Enhanced Choices for Care: A CCA Demonstration Program

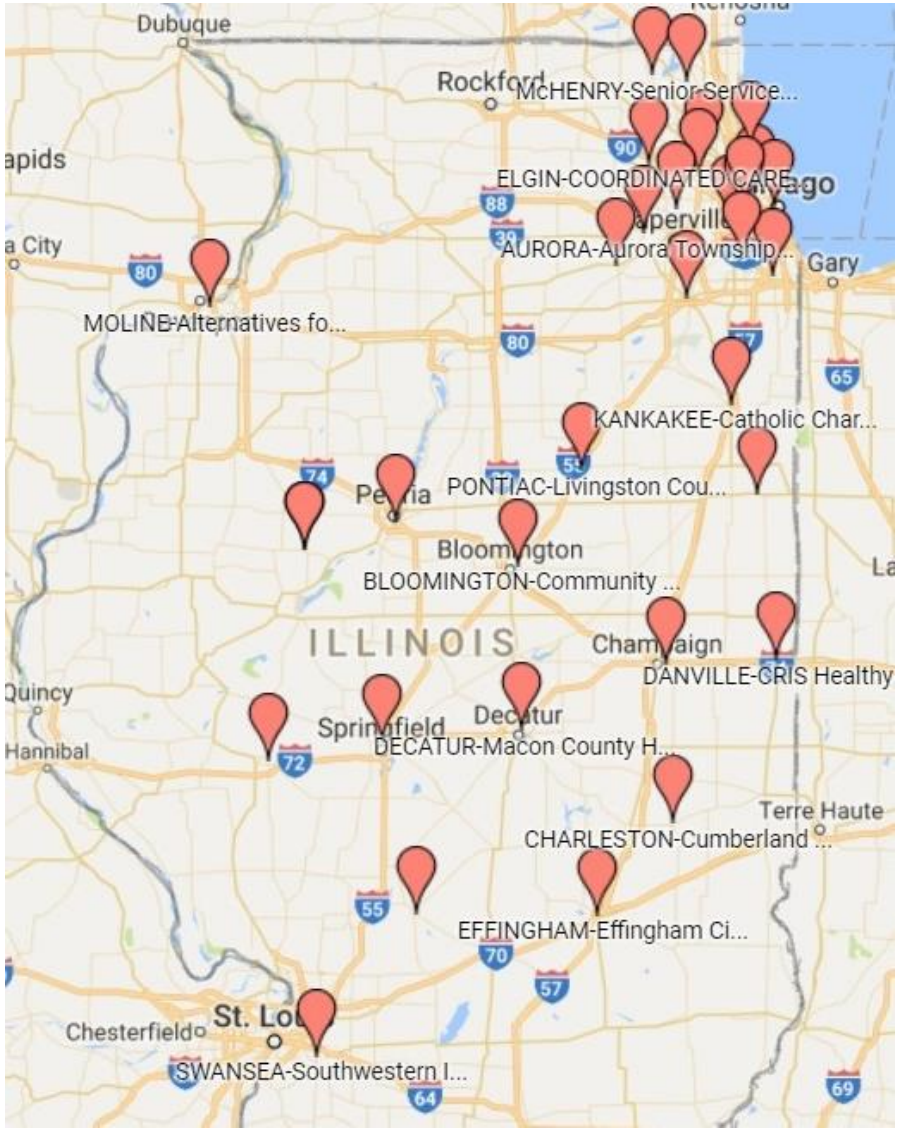
Bailey Huffman, LCSW

Dana Franceschini, LCSW

Coordinated Care Alliance (CCA)

An innovative statewide network of community-based organizations in Illinois that provide coordination and care transition support to at-risk populations

- Continuum of care services integrate social and medical aspects of care to achieve the best outcomes at the lowest costs for partners in health care, including hospitals, skilled nursing facilities, and health plans
- CCA provides a single point of entry to uniform services across the state/system or specialized programs to meet your unique patient population or regional needs.



Delivery Network Organizations

ACM

Aging Care Connections

Alternatives

Care Horizon, Inc

Catholic Charities of the Archdiocese of Chicago

Catholic Charities, Diocese of joliet

CCSI-Case Coordination, LLC

CRIS Healthy Aging

DuPage County Department of Community Services

Effingham City-County Committee on Aging

Elder Care of DeKalb

Grundy County Health Dept

Kenneth Young Center

Lifescape Community Service, Inc

Livingston County Public Health Department

Macon County Health Department/Starting Point

Mercy Health Visiting Nurses Assoc. Inc

Montgomery County Health Department

North Shore Senior Center

Oak Park Township

Pathlights

Prairie Council on Aging

Premier Home Health Care Services, Inc

Senior Resource Center (Stephenson County Senior Center dba Senior Resource Center)

Senior Services Associates

Senior Services of Central Illinois

Senior Services of Will County

Shawnee Health Service and Development Corp.

