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Community Care SOLUTIONS

COVID-19 Care Transitions Spotlight: Southern Alabama Regional Council on Aging

Care Transitions Experience Prior to COVID-19

In 2013, Southern Alabama Regional Council on Aging (SARCOA) participated in the Centers for Medicare & Medicaid Services (CMS) Innovation Center Community Care Transition Program (CCTP). In this CMS demonstration, SARCOA supported transitions using strategies from the Care Transitions Intervention® (CTI®) model and connecting individuals to home and community-based services (HCBS). SARCOA transition staff were embedded at participating hospitals to deliver these services (see box for detail).

To sustain their care transitions program beyond the CMS demonstration, SARCOA created a non-profit corporation called Community Care Solutions (CCS) that envisions a statewide network of Area Agencies on Aging (AAA) and contracted direct services providers. CCS began contracting with a local hospital, a major health insurance plan, a large physician group, and Fire/EMS for a range of services that included care coordination, case management, and care transitions. One of the most notable initial contracts was with a major Medicare Advantage Health plan in Alabama to provide a comprehensive care coordination service their members. A key component of the care coordination contract is care transitions. This contract covers four (4) southeast and central Alabama AAA service regions, encompassing eighteen (18) counties that are a mix of urban and rural. CCS deploys an intensive community-level case management intervention based on data driven member risk scoring to identify high-risk Medicare Advantage plan members as part of their community care coordination and care transitions program.

Community Care Transitions

Evidence-based, person-centered, and community-based

- Hospital-based care coordinators work with hospitalists and discharge planners to develop an integrated intervention plan, including a detailed in-home needs assessment conducted immediately post-discharge.
- Community interventions are initiated by supervised care transition health coaches to address medical, social and behavioral risk factors identified through home assessments.
- Medication review and potential social barrier impact analysis is performed to improve medication adherence.

COVID-19 Pandemic Response

When the COVID-19 hospitalization rate reached surge levels in Alabama, the CCS contract with a Medicare Advantage plan expanded their care transitions services to include community-level case management for members admitted to the hospital for COVID-19. As part of the expanded contract, CCS receives a list of referrals for the Medicare Advantage plan patients with COVID-19. CCS pairs strategies from the CTI® model with community case management focused on facilitating HCBS and addressing social determinants of health (SDoH) during the transition period. Key elements include:

- Conducting outreach
- Completing needs assessments
- Facilitating the development/activation of person-centered plans
- Deploying interventions to address SDoH
- Improving medication adherence
- Addressing health plan Gaps of Care
- Coordinating follow-up contacts with medical teams
- Increasing disease self-management skills

Throughout the pandemic, CCS continued to provide in-person services for individuals transitioning to home. In-person services included assessments, person-centered planning, social service coordination, emergency nutrition, HCBS enrollment assistance, and expediting HCBS services to facilitate nursing facility-diversion activities. The ability to contact patients prior to discharge allowed the initiation of some services during the hospital admission, supporting successful care transitions from hospital to home. In addition, CCS staff provide Medicare Advantage patients with education about potential worsening symptoms of COVID-19, assistance with self-monitoring of physiologic measures, and assistance monitoring for potential complications related to COVID-19. CCS' continuation of care coordination services through the pandemic has enabled Alabama residents, hospitalized with COVID-19, to safely return home and supported hospitals in managing immense surges.