



**MEDICAID
MANAGED CARE
BEST PRACTICES
COMPENDIUM**

2017-2018



**INSTITUTE FOR
MEDICAID
INNOVATION**

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ABOUT THE INSTITUTE FOR MEDICAID INNOVATION

The Institute for Medicaid Innovation (IMI), a 501(c)3 organization, is focused on providing innovative solutions that address important clinical, research, and policy issues in Medicaid through multi-stakeholder engagement, research, data analysis, education, quality improvement initiatives, and dissemination and implementation activities. To remain relevant and responsive to the evolving needs of the Medicaid population, the Institute seeks to understand what works well in the Medicaid program, identify areas for improvement, and disseminate innovative initiatives and solutions that address critical issues.

MISSION

The mission of the Institute for Medicaid Innovation is to improve the lives of Medicaid enrollees through the development, implementation, and diffusion of innovative and evidence-based models of care that promote quality, value, equity, and the engagement of patients, families, and communities.

VISION

The vision of the Institute for Medicaid Innovation is to provide independent, unbiased, nonpartisan information and analysis that informs Medicaid policy and improves the health of the nation.

ACKNOWLEDGMENTS

The work of this compendium could not be accomplished without the dedication and commitment of our national experts who serve on the Best Practices Review Panel. Their systematic and objective review of the submissions is critical for the success of this project. In addition, there are people who work behind-the-scenes to produce this annual publication. We especially want to thank Ashley Gray and Shawnise Thompson for their hard work and attention to detail.

INSTITUTE FOR MEDICAID INNOVATION BEST PRACTICES REVIEW PANEL

Anne De Biasi, MHA

Director of Policy Development
Trust for America's Health

Fred S. Goldstein

Founder and President
Accountable Health, LLC

Keith McCoy, MD

Regional Medical Director
Cardinal Innovations Healthcare

Meg Booth, MPH

Executive Director
Children's Dental Health Project

Caroline A. Grossman

Chair, Best Practices Review Panel
Principal
Mirepoix, LLC

Andrew Sperling

Director, Federal Legislative Advocacy
National Alliance on Mental Illness

Stacy Collins, MSW

Associate Director of Health System
Transformation
Association for Maternal & Child Health
Programs

Amy Haddad

Associate Director, Government Affairs
Public Policy & Government Affairs
Team
Association of Maternal & Child Health
Programs

Robert K. Thielen, DDS, MBA

National Dental Director
Aetna Medicaid

Nathaniel Counts, JD

Senior Director of Policy
Mental Health America

Gregory T. Howe, BA

Deputy Director and Senior Program
Officer
Center for Health Care Strategies, Inc.

Ashley Gray, MPP

Health Research Associate
Institute for Medicaid Innovation

Wendy R. Ellis, DrPH (c), MPH

Manager, Child Health Policy, Office of
National Child Health Policy and
Advocacy
Nemours

Anne M. Kaeser, MD, MBA

Senior Medical Director
Aetna Medicaid Utilization
Management

Jennifer E. Moore, PhD, RN

Executive Director
Institute for Medicaid Innovation

EDITORS



BEHAVIORAL HEALTH



Forensic Assertive Community Treatment (F/ACT) to Reduce Homelessness



MERCY MARICOPA INTEGRATED CARE (AETNA MEDICAID)

People who have been arrested and incarcerated and who also have serious mental illness (SMI) are at high risk for re-offending and re-incarceration. They also are often poorly served by standard Assertive Community Treatment (ACT) teams. The sheriff’s office, probation, or parole departments utilize a screening assessment to identify those at risk of recidivism. Since 2014, that assessment has been used by Mercy Maricopa Integrated Care (MMIC) through a value-based contract with Community Bridges, Inc. to provide Forensic Assertive Community Treatment (F/ACT) for these individuals in our plan. F/ACT teams collaborate closely with treatment providers and probation/parole officers to develop release plans that address the unique social and clinical needs of each individual. For example, the F/ACT team may facilitate peer support services to reduce continued involvement with anti-social peers and help individuals identify and participate in pro-social activities. This program has reduced arrests and homelessness and improved behavioral and physical health care.