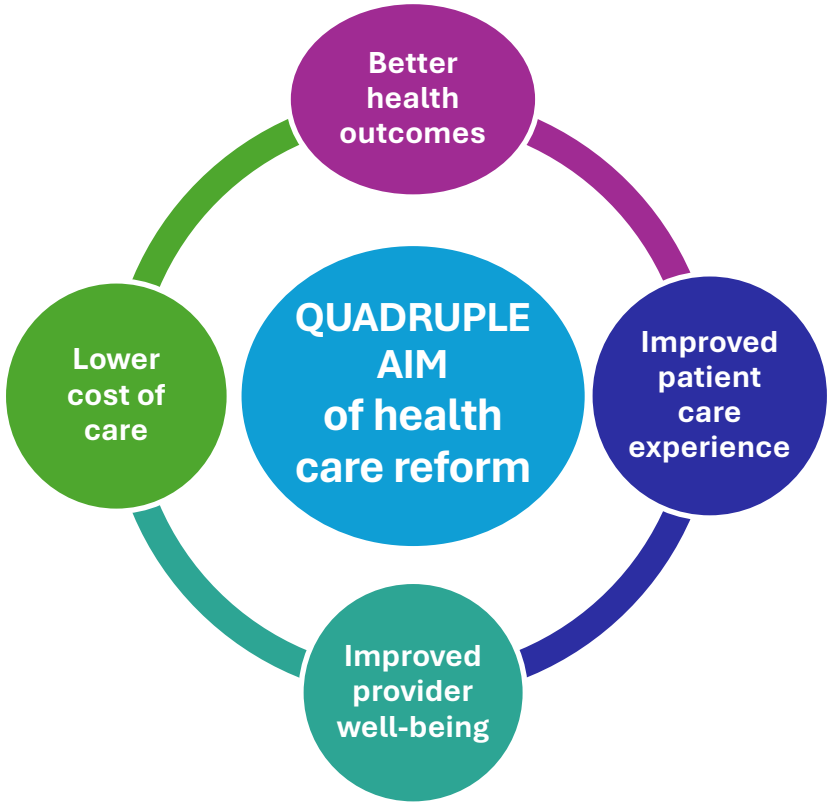
Solutions for Care

Southwestern Illinois Visiting Nurses Assn.

Stickney Township Office on Aging

West Central Illinois Case Coodination Unit

Setting the Stage: The Need for Enhanced Choices



What Shapes Our Health?

40-50% of readmissions are related to psychosocial problems and lack of community support resources. (E.K. Proctor et al, 2000)

CBOs Value to Healthcare

- Have a long history of meeting the needs of frail and vulnerable adults in every community in the state
- Address the SDOH, the non-medical aspects that correlate to 80% of health and health outcomes
- Mitigate barriers to healthcare
- Serve as an interpreter between patient and healthcare
- Ensure follow-through of healthcare plan in the community
- Provide eyes and ears to healthcare through home visits
- Identify additional barriers to health in the home
- Experts in local, state, and federal supports available, increase connectivity and decrease stigma to accept services
- Culturally competent, cost-effective workforce that works across the care continuum: *already located in hospitals, skilled nursing facilities and goes to patient homes*

Enhanced Choices Demonstration Program

- **<u>Evidence-based</u> Bridge Model of Transitional Care**
  - Person-centered, social work-led, interdisciplinary
  - emphasizes collaboration among hospitals, community-based providers, and the Aging Network to ensure seamless continuum of healthcare across settings

Program Goals

- Reducing avoidable hospital readmissions
- Reducing emergency room visits and observation stays
- Reducing skilled nursing facility utilization
- Reducing healthcare facility leakage
- Decreasing patient and caregiver stress
- Increasing education and patient activation to manage their chronic conditions
- Connecting the patient/family to quality long-term services and supports in a timely manner
- Increasing patient and family satisfaction
- Ensuring individuals stay safely in the community

