Belmont County **CARES** Program

Currently serving <u>any</u> client in Belmont County

740-827-0004

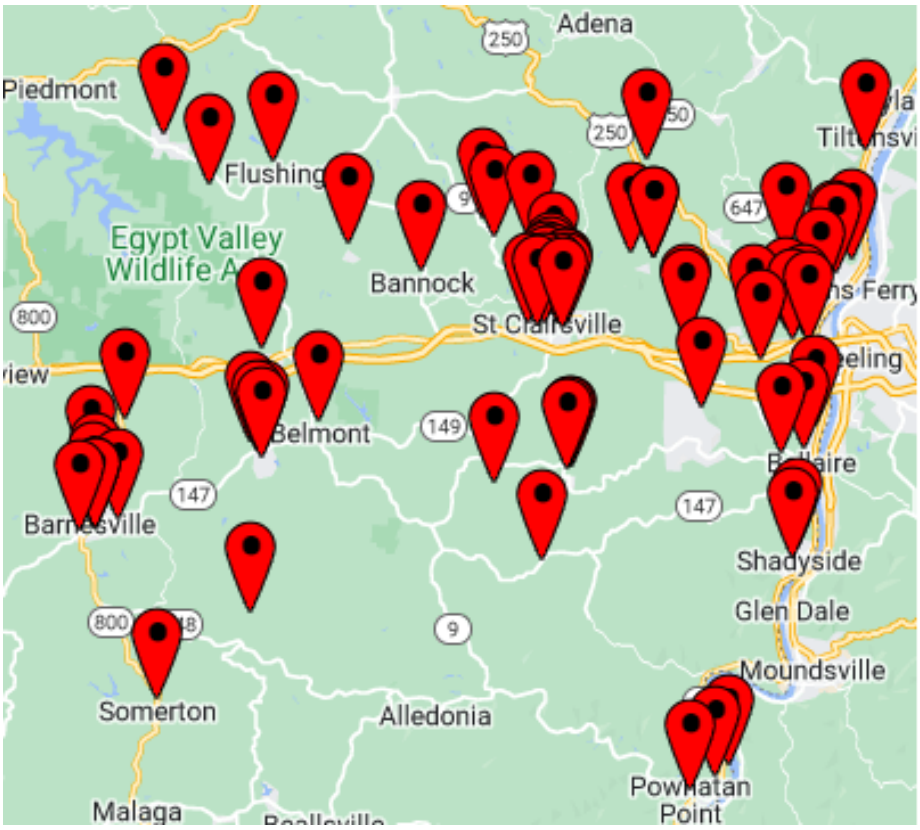
Community **A**ccess **R**esources **E**ducation & **S**olutions

