Commonwealth Care Alliance Senior Care Options (SCO)

Model of Care (2024)

Annual Provider Training

Improving care for people with disabilities and chronic health needs

commonwealth care alliance®

TRAINING OBJECTIVES

Purpose: The Centers for Medicare & Medicaid Services (CMS) **requires** providers to complete an annual Commonwealth Care Alliance SCO Model of Care (MOC) training if you are either contracted to see Commonwealth Care Alliance SCO members or an out-of-network licensed independent practitioner (LIP) who routinely treats and/or provides services to Commonwealth Care Alliance SCO members.

The intent of the CMS requirement is to ensure providers and SCO plans can seamlessly coordinate the care for this population with complex needs.

At the conclusion of this training, you will be able to:

- Define a SCO Plan
- Understand a SCO Model of Care
- Recognize common characteristics of SCO eligible members
- Identify Commonwealth Care Alliance
- Understand Commonwealth Care Alliance SCO plan basics
- Understand Commonwealth Care Alliance SCO Clinical Care Coordination Model including:
  - Interdisciplinary Care Team (ICT)
  - Assessments
  - Individualized Care Planning
  - Transitions of Care
- Understand Commonwealth Care Alliance's Quality Oversight
- Contact Commonwealth Care Alliance

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Senior Care Options Plan

Senior Care Options was established in 2004 and is part of a 1115(a) Medicaid demonstration program. SCO programs are specifically designed to provide targeted care to individuals 65 and older who are eligible for MassHealth Standard. Eligibility includes:

1. Individuals aged 65+
2. Individuals live at home or in a long-term care facility
3. Individuals not subject to 6-month deductible period under MassHealth regulations
4. Live in an area served by a SCO plan

What is a Senior Care Options (SCO) Plan?

A Senior Care Options (SCO) plan is a comprehensive health plan that covers services normally paid for through Medicare and MassHealth. This plan is designed to coordinate care among Medicare and Medicaid to improve care while also lowering costs. SCO plans do this by combining health services with social support services. In addition to care coordination, SCOs can also offer supplemental benefits specially designed to meet the needs of members within the plans service area.

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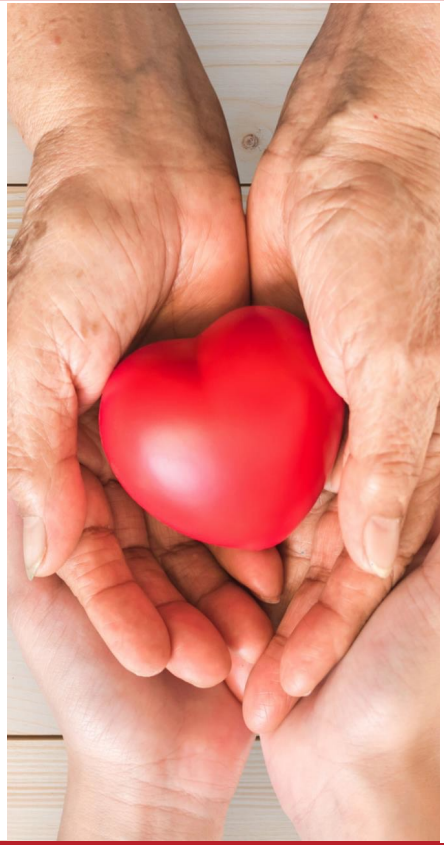
What is a SCO Model of Care?

The MOC provides the basic framework under which the SCO program will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SCO program and addressed through the plan's care management practices.

The MOC provides the foundation for promoting SCO quality, care management, and care coordination processes.



