Coordination of Care for the Returning Citizen

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Presentation Overview

1. The Challenges Of Re-entry
2. Caresource And The Re-entry Population
3. Serving The Returning Citizens Of Indiana
4. Coordinating Behavioral Health Services
5. Measuring Success

Challenges of the Returning Citizen

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Concerns of Returning Citizens

Health Status of Returning Citizens

Physical Health	Behavioral Health
40% have at least one chronic health condition	Up to 25% have serious mental illness
Hepatitis C is 9 -10x higher	70% have substance use disorder (SUD)
Tuberculosis is 4x higher	High incidence of comorbid SUD and SMI
STIs are high	Post-traumatic Stress Disorder is prevalent
HIV is 4 -5x higher	

The Risk of Transition

- 3.5x risk of death in the first 12 weeks post-release
- 12.5x risk of death in the first 2 weeks post-release
- Most common causes of death are overdose, cardiovascular disease, suicide and homicide

CareSource's Commitment

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Our Members, Our Mission

Disproportionate Chronic Health Needs

Complex Behavioral Health Needs

Significant Social Determinants of Health

Criminal Justice Data Integration Project

- Take multiple sources of criminal justice data and integrate into our IT systems
- Build capability to review, assess and analyze this data
- Identify medical, behavioral and social needs of these members
- Use predictive modeling to anticipate future needs