Model Process

REFERRAL & PRE-INTERVENTION PLANNING

Pre-Discharge

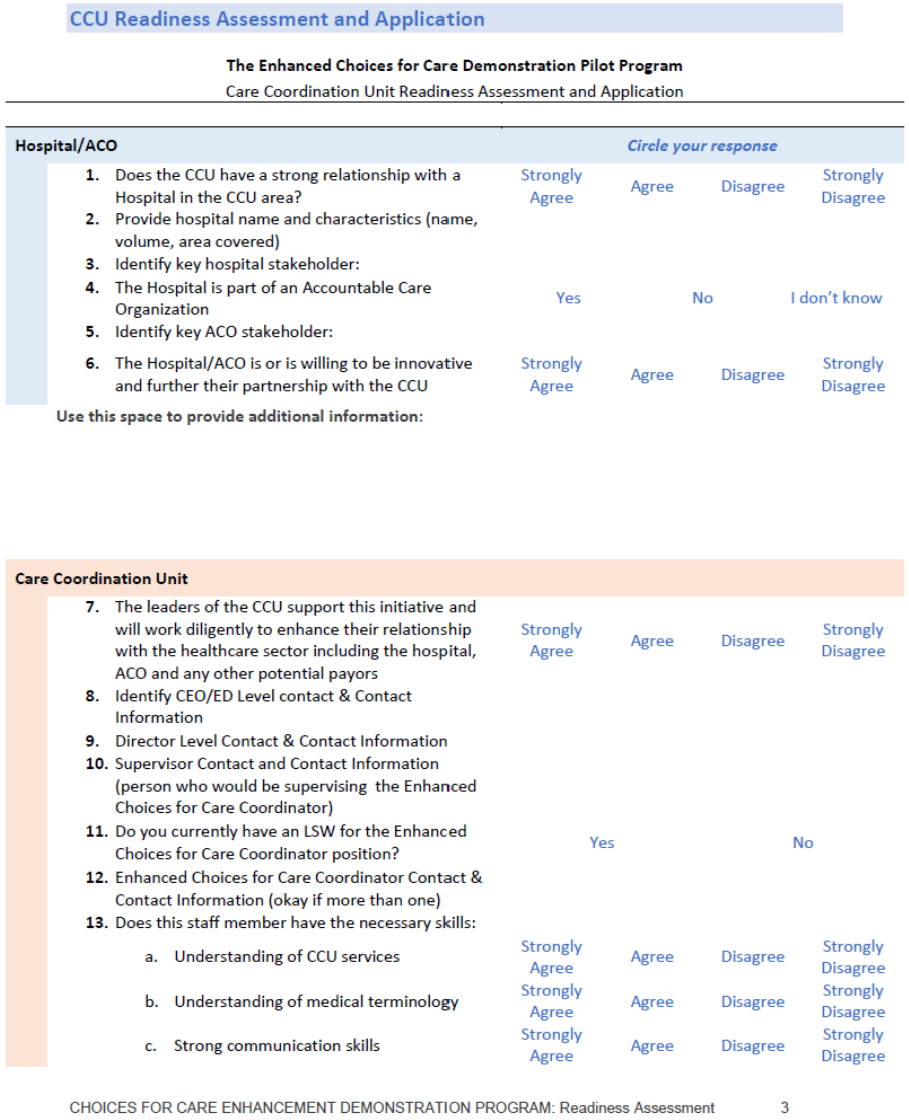
- EMR/Chart Review
- Bedside Visit
- Begins comprehensive assessment
- Anticipates needs/risks
- Expedites state, federal and local community resources

Post-Discharge

- Contact within 24-48 hours, complete a home visit, and follow up for 30 days post-discharge
- Identifies client-specific goals and
- Discusses the discharge plan and utilizes the teach-back method
- Ensures the patient has scheduled doctor's appointment(s), is prepared for the visit(s), and has appropriate transportation
- Completes a medication reconciliation
- Ensures home health, physical therapy, occupational therapy, homemaker services (as applicable) etc. are all coming and on time
- Connects with interdisciplinary team members as appropriate
- Utilizes psychotherapeutic techniques to ensure the patient is motivated in their own health care; to decrease patient/caregiver stress and anxiety; and address potential mental health concerns
- Connects the patient/family to community resources and long-term services and supports as appropriate

