Medica

Transition of Care

Lunch and Learn

Agenda

1. **Define Transition of Care**
   Courtney Chupurdy
2. **Importance of transitions, challenges & consequences of disruptions, and strategies for care management teams**
   Dr. Schellhase
3. **TOC Policies and Processes**
   Ashley Heehn
4. **Behavioral Health Transitions and Resources**
   Dr. Jean Balestrery, Liz Melcher, and Marsha Schauer

What is a Transition of Care?

- A transition of care is when a member moves from one setting of care to another, including moving back to one's usual care setting

Settings of care may include:

Hospital	Skilled Nursing Facility	Custodial Nursing Facility	Regional Treatment Center	Rehabilitation Facility
	Home	Inpatient Psychiatric Hospital	MH or SUD Residential Treatment	

- Note: any movement between sites of care is a separate transition

Why is Transition of Care Important?

When members move from one care setting to another, they are at risk of adverse outcomes due to fragmented care

Members are vulnerable following a transition and may need support understanding discharge instructions

This can be viewed as an opportunity to engage with members, especially if they have been unable to reach

The Care Coordinator has an important role in the TOC process:

-Help ensure ICT collaboration
-Help with adjustment to new care settings
-Can help reduce ED visits and readmissions
-Ensures there is one consistent person to support the member through each transition

Importance of transitions, challenges & consequences of disruptions, and strategies for care management teams

Dr. Schellhase

TOC Policies and Processes

Ashley Heehn

Documentation Requirements

Transition Log **(Now required for ALL products)**

CC Notification Date

Documentation must be present to show:

- Admission/discharge dates
- Communication with the receiving care setting
- Communication with PCP
- Communication with the member/responsible party
- Return to usual setting conversations occurred

- Verification follow-up appointment
- Verification discharge instructions were received and understood
- Verification of medication review completion
- Verification member is able to manage medications or medication management system is in place
- Verification of member's ability to verbalize warning signs and symptoms to watch for and how to respond
- Verification of adequate food, housing, and transportation
- Verification of safety in the home
- Address concerns regarding vulnerability, abuse, or neglect

Update the member's care plan/support plan and share with the member and their Interdisciplinary Care Team.

Case study- Notification

The first step of the transition process is CC notification of transition. This may occur through the CC receiving the Daily Admission Report via email from Medica, an internal EMR alert, a call from the member/their family/guardian, or communication from providers.

Within 1 business day of this notification, Care Coordinators must complete Transition #1 on the TOC log. CCs must have contact with the member or their responsible party, the receiving setting, and the PCP at a minimum.

TRANSITIONS OF CARE (TOC) LOG

TOC tasks should be completed by the CC within one (1) business day of notification of each transition.

Member Name: Bonnie Johnson		**Care Coordinator: Ashley Heehn**	**MCO/Health Plan Member ID#: 01234567**
Product: MSHO		**Agency/County/Care System: Medica**	
Transition #1			
Notification Date: **9/22/2023**	**Transition Date: 9/20/2023**	**Transition From: (Type of care setting)** **Home** **Is this the member's usual care setting?** ☒Yes ☐ No	**Transition To: (Type of care setting)** Hospital
Transition Type: ☐Planned ☒ Unplanned		**Reason for Admission/Comments: Fall, Hip Fracture**	
Contact member/responsible party to offer assistance with transition: 9/22/2023 **Shared CC contact info, care plan with receiving setting—Date completed: 9/22/2023** **Name and title of receiving setting contact: Sarah, unit social worker.**			
Notified PCP of transition—Date completed: 9/22/2023 Name of PCP: Dr. Bernard Method of PCP contact: ☒Fax ☐Phone ☐ EMR ☐ Secure e-mail **(OR)** ☐Member's PCP was the Admitting Physician **Comments: CC contacted Essentia Health St. Mary's by phone and was transferred to 8W where member is presently admitted. CC spoke to unit RN Amy and unit social worker Sarah. They reported member had a fall in her home which resulted in a hip fracture. She had surgery upon admission and will likely d/c to a TCU early next week. CC spoke to member who reported she understand plan to d/c to TCU and reported her pain has been well controlled.**			

Case Study- PCP Notification

FAX

CARE TRANSITION – PROVIDER NOTIFICATION

DATE:	9/22/23		
TO:	Dr. Bernard	FROM:	Ashley Heehn, CC/CM
COMPANY:	Essentia West Duluth Clinic	COMPANY:	Medica
FAX:	218-786-0000	FAX:	952-992-0000
PHONE:	218-786-0001	PHONE:	952-992-0001
SUBJECT:	Care Transition Notification		

MESSAGE:

As your patient's/client's care coordinator/care manager, **I was notified** on 9/22/23 that your

Patient/Client Name: **Bonnie Johnson** DOB: **10/31/1950**

☒ was **hospitalized/admitted** to **Essentia St. Mary's** on **9/20/22**.

☐ was **returned to their usual care setting/home** on .

As your patient's/client's care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

- Support the member through the transition process.
- Provide follow-up care and coordinate needed services or equipment.
- Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member's/client's care transition.

Thank you.

Comments: It was reported that Bonnie had a fall in her home which resulted in a hip fracture. She had surgery and will likely transfer to a TCU early next week.

PCP notification can be done via:

- Fax
- EMR (for appropriate care systems)
- Phone
- CCs can document if the PCP was the admitting physician.

PCP notifications will be requested for audit.

Case Study-Second Transition

The CC should continue to follow the member as they experience any change in care setting. It is common for members to transition from a hospital to a rehab unit or TCU before returning to their usual care setting. Remember to complete Transition #2 on the TOC log as appropriate.

Transition #2 *Complete additional tasks below, if this transition is a return to usual care setting.

Notification Date: 9/25/2023 **Transition To: (Type of care setting)* TCU**

Transition Date: 9/25/2023 **Transition Type:** ☒Planned ☐ Unplanned

Contact member/responsible party to offer assistance with transition: 9/25/2023

Notified PCP—Date completed: 9/25/2023 Name of PCP: Dr. Bernard

Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: 9/25/2023

Name and Title of receiving setting contact Katie, TCU RN Manager

Comments: CC received call from hospital social worker confirming member will d/c today to TCU. CC spoke to member to discuss the move. CC contacted TCU and spoke to RN Manager. It is anticipated to be a short-term stay, less than 30 days. She will notify CC of planned care conferences.