Indiana Re-entry Operations

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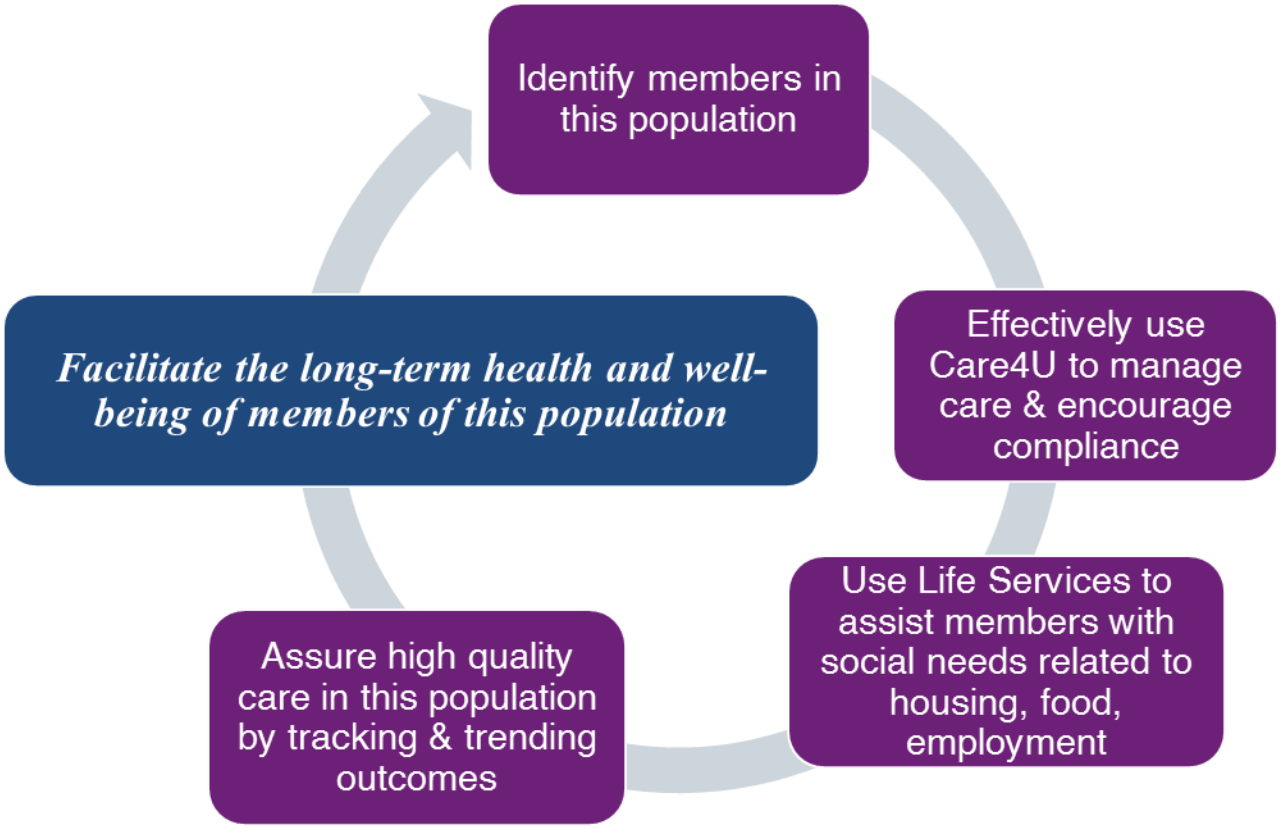
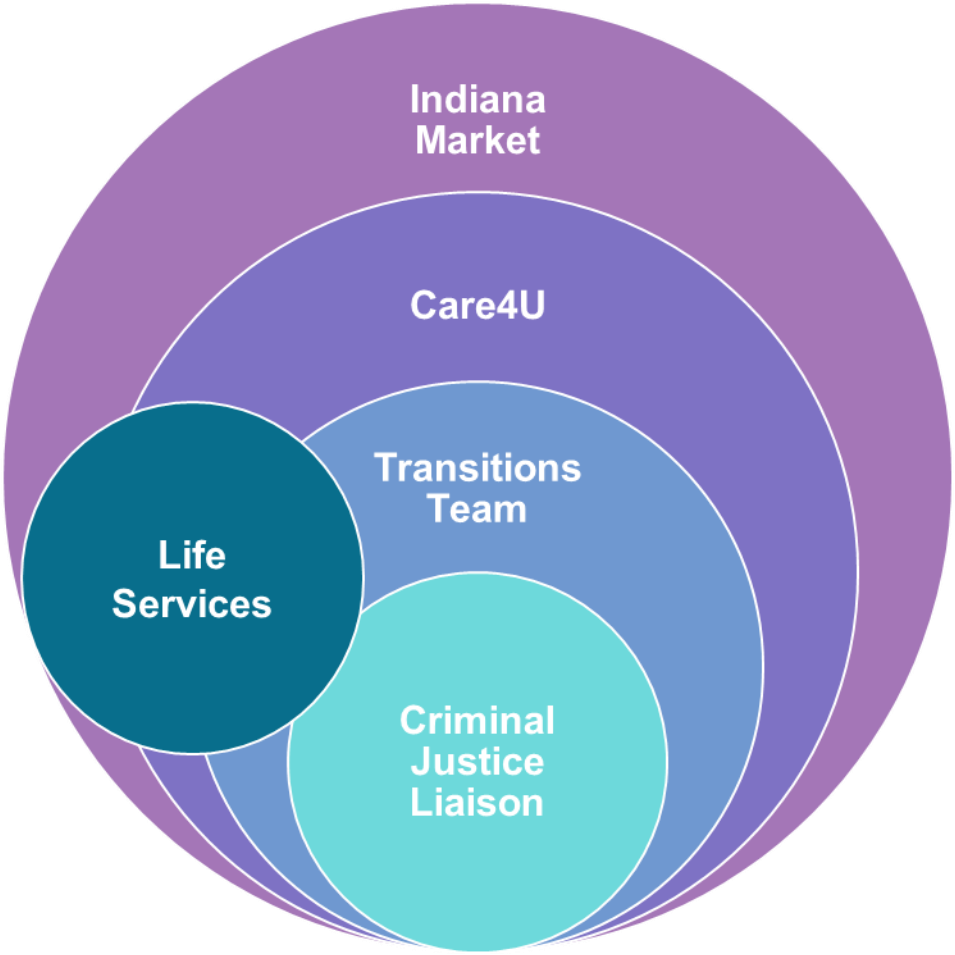
CareSource's Re-Entry Goals