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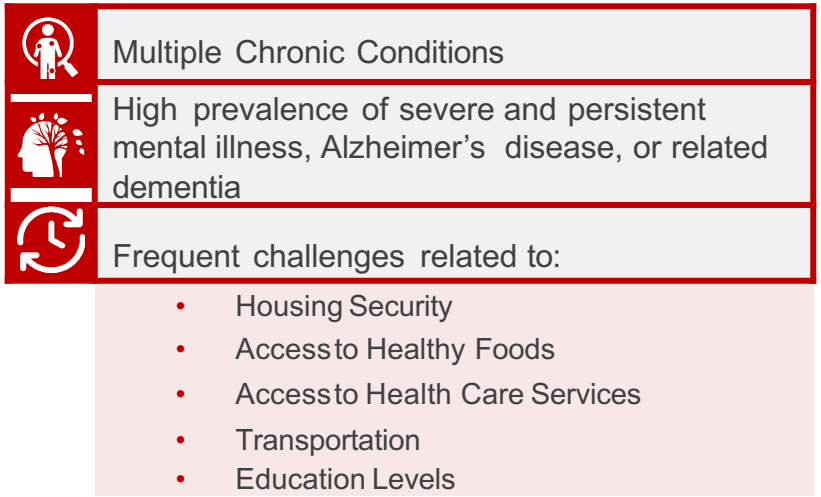
SCO Population Characteristics

As of January 2024, CCA had 15,217 individuals aged 65 years of age and older enrolled in the Senior Care Options (SCO) program. Approximately 66% are females and 34% are males. Members live mostly in communities that experience significant disparities in access to health care services within the Greater Boston and Greater Springfield areas. The vast majority have significant socio-economic needs, with many also experiencing problems related to housing, nutrition, transportation, cultural issues and/or family or relationship issues. Moreover, member access to essential healthcare services is frequently challenged by their inability to leave home to seek medical care, as well as by language barriers.

Common Characteristics of SCO eligibles:



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Intro to Commonwealth Care Alliance

Commonwealth Care Alliance focuses on complex care for high-need individuals, building on a comprehensive model of *uncommon care*.

This care includes:

- Integrated multi-disciplinary care;
- Inclusion of behavioral, medical and social factors influencing health;
- A commitment to engage and support all our members.

6

OUR VISION

To lead the way in transforming the nation's healthcare for individuals with the most significant needs.

OUR MISSION

To improve the health and well-being of people with significant needs by innovating, coordinating, and providing the highest-quality, individualized care.

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Intro to Commonwealth Care Alliance SCO

CCA's care model is based on our data-driven understanding of what puts people at risk, leveraging our unmatched ability to identify and engage hard-to-reach individuals.

Community focus to ensure the most appropriate site of care

Seamless integration of care coordination, care delivery and care partnership

Innovation to address members' unmet needs

Trusting partnerships, appropriate utilization, better outcomes

- Reduction in gaps in care
- Decrease in ED visits, admissions and readmissions
- Reduced poly-pharmacy, improved medication adherence, routine review of safety and effectiveness
- Greater provider satisfaction through clinical support and reduced administrative burden
- Affordability and responsible stewardship of funds

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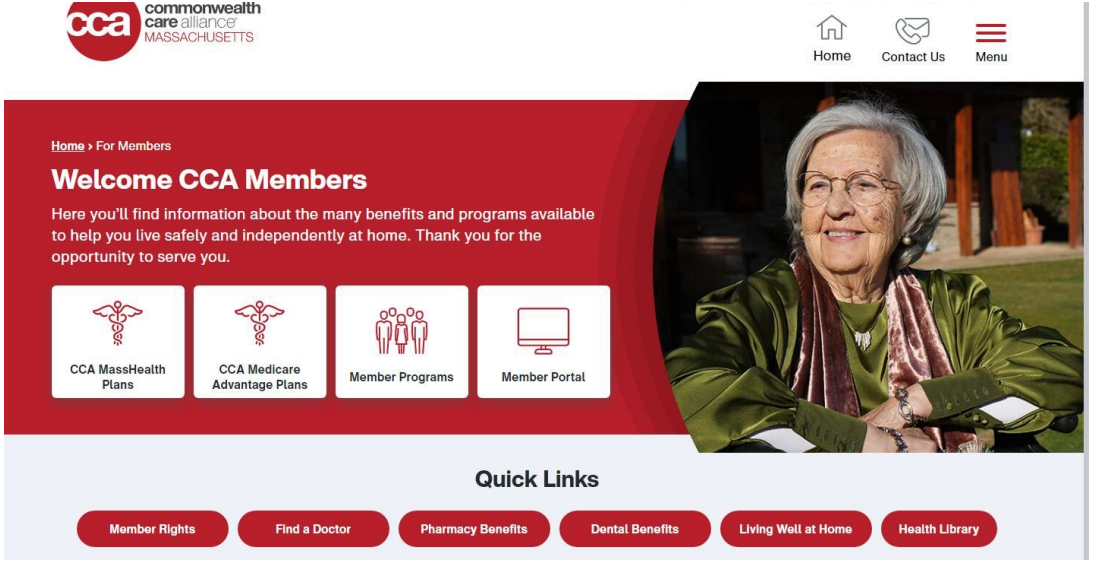
Member Documents



