OACHC 2020 Diabetes Collaborative
CareSource 2020 Diabetes
Strategy and Beyond

DALE J. BLOCK, MD, MBA
Ohio Market Medical Director, Medicaid and Marketplace
Who is CareSource?
Our MISSION
To make a lasting difference in our members' lives by improving their health and well-being.

CARESOURCE
- A nonprofit health plan and national leader in Managed Care
- 30-year history of serving low-income populations across multiple states and insurance products
- Currently serving members in Georgia, Indiana, Kentucky, Ohio and West Virginia
- 4,300+ employees located across 30 states

1.8M members
We will always put people over profit.

- Best-in-class administrative cost ratio delivers maximum benefits to members while being responsible stewards of government funds
- Serving members across the continuum of government programs, coordinating care as their eligibility changes
- Comprehensive, member-centric models of care to address our entire population’s health and social needs
- Help members navigate through daily life challenges and obstacles

As a non-profit, member-centric company, we are accountable to our members and the communities we serve - not shareholders.

8% Administrative Costs
91% Medical Cost Ratio
Redefining the Agenda
REDEFINING the Agenda

From the very beginning CareSource has been a disruptive force in the landscape of health care.

We firmly believe that the future of health care will be shaped by those who innovate and drive value for consumers.

The CareSource model is not business as usual. We bring innovative thinking and services to members, providers and government organizations.

Care4U
CareSource Life Services
CareSource Foundation
Our POPULATION HEALTH Approach

CareSource continues to lead health care in an innovative, new direction.

Care4U is a game-changing, holistic population health model. Through tailored care plans, CareSource can address the needs with the greatest impact for each individual member. The model fully integrates our commitment to Primary Care & Prevention, Care Management, Behavioral Health and Life Services, promoting health and wellness across the entire continuum of the population we serve.

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Care4U

No matter where our members are in their stage of wellness, we have services and supports for them.

- **CARE MANAGEMENT**
  One-on-one attention to support health needs

- **DISEASE MANAGEMENT**
  Assistance managing issues like diabetes, asthma, high blood pressure or high cholesterol

- **TOBACCO CESSATION**
  Health coaching from a Certified Tobacco Treatment Specialist

- **WOMEN & CHILDREN’S HEALTH**
  Pre-pregnancy and pregnancy programs plus support for young children

- **BEHAVIORAL HEALTH**
  Mental health and substance use services and resources

- **WELLNESS**
  Online wellness tool to learn about health topics

- **HEALTH RISK ASSESSMENT**
  Clarity on personal health and wellness including physical, mental and social health

We focus on our members’ health and socioeconomic needs.

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

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

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

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

**Social Relationships**
- Social cohesion
- Civic participation
- Perceptions of discrimination & equity
- Incarceration / institutionalization

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

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CareSource ™

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CareSource Life Services
HOW WE OPERATIONALIZE THE MODEL

We have created a “no-wrong door” approach to serving members.

A Life Coach and member begin a relationship that is focused on the member’s current resources, skills, talents and wishes for long-term employment through weekly interactions.

The Life Coach recommends an education path.

The Life Coach will begin to connect the member directly with employment opportunities.

The Life Coach will continue to meet with the member for up to 24 months to assist in retention efforts as well as advancement into the next steps on the career path and support with developing other life skills.
Ohio Market Quality Strategy
2020 CareSource
Ohio Quality Strategy

Guiding Forces

Pillars of Strategy

Ohio Department of Medicaid and Managed Care

Managed Care Organizations Collaboration

Member-Focused Approach

Ohio Department of Medicaid Value Programs
ODM-MCP Collaborative COVID-19 Response
**All MCP COVID-19 Population Health Quality Strategy  KDD**

To improve the state of Ohio’s overall health ranking, improve the ranking of the state's COVID response, and reduce disparities