Implementation

CCU Readiness Assessment Tool and Selection of Implementation Sites



CCU Readiness Assessment and Application

The Enhanced Choices for Care Demonstration Pilot Program

Care Coordination Unit Readiness Assessment and Application

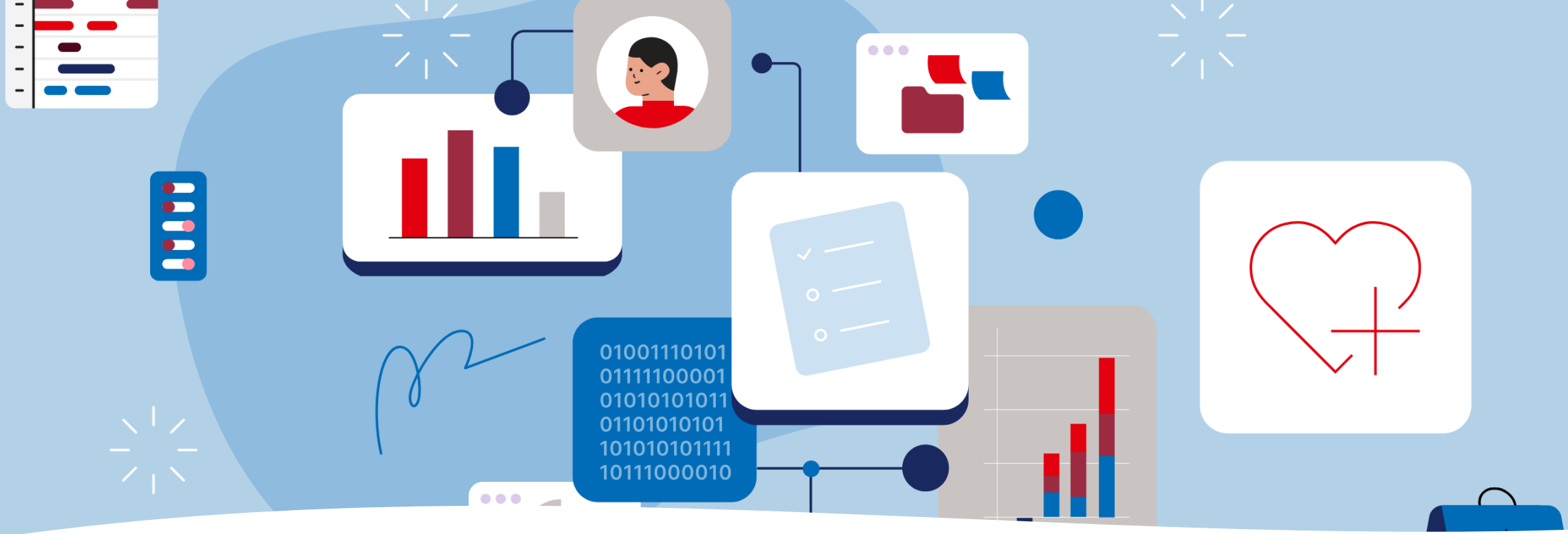
Hospital/ACO	*Circle your response*			
1. Does the CCU have a strong relationship with a Hospital in the CCU area?	Strongly Agree	Agree	Disagree	Strongly Disagree
2. Provide hospital name and characteristics (name, volume, area covered)				
3. Identify key hospital stakeholder:				
4. The Hospital is part of an Accountable Care Organization	Yes		No	I don't know
5. Identify key ACO stakeholder:				
6. The Hospital/ACO is or is willing to be innovative and further their partnership with the CCU	Strongly Agree	Agree	Disagree	Strongly Disagree
Use this space to provide additional information:				

Care Coordination Unit				
7. The leaders of the CCU support this initiative and will work diligently to enhance their relationship with the healthcare sector including the hospital, ACO and any other potential payors	Strongly Agree	Agree	Disagree	Strongly Disagree
8. Identify CEO/ED Level contact & Contact Information				
9. Director Level Contact & Contact Information				
10. Supervisor Contact and Contact Information (person who would be supervising the Enhanced Choices for Care Coordinator)				
11. Do you currently have an LSW for the Enhanced Choices for Care Coordinator position?	Yes		No	
12. Enhanced Choices for Care Coordinator Contact & Contact Information (okay if more than one)				
13. Does this staff member have the necessary skills:				
a. Understanding of CCU services	Strongly Agree	Agree	Disagree	Strongly Disagree
b. Understanding of medical terminology	Strongly Agree	Agree	Disagree	Strongly Disagree
c. Strong communication skills	Strongly Agree	Agree	Disagree	Strongly Disagree

CHOICES FOR CARE ENHANCEMENT DEMONSTRATION PROGRAM: Readiness Assessment 3

Hospital Partnerships

- Successes and Challenges
  - Access to EMR
  - Business Associate Agreement
  - Sharing of readmission data
  - Buy-in from hospital staff
  - Collaboration via ACL Care Transitions ECHO Series
  - Consistency of referrals
  - Dedicated CCU staff