- We have 2 documents available to members that provide information about CCA products and services -- the Member Handbook and the Summary of Benefits.
- These are mailed annually to currently enrolled members by September 30th

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Care Coordination – Interdisciplinary Care Team

We partner with our members and their doctors, family and caregivers to develop a specific care plan based on their needs that also integrates community resources. Our Member Onboarding team is a clinical function: specialists from our onboarding team will reach out to members to welcome them to the plan, walk through their benefits and ensure that members are connected with all the supports and services needed to support their health.

Community Provider Network

- Primary Care Providers
- Specialty Providers
- Hospital and Outpatient facilities
- Post-acute care and SNFs
- Pharmacies
- Dentists
- Transportation partners
- Long Term Support Services

CCA Integrated Care Team

CCA Clinical Supports

- 24/7 Clinical Response Unit
- instED Mobile Integrated Health
- Psychiatry & SUD Support
- Advanced Practice Clinicians (APC)
- Palliative Care Team

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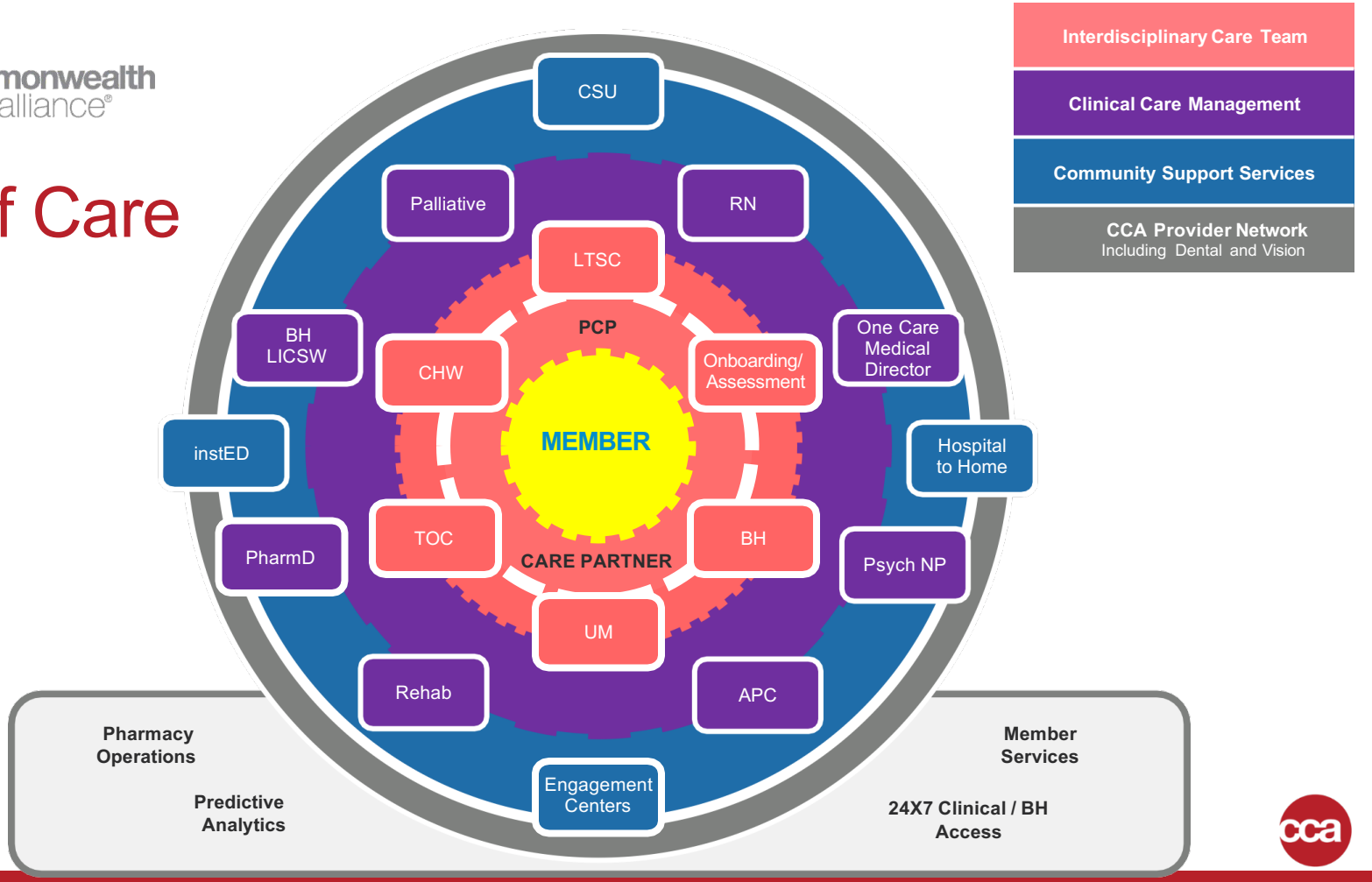
Model of Care