Case Study-Second Transition

FAX

CARE TRANSITION – PROVIDER NOTIFICATION

DATE:	9/25/23		
TO:	Dr. Bernard	FROM:	Ashley Heehn, CC/CM
COMPANY:	Essentia West Duluth Clinic	COMPANY:	Medica
FAX:	218-786-0000	FAX:	952-992-0000
PHONE:	218-786-0001	PHONE:	952-992-0001
SUBJECT:	Care Transition Notification		

MESSAGE:

As your patient's/client's care coordinator/care manager, **I was notified** on 9/25/23 that your

Patient/Client Name: **Bonnie Johnson** DOB: **10/31/1950**

☒ was **hospitalized/admitted** to **North Shore Estates** on **9/25/22**.

☐ was **returned to their usual care setting/home** on .

As your patient's/client's care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

- Support the member through the transition process.
- Provide follow-up care and coordinate needed services or equipment.
- Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member's/client's care transition.

Thank you.

Comments: Bonnie was admitted to North Shore Estates TCU today. It is anticipated to be a short-term stay, less than 30 days.

PCP notification is required for each transition.

Be sure to continue to document all contacts with member, the facility, and other members of the ICT in your case notes.

Case Study- Return Home

Upon the member's return to usual care setting, CC's must complete the final transition on the TOC log.

Transition #4 (if applicable) *Complete additional tasks below, if this transition is a return to usual care setting.

Notification Date: 10/16/2023 **Transition To: (Type of care setting)* Home**

Transition Date: 10/16/2023 **Transition Type:** ☒Planned ☐ Unplanned

Notified PCP—Date completed: 10/16/2023 Name of PCP: Dr. Bernard

Contact member/responsible party to offer assistance with transition: 10/16/2023

Shared CC contact info, care plan/services with receiving setting or, if applicable, home care agency—Date completed: 10/16/2023

Name and Title of receiving setting contact John, Home Care Coordinator

Comments: CC confirmed with TCU SW that member discharged home this morning. Member's DME was ordered and is to be delivered to her home today. Member's daughter is staying with her at her apartment this week to ensure a smooth return home. Senior Friends will be providing PT/OT/RN visits as ordered. Member has a follow up appointment scheduled on Friday which her daughter intends to drive her to.

Case Study Return Home

FAX

CARE TRANSITION – PROVIDER NOTIFICATION

DATE:	10/16/23		
TO:	**Dr. Bernard**	FROM:	**Ashley Heehn, CC/CM**
COMPANY:	**Essentia West Duluth Clinic**	COMPANY:	Medica
FAX:	**218-786-0000**	FAX:	**952-992-0000**
PHONE:	**218-786-0001**	PHONE:	**952-992-0001**
SUBJECT:	**Care Transition Notification**		

MESSAGE:

As your patient's/client's care coordinator/care manager, **I was notified** on 10/16/23 that your

Patient/Client Name: **Bonnie Johnson** DOB: **10/31/1950**

☐ was **hospitalized/admitted** to _____ on _____.

☒ was **returned to their usual care setting/home** on **10/16/23**.

As your patient's/client's care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

- Support the member through the transition process.
- Provide follow-up care and coordinate needed services or equipment.
- Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member's/client's care transition.

Thank you.

Comments: Bonnie returned home on 10/16/23. She has PT/OT/RN visits in place at this time. Follow up appointment scheduled on 10/20/23.

Case Study- Return Home

RETURN TO USUAL CARE SETTING *Complete tasks below when the member is discharging TO their usual care setting.

For situations where the Care Coordinator is notified of the discharge prior to the date of discharge, the Care Coordinator must follow up with the member or designated representative to confirm that discharge actually occurred and discuss required TOC tasks as outlined in the TOC Instructions. (This includes situations where it may be a 'new' usual care setting for the member. (i.e., a community member who decides upon permanent nursing home placement following hospitalization and rehab).

Discuss with Member/Responsible Party:

Check "Yes" - if the member, family member and/or SNF/facility staff manages the following: If "No" provide explanation in the comments section.

☒ Yes ☐ No Does the member have a follow-up appointment scheduled with primary care or specialist? *Medical transitions-the follow up should be within 15 days of discharge. Mental health hospitalizations—the follow up appointment must be with a mental health provider within 7 days discharge*

☒ Yes ☐ No Has a medication review been completed with member? *If no, refer to PCP, home care nurse, MTM, pharmacist*

☒ Yes ☐ No Can the member manage their medications or is there a system in place to manage medications? *(e.g. home care set-up)*

☒ Yes ☐ No Can the member verbalize warning signs and symptoms to watch for and how to respond?

☒ Yes ☐ No Does the member have a copy of and understand their discharge instructions? *If no, assist to obtain copy of discharge instructions, review discharge instructions, and assist to contact PCP to discuss questions about their recent hospitalization.*

☒ Yes ☐ No Does the member have adequate food, housing and transportation? *If no, add goal and discuss additional supports available to the member*

☒ Yes ☐ No Is the member safe in their home? *If no, document needs and support provided*

☐ Yes ☒ No Are there any concerns of vulnerability, abuse, or neglect? *If yes, document concerns and actions taken by Care Coordinator as a mandated reporter*

☒ Yes ☐ No Have you updated the member's care plan? *Add new diagnosis, medications, treatments, goals & interventions, as applicable. If No, provide explanation in comments.*

Comments: CC spoke to member on 10/16/23 to confirm she made it home. She is happy to sleep in her own bed again. She reported she has a follow up appointment scheduled and appropriate supports in place in her home.

Case Study-Return Home

Staying Healthy

Enter a description of any areas with which the person needs assistance for their health.

Bonnie was admitted to Essentia St. Mary's on 9/20/23 due to a fall that resulted in a hip fracture. Following surgery and a TCU stay, she is returning home on 10/16/23. Bonnie's daughter is staying with her for a week. She has PT/OT/RN visits ordered. The following DME was delivered: toilet riser, 4 wheeled walker, reacher.