QUARTERLY REPORT

2023 – Quarter 2

April 2023 – June 2023

Home Visits: 106



Find

Comprehensive Risk Assessment

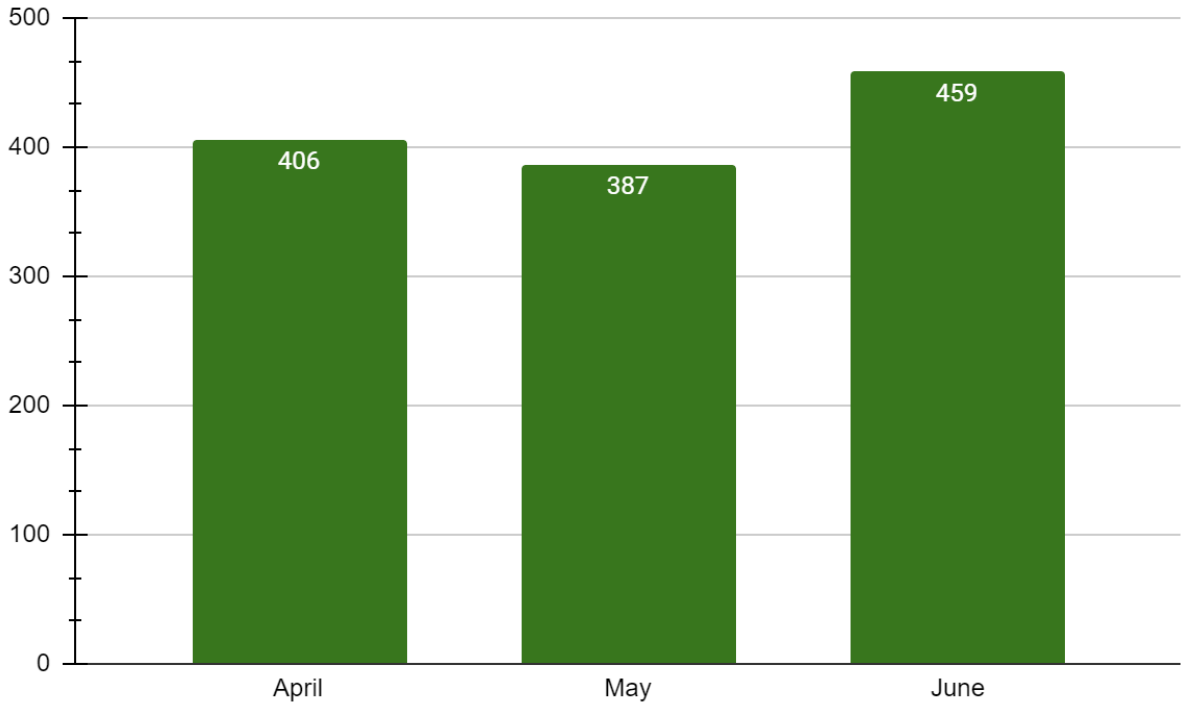
Treat

Assign Pathways

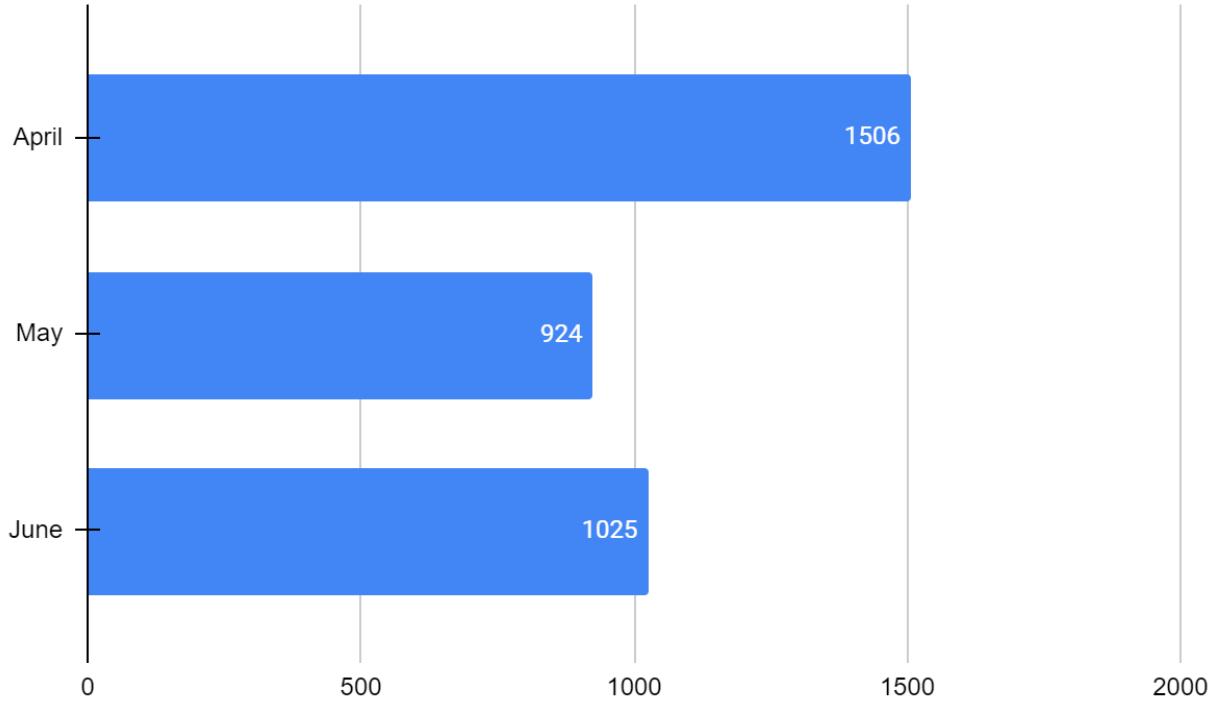
Measure

Track and Measure Pathways

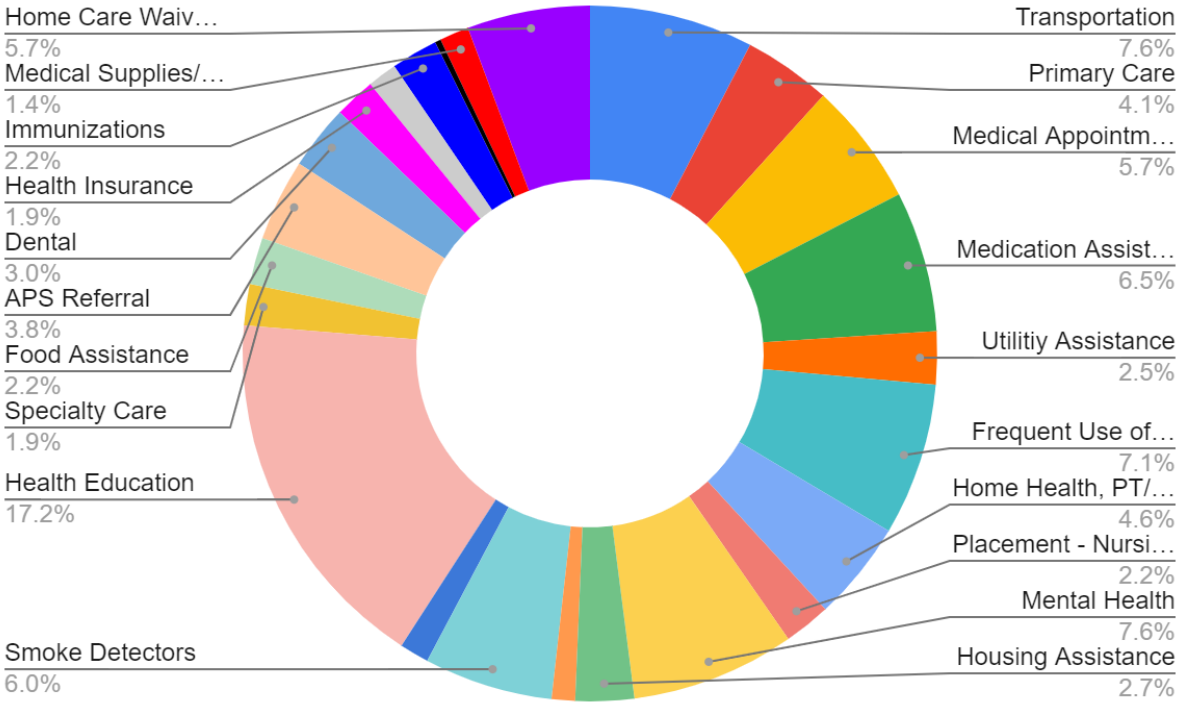
Phone Calls Received: 1252