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Complex Care Self-Management Program (CCSM)

Applies Chronic Care Model to readmission prevention and proactive self-management support for members with:

- **Heart Failure**
- **COPD**
- **Diabetes associated illness**

Using teach back method to assess and reinforce member's ability to self-manage chronic disease

Applies health coaching techniques to empower member's self-management capabilities using evidence-based tools for tracking symptom control and monitoring disease parameters

Reinforces the interdisciplinary team care partnership model to support our members

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Hospital Utilization Reduction Initiative (HURI)

Foundational principles of this initiative are aimed at preventing unnecessary hospitalizations:

- Identify member risk and needs
- Ensure appropriate clinical intervention
  (By Nurse, Advanced Practice Clinician, and/or Behavioral Health Clinician)
- Coordinate with Transitions of Care Team and Community Providers
- Involve clinical team and manager to review case and develop comprehensive plan

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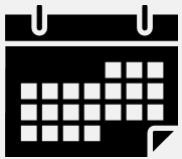
Care Coordination - Assessments

Commonwealth Care Alliance conducts a Minimum Data Set (MDS) assessment for all SCO beneficiaries, which helps our care team identify relevant medical, functional, cognitive, psychosocial, and mental health needs to inform and begin the care planning process.

WHO?

CCA Registered Nurse (RN)



WHEN?

Initial Assessment: SCO beneficiaries are outreached upon enrollment, and CCA's goal is to complete the MDS within 30 days of their coverage effective date

Reassessment: SCO beneficiaries are outreached for reassessment any time they have a change in health status or, minimally, every 6 months

Results inform opportunities, goals, and interventions that can be discussed with the beneficiary as part of the care planning process. Reassessments enable CCA Care Managers to identify changes to the beneficiaries needs and facilitate proactive intervention – the goal is to prevent extended periods of unmet needs for the beneficiary.

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Care Coordination – Care Plans

All members will work with their Care Partner, along with their Care Team, to develop an Individualized Care Plan (ICP). This originates after the initial assessment and is routinely updated. The Care Plan is at the center of the member's care. This document is member centered and identifies member's opportunities, goals, interventions, strengths, barriers, and priorities. The Care Team works in partnership with the member to meet their goals established in their Care Plan.