My Goals

Goal Statement

Bonnie will have no injury from falls.

Target Date

When will this goal be accomplished?

04/01/2024

Priority

High

How My Care Coordinator Will Support Me

Purpose of Care Coordinator Contact

Care Coordinator will follow up with member monthly following recent hospitalization and TCU stay to ensure her safety needs are met at home.

Our Meeting Schedule

Every month

Monitoring progress

Enter a description of the person's progress toward completing the goal. If there is no update, enter the reason or N/A.

10/16/23- Bonnie experienced a fall in her home in September which resulted in a hip fracture. She returned home 10/16/23.

Status of Goal

In Progress

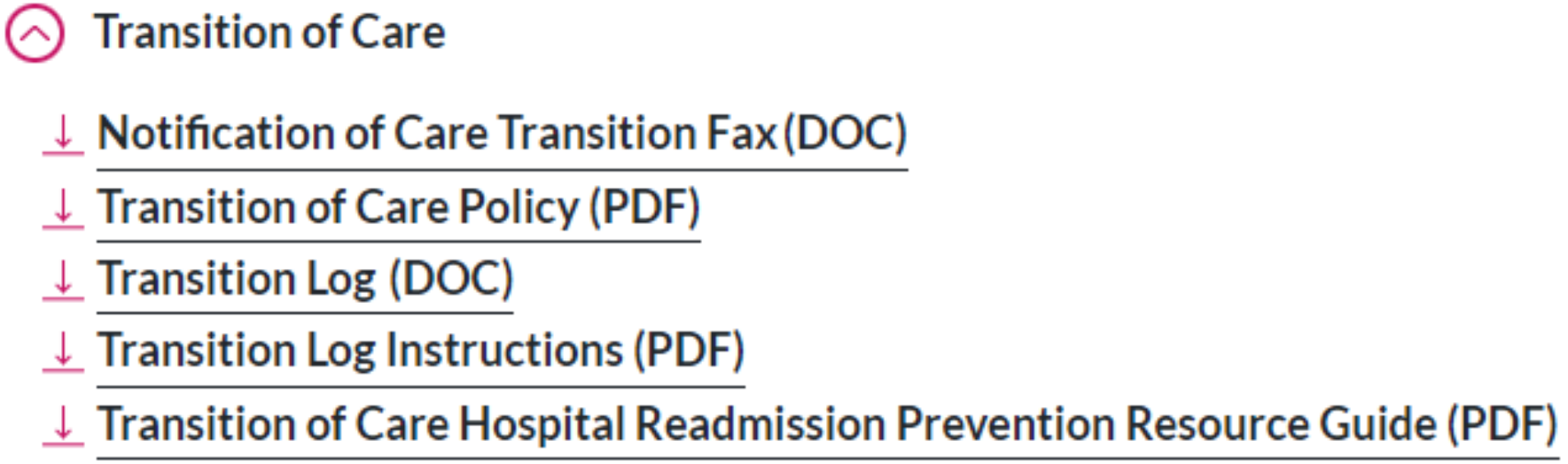
Without Care Coordination Support

Members are at risk of:

- Fragmented care
- Lack of follow up care
- Lack of ICT collaboration
- Unsafe care due to changes
- Unnecessary hospital readmission
- Lower quality of care/satisfaction
- Lack of member-focused care
- Unsafe medication management

Resources

Refer to the Care Coordinator Hub here: Care Coordination | Medica



Behavioral Health Transitions and Resources

Dr. Jean Balestrery, Liz Melcher, and Marsha Schauer

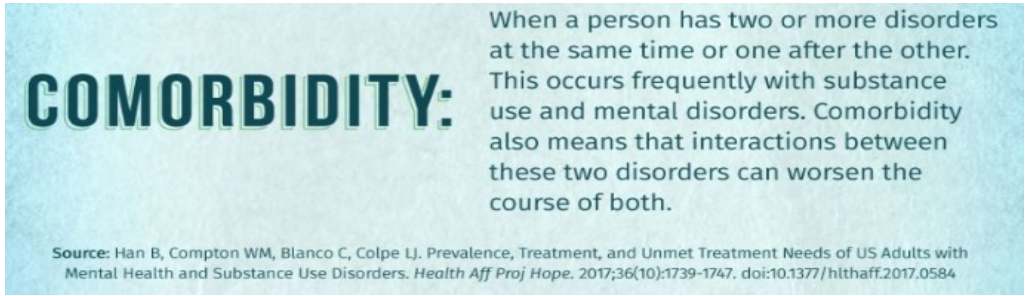
Exploring the Intersections: Mental Health & Substance Use Disorders

•**“Any mental illness (AMI)** is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below).

•**Serious mental illness (SMI)** is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.”

- National Institute of Mental Health

“**Substance use disorder (SUD)** is a treatable mental disorder that affects a person’s brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD.”



Mental Health (MH) + Substance Use Disorder (SUD)
=
Behavioral Health (BH)

*Every admission is a single point of time in a member's life-long journey

*Medica provides notification for Admissions: Any BH Inpatient or Residential treatment

Levels of Care

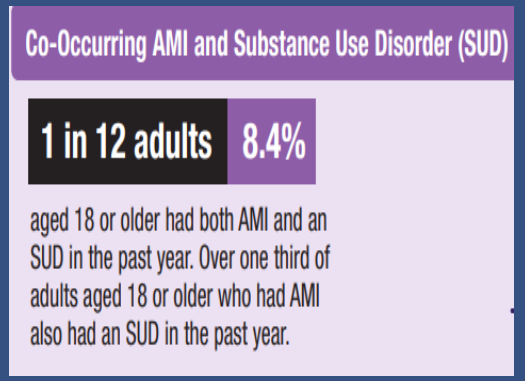
Intensity	Mental Health	Substance Use
Most Intensive  **Least Intensive**	Inpatient 23-Hour Observation Crisis Stabilization Residential Treatment Center (RTC) Partial Hospitalization Program (PHP) Intensive Outpatient Program (IOP) Outpatient/Home Health Services	Inpatient Detoxification Inpatient Rehabilitation 23-Hour Observation Crisis Stabilization Residential Detoxification/RTC PHP IOP Opioid Treatment Services Outpatient