Our Team-Based Approach to Re-entry



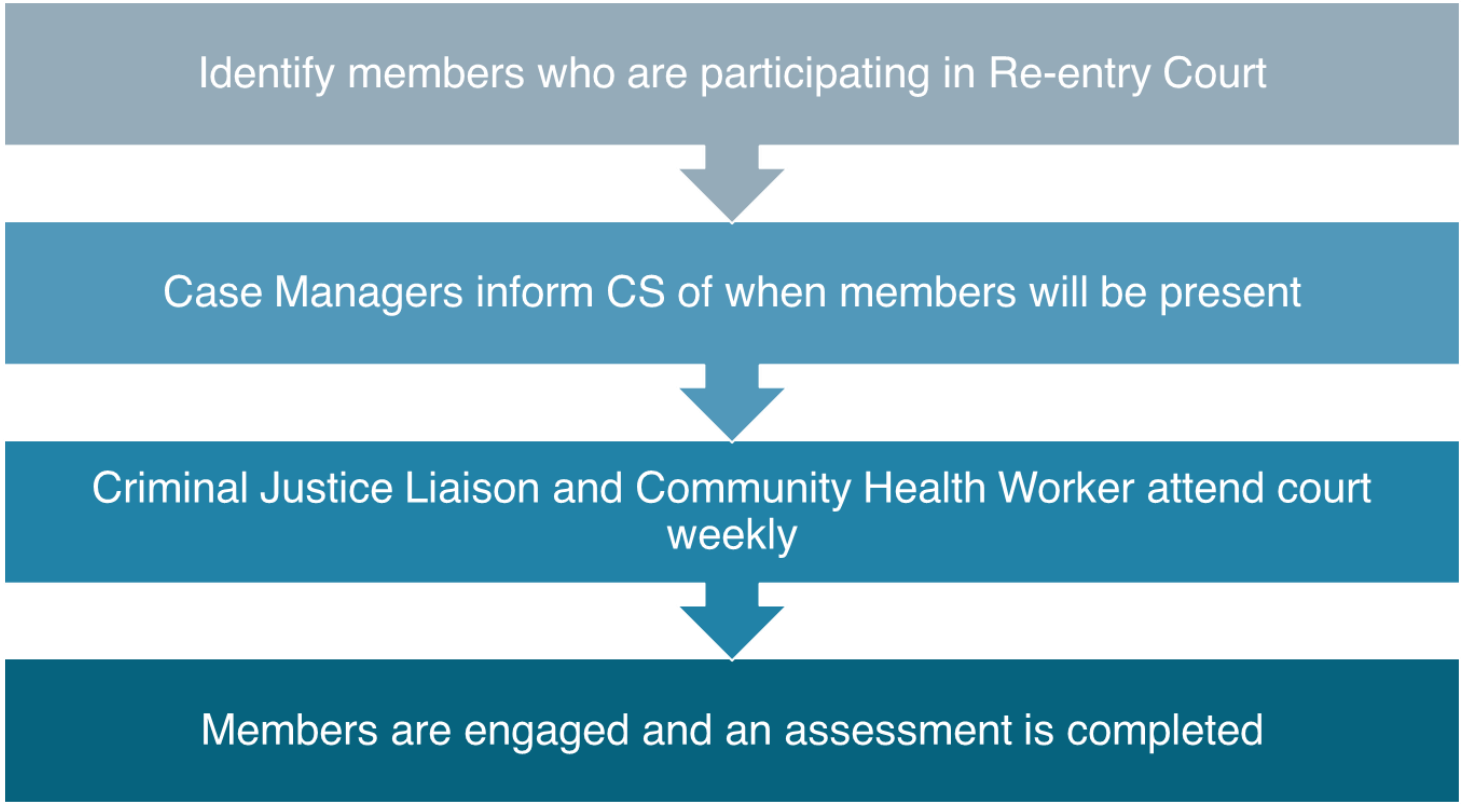
Collaboration with State Entities

- CareSource has worked with OMPP, IDOC and FSSA to enhance re-entry processes.
- We now receive a list of individuals scheduled to leave incarceration in the next 21 days.
- We process this list internally to determine who are our members and outreach to them.

