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
Concerns of Returning Citizens
## Health Status of Returning Citizens

<table>
<thead>
<tr>
<th>Physical Health</th>
<th>Behavioral Health</th>
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<tbody>
<tr>
<td>40% have at least one chronic health condition</td>
<td>Up to 25% have serious mental illness</td>
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<td>Hepatitis C is 9 -10x higher</td>
<td>70% have substance use disorder (SUD)</td>
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<td>Tuberculosis is 4x higher</td>
<td>High incidence of comorbid SUD and SMI</td>
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<td>STIs are high</td>
<td>Post-traumatic Stress Disorder is prevalent</td>
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<td>HIV is 4 -5x higher</td>
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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
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
CareSource’s Re-Entry Goals

- Identify members in this population
- Effectively use Care4U to manage care & encourage compliance
- Use Life Services to assist members with social needs related to housing, food, employment
- Assure high quality care in this population by tracking & trending outcomes

Facilitate the long-term health and well-being of members of this population
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

- Identify members who are participating in Re-entry Court
- Case Managers inform CS of when members will be present
- Criminal Justice Liaison and Community Health Worker attend court weekly
- Members are engaged and an assessment is completed
Re-entry Process Pathway

Care4U Model

21 day list

Wexford

DOC Reentry Monitor

Reentry Court

Care Manager

Criminal Justice Liaison

CJL completes HNS and transition plan

CJL develops care plan

CJL sends member to 1:1 case management

CJL sends member information for medically frail determination

CJL provides identified referrals to member

CJL outreaches to member face to face or telephonically

Correctional Facility
Case Management and the Re-entry Population
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
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
CareSource Life Services

Addressing the social determinants of health well beyond health care.

HEALTH-RELATED SOCIAL NEEDS

**ECONOMIC**
- Access to long-term employment
- Access to financial literacy
- Access to adult education & job training
- Increased assets such as home ownership

**HOUSING**
- Access to healthy foods
- Increased quality of safe & affordable housing
- Improved environmental conditions

**EDUCATION**
- Early childhood education & development
- Access to extracurricular activities & mentoring
- Increase high school graduation
- Enrollment in job training or post-secondary education

**SOCIAL**
- Social cohesion
- Civic participation
- Perceptions of discrimination & equality
- Incarceration / institutionalization

**NUTRITION**
- Regular & consistent access to healthy foods
- Education on nutrition & overall health impacts
- Addressing food deserts & inequalities

Health-related social needs are found where people live, work, play and pray; they impact health outcomes.
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.

JobConnect Components

- Resume writing
- Financial Assistance
- Interview Preparation
- Job Training/ Skill Development
- Transportation
- Education Assistance

Life Coach
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
# Program Quality Metrics

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

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