THE COMMUNITY CARE ALLIANCE OF ILLINOIS

“Medicaid Care Coordination: Making it Work in Illinois”
December 19, 2012
Greg Alexander
Agenda

I. Introduction

II. Mission, Vision & Model of Care

III. Anchor Medical Homes & Enhanced Care Sites, and Centers of Excellence

VI. Questions/Discussion
I. INTRODUCTION
Who we are

• Non-Profit MCCN
• Wholly owned subsidiary of Family Health Network
• Modeled after Commonwealth Care Alliance of Massachusetts

Collaborators,

• Access Living
• Family Health Network
• Health and Medicine Policy Research Group
• Schwab Rehabilitation Hospital
• Sinai Health System

COMMUNITY CARE ALLIANCE
Health Programs for Independent Living
CCAI Board of Directors

- Chair: Jeff Miller
- Consumer Rep: Judy Panko Reis
- Consumer Rep: Sharon Lamp
- FHN Jose Sanchez
- FHN Keith Kudla
- Kristen Pavle
- Kristi Kirschner
RFP Update

Innovations: Seniors and People with Disabilities

- Awarded a contract with HFS as a MCCN
- Implementation date: 4/1/2013
- Voluntary enrollment in Year 1; membership on par with Integrated Care Plans in Year 2 and beyond
CCAI Model of Care

- Person-centered.
- Wraparound “all-in” care, integrating medical, psychosocial and long-term care.
- Focus on prevention, health and wellness.
- Disability-competent primary care services with integrated care teams. Integral role for disability-trained primary care nurse practitioners.
- Flexible sites of services including more home care and fully accessible sites of care (Anchors)
II. MISSION, VISION & MODEL OF CARE
Mission:

The Community Care Alliance of Illinois is a health plan dedicated to consumer-directed, community-based innovative health services specializing in the care of seniors and people with disabilities.

Vision:

To be the leader in Choice, Access, and Quality of Health Services for people we serve.
Underlying Philosophy of CCAI

To achieve a higher quality of care, with improved patient satisfaction and cost savings

• Secondary prevention of complications through care coordination
• Empowering consumer voice and utilizing community peer resources
• Incorporating long term services and support
• Decreasing ER visits
• Reducing hospitalization rates
CCAI Target Population

Adults and Seniors with Disabilities, Including:

- Multiple Chronic Illnesses
- Severe Mental Illness
- Deaf and Hard of Hearing
- Intellectual Developmental Disabilities
- Physical Disabilities
CCAI Clinical Model of Care: “Patient Centered”

CCAI Wrap-Around Services

CCAI Specialized Primary Care Team

Consumer/Patient/Caregiver

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Interdisciplinary Care Team:

**Disability Competent Primary Care**
- PCP (MD/DO or NP - family medicine, internal medicine, pediatrics)
- Nurse care coordinators
- Long-Term Services and Supports Coordinator (social worker)

**Specialty Care**
- Rehab professionals
- Behavioral/mental health providers
- Specialists (orthopedics, neurosurgery, pulmonary, etc.)

COMMUNITY CARE ALLIANCE
Health Programs for Independent Living
Stineman MF, Streim JE. The Biopsycho-ecological paradigm: A foundational theory for medicine. *PM&R* 2010; 2(11); 1035-45.
Based upon HRA, Initial Health Risk and Complexity Stratification

TIER 1 – HIGH RISK

TIER 2 – MEDIUM RISK

TIER 3 – LOW RISK
## CCAI 6-Domain HRA, Individualized Care Plan

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>medical</strong></td>
<td>• Active/acute medical issues: Primary prevention of acute disease/illness, Secondary prevention of disability complications, CDM, Health behaviors</td>
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<tr>
<td><strong>functional</strong></td>
<td>• Functional assessment; Mobility, ADLs, IADLs, communication, social skills, leisure and vocational pursuits</td>
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<td><strong>environmental</strong></td>
<td>• Housing with appropriate accessibility both into home and within home; Community transportation and access to needed services.</td>
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<tr>
<td><strong>financial security</strong></td>
<td>• Financial security- ability to meet basic needs (food, rent, medication co-pays, etc.)</td>
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| **social supports**            | • Primary and backup social support  
• Proxy for advance directive  
• Respite services for caregivers |
| **psychological/behavioral health** | • Mental/behavioral health history; Active issues, Level of stress, Substance Abuse and Coping skills |
Model of Care Diagram

Initial HRA (Member)

Comprehensive HRA (RN Care Manager)

HRA Care recommendations
Referrals for Behavioral Health Generated

PCP Yes, member want to continue current relationship with PCP

Collaborating MD Monthly meetings Consultation

Specialists

Pharmacy

DME LTC Rehabilitative Services

PCP working with care manager LTSS

Mental Health Services

PCP No Assigned to NP PCP

Specialists

Pharmacy

DME LTC Rehabilitative Services

PCP/NP working with care manager LTSS

Mental Health Services

Collaborating MD Monthly meetings Consultation
III. ANCHOR MEDICAL HOMES, ENHANCED CARE SITES, AND CENTERS OF EXCELLENCE
Anchor Medical Homes: Gold Star Designation

Fully accessible and user-friendly environment for people with disabilities and complex needs, Anchor Medical Homes will provide the following:

- Physical access (parking, entrance, clinic space, bathrooms)
- Communication access including interpreting services
- Accessible medical equipment including exam tables, wheelchair accessible scales, transfer equipment and staff training
- Staff knowledgeable regarding disability care and accommodations
- 24/7 access
Anchor Medical Homes: Gold Star Designation (continued)

• Commitment to incorporating health information technologies and enhancements

• Interdisciplinary Care Team meetings, case reviews, etc.

• Jointly-hired Nurse Practitioners as collaborative plan liaisons

• Commitment to adapted health, wellness and secondary prevention resources for all CCAI members

• Commitment to incorporating consumer input and peer support services
Initial CCAI Anchor Medical Homes

- Swedish Covenant Hospital
- Mercy Diagnostic and Treatment Center
- PrimeCare, Inc. (St. Mary/St. Elizabeth)
- Sinai for SMI
- Schwab Rehabilitation Hospital: Deaf and Hard of Hearing and People with Disabilities
- St. Bernard Hospital
Enhanced Care Sites

• Pre-existing PCP relationships that member desires to preserve

• PCP/member can access all CCAI enhanced services (Nurse Practitioner, Nurse Care Coordinators, Long-Term Services and Supports Coordinators (LTSS) available to them)
Centers of Excellence: Specialty Services

- Continuum of rehabilitation services
- Continuum of behavioral/mental health services (coordinated through PsycHealth)
- Pursuing specialty care clinics:
  - Muscular dystrophy
  - Adult spina bifida
  - Dementia
  - Intellectual/Developmental disabilities
  - Deaf and Hard of Hearing services
  - Reproductive health
  - Preventative dental
IV. QUESTIONS & DISCUSSION