Medica Behavioral Health

Behavioral Health Levels of Care

	Description	Typically Lasts	Duration of Session
Inpatient (IP)	Services rendered/received at a facility such as a hospital or treatment center.	1 - 7 Days	24 hours
Inpatient Detox (Detox)	Used only for Substance Abuse.	1 -3 Days	24 Hours
Residential Treatment (IRTS) (Crisis Res)	A live in health care facility.	1 day - 2 to 3 weeks	24 Hours
Partial Hospitalization (Day Treatment) (PHP)	Comprehensive, short-term, intensive, clinical treatment program.	Several days to a couple weeks	5-8 hours per day, 5-6 times per week (go home in the evening)
Intensive Outpatient (IOP)	Intensive therapy for severe and/or chronic behavioral health conditions.	1 - 6 Weeks	3-4 hours per day, 3-6 times per week
Outpatient (OP)	Individual or Group Therapy	Varies	Usually one 45-50 min visit per week

PREVALENCE & Access-to-Care



- **Almost 1 in 4** U.S. adults aged 18 or older experience any mental illness **(AMI)** each year (23.1% or 59.3 million U.S. adults)
- **1 in 20** U.S. adults aged 18 or older experience a serious mental illness **(SMI)** each year (6.0% or 15.4 million U.S. adults)
- **More than 1 in 6** U.S. adults aged 12 or older had a substance use disorder **(SUD)** in the past year (17.3% or 48.7 million U.S. adults)
  - About 1 in 5 had a severe disorder
  - About 1 in 5 had a moderate disorder
  - More than half had a mild disorder

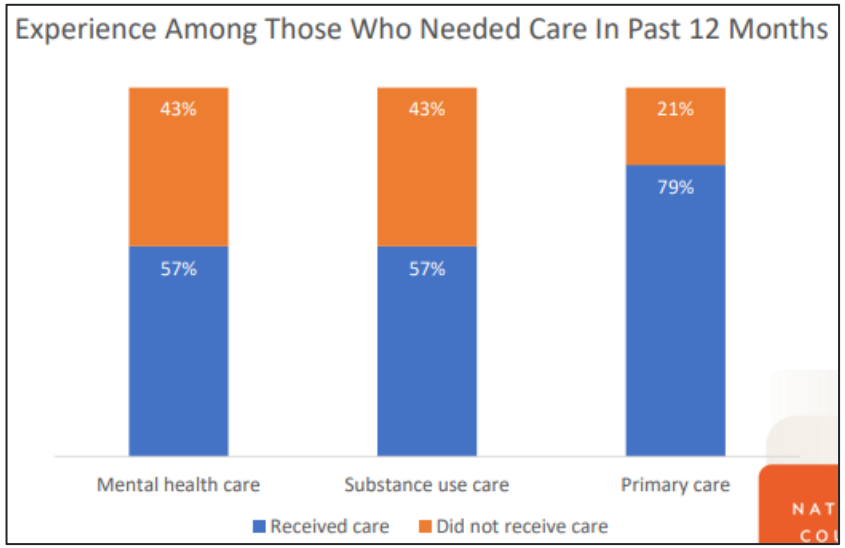
Top barriers to getting needed BH care in past 12 months:

1) More than 1/3 of Americans (37%) say cost-related issues
2) More than 1 in 4 Americans (28%) say not being able to find a provider who was conveniently located
3) 1/4 of Americans (25%) say not being able to find a provider who offers a preferred visit format
4) 3 in 5 Americans (60%) believe there are not enough BH care providers available who accept insurance

Top difficulties for those who got needed BH care in past 12 months:

1) Inconvenient appointment times or locations
2) Having to wait too long to see a provider
3) Having to reach out to several providers to find one accepting new patients

- **"There is a substantial unmet need when it comes to mental health and substance use care, far more so than physical health care needs."**

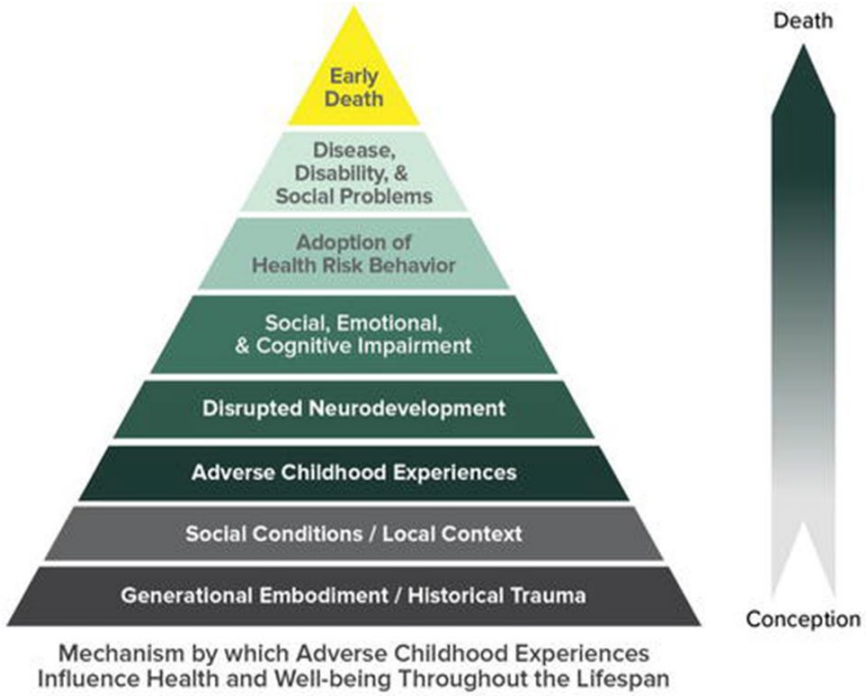


- SAMHSA: 2022 National Survey on Drug Use and Health (NSDUH) & National Council for Mental Wellbeing: 2022 Access to Care Survey Results

FAST FACTS

"There is no health without mental health"
World Health Organization

Behavioral Health + Physical Health = Integrated Care



Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

WORLD

Depression is a leading cause of disability worldwide

Depression and anxiety disorders cost the global economy **$1 trillion** each year in lost productivity