<table>
<thead>
<tr>
<th>Vulnerable Populations</th>
<th>Healthy Ohioans</th>
<th>Social Determinants of Health</th>
<th>Provider / System Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide improved access and care to enable self management of chronic conditions and those that are high risk (pregnancy, newborns, elderly)</td>
<td>Decrease transmission of COVID and provide improved access and care to keep all Ohioans healthy</td>
<td>Improve the health of communities across Ohio</td>
<td>Provide resources to reduce burden on the healthcare system in rural and urban areas</td>
</tr>
</tbody>
</table>

**Congregate Settings Global Aims**

- Ensure access to a location to quarantine post-release (State prisons and jails) and smooth transition
- Ensure those transitioning between SNF, assisted living, group homes and other settings have needed supports and safety

**Vulnerable Populations Global Aims**

- Ensure have the ability to seek pregnancy and post-partum care in both urban and rural settings
- Ensure ability to self-manage chronic conditions
- Ensure access to COVID testing and support for isolation/quarantine
- Ensure access to equitable care

**Healthy Ohioans Global Aims**

- Ensure children receive age appropriate immunizations, in both urban and rural areas
- Ensure adults receive appropriate preventative services (cancer screening and well checks) in both urban and rural settings
- Increase resources to address social isolation and other behavioral health needs

**SDoH Global Aims**

- Improve ease of access to transportation
- Improve access to care via telehealth with a focus on reducing the digital divide
- Ensure access to housing and food during quarantine

**Provider/ Systems Global Aims**

- Reduce barriers to provision and billing of telehealth services
- Ensure providers have resources to provide telehealth and other appropriate services
- Ensure rural and safety net (i.e., CPCs, FQHCs) providers have needed supports

**Social Determinants of Health**

- Improve the health of communities across Ohio

**Provider / System Support**

- Provide resources to reduce burden on the healthcare system in rural and urban areas

**Healthy Ohioans**

- Decrease transmission of COVID and provide improved access and care to keep all Ohioans healthy

**Congregate Settings**

- Provide safe transitions and needed support

**Support adequate resources for COVID testing and tracing**

**Helping those who are COVID positive**

**Provider / System Support**

- Provide resources to reduce burden on the healthcare system in rural and urban areas

**Likely greater individual plan focus, with shared learnings**

**Plans to participate in State wide staffing and measure/ track participation, but not drive overall work in this space**
ODM-MCP Collaborative
DM Quality
Improvement Plan
What can we do to make the Diabetes QIP relevant now with COVID-19?

- Implement 90-day Rx delivery to member’s place of residence
- Promote glucometers and home arm blood pressure monitors
  - Shipped directly to the member’s place of residence
- Promote CST (Critical Signals Technology) partnership
  - Provides glucometers with Bluetooth data uploads
  - Tracking diabetic health needs remotely
- Promote Health Coaching
  - Member identification
    - Clinical practice sites input
    - MCO PHM risk stratification
  - Nutrition and exercise counseling
What can the MCPs do to encourage the use of telehealth to manage Diabetes?

- Determine technology needs
  - Survey providers
  - Overcome Digital Divide for members
- Virtual Care Management
- Virtual peer-led community-based DSME
  - Vendor partnership with Evi-Base
- Developing community partnership with YMCA
  - Virtual DSME services
  - Diabetes Prevention Program
- Advocate for continued relaxation of telehealth/telemedicine rules
  - Advocate inclusion of preventive/WCC CPT codes
How will COVID-19 pandemic impact choice of interventions for testing?