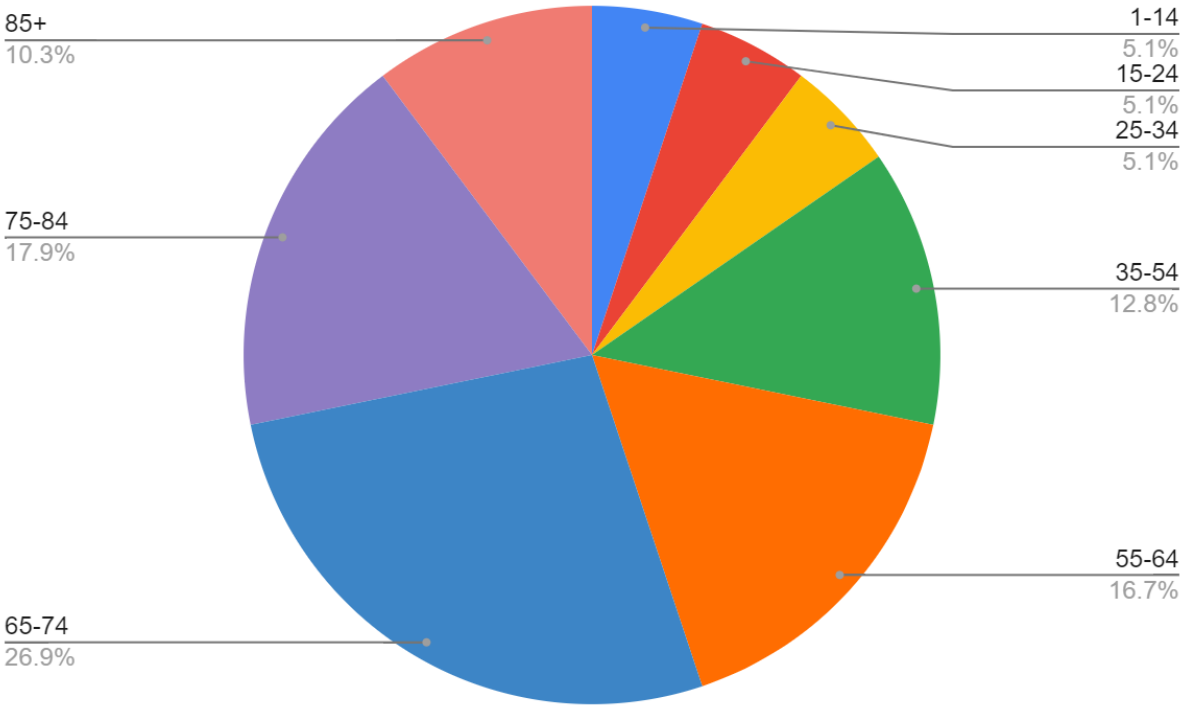
Time Spent on The Phone (in minutes)



Assistance Provided:



Age of Population Served:



55% of the population served is age 65 or older

What the CARES Program provides:

The Belmont County CARES Program currently provides one Community Care Coordinator that answers phone calls and schedules appointments with patients/clients. Enrollment into the program typically involves a home visit, this can also be done at a community location such as a library, senior center, restaurant, etc. The goal is to meet in the homes of patients – so the Community Care Coordinator has a better understanding of the patient/client's personal and home life.