COMMUNITY

21% of unhoused people experience serious mental illness

Depressive disorders are the #1 cause of hospitalization for people aged <18 *after excluding those related to pregnancy and birth*

Psychosis spectrum and mood disorders lead to nearly 600k hospitalizations per year for people aged 18-44

PERSON

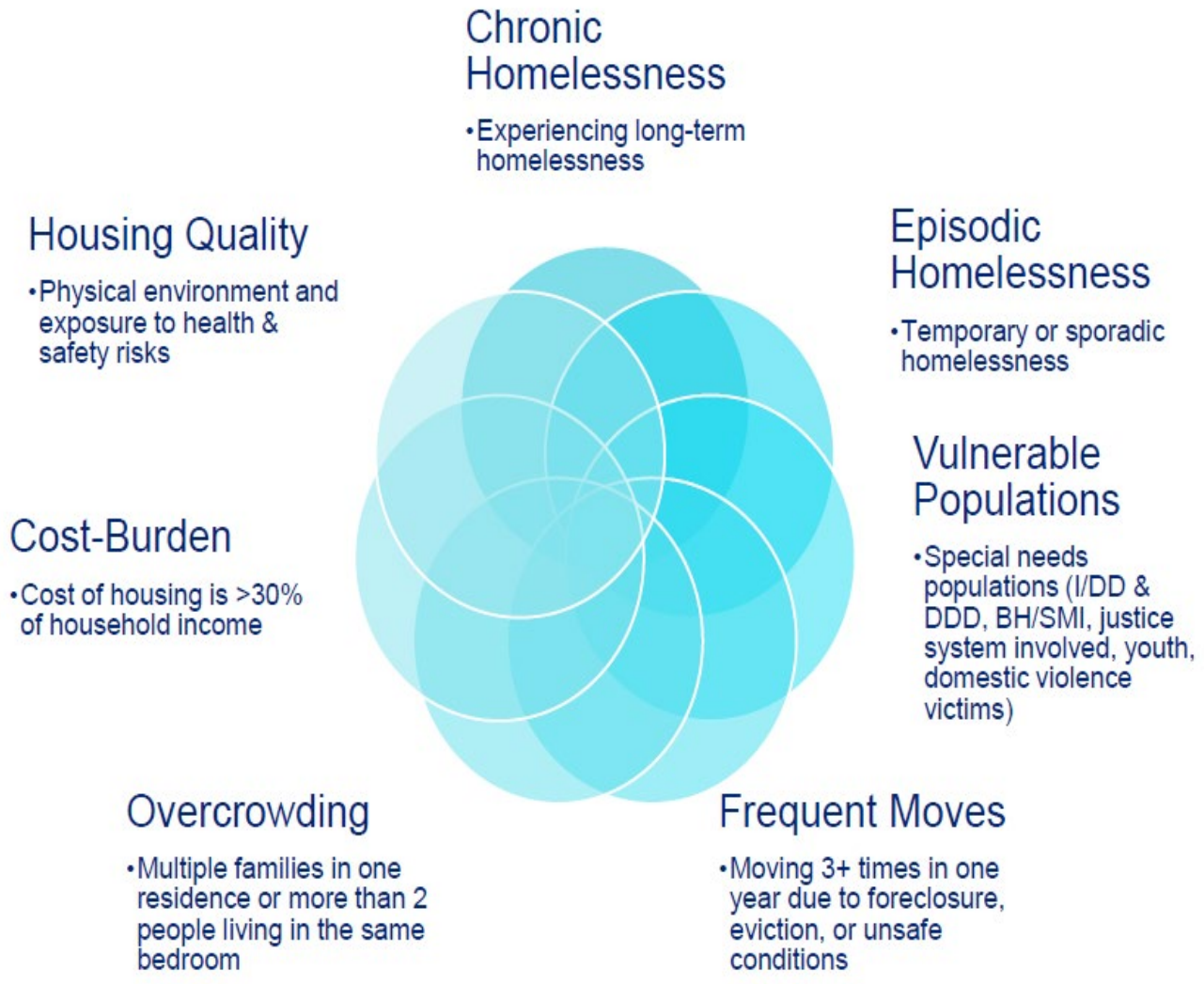
People with serious mental illness have an increased risk for chronic disease, like diabetes or cancer

34% of U.S. adults with mental illness also have a substance use disorder

Rates of cardiometabolic disease are twice as high in adults with serious mental illness

- National Alliance on Mental Illness, NAMI

What is housing instability?