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An Interdisciplinary Approach

CARE PARTNER

- Case Management and Member's Point Person
- Monitor HEDIS/Quality Gaps
- Coordinate Member Requests

RN

- Post-Discharge Visit
- Patient Education and Support
- Acute Nursing Need
- Assessment for Home Service Needs

CHW

- Housing Resources
- MassHealth Reapplication
- Food Insecurity
- General Health Coaching

APC

- Post-Discharge Visit
- Chronic Disease Management
- Acute Medical Need
- Annual Wellness Visits (AWV)

BH

- Post-Psych Hospital Visit
- BH Assessment/Consult
- CSU Screening/Admission
- BH Crisis Consult and Follow up

REHAB

- Home Safety/PT evaluations
- Post-Discharge needs
- Caregiver Education and Training
- Functional assessment,
- Fall prevention & Post-fall assessment

LPN*
Not All Teams

- Medication management
- Vital signs and objective assessments
- Specimen collection
- Disease management education
- Wound/catheter care and education

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Care Coordination – Individualized Care Plan (ICP)

Individualized Care Plans are developed as a guide to care delivery based upon findings from the Comprehensive Needs Assessment. The ICP is created in conjunction with the member/caregiver, primary care provider, appropriate specialists, and other key community or institutional professionals.

Care Plans include:

- Summary of Enrollee's health history
- A prioritized list of concerns, goals, and strengths
- The plan for addressing concerns or goals
- The person(s) responsible for specific interventions
- The due date for each intervention

All ICP include beneficiary reported care needs and the agreed upon interventions to meet those needs. The ICP contains a description of the member's strengths and barriers to meeting these identified goals. The ICP includes any Long-Term Support Services the consumer receives and any assistance the member needs to meet their goals.

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Care Coordination – Transitions of Care (TOC) Team

WHILE INPATIENT:

The Transitions of Care (TOC) Team communicates directly with the hospital staff when the member is inpatient. They are responsible for coordinating the authorizations for continued stays and for obtaining hospital documents, including the discharge summary. The TOC Team do not necessarily perform discharge planning activities, but they coordinate communication about discharge between the hospital staff, the receiving facility (if applicable), and the member's care team. The TOC Team and members of the Care Team participate in discharge planning meetings as needed.

UPON DISCHARGE:

The Care Manager coordinates with the member to ensure they understand their discharge plan and have the appropriate supports in place. The Care Manager will also assist the member with medication reconciliation, scheduling a follow up appointment with their provider, and will reassess the member to identify any changes to their health needs. The Care Manager will utilize the ICT to assist in identifying/meeting the member's emerging needs. For many members this may include sending a clinician to the member's home for further evaluation and support.

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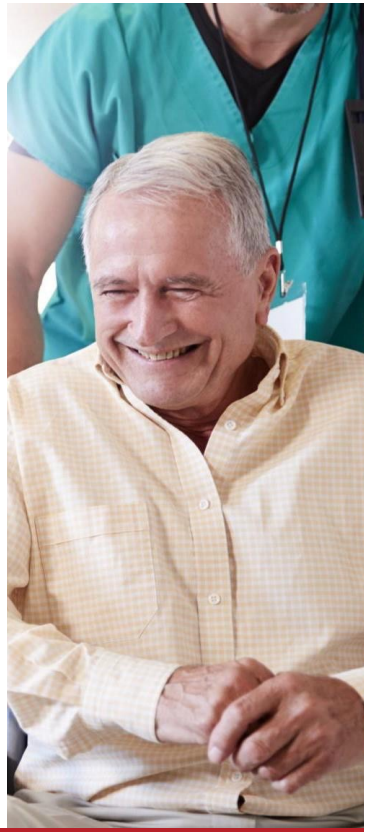
Care Coordination – Transitions of Care (TOC) Team

- Coordinates with facility discharge planners and member's Care Team to support safe and member-centered transitions between hospital, long-term care and/or home
- Supports direct admission to appropriate facilities as needed
- Consults and collaborates with care team members to ensure services meet new or changing needs
- Monitors utilization to ensure cost-effective and timely interventions



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Key Features of the Commonwealth Care Alliance SCO Program

instED

Clinical Response Unit (CRU)

