

PROFILES IN INNOVATION

COMMONWEALTH CARE ALLIANCE, Massachusetts

Commonwealth Care Alliance (CCA) is a health plan that provides care to some of Massachusetts' most vulnerable populations.

CCA has numerous partnerships with clinics, medical groups, and social service agencies that help deliver care to its patients. It provides services well beyond those typically covered by a health plan, including in-home care, 24-hour provider access, patient education, and enhanced behavioral health services. These features have helped CCA achieve impressive cost-savings and reductions in nursing home placements.

- ▶ **Population:** The organization serves Medicare and dual eligible seniors through its Senior Care Options plan, and individuals with disabilities through its Disability Care Program. There are more than 5,500 members enrolled in CCA, the majority of whom have such high needs that they have been deemed eligible for nursing-home placement.
- ▶ **Delivery Model:** CCA's multi-disciplinary care team is led by nurse practitioners and includes geriatric social workers, behavioral health providers, community health workers, and other specialists. Teams provide direct treatment and care coordination services, frequently in the patient's home. Teams create a care plan with the patient that outlines the patient's goals and the interventions necessary to meet them. The care team works closely with the patient to ensure that the goals are being met and adjusted as needed.
- ▶ **Financing:** CCA has risk-adjusted capitated contracts with Massachusetts Medicaid and Medicare. It also has a contract with Neighborhood Health Plan to provide services through its Disability Care Program. It has partnerships with community clinics, health plans, and providers, and pays these entities a portion of the capitated rate for services. Savings are aggressively reinvested in the organization to finance its multi-disciplinary staff of clinicians and health care professionals, and to support the provision of enhanced services.

KEYS TO SUCCESS

1. **Global payment financing** that is risk adjusted, thereby allowing delivery systems to be accountable and responsive;
2. **Enhanced primary care** that brings together a team of individuals to care for the patient, rather than a single primary care physician (CCA's experience is that almost three times more money needs to go to support this model of primary care and patient management than the current standard investment);
3. **Individualized care plans** that empower the care team to proactively provide necessary services to the patient and put an emphasis on home- and community-based care;
4. **Flexible staff schedules and organizational processes** that allow nurse practitioners to quickly respond to the urgent patient needs that regularly arise; and
5. **Information technology that "ties it all together,"** providing care teams with 24-hour access to electronic medical records and case management/care plan development capabilities.

Spotlight: Lessons from the Complex Care Needs Program

Having tested new approaches in this field for over 40 years, CCA founder Dr. Robert Master said that “*innovation* means, if you’re not getting some failures, you’re not pushing the envelope enough.” In 2010, CCA partnered with the Cambridge Health Alliance (an integrated health care system) and Network Health (a nonprofit health plan) to launch a pilot Complex Care Needs Program to reach Medicaid-covered adults and children with multiple chronic conditions. CCA served as a subcontractor, connecting some of Network Health’s most complex patients, many with substance abuse and mental health disorders, to enhanced primary care.

In spite of recruiting a significant number of participants, the project was stymied by the issue of patients continuously cycling on and off Medicaid rolls. This churn was due to various factors, including patients not renewing their eligibility on time or temporarily exceeding the income requirement. At any given time, CCA estimates that 40-45 percent of the population was churning, making it virtually impossible to provide continuous services. “We would get referrals, do comprehensive assessments, engage the patients, do the work, and then get notice that the person was no longer eligible,” says Dr. Master. “It was a continuous care system operating under a discontinuous financing system.” Though this systemic issue ultimately proved too large a challenge to overcome, and the program was eventually phased out, valuable insights were gained. In particular, the necessity of going ‘upstream’ to identify and address the issues that can impact a well-intentioned intervention.

BEHIND THE INNOVATION



Toyin Ajayi, MD, MPhil is chief of medicine at Commonwealth Care Alliance, a nationally-recognized Massachusetts non-profit health provider and payer caring for individuals who are dually eligible for Medicaid and Medicare. She manages acute care transitions and participates in the design, implementation, and ongoing evaluation of a portfolio of clinical interventions to improve the quality, patient-centeredness, and cost of health care delivery in a complex and multi-morbid patient population. Dr. Ajayi is board certified in family medicine, and is a graduate of Stanford University, the University of Cambridge, and King’s College London School of Medicine. Her academic interests include applied research around interventions to improve the quality of care delivered to under-served populations, as well as maternal and child health service delivery in sub-Saharan Africa.



John Loughnane, MD, serves as medical director for Commonwealth Community Care, as well as medical director for Commonwealth Care Alliance’s Palliative Care Life Choices Program and the organization’s Hospitalist Program at Boston Medical Center. He is board-certified in family medicine, as well as palliative and hospice medicine.

PROFILES IN INNOVATION SERIES FROM THE *COMPLEX CARE INNOVATION LAB*

These profiles highlight the organizations and individuals participating in the Center for Health Care Strategies’ [Complex Care Innovation Lab](#). The *Innovation Lab*, made possible by Kaiser Permanente Community Benefit, is bringing together innovative organizations from across the country working to improve care for vulnerable populations with complex medical and social needs. Participants are exploring new ways to advance complex care delivery at the local, state, and national level. For more information, visit www.chcs.org.