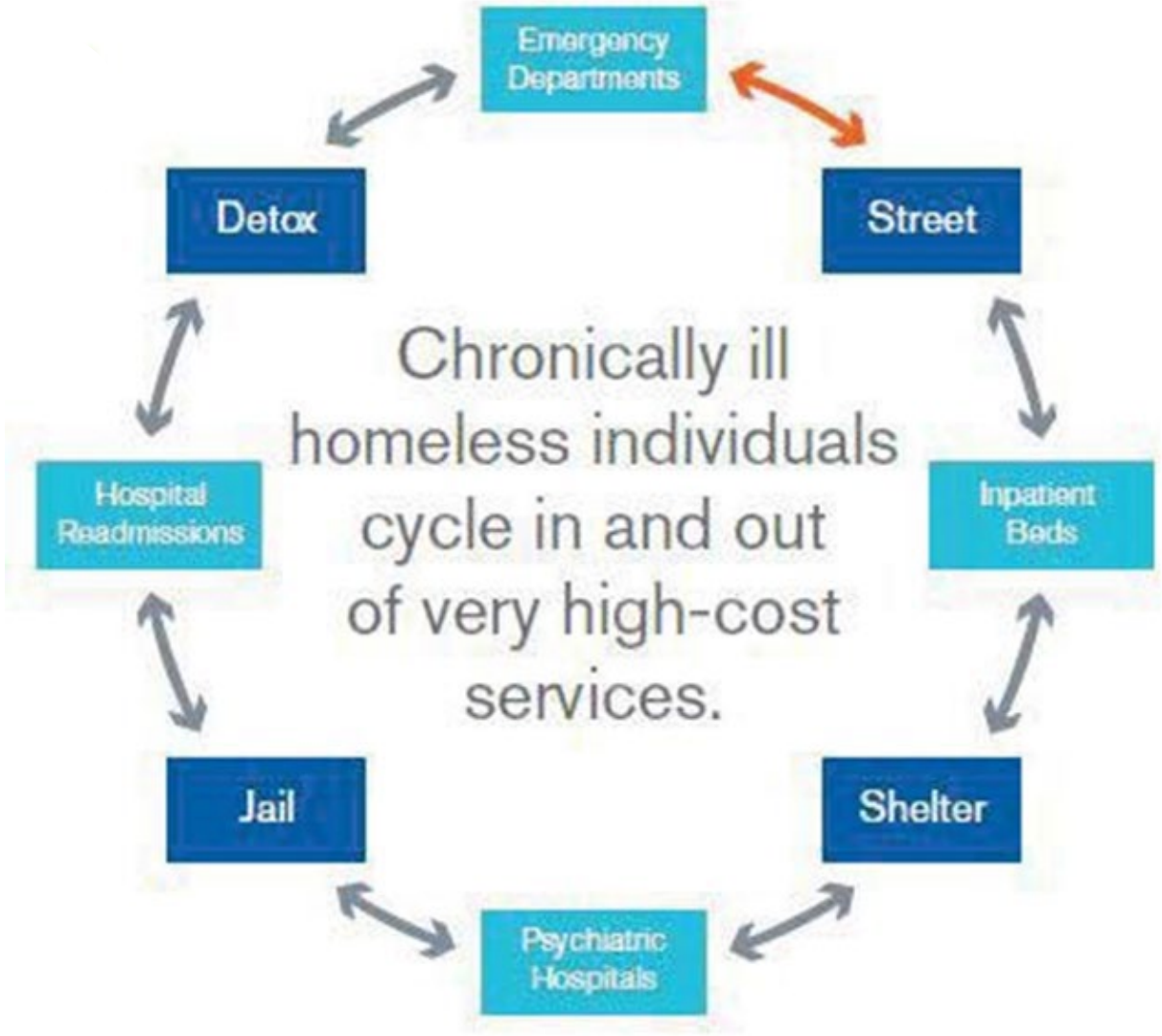


HEALTHY PEOPLE 2023

- Housing instability encompasses a number of challenges that may negatively affect mental health and physical health - making it harder to access healthcare
- Once stable housing is in place, its easier to address all the other medical, behavioral, and social needs.
- **Housing is a key social driver of health**
  - more than 650,000 people were homeless in the U.S. in 2023
  - 6 in 10 experienced sheltered homelessness
  - 4 in 10 experienced unsheltered homelessness

- Annual Homelessness Assessment Report (December 2023), U.S. Department of Housing & Urban Development

Systems intersect but lack coordination & integration



- Fragmentation in healthcare ecosystem
  - lack of understanding about changing funding sources and targeted populations, poor interagency communication, and data sharing/privacy challenges at the provider level contribute to individuals with high needs cycling through various systems

- Among persons experiencing Chronic Homelessness:
  - about 30% have a **serious mental illness**
  - about 60% have a **primary substance use disorder** or **other chronic health condition**

- Healthy People 2023

TOC Healthcare Intersections: Hospital ED & Readmission

Individuals with unstable housing use medical services and the emergency department (ED) more than those who have stable housing.

33% of all ED visits are made by individuals who experience chronic homelessness[10]

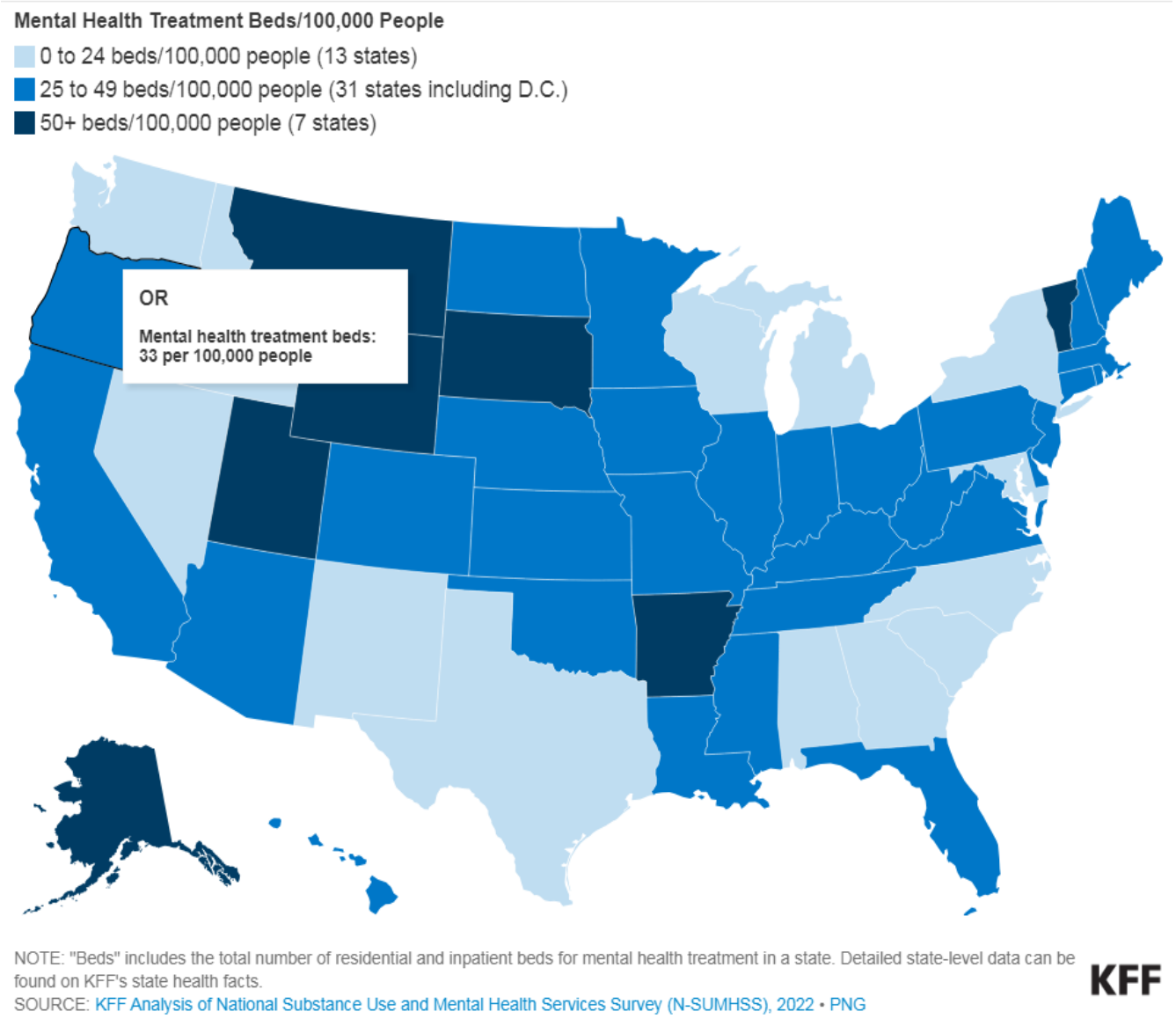
Individuals experiencing homelessness visit the ED an average of five times annually[10]