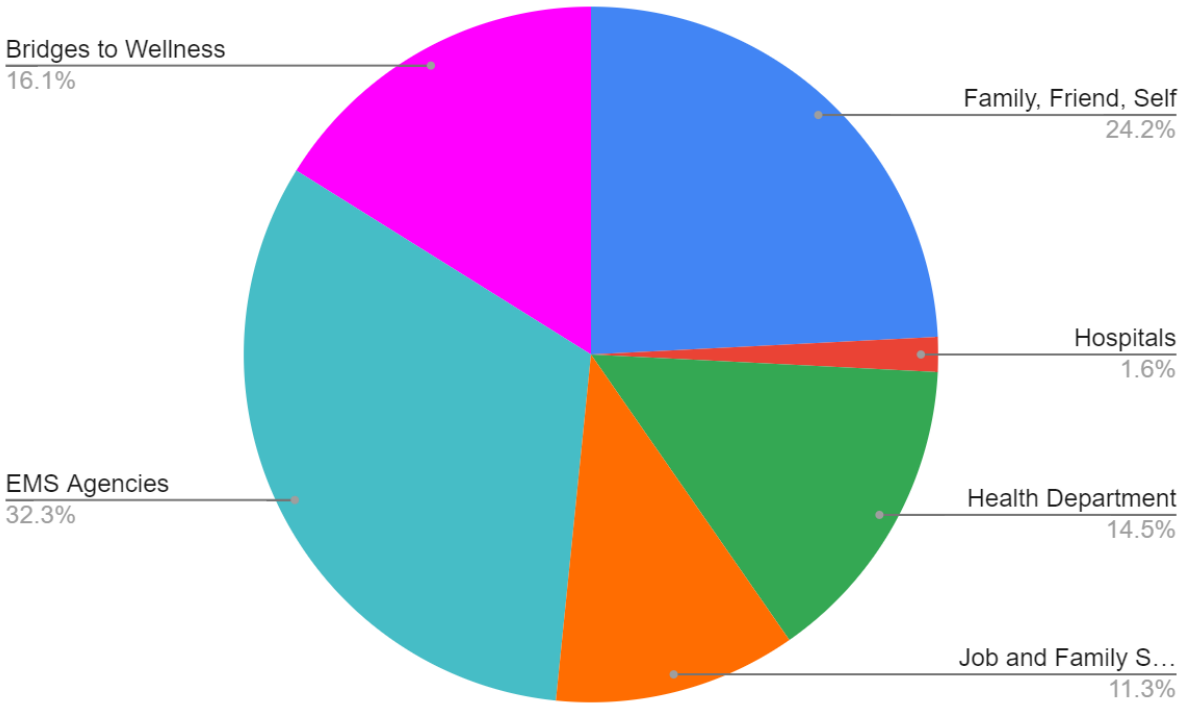
How the CARES Program works:

Typically, an intake process includes reviewing the care the patient/client already receives, discussing their support systems, reviewing their needs, and developing a plan to obtain the needed services. *This process can vastly vary based upon the needs or the patient/client, their resources, and their insurance.* See the assistance provided section below for more information.

The Community Care Coordinator will refer patients/clients to agencies and providers to meet their needs. This includes making appointments, scheduling transportation, sending reminders, and following up. The Community Care Coordinator also follows the patient/client to ensure follow up and makes sure that solutions were found.

Where do referrals to the program come from?

Referrals for the CARES Program can come from healthcare providers (EMS agencies, hospitals, physicians, etc.), social services (health department, adult/child protective services, senior services), insurance providers, families, and friends of individuals – or individuals themselves.



Assistance Provided:

Transportation: Reviewing eligibility for transportation. Depending upon age and insurance provider, clients/patients may be eligible for difference transportation services. This includes Senior Services of Belmont County Transportation, Non-emergency transportation services with Job and Family Services, insurance specific transport services.

Primary Care: If a patient/client is found to have no primary care provider. The Community Care Coordinator will stress the importance of having a 'medical home' and will work with them to find a provider in a local health system. This typically includes also scheduling, sending reminders, and arranging transportation – as well as medication assessments prior to the appointment.

Medical Appointments: If a patient already is established with a primary care provider, but has not been seen in 6+ months, education is provided and an attempt is made to schedule them for an appointment. Some patients are not able to easily attend appointments due to many obstacles – sometimes this means help with transportation, getting prepared, or facilitation of a virtual appointment.

Utility Assistance: If a need is found to assist with utilities, the Community Care Coordinator can refer to Community Action Commission Home Energy Assistance Program (HEAP). This often includes communication with the HEAP office and ensuring the proper documentation. There are also other programs available, such as the Area Agency of Aging's Utility Assistance Program – the Community Care Coordinator can assist with filing an application and submission.

Frequent Use of Emergency Services: When a patient is identified to frequently use emergency services, the Community Care Coordinator will follow up with the individual and explain the program. Often this identifies numerous needs and deficiencies in the care the individual receives. The Community Care Coordinator will assist with finding resources and provides education.

Home Health, PT/OT, or Palliative Care*:* When a patient requires or requests in home assistance, an assessment is completed. For Home Health, Skilled Nursing Care, Physical Therapy, and Palliative care, the Community Care Coordinator will work with the patient's provider to obtain an order. This often includes scheduling an appointment in their office or facilitating an alternative plan (virtual, etc.)

