Washington Square Health Foundation
Community Health Care Report
Improving Overall Health through the Integration of Care Coordination and Pharmacy
Coordinated Care Alliance
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The members of the Coordinated Care Alliance, through collaboration with managed care, health care and direct service organizations, provide efficient and effective coordination of quality services that enhance the health and welfare of vulnerable populations.

1. Identify the high risk/underserved and/or disadvantaged populations in the community(ies) that you serve and describe specifically the actions you have taken, based on relevant assessment data, to increase their accessibility to health services.

   Coordinated Care Alliance serves high-risk, underserved and/or disadvantaged populations across the state of Illinois. Coordinated Care Alliance members provide care coordination services to at-risk older adults and individuals with disabilities throughout the state.

   Coordinated Care Alliance member, Catholic Charities, identifies older adults in low-income communities particularly communities of color and marginalized immigrants who are in need of community-based resources to age in place with dignity. Catholic Charities assists older adults in applying for medical and other benefits and uses internal and external resources such as transportation, immediate access to food and clothing, to reduce the social determinants that create barriers to health services.

   KodoCare Pharmacy identifies uninsured and underinsured patients in need of financial assistance and connects them with pharmacy discount cards and manufacture assistance programs to improve their access to medications.

2. Describe specifically the strategies you have used to gather input from high risk, underserved and/or disadvantaged population and their leaders as a basis for program or service development.

   Coordinated Care Alliance's network members receive input from their underserved and at-risk clients on a daily basis through their assessments and coordination of care.

   Specifically, in the last two years, Catholic Charities has expanded its presence on the Southwest and West sides of Chicago. Both areas consist of majority low income African American and/or Latino older adults who been underserved for many years. Catholic Charities has provided in-home assessments and assistance in these neighborhood hospitals to help connect older adults to health care and age safely in their homes, if possible. By also working with area churches and parishes, Catholic Charities has been able to further connect with people in the community to establish rapport and provide access to much-needed services. Care Coordination has served as a gateway to other services older adults so desperately need in the community such as benefits access, housing, mental services, adult protective services and caregiver resources.

3. Describe specific partnerships with other providers and community-based organizations to promote continuity of health care for high risk/underserved and/or disadvantaged populations.

   Coordinated Care Alliance partners with Illinois Health and Hospital Association and health care entities including hospitals, accountable care organizations, managed care and Medicare Advantage plans to improve and promote continuity of health care.

   Catholic Charities partnered with two local hospitals to reduce 30-day readmissions rates by helping older adults transition back into the community immediately following a hospital stay. By working one on one with individual patients, Catholic Charities enhances the coordination services and thus the improvement of health outcomes, reduction in costs and prevention of unnecessary hospital readmissions. Catholic Charities works with patients to create and adhere to goals of care which allows older adults to transition safely to the community.

   Catholic Charities has also partnered with the University of Chicago Hospital to provide access to health for underserved communities. Catholic Charities is helping individuals apply for Medicaid and answers questions regarding Medicare.

4. Provide two examples of how you have used the community-oriented approach to program development specified in the attached principles to develop a program of service for high risk/underserved and/or disadvantaged populations specified in the guidelines. Include in each description components of the current program and the following quantitative information for the most recent year available:

   Partners with relevant providers and other community-based organizations:
   Coordinated Care Alliance has partnered with Illinois Health and Hospital Association to improve continuity of care as older adults transition from hospitals to the community. The partnership includes the Illinois Health and Hospital Association, local hospitals and their partnered Care Coordination Unit. Hospitals and community-based organizations learn about the services each of them provides and develops important linkages to promote continuity of care. Coordinated Care Alliance has co-hosted one 4-month long cohort in the last year and is co-hosting 4 more cohorts in the next 12 months. The best practices of these cohorts will be identified in a publication which will allow for replication of these partnerships across the nation.

   Coordinated Care Alliance will relay these best practices to the two partnering organizations to ensure program success. Additionally, relevant providers and community-based organizations will be incorporated into the program as needs are identified.

   *Utilizes a community-oriented approach to program development***:** Coordinated Care Alliance participates in interdisciplinary transitional care meetings with local hospitals and their community-based organizations. The teams identify continuity of care patient/family needs and opportunities for improvement of services provided to high risk and disadvantaged patient populations. CCA has participated in 22 of these meetings in the last year. These meetings include multiple perspectives from the patient, hospital multidisciplinary team members, and individuals from skilled nursing facilities, home health, and community-based organizations. These meetings utilize a quality improvement lens where root causes of readmissions are identified, and macro themes emerge which allow hospitals and community-based organizations to change their processes and services provided.

5. Number of clients served 60

6. Total amount budgeted by your organization for the program $20,000 requested for 3 organizations
7. Percent that program budget is of total agency budget 4%
8. Percent of program budget that is directly reimbursed by third-party payers 0%
9. Percent of program budget that is covered by public/private grants 0%