- Current member focus for outreach
  - A1C > 8
  - No A1C in past calendar year
- Delay clinical optimization
  - Annual diabetic eye examination
  - Annual diabetic foot examination
- Home Health Visits (resumed F2F after 2 month suspension)
  - Close gaps in care
  - Extension of office into the home
  - Outreach for social isolation
All Plan Standardization

- All plans developed standardized forms
  - Diabetic care coordination
  - Diabetic testing supplies
- Efficient and effective
- Decreases provider abrasion
- Contact information for each of the plans
# All Plan Diabetic Testing Supplies Form

## Patient Information
- **First Name:**
- **Last Name:**
- **Address:**
- **City:**
- **State:**
- **ZIP:**
- **Phone:**
- **Fax:**

## Medication Information
- **Prescription Order:**
- **ICD-10 Diagnosis Code:**
- **Sign/Physician Order:**

## Provider Information
- **Provider:**
- **Contact Name:**
- **NPI:**
- **TIN:**
- **Phone:**

## Plan Information
- **Plan Contact:**
- **Plan Contact:**
- **Plan Contact:**
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- **Plan Contact:**

## Diabetic Supplies Coordinated Under Pharmacy Benefit
- **Diabetic Supplies Coordinated Under Pharmacy Benefit:**
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## Additional Information
- **Physician Signature:**
- **Physician’s Name:**

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*Fax only to the Provider matching the identified MCP Diabetes*

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*Versions 6.0 - CareSource*
# All Plan Diabetic Care Coordination Form

## Patient Information

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contact Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIP:</td>
<td>TIN:</td>
<td></td>
</tr>
</tbody>
</table>

### Plan Coordination Options

- **Aetna**: Care Coordination 1-855-764-0974
- **BlueCross**: Care Coordination 1-866-246-4355
- **CareSource**: Care Coordination 1-833-888-3388
- **Centene**: Member Services 415-387-3399
- **United Health Care**: Member Services 1-800-562-5581
- **Molina**: Member Services Medicaid: 800-442-4168

### General Information

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Contact Name</th>
<th>City, State, Zip</th>
<th>Phone</th>
</tr>
</thead>
</table>

### Medical Information

- **Patient First & Last Name**: [Name]
- **Medicaid ID**: [ID]
- **Date of Birth**: [Date]

### Additional Comments:

- **Referral to Nutrition/Dietician Services**: [Referral]
- **Referral to Optometry Services**: [Referral]
- **Referral to Podiatry Services**: [Referral]
- **Referral to QMFP Training**: [Referral]
- **Referral to QMFP Self-Management Training**: [Referral]
- **Referral to Smoking Cessation**: [Referral]
- **Transportation Assistance Needed**: [Yes/No]
- **Referral to Behavioral Health Professional**: [Referral]
  - [Depression]
  - [Bipolar disorder]
  - [Anxiety]
  - [Other: ____________]

### Fax Information

Fax only to the Provider matching the identified MCP

**Diabetes**

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**CareSource™**

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Model for Improvement & Theory of Knowledge

Change ideas = Interventions

What change(s) can we make that will result in improvement?

SMART Aim

What are we trying to improve?

Drivers

What will impact the SMART Aim?

What do we believe will lead to improvement?

Interventions

How will we make this change operational?

How will we apply this change?

PDSA Tests of Change

Outcome, Process, and Balancing Measures

How will we know that a change is an improvement?

**Improvement Science Resources**

- **What's your theory?**
  - [https://www.apiweb.org/QP_whats-your-theory_201507.pdf](https://www.apiweb.org/QP_whats-your-theory_201507.pdf)

- **The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement**
  - [http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx](http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx)

- **The Problem with Plan-Do-Study-Act cycles**
  - [https://qualitysafety.bmj.com/content/25/3/147.full?sid=4b04c2a5-69c3-40a8-8a56-c97193a721ec](https://qualitysafety.bmj.com/content/25/3/147.full?sid=4b04c2a5-69c3-40a8-8a56-c97193a721ec)

- **Games & Exercises**
  - [http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Tools/default.aspx](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Tools/default.aspx)
Collective Impact

For all MCPs to be successful, we must identify the needs of our members and clinical practice sites in order to meet them where they are, and begin creating necessary interventions to reach our collective goals.
Thank you!

Questions?