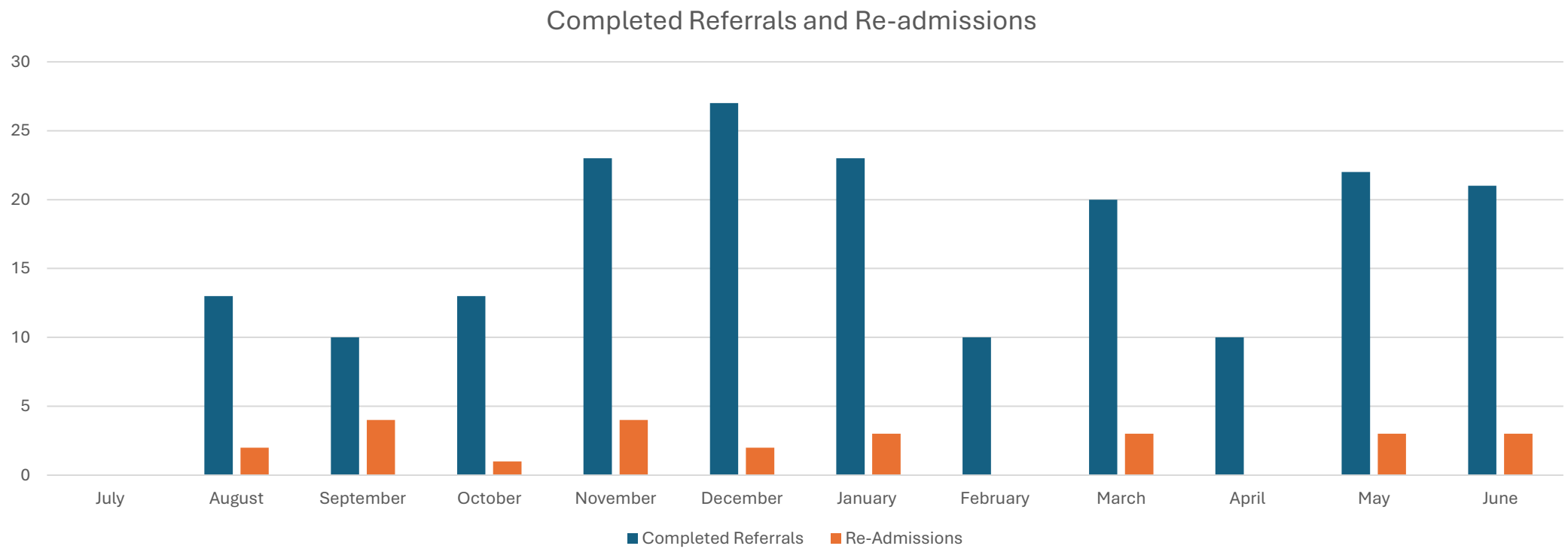


Data Considerations: What to collect? What is missing?

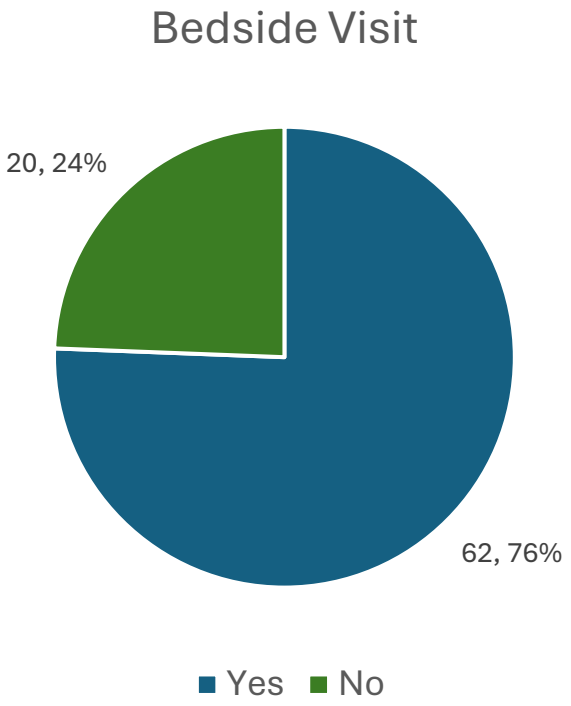
- Total number enrolled/offered/educated
- Process Metrics (data about the intervention like number of calls, home visits, type of supports)
- Available Hospital Data (readmission rate, diagnosis, face sheet…)
- Case Studies
- Care Coordinator Interviews
- Satisfaction Surveys
- ACL Evaluation- more to come!