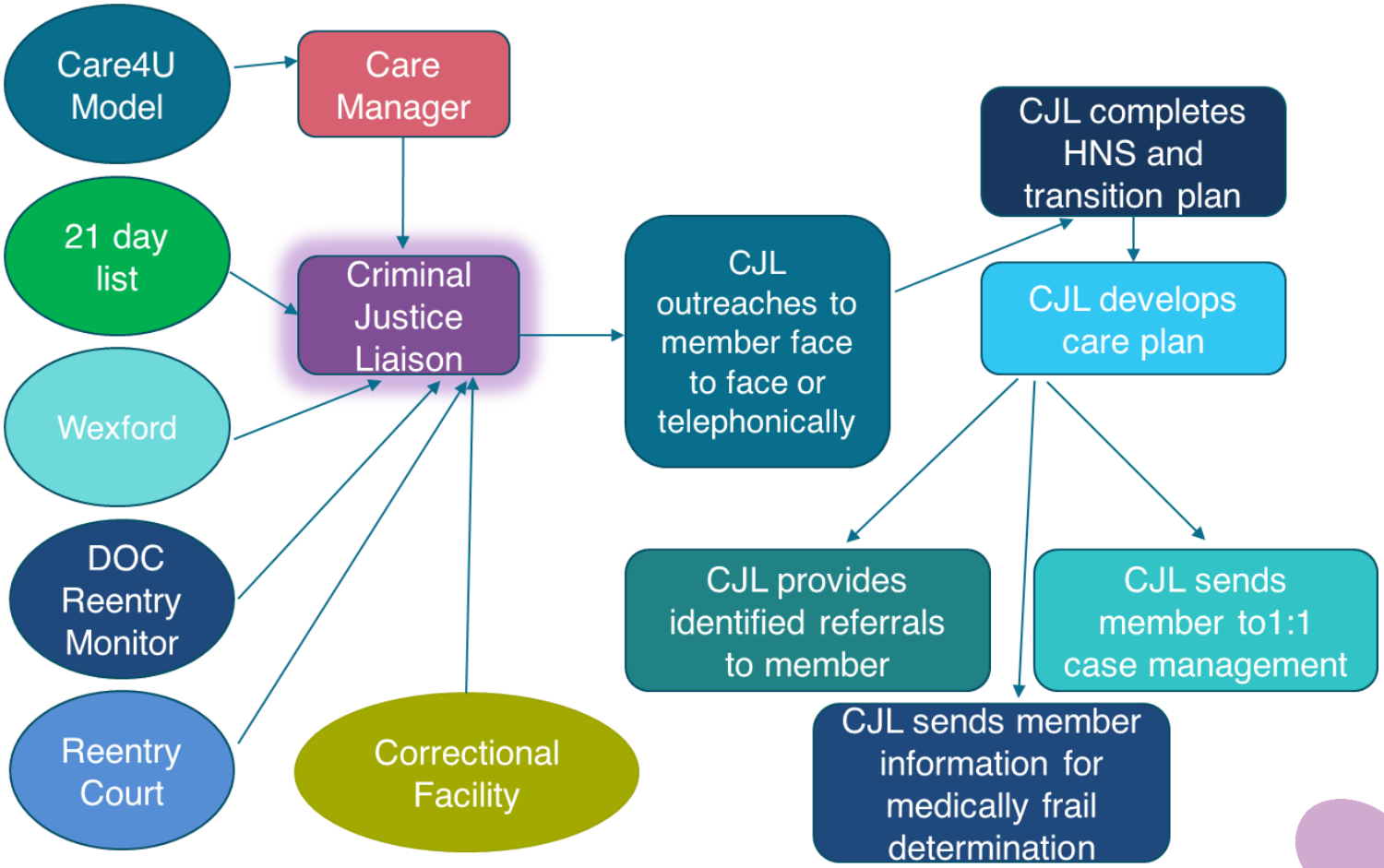
Engagement at Correctional Facilities

- Identified 2 correctional facilities to be pilot sites for face to face engagement of offenders.
- Given the opportunity to provide group education and meet with offenders individually.

