CASCADIA COMMUNITY CARE ALLIANCE

SEEING THE BIG PICTURE

GETTING HEALTHCARE IS COMPLICATED

With Cascadia Community Care Alliance, you gain an extra layer of support.

This program is for Medicare beneficiaries. It can lower the chances that you'll need to stay in the hospital and make it easier to get care in your own home or community. It also saves you time and money by avoiding repeated tests and unneeded doctor visits.

There's no cost to join Cascadia CCA. And you can qualify based on your past primary care visits.

Benefits include care coordinators who keep track of who you see and when, so you can focus on getting better. You'll also avoid some copays and have better access to rehabilitation or home health services when you need them.

Our partners:

- Northwest Health Partners
- PeaceHealth Medical Group
- Rebound Orthopedics and Neurosurgery
- Salem Health

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OVERVIEW

Cascadia CCA is physician-led and centers around primary care. This means we focus on keeping you well, not layering on lots of tests and treatments once you're sick.

Doctors who care deeply about the health of older adults designed the program so that all your providers work as a team. This is true whether you get care with your primary care provider, as an outpatient, in-hospital or through home-health and supporting agencies.

This approach can prevent serious illnesses and simplify your healthcare. The emphasis is on the quality of your care, not how many services you get.

Cascadia CCA's providers are dedicated to improving communication and removing roadblocks. For some patients, that means priority scheduling. For others, it's extra support to manage your diabetes or COPD. Or helping you find a nursing home near your family, so your children and grandchildren can visit.

The goal is to make sure that Medicare beneficiaries like you get the right care at the right time — without added stress, cost or complexity.

Joining Cascadia CCA does not mean your Medicare benefits have changed. You can still go to any provider or facility that accepts Medicare.

Seeing providers that are part of Cascadia CCA gives you more support, such as:

- Getting home health services even if you're not completely "home bound."
- Going to a nursing home without first having a three-night stay in the hospital.
- Getting priority scheduling for in-person appointments.
- Joining PeaceHealth's Flourish program without a fee. Flourish can help you manage multiple chronic health conditions. Cascadia CCA covers the cost.
- Working with a care coordinator who tracks your visits, sees gaps in care, communicates with your caregivers, recommends next steps, or helps reduce barriers such as missing referrals or forms.
- The ability to see a mental health provider at the same clinic where you get your primary care.

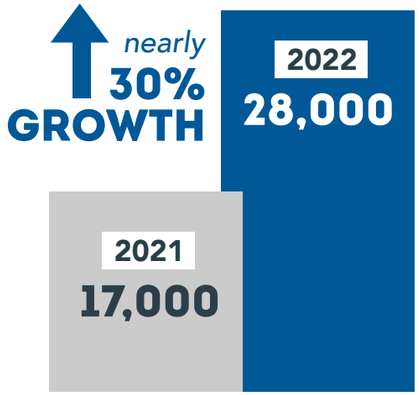
WHERE WE ARE AND WHO WE SERVE

Cascadia CCA launched in 2021 and is now in its second year. As the program grows, we are on pace to serve more than 30,000 patients.

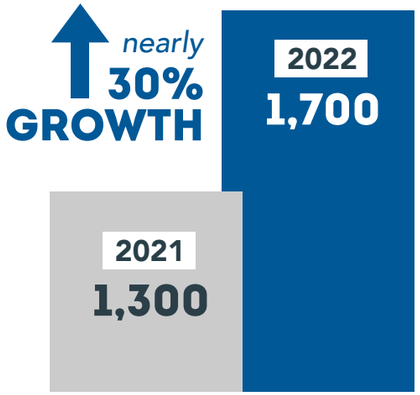
The care team involved in Cascadia CCA includes PeaceHealth Medical Group, community providers, skilled nursing homes and home health agencies. Our partners must meet national standards for high-quality care to be part of Cascadia CCA. In 2022, Salem Health joined the program, bringing in about 80 providers and nearly 4,000 patients.

You may hear Cascadia CCA called a "Medicare direct contracting entity" (DCE). Sometimes it is also called an "accountable care organization" (ACO). This means we are part of a national effort to improve healthcare through new approaches and tools. Cascadia CCA is one of the first programs to offer Medicare services this way.

PATIENTS ENROLLED

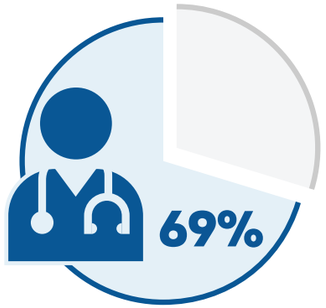


PARTICIPATING PROVIDERS



DOCTOR-LED PROGRAM

Most Cascadia CCA board members (69%) are doctors. The board also includes patient representatives. These leaders bring their insights as a care team into their oversight of the program.



COLLABORATIVE CARE

30+ hospitals, clinics and agencies working together. This includes independent providers, nursing homes and home health services.

RISK REDUCTION AND COORDINATED CARE

1/10
patients gets added support through these programs

2,700 Cascadia CCA patients are enrolled in care management or coordination programs: Chronic Disease Registry Outreach, Care Coordination, Chronic Disease Management, Flourish Complex Care Management.

5,600
care or screenings

Working with care coordinators, thousands of patients scheduled their yearly checkups. More than 5,600 got needed care or screenings that they'd missed in the past.

TODD'S STORY

Todd lived an active lifestyle in his 60s. He felt fine, so he didn't go to the doctor often. Then he got a letter from his Cascadia CCA team that said he was past due for a colon cancer screening. He learned more about his risk and booked a colonoscopy for a few months later.