APC and Behavioral Health Resources

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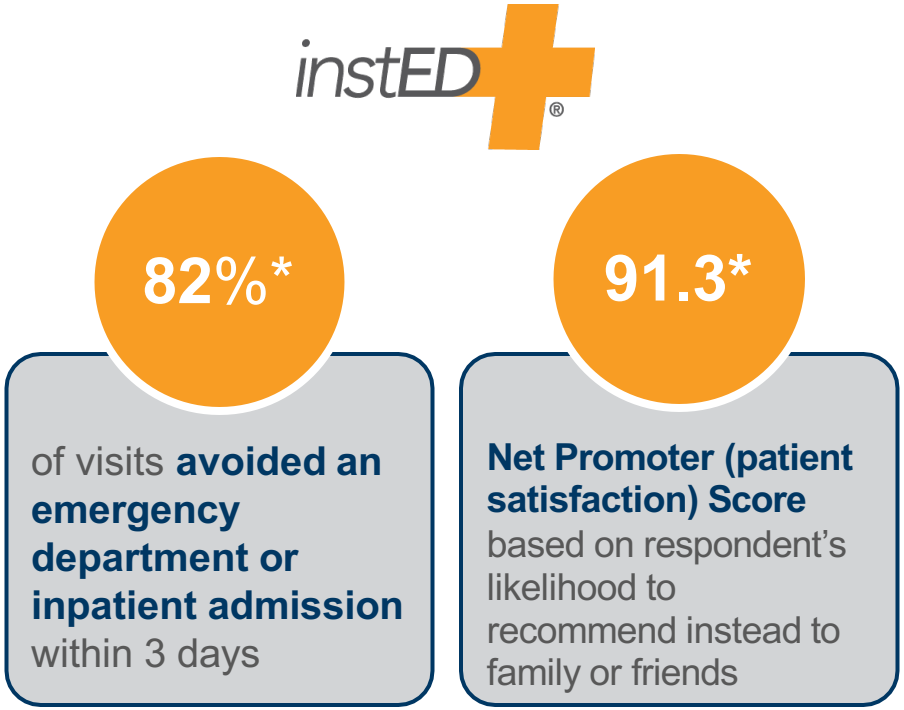
instED - Mobile Integrated Health Program

- CCA's mobile integrated health program, instED, provides in-home, high-intensity care in the member's setting of choice.
- instED is a reliable resource that fills the gap between primary care and emergency care—even for those with significant health needs.
- instED's website provides direct access to request a visit. instED visits are covered at no cost share for CCA Health RI members.



20 *Calendar Year 2021 performance

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instED - Mobile Integrated Health Program

instED brings diagnostic testing and treatment capabilities to the patient's home.

Illnesses and symptoms:
- Urinary Tract Infections
- Cellulitis
- Shortness of breath
- COVID and flu-like symptoms
- Migraine/Headaches
- Back and joint pain
- Abdominal pain
- Weakness/lethargy
- Dehydration
- Nausea/Vomiting
- Altered Mental Status
- Edema
- Fever/chills
- Anxiety/depression

Chronic Conditions:
- Congestive Heart Failure
- Asthma/COPD
- Chronic kidney disease
- Diabetes
- Autonomic dysfunction
- Behavioral Health

Injury Treatment:
- Fall Assessment
- Muscle strain and spasm
- Basic Wound Care
- Sprains and Strains
- Burns

Including point-of-care testing, blood draws, cultures, ECGs, IV therapies, and first dose medication.

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Commonwealth Care Alliance's Clinical Response Unit (CRU)

24/7 clinical first response by CCA can take the burden off PCPs, Emergency Departments, and Outpatient Urgent Care

- The CRU triages clinical concerns from members experiencing acute medical or behavioral health symptoms 24 hours per day/365 days per year.
- Members speak with a CRU Nurse or Behavioral Health Clinician for assistance, and many issues can be resolved over the phone with the support of the CRU clinicians.
- As needed, the CRU will collaborate with the member's Care team to deploy CCA's clinical resources for a member home visit for urgent care: the community clinical team during business hours, or the instED paramedic team after hours.
- The CRU may determine a member needs 911, ER, or Urgent Care as part of the triage process. The CRU clinician will assist members with accessing the most appropriate site of care.

A member with an immediate medical or behavioral health need can call CCA to speak with a nurse or licensed behavioral health clinician at 866-610-2273

"I need to speak with a nurse/BH clinician"

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Palliative Care

Supporting *Life* Choices

Our palliative care program is designed to improve the whole health of our members with serious illnesses.