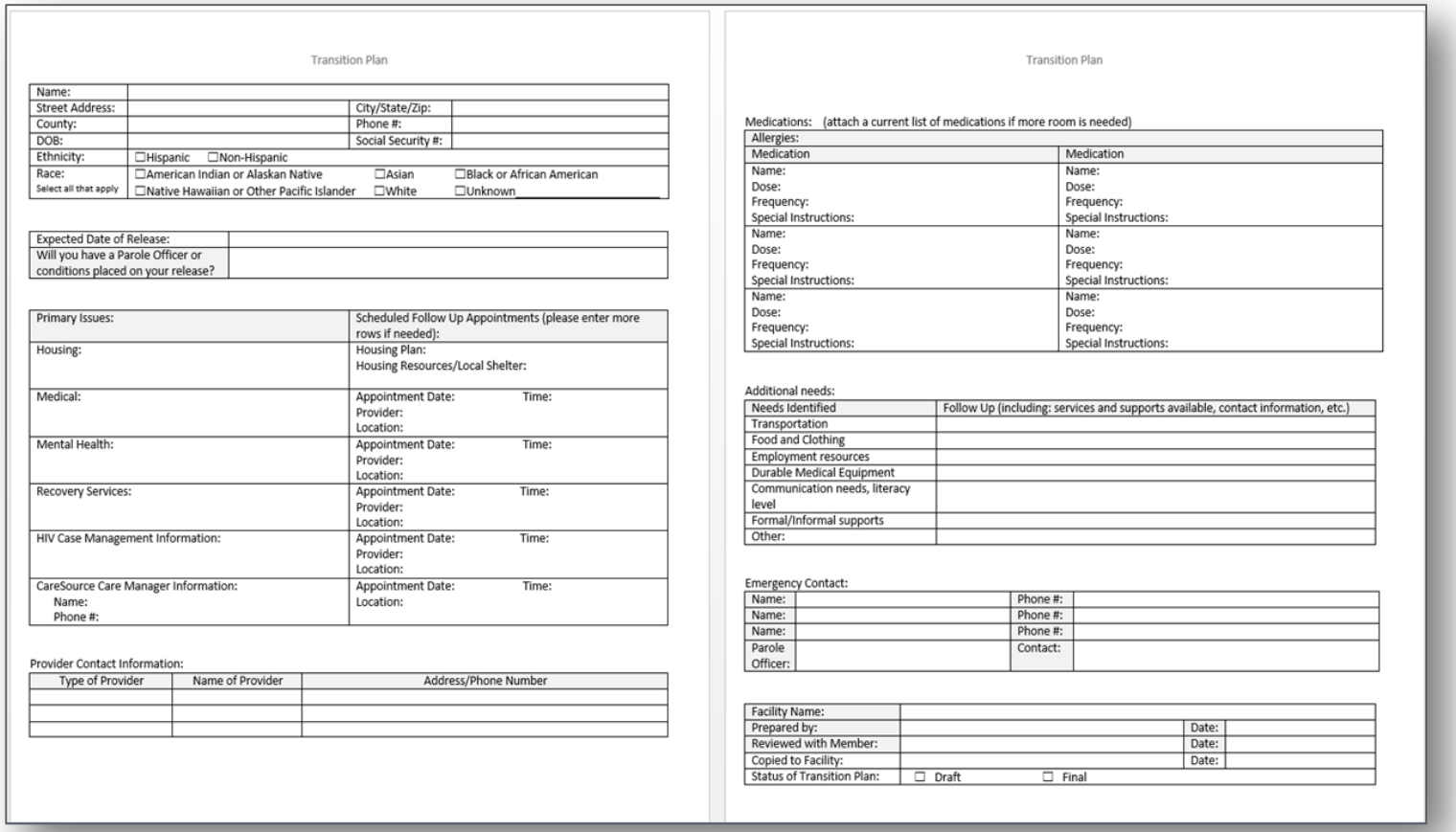
Re-entry Court



Re-entry Process Pathway



Transition Form



Transition Plan

Name:			
Street Address:		City/State/Zip:	
County:		Phone #:	
DOB:		Social Security #:	
Ethnicity:	☐Hispanic ☐Non-Hispanic		
Race: Select all that apply	☐American Indian or Alaskan Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Unknown_____		

Expected Date of Release:	
Will you have a Parole Officer or conditions placed on your release?	

Primary Issues:	Scheduled Follow Up Appointments (please enter more rows if needed):
Housing:	Housing Plan: Housing Resources/Local Shelter:
Medical:	Appointment Date: Time: Provider: Location:
Mental Health:	Appointment Date: Time: Provider: Location:
Recovery Services:	Appointment Date: Time: Provider: Location:
HIV Case Management Information:	Appointment Date: Time: Provider: Location:
CareSource Care Manager Information: Name: Phone #:	Appointment Date: Time: Location:

Provider Contact Information:

Type of Provider	Name of Provider	Address/Phone Number

Transition Plan

Medications: (attach a current list of medications if more room is needed)

Allergies:	
Medication	Medication
Name: Dose: Frequency: Special Instructions:	Name: Dose: Frequency: Special Instructions:
Name: Dose: Frequency: Special Instructions:	Name: Dose: Frequency: Special Instructions:
Name: Dose: Frequency: Special Instructions:	Name: Dose: Frequency: Special Instructions:

Additional needs:

Needs Identified	Follow Up (including: services and supports available, contact information, etc.)
Transportation	
Food and Clothing	
Employment resources	
Durable Medical Equipment	
Communication needs, literacy level	
Formal/Informal supports	
Other:	

Emergency Contact:

Name:		Phone #:	
Name:		Phone #:	
Name:		Phone #:	
Parole Officer:		Contact:	

Facility Name:			
Prepared by:		Date:	
Reviewed with Member:		Date:	