Todd's care team reached out again a month before the screening to say he also was due for his yearly Medicare wellness visit. His care team explained how important these yearly visits are. When Todd found out how staying up-to-date on his vaccines and screenings could prevent health concerns later on, he scheduled a visit.

Both visits were in the spring. The colonoscopy showed that Todd had a higher risk of colon cancer, so his care team helped Todd get ahead of the issue. They planned for him to get tested again in seven years instead of the standard 10-year timeframe. At the wellness visit, Todd had a physical and several screening tests. He and his provider talked about his diet, the medications he was taking and how he stayed active. Todd's provider praised him for his daily habits, which would help lower his risk of heart attack and stroke. Todd left both visits with information about how to keep up with his health as he gets older.

WENDY'S STORY

Wendy is a long-term resident of a nursing home. Her health issues include anxiety and memory loss. When she gets anxious or confused, she sometimes calls 911 when it isn't an emergency. Recently she hurt her back. Instead of telling the nursing home, she decided to take a taxi to the emergency room.

After getting treatment, Wendy went to her own home instead of back to the nursing home. Her PeaceHealth providers worried that because of this, the nursing home wouldn't take her back. But Wendy belonged to Cascadia CCA, so she had a care coordinator keeping track of her doctor visits.

The care coordinator reached out to Wendy's family and to the nursing home to straighten things out. Because of this extra layer of support, Wendy returned to the nursing home, where she could safely continue her care.

ANTONIO'S STORY

Antonio has Parkinson's disease, high blood pressure and dementia. As he's gotten older, he's become weak and it's hard for him to do daily activities. Unable to care for himself, Antonio was admitted to a PeaceHealth hospital.

He was well enough to go home after one day in the hospital. But he couldn't live on his own, and his loved ones couldn't handle his day-to-day care. Each night he spent in the hospital would mean big bills for the family.

Hospital staff realized that Antonio belonged to Cascadia CCA, so he could go to a skilled nursing home without first having a three-day hospital stay. But it was already late afternoon. His care coordinator had to act quickly.

Most nursing homes won't take new patients after 4 p.m. The care coordinator arranged for Antonio to get a same-day evaluation and referral, so he wouldn't have to spend another night in a hospital bed. By 9 p.m., he was accepted and settled into the nursing home.

BETHAN'S STORY

Bethan was recovering from an illness in a nursing home that did not belong to Cascadia CCA. She wanted to continue her rehab at home, with the help of her husband and an aide. Her Cascadia CCA benefits made this a possibility for Bethan. But before she went home, she needed a prescription to relieve her chest pain and high blood pressure.

When the nursing home didn't act quickly to prepare for Bethan's discharge, her PeaceHealth primary care nurse let her Cascadia CCA care coordinator know about Bethan's concerns.

The care coordinator moved up an appointment so Bethan could get the medication. She also made sure the home health agency scheduled a visit within three days of Bethan's discharge. The home health aide reached out to Bethan ahead of time to offer support and explain what would happen once Bethan got home.

SPOTLIGHT: AVALON HEALTH PARTNERSHIP

Avalon Health Care Group is a network of nursing homes that serves patients throughout the West, including in Oregon. When Cascadia CCA first launched, Avalon saw a chance to make its partnership with PeaceHealth even better.

PeaceHealth hospitals already referred many patients to Avalon's skilled nursing homes. Now, Cascadia CCA's new technology tools and care coordinators would make sure patients had what they needed at every point in their care.

In the past, a stray fax or missed phone call could slow a patient's move from the hospital to the nursing home. The electronic medical records and computerized referrals Cascadia CCA used meant easier and quicker transitions to Avalon. Care coordinators also joined Avalon's providers for treatment planning, so they knew the details of each patient's case.

When each of Cascadia CCA's dozens of Avalon patients went home, care coordinators checked in with them and their families to make sure they were doing well. If a patient needed more recovery time, they often could go back to Avalon without having to go to the hospital first. If they were doing fine at home, their primary care provider knew what their Avalon treatment had been and could plan clear next steps to help them stay healthy.

WHAT'S NEXT

Each year we learn more about the needs of Cascadia CCA patients. The program will keep improving to best serve our communities.

IN YEARS THREE THROUGH FIVE, YOU CAN EXPECT:

COMMUNITY COUNCILS

Provider partners of all kinds, from family doctors to hospital specialists, will meet regularly in each area where Cascadia CCA operates. These healthcare leaders will compare notes and work together to make sure the right services are available where each community's needs are greatest.

ADDED SUPPORT SERVICES

It's hard to stay healthy when you don't have a place to stay, or you can't afford your medication. Challenges with mental health or substance use can make it even harder. That's why our care coordinators are building relationships with social workers, mental health providers and community agencies who help people get back on their feet.

LESS PAPERWORK FOR CERTAIN CONDITIONS

If your primary care provider is a nurse practitioner, they will be able to get you access to some equipment or services faster. This includes things like diabetic footwear and hospice services. Both currently require a doctor's sign off.

ENROLLMENT DETAILS

You may have already been signed up for Cascadia CCA based on your primary care Medicare claims.

If you got an enrollment letter, call **1-833-838-6307** to learn how to make the most of your benefits. A patient navigator can walk you through the details.

For answers to common questions, you can also visit peacehealth.org/direct-contracting.

If you are not yet enrolled, you can choose to sign up through Medicare. Call **1-800-MEDICARE (1-800-633-4227)** or visit **medicare.gov** to get started.