Key Priorities

- Reduce recidivism.
- Reduce inpatient psychiatric hospitalizations.
- Reduce the need for behavioral health crisis services and emergency department utilization.
- Reduce substance abuse/misuse.
- Improve psychosocial adjustment.
- Decrease homelessness.
- Increase the number of members competitively employed.
- Reduce societal and health care costs per member for Maricopa County.

Geographic Location

Maricopa County, Arizona

Population

Focusing on vulnerable members with SMI at high risk of recidivism, longer jail stays, and associated higher behavioral/physical health care costs enables staff to meet with individuals before release to provide intensive wraparound services in coordination with probation/parole, thus engaging them in healthier behaviors and reducing re-arrests.

The target population of adults with SMI is 79 percent male, and 45 percent are ages 30-45. Of the 240 members participating, 66 percent are primarily located in Phoenix, and the remaining population is located across Maricopa County. Most are Caucasian (66 percent), while 10 percent are African American, 5 percent are Hispanic, and 2 percent are Native American.

Key Partners and Community Groups

The following key partners were critical to the implementation of Forensic Assertive Community Treatment:

- Mercy Maricopa Integrated Care (administered by Aetna Medicaid)
- Community Bridges, Inc. (CBI)
- Maricopa County Smart Justice Committee
- Maricopa County Criminal Justice System

Intervention and Methods

As a member of the Maricopa County Smart Justice Committee, Mercy Maricopa Integrated Care (MMIC) partnered with justice system leaders to examine the causes related to incarceration and identified populations where we sought to focus our interventions. The findings reflect an increased rate of recidivism and longer length of incarceration for the SMI population compared with the overall jail population. Members with SMI assessed by adult probation who are at high risk of recidivism experienced increased interaction with the criminal justice system even when they were enrolled in services through one of our providers. Addressing mental health and substance abuse issues alone did not have an impact on the length-of-stay in jail or recidivism.

Risk assessments completed by the criminal justice system differentiate people who are at risk of recidivism and identify criminogenic factors that can lead to continued acts of criminal behavior. MMIC identified members for F/ACT using booking data from the jail, risk to re-offend assessment scores, court-provided adult probation data, and pre-release notices 60 days in advance. These data were combined to target SMI members for F/ACT to prevent re-offending or rearrests. Although the State of Arizona suspends Medicaid eligibility during incarceration, it makes Medicaid benefits immediately available upon release from jail. The project relies on training from the Adult Probation staff on assessing factors that increase the likelihood of re-offending and uses a Risk Needs Responsivity (RNR) model to develop holistic treatment plans for each SMI member.

Based on the risk assessments, individuals designated with SMI and at the highest risk for re-incarceration were referred to one of three F/ACT teams at Community Bridges, Inc. These teams included probation officers, a psychiatrist, nurse, primary care physician, and specialists in substance abuse, housing, peer support, and employment. This team collaborated to develop treatment plans that addressed the clinical and social needs of each individual, as well as criminogenic factors identified through justice system assessments. For example, individuals with criminogenic factors often continue to associate with others involved in the justice system (i.e., anti-social peers). Therefore, treatment plans may include forensic peer-support services focused on helping those individuals identify and participate in pro-social activities. This initiative enabled MMIC, in partnership with county and area justice system leaders, to meet with individuals prior to release to provide intensive,

wraparound services in a holistic, person-centered approach in coordination with probation/parole, thus reducing re-arrests, hospitalizations, emergency room utilization, homelessness, and more.

Outcomes

Patient/Family Outcomes Social determinants of health such as housing have a significant impact on behavioral health. Numerous individuals with SMI experience difficulty obtaining housing because of their criminal backgrounds. This initiative resulted in a 19 percent reduction in the number of homeless members over the past 25 months.

Clinician Outcomes From August 1, 2014, through September 30, 2016, F/ACT teams achieved an 84 percent increase in the percentage of members who had seen a clinician at least once per year.

Community Impact From August 1, 2014, through September 30, 2016, F/ACT teams achieved a 76 percent reduction in the number of jail bookings for this population.

Cost Savings From August 1, 2014, through September 30, 2016, F/ACT teams achieved a 31 percent reduction in psychiatric hospital admissions, as well as an 18 percent reduction in the number of members who utilize the emergency room.