Patients without housing are 51% more likely to be readmitted to hospitals[11]

80% of ED visits by individuals experiencing homelessness are for preventable illnesses[12]

American Hospital Association, 2021

Number of MH & SUD Treatment Beds Vary Across States

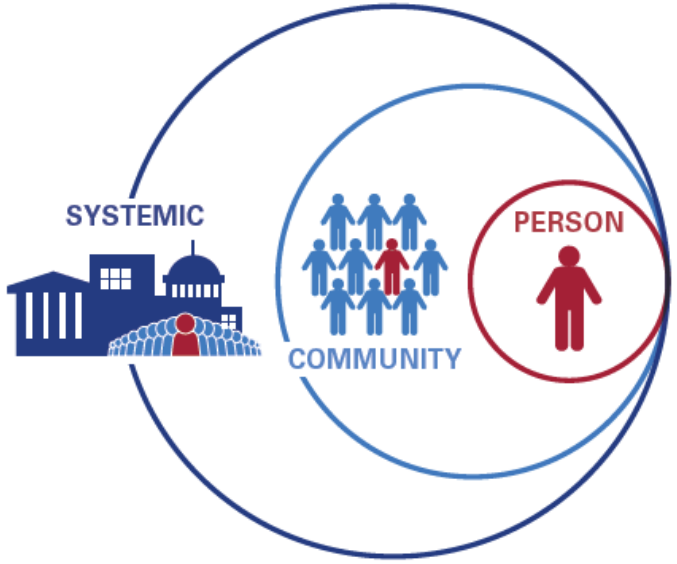


- "Our members report that the practice of boarding — keeping patients in an acute-care setting or ED while they await the availability of a psychiatric treatment bed — has also increased significantly in recent years"

- American Hospital Association, "America's Mental Health Crisis February 2, 2022"

Multi-level Framework for Improving Health

Societal Factors That Influence Health: A Framework for Hospitals



PERSON

Social Needs

Individuals' non-medical, social or economic circumstances that hinder their ability to stay healthy and/or recover from illness.

COMMUNITY

Social Determinants of Health

Underlying social and economic conditions that influence people's ability to be healthy.

SYSTEMIC

Systemic Causes

The fundamental causes of the social inequities that lead to poor health.

Providing permanent supportive housing for individuals experiencing homelessness can:

- Reduce health care costs by 59%
- Decrease ED costs by 61%; and
- Decrease inpatient hospitalizations by 77%

Over the past three years, hospitals and health systems have invested at least $1.6 billion in housing-related interventions

- American Hospital Association, 2021

How can we help our members with BH needs?

Housing Stabilization Services / Minnesota Department of Human Services

- Housing Benefits 101 HB101 Minnesota - Coordinated Entry for Homeless Services

"If you are experiencing homelessness, at risk of homelessness, or don't have a place you can stay for very long, get help from Minnesota's Coordinated Entry System."

- Resource: Person-Served Workflow (document)

- *Medica Behavioral Health is available for consultations*
- *Understanding complexity of interconnection with behavioral health/mental health/substance use*
- *Government and local landscape of housing crisis*
- *Difference in support for populations experiencing homelessness vs. currently in housing*
- *Understanding federal and state resources: housing types, vouchers, eligibility requirements, waitlists, coordinated entry system etc.*
- *Trauma-informed approaches to supportive housing, eviction prevention, landlord issues, reasonable accommodations*

65+ Population: Mental Health Hospitalizations

No history of suspected or diagnosed mental illness

- Symptoms are typically attributed to a medical cause
- Person has not had previous behavioral health inpatient says
- Goal for the stay is accurate diagnosis, treatment, or management of medical issues
- Goals for discharge:
  - Follow up with PCP within 15 days (and appointment with BH provider within 7 days of discharge if a mental illness was diagnosed or member has BH needs).
  - For conditions that cannot be cured, member/caregivers should connect to community providers to manage the condition long term
- Step down level of care before discharging to their typical environment: members may discharge to a skilled nursing facility that can continue to offer rehabilitative services including OT, SLP, PT, and skilled nursing.

Person has a known history/diagnosis of a mental illness

- Symptoms are attributed to a known mental illness
- Person may be known to the inpatient hospital staff from previous stays
- Goal for the stay is to stabilize symptoms, manage medications
- Goals for discharge: psychiatric appointment within 7 days of discharge, PCP appointment within 15 days of discharge
- Step down level of care before the person returns to their typical environment : Members may discharge to an IRTS (intensive residential treatment services) to continue to improve mental health symptoms and stabilize medications.

