



CareSource 2019 Accomplishments

OMPP/DMHA SUD Provider Meeting
January 24, 2020
9:30-4:00 pm



CareSource Partnership



- Partnership with Valle Vista as of May 2019
- Embedded a Transitions Coordination Specialist twice per week

Goals:

1. Improve care coordination for the member
2. Improve coordination and communication between CareSource and Valle Vista
3. Reduce readmissions



Our Process



- Transitions Coordination Specialist (TCS) reviews internal IMD on-demand report to determine member admissions prior to her arrival. This allows the TCS to prep before meeting with any members.
- TCS receives a CareSource census report from the Valle Vista Social Worker when she arrives.
- TCS meets with discharge nurse on the appropriate unit (SUD/MH) prior to meeting with the member
- TCS meets with the member in a private room and completes the Transitions Questionnaire (inpatient portion)

Our Process



During the face-to-face visit with the member, the TCS collects and assesses for the following:

- Member's current address
- Phone number
- Alternate phone number
- Discharge diagnosis
- Discharge medications
- Tentative discharge date
- Current OP behavioral health provider
- Follow-up appointments
- Assigned PMP
- Transportation barriers
- Reviews HHW and HIP benefits

The member is given a CareSource folder that includes: Consent/HIPAA Authorization Form, information on the Transitions of Care Program, CareSource Rewards, and a Care Coordination letter with the TCS name and contact information.

Hospitalization Letter




P.O. Box 8738, Dayton, OH 45401-8738 | CareSource.com


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<Date>
To: <CareSource Member Name>
DOB: <CareSource Member DOB>
<BH Hospital Contact Fax Number>
From: CareSource Care Management

Hello. We have learned that you will be discharged from <facility name> soon. We want you to know that our Care Team is here to help make life a little easier for you when discharged

Please know, we can assist you with your to "to do" list after your discharge including:


 **Your schedule.**

We can set appointments to help keep you on track in your healing
It is really important to have a follow-up appointment with a behavioral health (BH) provider within 7 days after your discharge.

 **Rides to and from doctor's appointments**

Transportation benefits to and from your CareSource covered services are part of your plan. We can schedule for you OR you can call Member Services to arrange transportation at 1-844-607-2829 (TTY: 1-800-743-3333 or 711). Please call two business days before you need the ride.

You can also use these great resources anytime day or night.

 **CareSource24[®]** – A 24/7 nurse advice line to help you when you have questions about your care, medicines, health, symptoms OR for health advice.

 **Online access** to member websites to give you information about issues you are facing:

- **My Strength** is an online support program promotes coping skills, mood tracking, and more. <MyStrength website>
- **MyHealth** is your online CareSource account that provides custom information about your treatment and recovery
- **Find My Prescription** will help you to find out if your prescriptions/medicines are included in the plan. Visit [CareSource.com/in/members/medicaid/](https://www.caresource.com/in/members/medicaid/) then click on "Find

IN-MMED-2982 Date Issued:

Member Copy

OMPP Approved:

Hospitalization Letter



My Prescriptions” and choose your health plan. If you cannot find your prescription or need help finding another, please call Member Services at 1-844-607-2829.

<Also, you have been assigned [Care Manager Name] as your Care Manager. He/she can be reached by phone at: 1-XXX-XXX-XXXX>. [or]

<Please call Care Management at <X-XXX-XXX-XXXX to speak with a team member.>

A Care Manager can work with you to:

- Talk about possible challenges you may face when you are discharged.
- Learn about your medications, help to avoid or work through medication-related problems and make sure you are able to fill your prescriptions.
- Get Home Health Services or equipment you may need.
- Lower costs and stick to your treatment plan through the Medication Therapy Management (MTM) program.
- Connect with medical and behavioral health providers.
- Link with needed resources such as food and housing, as well as support groups in your local area.
- Understand your discharge plan and any follow-up appointments.

We wish you the very best in your recovery. Please call Member Services with any questions at <1-800-607-2829 (TTY: 1-800-743-3333 or 711), or visit CareSource.com for more information.

Sincerely,

CareSource Care Management

IN-MMED-2982; Date Issued: 6/17/2019

OMPP Approved: 6/13/2019

Our Process



- The TCS leaves a copy of the discharge letter at the nurse's station.
- The letter is placed in the member's chart for the discharge coordinator.
- The TCS tasks herself in the clinical platform to follow-up with the member within two days post discharge.
- The TCS finishes the Transitions Questionnaire, review the discharge summary, review medications, and remind the member of upcoming follow-up appointments.

Summary



- Since May 2019, the TCS has met with 80 members face-to-face and of those 80 members, only 6 have readmitted
- Readmissions have reduced by more than 50%
- The TCS offers Care Management to **all** of the members that she assesses.
- The TCS collects data for this project on-going using a tracking sheet in Excel.
- The TCS has been invited to participate in case conferences on complex members with frequent readmissions.

CareSource Partnership



- Established a partnership with OpenBeds in October of 2018
- OpenBeds allowed CareSource to trial the software platform prior to entering into a contract agreement



Goals:

1. Improve efficiency of referrals
2. Increase access to SUD treatment

Summary



- First Managed Care Entity to utilize the software platform
- Over the last year, we have made 54 total referrals, of which 30 were connected to 2-1-1 Community-Based Services, 13 to mental health or dual diagnosis treatment, and 11 to SUD treatment. Of the same 54 referrals, 14 remained open, 39 accepted the referral/transition, and 1 declined.
- We have found the use of OpenBeds to be a game-changer in achieving timely access to care.
- Success stories of members referred through OpenBeds
- Feedback has led to the development of new functionalities
 - Simultaneous referrals
 - Declined referral structured rationale
 - Show/no show feedback

Plans for 2020



- Partner with high volume OTP provider and explore the possibility of embedding a Community Health Worker to assist in treatment planning, adherence, and to coordinate physical health needs
- Partner with another high volume inpatient facility and explore the possibility of embedding another Transitions Coordination Specialist (TCS) to assist with discharge planning and coordination of care
- Implementing a weekly pharmacy report of women filling prenatal vitamins plus MAT prescriptions to distribute to Care Management for targeted outreach
- Designating a Quality Improvement Coordinator that will focus on reminder phone calls to members who have upcoming SUD appointments, confirming appointments with providers, and rescheduling any missed appointments
- Continue UM referrals to Care Management for members denied SUD inpatient and residential stays so that members can be assessed for the appropriate level of care

Plans for 2020



- Continue educating SUD providers on our Care Management Program
- Continue educating hospitals with higher readmission rates on the benefits of Care Management services
- Continue utilizing OpenBeds software platform to link members with SUD and mental health services immediately
- Continue to develop partnerships with local schools in rural areas to offer telebehavioral health services that will address SUD, teen suicide, bullying, anxiety, depression, etc.
- Offer Mental Health First Aid (MHFA) education in schools and department of correction facilities for staff to be educated on the signs of mental health and substance use issues.



CareSource™

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