Lessons Learned

Sustainability MMIC is committed to the continuation of this critical initiative given its demonstrated return on investment. Continued ongoing collaboration among MMIC, F/ACT teams, county and justice system leaders, and adult probation personnel, coupled with continued funding through Medicaid dollars, are essential to sustaining this initiative on a long-term basis.

Challenges Each agency employed policies that required updating to accommodate the F/ACT model. For example, convicted sex offenders were historically unable to be brought into the transition center associated with the F/ACT teams. The sheriff's office did not allow individuals with previous felony convictions to enter jails to conduct release planning. Mercy Maricopa required all referrals to Assertive Community Treatment (ACT) teams to be initiated by a member's current clinical team. This was modified to allow referrals directly from Adult Probation. Each of these policies was changed as part of F/ACT implementation.

Successes The success of this initiative is the result of strong collaboration among stakeholders and utilization of evidenced-based interventions. In addition, it is the result of ensuring the incorporation and support of key staff members such as an ACT manager, court services administration, adult services administration, and clinical leadership.

Advice Replication of this initiative is both appropriate and effective for health plans with high-risk SMI populations. Such an initiative requires close monitoring of the F/ACT teams, consistent review of outcomes, active and ongoing collaboration with stakeholders, and adherence to evidence-based practices. While MMIC has a unique role in Maricopa County, the F/ACT teams were established based on an identified need among local partners that exist in every state.

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Kudos to the Team

Team Lead

Tad Gary, MEd, MA, CRC, LPC
Chief Clinical Officer
Mercy Mericopa Integrated Care

Team Members

Mercy Maricopa Integrated Care (MMIC)
Tad D. Gary, MEd, MA, CRC, LPC, Chief Clinical Officer
Blythe FitzHarris, Ph.D., LCSW, Adult System of Care Administrator
Christie MacMurray MA, LMSW, Senior ACT Manager
Shelley Curran, MA, LPC, Court Services Administrator

Community Bridges Inc.

Frank Scarpati, Ph.D., LISAC, President/Chief Executive Officer
John Hogeboom, LISAC, VP/Chief Operations Officer

Maricopa County Smart Justice

MaryEllen Sheppard, MAOM, CPM, SPHR, Assistant County Manager, Maricopa County
Dawn Noggle, PhD, CCHP, Mental Health Director, Maricopa County Correctional Health Services
Deputy Chief Therese Wagner, Pretrial, Presentence, Programs & Reentry Services, Maricopa County Adult Probation
Deputy Chief Brian Lee, MBA, CPM, CJM, CCE, Maricopa County Sheriff's Office, Custody Bureau Region II

Contact

Janet Grant
Head, Great Plains Region, Aetna Medicaid
602-686-6189
GrantJ4@aetna.com

Turning Point - Psychiatric Diversion Program for Children in Foster Care

SUPERIOR HEALTHPLAN AND ENVOLVE (CENTENE)

The Turning Point program is an inpatient psychiatric diversion program in Texas, specifically tailored for children and youth in foster care. For situations where additional resources and supports are needed, but inpatient hospitalization is not appropriate, Turning Point offers a positive alternative. The program has a 24/7 crisis response line, along with clinicians who come into the home and work with the child and caregiver. In situations where a child needs a break from the caregiver, there is a therapeutic bed the child can reside in for up to 14 days while participating in an intensive outpatient targeted intervention plan. The program allows a child to maintain his/her placement and avoid unneeded hospital stays. The original location launched on January 1, 2013. In 2016, Superior Health Plan added three additional locations throughout the state.

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Key Priorities

- Decrease inpatient psychiatric hospitalizations and readmissions.
- Stabilize the foster care placement.

Geographic Location

Dallas/Fort Worth, San Antonio, Houston, and Abilene, Texas.

Population

The health plan observed a pattern of inpatient psychiatric admissions that frequently led to a change in foster care placement. This led to treatment disruptions that contributed to inpatient readmissions. By diverting those admissions, Superior Health Plan could stabilize the child's placement and outpatient treatment to allow the child to be successful.

The target population for Turning Point is children and youth in the Texas foster care system. There are no limitations based on gender or race/ethnicity. The program serves those ages 10-17. The original location in Fort Worth served 153 children and youth through this program in 2016. Because of the success of the program, Superior Health Plan expanded to three additional locations during 2016. Those locations served an additional 107 children and youth.