Placement – Nursing Home or Assisted Living: If a patient's needs are beyond that of staying at home, health education is provided. Personal conversations review the status of their health and work to ensure they understand their needs and availability of care. All placement is done with the patients consent after thorough education. Sometimes, CARES referrals are obtained when a patient is seen by EMS and transported to a hospital – on occasion the Community Care Coordinator will work with the hospital social workers to help find resources for the patient.

Mental Health: Every patient receives education on behavior health resources in the county (from the Mental Health & Recovery Board) and the crisis hotline and text line information. If a patient or client expresses a need for behavioral health treatment, the Community Care Coordinator will work with them to find mental health resources, such as a counselor, therapist, LSW, psychologist, or

psychiatrist. In many cases, the Community Care Coordinator completes a PHQ-9, a diagnostic tool used to screen for the presence and severity of depression; results are reported to a clinician if appropriate. The Community Care Coordinator may experience patients in mental health crisis and may have to work with them and their provider to obtain emergency treatment or facilitate an application for emergency admission.

Housing Assistance: When a client requires permanent housing that they are unable to obtain the Community Care Coordinator can work with them to locate housing and fill out applications. This includes working with senior living facilities, public housing, and other apartment facilities. This may also include assistance with locating emergency funds to help cover rent, security deposits, etc.

Clothing and Food Assistance: Referrals are made to community organizations such as the Salvation Army, Greater Wheeling Coalition for the Homeless, Catholic Charities West Virginia, Project Manna, St. Vincent De Paul Society, and the Miracle of Life Group. This may include assistance with picking up and delivering items.

Smoke Detectors: Clients are asked if they have a working smoke detector in their home. If they do not, they are provided with one and help with installing if necessary.

Medical Alarm: If clients need a medical alarm, they likely have other needs. They may qualify for home health, PASSPORT, etc. – this may qualify them for a medical alarm. If they are unable to qualify for coverage the Community Care Coordinator can help them shop for one – typically online.

Health Education: Often clients do not understand their health or disease. Providing personal education on their education level can be very informative and help patients understand their need for treatment.

Specialty Care: If a patient requires or would benefit from specific health treatment such as wound care, physical therapy, etc. – the Community Care Coordinator will work with them to obtain the treatment. This often includes involving their primary care provider.

APS/CPS Referral: If a senior/child is found living in deplorable or unlivable conditions a referral is made to Adult/Child Protective Services. The Community Care Coordinator will then work with the APS/CPS worker to assist with their needs. Referrals are also made when it is believed that a senior/child is being abused, neglected, or exploited.

Dental: Patients are screened to see when their last dental appointment was. If it was over a year, education is provided on dental health and there is an attempt to schedule an appointment with their dental provider. If they do not have a dental provider, the Community Care Coordinator will assist the patient with becoming established with a provider.

Health Insurance: If a client/patient does not have insurance the Community Care Coordinator can help them review programs they may be eligible for – this includes Medicaid, Medicare, and supplement plans. The Community Care Coordinator can work with them to complete the necessary applications and gather paperwork.

Home Repair/Accommodations: If a patient needs a home repair or accommodation in order to safely stay in their home, the Community Care Coordinator can make referrals to charitable organizations and be an advocate for them. The Community Care Coordinator can also assist them with calling area businesses to obtain quotes for improvements.

Immunizations: Clients/patients are screened for immunizations. If they have not received common immunizations, the Community Care Coordinator may offer to assist them with obtaining immunizations. This can be either through the Belmont County Heath Department or working with their primary care provider.

Employment Assistance: The Community Care Coordinator can work clients to obtain employment. This includes education, assistance with access, referrals to Ohio Means Jobs and follow up.

Medical Supplies/Equipment: The Community Care Coordinator has assisted clients with obtaining needed medical supplies. This includes communication with their insurance, providers, and area agencies.

Home Care Waiver / PASSPORT: For Ohio Home Care Waiver and/or PASSPORT, the Area Agency on Aging Region 9 is contacted and a referral is made. The Community Care Coordinator will follow up and see that AAA9 completes a nursing assessment; then will follow up with the patient and see that their needs are met.