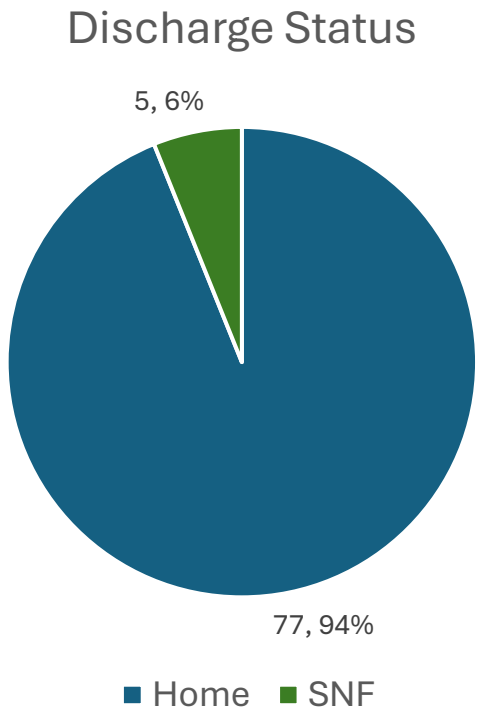
FY24 (Year One) Data

192 individuals were enrolled
13% average readmission rate

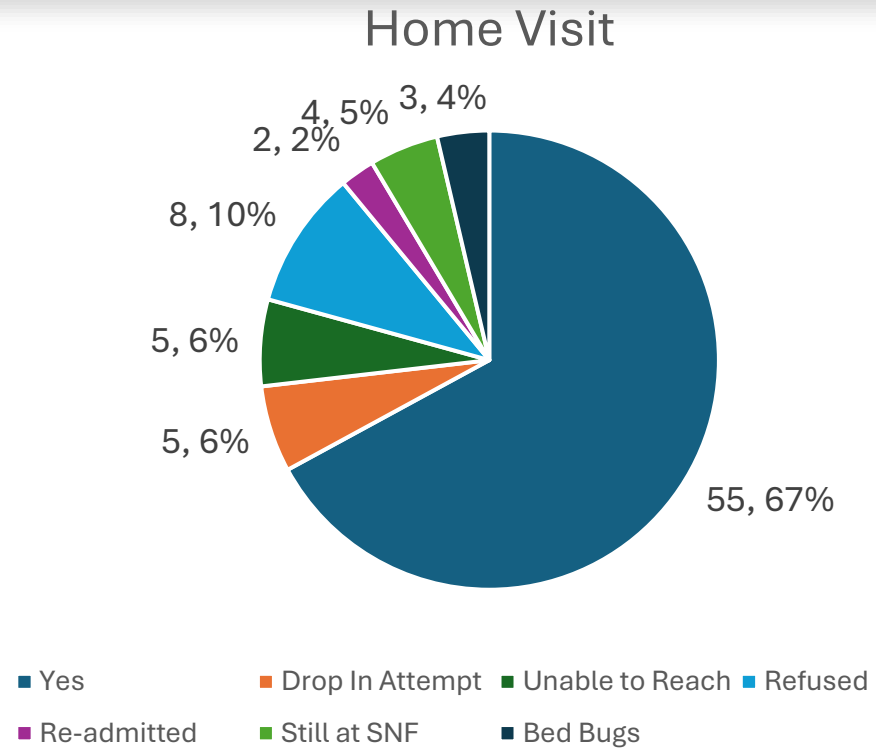


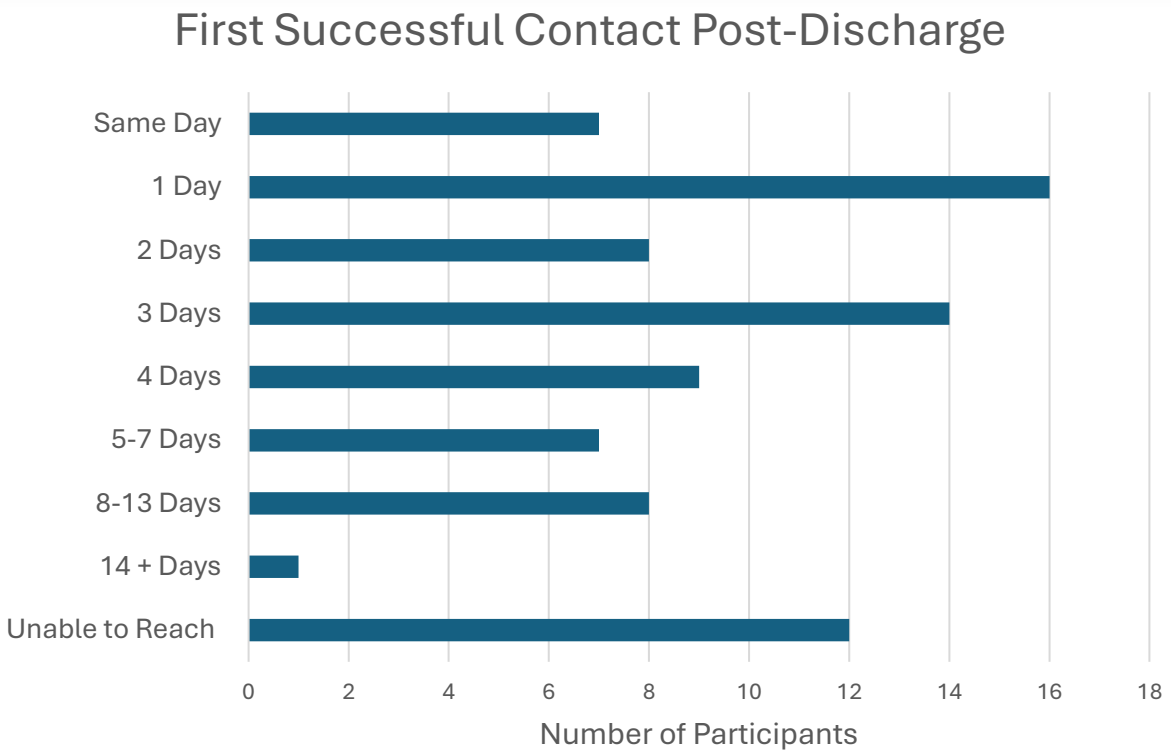
Process Metrics: FY25 Q1





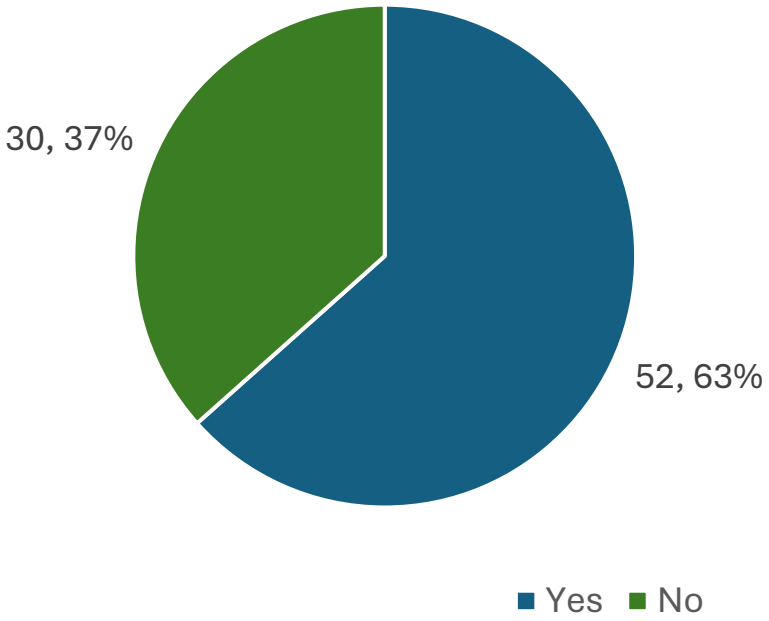
Data: FY25 Q1


Home Visit
4, 5%
3, 4%
2, 2%
8, 10%
5, 6%
5, 6%
55, 67%
Yes
Drop In Attempt
Unable to Reach
Refused
Re-admitted
Still at SNF
Bed Bugs


First Successful Contact Post-Discharge
Same Day
1 Day
2 Days
3 Days
4 Days
