June’s Care Management Webinar

Wednesday, June 18th , 2025

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Meeting Schedule

June 18th, 2025

1. Ericka Hall- New Member Portal

2. Kelli McGary- Peters - SOP (Standard Operating Process) Discharge Barriers

3. Kasey Parker-Reid - CM Program Manual: Version 20 and the Death Notification Submission.

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New Member Portal

Olesya Fantin

Ericka Hall

Kera Beskin

Maeve Dixon

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New Member Portal

- Went through a Demo of the portal

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Discharge Planning Resources Guide & SOP Discharge Barrier Escalation Process

Kelli McGary-Peters

June 18th, 2025

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Discharge Planning Resource Guide on the Separate Word Docx.

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Discharge Barrier Escalation Standard Operating Procedure

Document	Effective Date:	Last Reviewed:	Document Owner:
UM SOP – DC Barrier	**4.10.2025**	4.10.2025	**Kelli McGarey-Peters**

Client(s)			
☐ All Clients ☐ Clarion ☐ Cook Medical Group ☒ CountyCare	☐ Deaconess ☐ Empower ☐ Indiana University Health ☐ Lighthouse ☐ MedStar	☐ Miami Children's ☐ MPC ☐ New Mexico Health Connections	☐ Northshore Physicians Group ☐ Passport ☐ Premera ☐ SOMOS ☐ Vivida

Functional Area:	Job Role(s) Applicability:	LOB(s)
☒ Utilization Management ☐ Appeals and Grievances ☒ Care Management ☐ Quality ☐ Trainers ☐ Business Analysts ☐ Other: _____	☐ All UM and A&G staff ☐ Intake Coordinators ☐ Appeal &Grievance Coordinators ☒ UM Nurses ☐ Appeals Nurses ☐ Quality Auditors ☒ Other – UM/CM Liaisons	☐ All LOB ☐ Fully Insured Commercial ☐ Fully Insured Exchange Commercial ☐ Self-Insured Commercial ☒ Medicaid ☐ Medicare Advantage

Purpose: To provide clear direction and assistance with discharge barrier concerns for CountyCare members**.**

Examples: Difficulty securing an accepting Skilled Nursing Facility; Difficulty securing an accepting Home Health Company; Difficulty securing an accepting Dialysis Facility; Difficulty securing transportation; Difficulty securing a Primary Care Physician (PCP) post discharge follow up appointment; Difficulty securing a Behavioral Health Specialist appointment within 7- and 30-days post Behavioral Health discharge; Any additional area when additional assistance may be needed; Difficulty reaching hospital Case Manager/Discharge Planner, etc.

Process:

When a discharge (d/c) barrier is identified by facility, provider, UM, and/or CME, that requires assistance and resolution, the following steps will occur**:**

1	Receiving entity will Identify the issue and obstacles to include inquiring on providers already contacted as well as reasonings why services cannot/have not been secured.
2	Receiving entity will evaluate and determine additional resources that might be available to obtain the needed services, if available
3	Receiving entity will determine if coordination is needed with Provider Relations i.e.: INN servicing providers resources (current and new), issues with providers declining acceptance, etc. Email outreach to PR must Include member, plan information, needs/issues, and provider contact information.
4	Receiving entity will ensure notification of other supporting teams occur. Notification should include the CME oversight team-- general referral inbox at CountyCare Referrals @ countycarereferrals@cookcountyhhs.org
5	Upon escalation by the receiving entity, if no CME has been assigned, assignment will occur within 1 business day. An email will be sent to the assigned CME/manager for outreach/follow up.

6	The assigned CME/Manager will hold the facilitator /coordinator and communicator role from this point of notification until successful discharge/service has been obtained for the member.
7	The assigned CME/Facilitator will confirm receipt of barriers via email response to team (UM, CM, CCHHS Leadership), within 1 business day of notification.
8	The assigned CME/Facilitator will follow up with provider/member and validate any continued issues with discharge barriers. They will review providers contacted for services and evaluate continued reasonings why services have not been secured.
9	The assigned CME will evaluate and determine if follow up is needed with any contacted providers or if there are additional resources that might be available to obtain the needed services
10	The assigned CME will follow up on Provider Relations (PR) outreach, if any needed and outcome of same, as well as any continued needs that may exist.
11	The assigned CME will continue to follow up with provider/member on actions, responses, and outcomes until successful discharge occurs or services are obtained.
12	The assigned CME will report actions, progress, and outcome(s) to identified contacts (refer to step 4 for list) for CM, UM, CountyCare on a weekly basis until discharge/service barriers are resolved.
13	If barriers continue beyond 7 days, the assigned CME will escalate the issue to the Manager of Case Management (Kasey) who will then coordinate or delegate and oversee the coordination of scheduling an ICT meeting, for ongoing review and coordination of discharge barriers.
14	The assigned CME/Facilitator and Manager of Case Management will continue to follow steps 8 through 13 above until the resolution of barriers and successful transition of care or services are obtained.