Copied to Facility:		Date:	
Status of Transition Plan:	☐ Draft ☐ Final		

Case Management and the Re-entry Population

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Evaluation of Medical Needs

Relevant assessments done to determine needs

- Health Needs Screening
- Transition Questionnaire
- PHQ-2/PHQ-9 (embedded in many of the assessments)
- Adult and Pediatric Needs Assessment
- Indiana Prenatal Assessment
- Comprehensive/Overlay Assessment

Care Plan created based on medical history, social needs and assessment results

Provide Necessary Referrals

- Refer member to PMP to establish medical home
- Refer member to behavior health provider as necessary
- Locate specialty providers
- Arrange transportation as necessary
- Facilitate prior authorizations for services and medications
- Organize care conferences
- Facilitate communication between providers
- Make internal referrals; 1:1 case management, medically frail, Life Services, Tobacco Quitline, and MyStrength.
- Make external referrals; food pantries, housing, Father's and Families, etc.

Coordination of Planned Interventions

- Schedule necessary labs, tests and follow-up appointments
- Review health benefits and coverage
- Assist with obtaining necessary DME
- Review care gaps/preventative screenings
- Locate a PMP and schedule a new patient appointment

Optimize Use of Member Benefits

- Educate members on insurance benefits
- Encourage payment of POWER account contribution
- Highlight plan differences
- Educate on insurance card
- Educate on use of CareSource app
- Educate on overutilization of services, including ED
- Medically Frail Determination

Meeting Mental Health and Substance Abuse Needs

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Behavioral Health Case Management

Behavioral Health is fully integrated with physical health in the Care4U model. We address the whole person.

