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).
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

<Date>

To: <CareSource Member Name>

DOB: <CareSource Member DOB>

<BI 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 do” list after your discharge including:

1. 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.

2. Tidbits 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:

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

4. 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 then click on “Find
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 1-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: 8/13/2019
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.