Our team of experts partner with members and their support teams to help them receive the care they need in the setting they choose. We're focused on helping members and caregivers make plans according to their wishes and beliefs.

What is palliative care?

Palliative care aims to improve the quality of life for people living with a serious illness. This type of care is focused on relief from the symptoms and stress and the goal is to treat the person as a whole—to consider the life experiences, people, and goals that are important to them.

VOLUNTARY SERVICE

COMMUNITY NURSES AND BH CLINICIANS

COORDINATE WITH CARE TEAM

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Marie's Place® Crisis Stabilization Unit

- CCA's Crisis Stabilization Unit (CSU) Marie's Place® offers an alternative to psychiatric hospitalization for members with behavioral health and/or substance use disorder needs with integrated medical support.
- The three-story Victorian-style house, conveniently located in Brighton, provides a structured setting where members work with our clinical teams and peer support groups on recovery and a safe return to the home/community.

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Community APC and Behavioral Health Supports

Community Advanced Practice Clinician (APC)

The Community APC is a mobile resource that is available to support the member with:

- Post-Discharge Visit
- Chronic Disease Management
- Acute Medical Needs, including Bridge Prescribing
- Annual Wellness Visits (AWV)

Psychiatry & SUD Support/

CCA has BH resources that are available to support the member with:

- Post-Psych Hospital Visit
- BH Assessment/Consult
- BH Crisis Consult and Follow-Up

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Evaluating Quality Across the Care Continuum

Who Is Evaluating:

- **CMS:** Centers for Medicare and Medicaid Services
- **NCQA:** National Committee on Quality Assurance
- **Commonwealth Care Alliance**

What Is Being Evaluated:

- Evidence-based care
- Member reported experience and care
- Operational performance experience

How Are Evaluations Conducted:

- **HEDIS**: Healthcare Effectiveness Data and Information Set
- **CAHPS**: Consumer Assessment of Healthcare Providers and Systems
- **HOS**: Health Outcomes Survey

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CCA Quality Initiatives for 2023/2024

- Maximizing preventative care and annual screens
- Improving Transitions of Care and Reducing Readmissions
- Improving medication adherence to support chronic condition control
- Improving access and availability of ambulatory care to reduce ambulatory sensitive ED utilization
- Improving the delivery of equitable care

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CCA Quality Initiatives – Improving the Delivery of Equitable Care

WE DEFINE HEALTH EQUITY:

When everyone has a fair and just opportunity to be as healthy as possible regardless of age, race, ethnicity, gender identity, sexual orientation, disability status, socioeconomic status, or English proficiency.

- CCA's health equity strategic objectives to reduce disparities:
  - Data standardization and improvements in data collection
    - Develop clinical and provider opportunities to share data and collaborate on reduction of health disparities
  - Identify and prioritize key opportunities to advance health equity efforts across the organization including
    - Screening for and addressing Social Determinants of Health (SDOH)
    - Analyzing data sources to understand where disparities exist (for example, HEDIS, CAHPS, etc.)
  - Incorporate member feedback and experience, including member involvement and representation in CCA Health Equity work
  - Ensure a transparent and integrated approach and accountability throughout the organization

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Commonwealth Care Alliance Contacts

Contracting (Massachusetts)
For organizations interested in contracting with Commonwealth Care Alliance:

CCAContracting@commonwealthcare.org

instED
To refer a patient, call or visit the instED website:

https://www.insted.us/request-a-visit/

833-946-7833

Provider Enrollment
For provider network status, enrollment, disenrollment, or a change to a provider's information:

pnmdepartment@commonwealthcare.org

Provider Services
Call or email with inquiries about covered services, authorization status, service denials, claims, and benefits:

providerservices@commonwealthcare.org

866-420-9332

For clinical concerns or to contact the Care Partner team, select option 4.

Member Services
Members can call or email for information about their health care coverage:

memberservices@commonwealthcare.org

833-346-9222

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START ATTESTATION

cca commonwealth care alliance®

Improving care for people with disabilities and chronic health needs

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