Members provided case management based on behavioral health triggers:

- Serious mental Illness
- Major Depression
- Suicide or self-harm prior authorization
- Behavioral health diagnosis and pregnancy or postpartum
- Psychiatric or substance abuse hospitalization

Behavioral Health Case Management

- The transitions team provides these members at least 90 days of case management with several touchpoints during this time.
- Facilitate IOP, PHP, individual therapy, group therapy, and MRO services.
- We provide notification to BH providers and PMP of BH admissions within 5 days
- 7-day follow-up after a behavioral health inpatient stay is coordinated for the member.

Case Management for Substance Use Disorder

- We will assist members with finding MAT providers.
- No prior authorization for MAT medications, including Vivitrol
- Coverage for residential SUD treatment

Medically Frail Determination

Medical

- Cancer
- Stroke
- Transplant or transplant wait list
- HIV, AIDS
- Blood clotting disorders
- Lipid storage diseases
- Primary immune deficiencies
- Paraplegia or quadriplegia
- Muscular dystrophy
- Primary pulmonary hypertension
- Amyotrophic lateral sclerosis
- Cirrhosis
- Chronic hepatitis B or hepatitis C
- Cystic fibrosis
- Diabetes mellitus/end-stage renal disease
- CMV retinitis
- Tuberculosis

Behavioral Health

- Alcohol and substance abuse
- Mental illness including major depression, schizophrenia, bipolar disorder, or post-traumatic stress disorder

Activities of Daily Living

Need assistance with:

- 24 hour supervision and/or direct assistance to maintain health or safety
- Turning or repositioning every 2 to 4 hours
- Eating, dressing, or bathing
- Transferring from bed or chair
- Using the toilet
- Walking or using a wheelchair

Life Services

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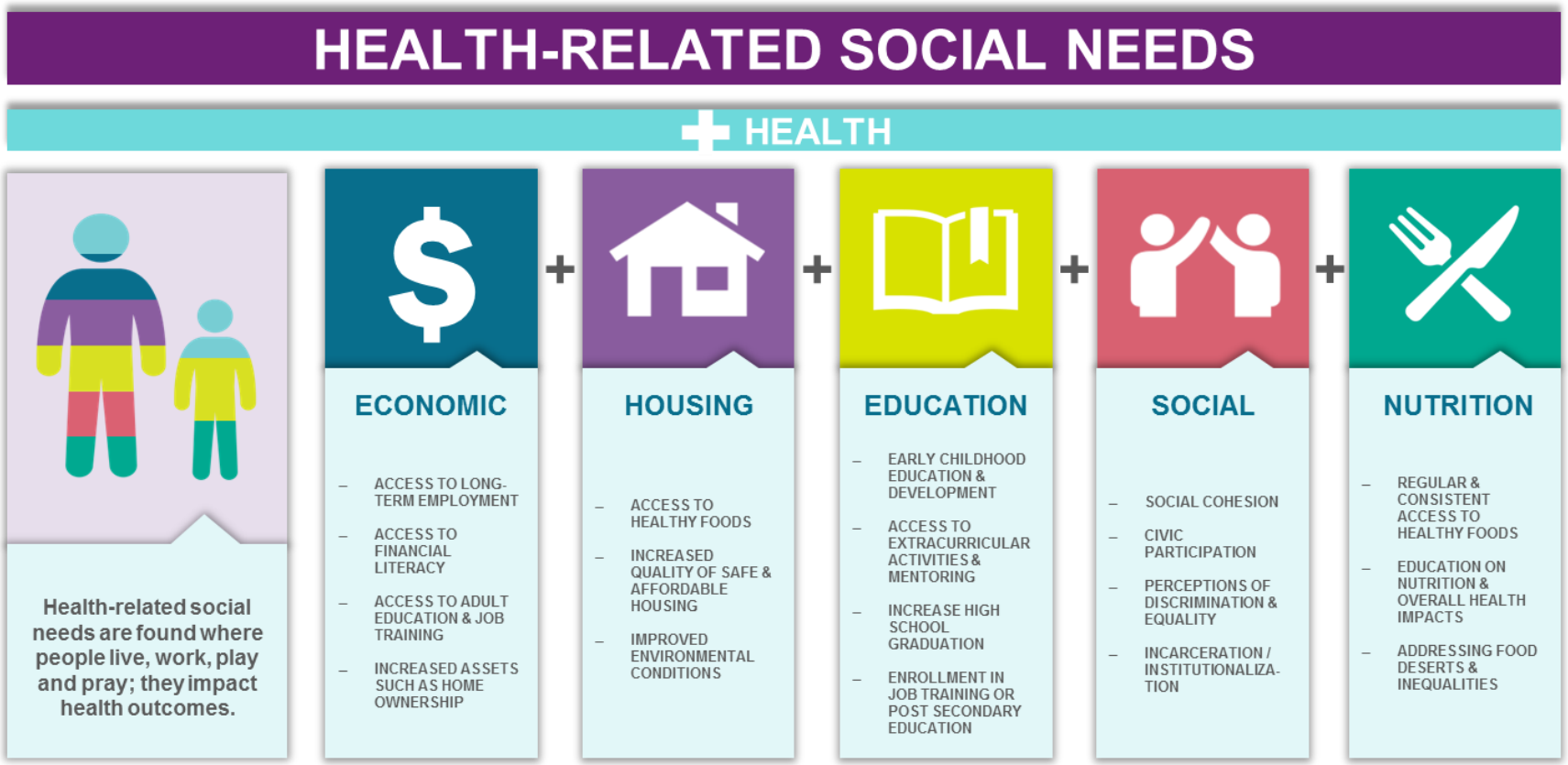
CareSource Life Services