5-7 Days
8-13 Days
14 + Days
Unable to Reach
0
2
4
6
8
10
12
14
16
18
Number of Participants

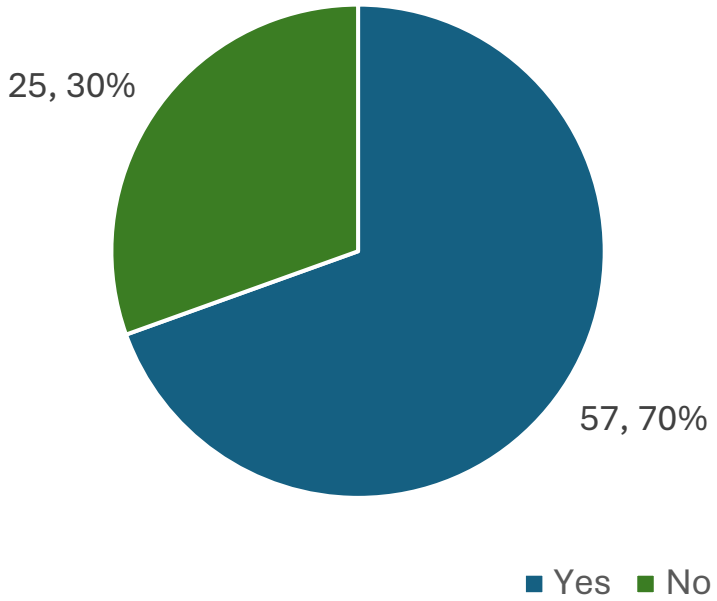
Data: FY25 Q1

Medical Education Provided



Includes:
1. Importance of PT
2. Communication with MD
3. Importance of sleep
4. Medication management
5. Medication changes
6. Heart Failure management
7. Diabetes education
8. Home Health process
9. Palliative Care/Hospice
10. DME use and process
11. SNF care
12. Advanced Directives
13. Precautions with smoking and oxygen use

