Network Notification

Notice Date: January 2, 2020
To: Kentucky Marketplace Providers
From: CareSource
Subject: Closing Quality Gaps in Care

CareSource promotes member access to care by working with you, our health partner, to provide appropriate interventions at the right time.

Chronic conditions such as diabetes, heart failure, asthma and chronic obstructive pulmonary disease (COPD) are considered Ambulatory Care Sensitive Conditions (ACSCs) in which having access to quality ambulatory care for early intervention can potentially prevent complications, more severe disease and hospital admissions (AHRQ, 2018), as well as emergency department (ED) visits (Fingar et al., 2015).

GUIDE & BEST PRACTICES TO CLOSE QUALITY GAPS IN CARE

<table>
<tr><th>Target</th><th>Intervention Strategies</th><th>Outcomes</th></tr>
<tr>
<td rowspan="4">Identify your high-risk and highly complex patients age 18 and older with a history of frequent ED visits or recent hospitalization(s). Include patients with chronic conditions such as ACSCs and/or eight
or more prescribed medications; or other concerns.</td>
<td>Instruct high-risk and highly complex patients when to call you and report changes in their condition (i.e. sudden weight gain, increased shortness of breath, high/low blood sugar readings, high/low blood pressure readings, medication changes). In addition, educate patients when to use walk-in or urgent care, as appropriate.</td>
<td rowspan="4">✓ Improve health outcomes.
✓ Increase patient satisfaction.
✓ Increase patient’s knowledge and adherence to self-care.
✓ Improve connections with primary care provider (PCP) and other practitioners.
✓ Enhance care coordination.
✓ Optimize members’ access to high quality of care at the appropriate time.
✓ Reduce costly and unnecessary return visits to the ED/readmissions to the hospital.
✓ Increase Quality Performance Goals.</td>
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<tr>
<td>Instruct patients to notify you if they recently had a visit to the ED or were discharged from the hospital. See patients within seven days of discharge.</td>
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<tr>
<td>If patients had a recent hospitalization, obtain the hospital discharge summary, or ask the patients to bring the documents to their appointment. Include the following in the patient’s medical record:
✓ The hospital discharge date.
✓ The date the medication reconciliation was completed.
✓ Documentation indicating the patient’s current list of medications was reconciled against the hospital discharge list of medications.</td>
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<tr>
<td>Perform medication reconciliation within seven days of discharge, no later than 30 days post discharge. Studies have shown that medication reconciliation helps prevent medication related readmissions. Ask your patients if they are taking their prescriptions as recommended. Include the following CPT® codes on the claim, as applicable:
<table>
<tr><th>CPT® Code</th><th>Description</th></tr>
<tr><td>1111F</td><td>Discharge medications reconciled with the current medication list in the outpatient</td></tr>
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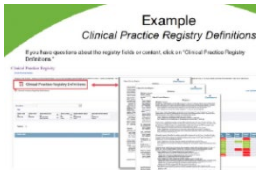
</table>

		medical record within 30 days of inpatient discharge	
	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as prescriptions, OTCs, herbal therapies and supplements) documented in the medical record	



The Clinical Practice Registry (CPR) or care gap reports are available in the **CareSource Provider Portal**. Reports provide member-level detail for a patient's care gaps related to clinical and HEDIS® effectiveness of care measures for CareSource members. Alerts provide an easy way to look at patients and see what measures to address based on claims recently received and processed. **The CPR Definitions document** helps if you have questions about the registry fields or content.

Examples of CPR Report Measures & Alerts

Current members who had visits to an ER during a 12-month timeframe. ER visits resulting in an inpatient stay on the same day or next day are excluded.	▪ **Yellow** – Member had 1 or 2 visits to an Emergency Room. ▪ **Red** – Member had 3 or more visits to an Emergency Room.

WHEN TO SEE OR COMMUNICATE WITH PATIENTS

Patients with:	Should have access:
Recent discharge from a hospital	Follow-up visit within seven days of discharge.
Emergency needs immediately upon presentation	24 hours a day, seven days a week.
Urgent care	Not to exceed 48 hours from date of member's request.
After-Hour Needs	After-Hours Service ▪ Direct contact with PCP or another designated medical practitioner who is available to return the call within a maximum of 30 minutes; ▪ A recording that directs the patient to call another number; or ▪ A call transfer to another location where someone can answer the phone and contact the PCP or designee within 30 minutes.
Routine care needs	Not to exceed 30 days from date of a member's request.

CareSource Services

CareSource helps members decide where to go for care if they are unsure. Your patients can call our 24-Hour Nurse Advice Line at **1-866-206-7879**, and a nurse will help them make the decision. Members can call 24 hours a day, seven days a week at no cost.

CareSource Care Management

Refer patients to CareSource Care Management (CM) team if you identify needs, if members are having high utilization of emergency services or have had a recent hospitalization. You can refer a member to KY CM by calling **1-855-202-0385**. CM can be especially effective in reducing admission and readmission risks, managing anticipatory transitions, encouraging non-compliant patients, reinforcing medical instructions and assessing social needs.

CareSource strives to make it easy for you to work with us, whether online or over the phone.

- ✓ Visit our **Provider Portal** to check claims, prior authorization status, member eligibility, coordination of benefits and more, day or night
- ✓ For questions not addressed on our website, please call **Provider Services** at **1-855-852-5558** (Monday through Friday, 8 a.m. to 6 p.m. Eastern Standard Time)
- ✓ In addition, our **Health Partner Engagement Representatives** will be happy to answer your questions Monday through Friday, 8 a.m. to 6 p.m. Eastern Standard Time

Resources

Preventing Avoidable Readmissions. Content last reviewed February 2017. Agency for Healthcare Research and Quality, Rockville, MD.
https://www.ahrq.gov/patient-safety/resources/improve-discharge/index.html