Addressing the **social determinants of health** well beyond health care.

Criminal Justice and Employment

- 36% of returning citizens do not have a GED or Diploma
- Having a history of incarceration (jail or prison) can reduce your chance of being hired by 15-30%
- 60% of employers surveyed stated they would not consider hiring a job applicant with a criminal history
- Many job avenues are closed to those with a criminal record including: childcare, barber, nurse, security guards, etc.

https://www.prisonlegalnews.org/news/2011/dec/15/study-shows-ex-offenders-have-greatly-reduced-employment-rates/

JobConnect Components

Proud *Partnerships*

American Senior Communities

Cummins

Fastenal

FedEx

Goodwill

Lippert Components

Pepsi

Sysco

UPS

Walgreens

JobConnect Facts

≥ 90 employer partners

24 new employer partners in Q1 2018

~ 50% of all employer partners identify as second chance employer

29% of JobConnect members are criminal justice - involved

36% of JobConnect members with felonies are employed

JobConnect Employment Placement Partners

City
- City of Indianapolis Mayor's Office for Re-entry
- City of Indianapolis HIRED program

County
- Marion County Re-entry Coalition
- Public Advocates for Community Re-entry (PACE)

State
- Indiana Department of Workforce Development HIRE program

National
- SAFER Foundation

Other JobConnect Initiatives

- Co-chairing the **Marion County Re-entry Coalition Sector Partnership Task Force** to bring talent, employers, educators and support services together
- Submitted multiple grant applications to fund additional JobConnect positions and growth in re-entry efforts

Quality and Analytics

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Program Quality Metrics

Pre-screen 0-60 days prior to release	Process Measures	Intermediate Impact	Short-term Outcomes	Long-term Outcomes
% Completed intake information: **1. Transition form** **2. Health Needs Screening** **3. Transition Plan** **4. Referral to PMP, BH provider**	%CM Assessment w/in 5 days of release #Members identified for 1:1 coordination %PMP visit within 7 days of release %Participating in CM program as identified % Participating in Life Services	%Employed %Preventive visit %HNS completed %Medication Adherence (PDC) (targeted chronic care conditions) %SUD treatment compliance (as identified) % Adherent to HEDIS targets IET, AMM, AAP	Rate ED visit/1000 members Rate inpatient admission/1000 members Total Cost PMPM Total Medical Cost PMPM Total Pharmacy Cost PMPM Recidivism rate	Recidivism rate Rate of HEDIS measures

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