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Related Documents:

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	REVISION DATE
SOP finalized	3/25/2025
IDT scheduling updated from 14 days to 7 days	4/1/2025
SOP adopted/implemented	4/10/2025

Death Notification Submission & CM Manual Updates

Kasey Parker-Reid

June 18th, 2025

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Death Notification Submission Workflow
Effective: 6/1/25

- When Care Coordinator/Care Manager is notified of the death of a member, the CC will send a secured (**SECURELOCK**) email to the County Care Referral Inbox.
- Email address: countycarereferrals@cookcountyhhs.org
- Acceptable documentation of death notification includes **Death Certificate; Obituary, Notification directly from a Long-Term Care or Supportive Living Facility Provider**, or any additional documentation of notification, ie., medical documentation, proof from IDoA, DRS, etc.
- **Please attach documentation to email.**

The following information is required within the body of the email to the County Care Referral Inbox for submitting a Death Notification.

Care Coordinator Name:

Date of Submission:

Member Last Name:

Member First Name:

Member ID/RIN:

Date of Birth:

Date of Death:

Social Security Number (If RIN is not provided):

Death Certificate Provided: Y/N

Obituary Provided: Y/N

Notification from a LTC or SLF Provider: Y/N

Comments:

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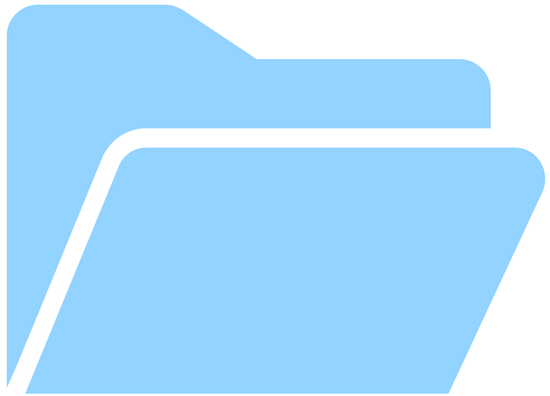

- Kasey RP will compile spreadsheet and upload documents to Ops Sharepoint Folder on a weekly basis.
- Ops Team will go in on a biweekly basis to pull documents and spreadsheet for submission to HFS.
- **Kasey Reid-Parker: Lead**
- **Lauren Dillon: Backup**

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CM Manual Updates: Version 20

Version 20	**April 30, 2025**	**Additions/Edits to the CM Program Manual during this quarter were completed per our HFS contractual agreement/NCQA Standards** Table of Contents: Carenet Health 24/7 Nurse **Line (Pg. 2 and Pg. 20)** • **Removed Health Dialog and added Carenet Health 24/7 Nurse Line –(vendor that replaced Health Dialog)** Table of Contents: Carenet Health 24/7 Nurse Line Follow up **(Pg 2 and Pg. 24)** • **Removed Health Dialog and added Carenet Health 24/7 Nurse Line** Crisis, Help Lines, and Care Coordination Follow **Up (Pg. 20)** • **Added contact numbers for Cares Line 1800-345-9049 (TTY: 1-773-523-4504) and Carenet Health 24/7 Nurse Line 312- 864-8200 (TTY: 855-444-1661)** Children's Behavioral Health Crisis **Follow-up (Pg. 21)** • **Added: arrange for the necessary transportation when an Enrollee requires transportation assistance to be admitted to an appropriate inpatient institutional treatment setting**

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LTSS Team Additions/Edits

Contents of Health Risk Assessment for M(LTSS**) (Pg. 61-62)**

- **Added: The completion of the initial HRA and subsequent HRA reassessments is monitored and reported monthly to the state and audited quarterly.**
- **Added: 18 Elements/Content of the newly updated Health Risk Assessment per NCQA standards/HFS Contract. (see CM Manual for details)**

Elements of individualized Plan of **Care (Pg 72-73)**

- **Added: Elements/Content of IPOC per NCQA standards/HFS Contract (see CM Manual for details)**

MLTSS Appeals **Process (pg. 81)**

- **Added: If the adverse decision is upheld, the Decision Notice will include specific reasons for the appeal determination decision in easily understood language. It will reference the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based. And will detail member's right to request a State Fair Hearing.**

Timeframes for Service **Planning (pg 110)**

- **Added: Additional service requests, including a change in the number of hours, would be determined at a reassessment with the member.**
- **For newly eligible SLF members, the notification date and 15-day clock for the service plan will start the day the health plan receives the Resident Assessment Instrument (RAI) and Individualized Support Plan (ISP) information form from the Supportive Living Provider Added: or from notification made to the health plan of the new SLP waiver status.**

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Thank you!

Comments or Questions?

Announcements

- Next webinar is July 16th, 2025!
- Slides posted on CountyCare Care Coordination Webpage:
  - http://www.countycare.com/carecoordination
- Have feedback? Ideas for future topics? Please share!
  - https://redcap.link/23k1fzzb

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- Please email questions/concerns: stephanie.nickles@cookcountyhealth.org