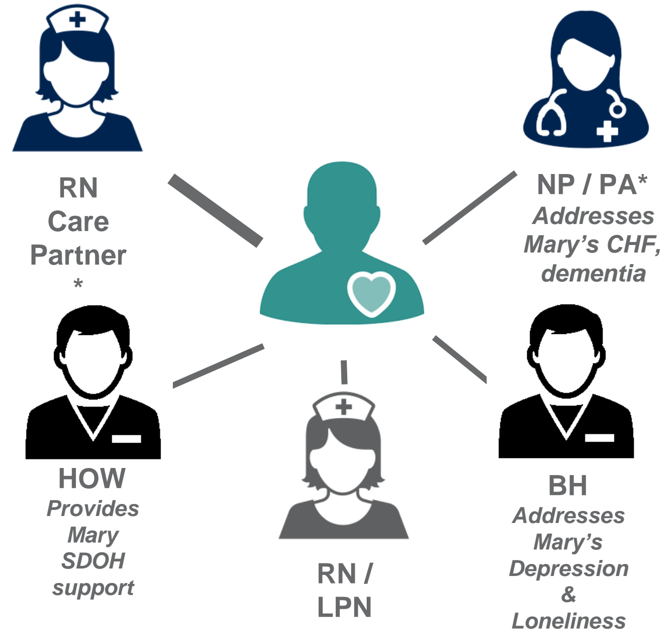
Member view of evolved care model: Access to interdisciplinary team

Example CCA member: 78-year-old Mary has depression, loneliness, congestive heart failure, dementia, no transportation, nearby kin or support



*All CCA members will have access to an RN care partner and advanced practice clinician (NP or PA)

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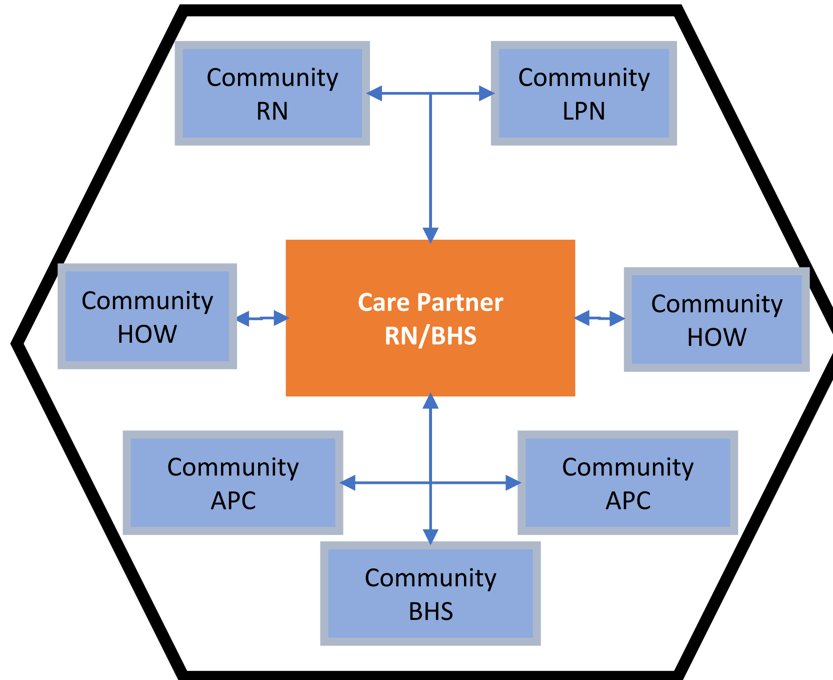
Interprofessional Care Team

External CCA Partners

- Providers especially primary care
- GSSC/LTSC
- InstED



Internal CCA Partners

- ED2Home
- Transition of Care
- Palliative Care
- Health Education Team
- PCA Team
- UM
- Fulfillment
- Rehab
- Admin
- CPU
- CRU
- Onboarding