Multidisiplinary Connects



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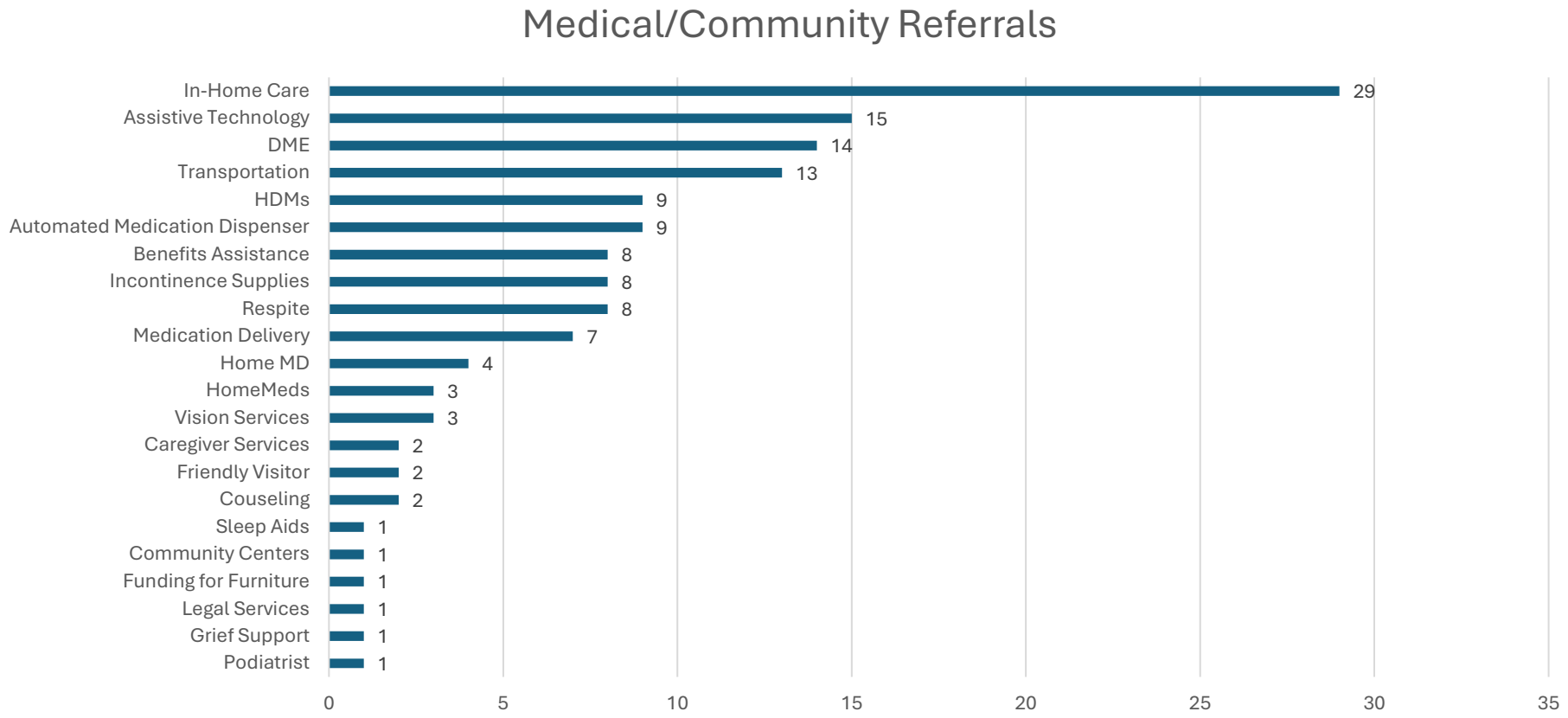
Medical/Community Referrals
In-Home Care 29
Assistive Technology 15
DME 14
Transportation 13
HDMs 9
Automated Medication Dispenser 9
Benefits Assistance 8
Incontinence Supplies 8
Respite 8
Medication Delivery 7
Home MD 4
HomeMeds 3
Vision Services 3
Caregiver Services 2
Friendly Visitor 2
Couseling 2
Sleep Aids 1
Community Centers 1
Funding for Furniture 1
Legal Services 1
Grief Support 1
Podiatrist 1
0 5 10 15 20 25 30 35

Satisfaction Surveys

20 completed thus far

Likert-scale: Strongly Disagree (1) to Strongly Agree (5)

Average Score= 4.10/5

Would recommend the program to others= 4.44/5

Client Testimony

"It was very very helpful for me. At the point where they came in, I was at a loss, I was at the point of being homeless, and I wasn't being treated fairly at home. Paige was in on a lot of it, and she really extended a hand and an ear, a shoulder to cry on, she gave me some good advice, and she explained how to reach out and ask for help from different resources. She was just there for me. She was more than just someone doing a job. She was more like a friend, and you don't see that very often in the workforce. She is just humble. I appreciate everything she has done for me."

Looking to the Future

- Sustainability
  - Care Transitions Evaluation Grant
  - Codes
- Support and resources
- Program report to come after pilot's second year