Role of Care Coordinator for Behavioral Health Hospitalizations

- Speak to the hospital discharge planner as soon as possible. CC should introduce self, share contact information and explain the CC role.
- Notify member's PCP and care team of hospitalizations per typical TOC process.
- Communicate with MBH UM Care Advocate if contacted.
- CC should keep in contact with the hospital care team throughout the hospitalization (Example: call once/week for updates while treatments are onboarded, before there is a discharge plan).
- Follow up visits in the community:
  - When the member needs to establish with a psychiatrist at discharge and the hospital discharge planner is having difficulty finding an appointment, it is okay to for the CC offer assistance via reserved psychiatry appointments available through MBH.
  - Discharge planners may schedule psychiatric appointments more than 7 days after discharge in some cases. (Example: member is already established with a provider and the earliest appointment available is 10 days after discharge). In those cases, CC should note the explanation for the exception in the TOC log.
- Transportation: In some cases, the CC may need to assist the discharge planner with post-discharge transportation, especially when a 30/60 mile rule exception is needed.
- For members who discharge from the hospital to a different setting (IRTS, residential treatment, etc.) follow these steps again for each care setting until the person returns to the community.

First hospitalization for psychosis

There are 3 programs in Minnesota for a first episode of psychosis, serving ages 15-40

- Hennepin Health
- University of Minnesota
- Human Development Center

For more information: MN DHS First Episode of Psychosis Information

Assessing behavioral symptoms through an interpreter

- Words for somatic symptoms can be clear for interpreters to translate and can be easily understood across cultures.
- If appropriate and within your scope of practice, provide education on how somatic symptoms of mental illness are treated in health care system
- Use the words your members and interpreters use. Example: if a member describes sleeping too much, lack of energy, and feeling sad, repeat those words back instead of using the word depression. This keeps the information clear for the interpreter and the member.

Examples of somatic symptoms for depression and/or anxiety

- Abdominal pain
- Nausea
- Fatigue
- Headaches
- Insomnia
- Sleeping too much
- Lack of energy

Resources accessed through Medica Behavioral Health

- Reserved Psychiatry Appointments
- Behavioral Case Consultations for CC's
- BH Case Management for MSHO Members
- ICBS (Intensive Community-Based Services)
- Medica SUD Program

Reserved Psychiatry Appointment

- Available to all MN residents with Medica insurance
- Virtual 1 hour appointment
- Needs email address and video capability
- Provider sends paperwork ahead of time by email
- Members within driving distance of metro may be able to arrange for an in-person appointment
- Suboxone treatment also available

- Call MBH Intake **800-848-8327** and ask to speak with a Care Advocate to make a Reserved Psychiatry Appointment

Behavioral Case Consultation for CC's

- When you are working with a member experiencing BH symptoms and you would like to consult with BH clinical staff at MBH about the case
- When you have a question about a specific MH diagnosis or a substance abuse issue
- When you have questions about new or worsening symptoms and would like some ideas on next steps, approaches with the member, etc.
- Not for crises or urgent needs

- Complete the ***Behavioral Case Consultation for MBH*** form and email to mbh_caseconsultation@optum.com

* If member just needs to find behavioral providers, call MBH Intake at **800-848-8327**

BH Case Management for MSHO Members

- Telephonic case management for MSHO member by licensed BH clinician at MBH
  - MSHO Members with recent history of:

- Psychiatric Inpatient treatment (Dementia diagnosis out of scope)
- SUD Withdrawal management
- Eating Disorder Inpatient treatment
- 2 or more Emergency Room visits for MH or SUD reasons
- MH or SUD Residential treatment

- Gain additional support for BH goals for treatment and discharge planning
  - Multidisciplinary collaboration with member's care team

- Call MBH Care Management Intake at **877-495-9422** or
- Complete ***MBH CM for MSHO Members*** form and email to Integrated_Solutions@Optumhealth.com

ICBS

Intensive Community Based Services

Medica's ICBS program delivers face-to-face intensive and virtual support for Medicaid and Commercial[a] individuals. ICBS is designed to assist members who would benefit from additional interventions beyond their current providers and/or supports.

Who to Refer:

- For most Medica members in Minnesota
- History of multiple admissions to higher levels of care (Mental Health Inpatient or Emergency Departments)
- At risk for readmission
- Frequent crises
- Lack of supports
- Homelessness

To Make a Referral to ICBS or For More Information Please Contact:

Jane Wilka-Pauly

Provider and Community Liaison

Telephone: 612-476-6426

E-Mail: Jane.Wilka-Pauly@Optum.com

or

Medica Behavioral Health

1-800-848-8327

What is ICBS?

- Intensive, Short-Term [b] Intervention
- Does not require an SPMI Diagnosis
- ICBS workers can assist with transportation
- Combination of case management and skills support
- Coordination of care across medical and behavioral health providers
- Connect members to providers and community-based supports in addition to ARHMS, TCM, and Waiver Services

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Medica Substance Use Disorder (SUD)

Medica partners with Mental Health Resources (MHR) to provide this exclusive service to Medica members.

The Substance Use Disorder (SUD) program, unique to Medica members, delivers face-to-face, intensive support for Medicaid and Commercial[a] individuals (call to confirm eligibility). The Medica SUD Program is designed to assist members who would benefit from additional SUD interventions beyond their current providers and/or

Who to Refer:

- For most Medica members in Minnesota
- History of multiple SUD treatment episodes encompassing all levels of care
- At risk for continued use, readmission and/or ongoing treatment episodes
- Lack of supports

To Make a Referral to the Medica SUD Program or For More Information Please Contact:

Jane Wilka-Pauly, Provider and Community Liaison, 612-476-6426
E-Mail: Jane.Wilka-Pauly@Optum.com
or
Medica Behavioral Health
1-800-848-8327

What is the Medica SUD Program?

- Long Term Program – 6 month to several years for members with an SUD diagnosis
- Client-centered programing offering both harm reduction and abstinence-based approaches based on individual's needs
- Coordination of care across medical, behavioral and substance use providers
- Connect members to providers and community-based supports beyond the scope of , ARHMS , TCM, and Waiver Services

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Behavioral Resources accessed through Referral to County of Financial Responsibility

- Targeted Mental Health Case Management
- ACT (Assertive Community Treatment) Team

- Referrals to these services are often made by hospital
- Must meet criteria for service

Behavioral Resources accessed through contacting Community Agency

- **Behavioral Health Home Services**

Behavioral health home services / Minnesota Department of Human Services (mn.gov)

- **ARMHS (Adult Rehabilitative Mental Health Services)**

ARMHS-certified providers / Minnesota Department of Human Services (mn.gov)

Questions?


Medica®