Key Partners and Community Groups

The following key partners are critical to the implementation of Turning Point:

- All Church Home Child Placing Agency, which provides therapeutic beds in the Dallas/Fort Worth area
- Empirica, which provides a clinical crisis line and treatment for the Dallas/Fort Worth area
- Pathways, which provides therapeutic beds, a crisis line, and therapeutic treatment in the San Antonio, Houston, and Abilene areas

Intervention and Methods

Children in foster care are at risk for placement disruption from "acting out" behaviors that might result from a traumatic experience and require different caregiver and clinician interventions than non-trauma-related psychiatric conditions. Disrupted placements can negatively impact a child's education, health, and social development. Failure to recognize the impact of trauma on behavior results in over-hospitalization of youth in foster care, and foster parents are more likely to request that a child be moved to another foster home following inpatient hospitalization.

This program is uniquely designed to give foster parents resources for appropriately identifying and de-escalating acting-out behaviors that do not require inpatient hospitalization. Foster parents are trained to contact the Turning Point 24/7 crisis line, rather than a hospital emergency room, and access to a trauma-informed clinical assessment that can be done in the home. The assessment determines the appropriate care plan: stabilize the child in the home with enhanced services and supports; admit the child to the Turning Point crisis residential services for more intensive stabilization services (maximum of 14 days); or refer the child for admission to an inpatient psychiatric facility.

In addition to the child receiving the appropriate level of care, foster parents are engaged in the care plan and are provided support services and education that decrease the likelihood of placement disruption and avoid the risk of the related negative impacts for the child. Foster parents participate in treatment and learn skills to better manage the child's behaviors, whether trauma-related or resulting from mental health conditions.

For those children and youth who went into the hospital, Superior HealthPlan staff work to identify the cause of acting out behavioral issues and identify which areas and child-placement agencies could use more training and communication about this program and how to access it.

Outcomes

Patient/Family Outcomes In 2016, the 90-day readmission rate for children and youth who accessed Turning Point was 3 percent, compared to 39 percent for members admitted to the hospital.

Clinician Outcomes No reported outcomes.

Community Impact There was a high level of community engagement in the Turning Point program, and quarterly in-person meetings were hosted in all four locations. This allowed for specific regional questions to be addressed and to build relationships with local partners. Community stakeholder groups joined the meetings and actively used the program.

Cost Savings Decreased inpatient hospital admissions have contributed to cost savings that cover the cost of the program. In 2016, Superior HealthPlan realized approximately \$236,213 in savings.

Lessons Learned

Sustainability The program is financially sustainable by diverting avoided inpatient hospitalization funds to cover the cost of the initiative. We also have the support of the health plan, the state contractor, and the state child welfare leadership to continue to offer this program.

Challenges One of the primary challenges was changing the way foster parents accessed crisis services for children in their care. Through in-person meetings in the community with a variety of smaller groups, which included Child Protective Services workers, foster families, and supporting agencies, the health plan was able to educate the community about the program and drive participation.

Successes State child welfare leadership made a decision to allow the placement to be held while a child receives additional treatment through the Turning Point program, which was key to ensuring that the program would be successful in preventing placement disruptions. Also, providers began to increase engagement efforts with the caregivers to give them the skills needed to better support the child in the home and prevent subsequent inpatient psychiatric admissions.

Advice It is important to have solid provider partners and good working relationships with them, as well as to determine your geographical boundaries. This affects one's ability to offer a high-quality program. Also, it is important to be prepared and committed to staying the course even if the program starts out slowly. Lastly, it is important to stay focused on the individual lives affected.

Kudos to the Team

Team Lead

Nathan Hoover, M.Ed., LPC
Clinical Director
Cenpatico/Engolve PeopleCare

Team Members

Karen Rogers, LBSW, LCPAA, Cenpatico/Engolve PeopleCare
Stephen Whitaker, LMSW, Cenpatico/Engolve PeopleCare
Ailene Correia, LPC, Cenpatico/Engolve PeopleCare

Contact

Nathan Hoover, M.Ed., LPC
Clinical Director, Cenpatico/Engolve PeopleCare
806-549-5771
nathan.hoover@engagehealth.com

Desert Clinic Pain Institute - Multidisciplinary Chronic Pain Management Program

INLAND EMPIRE HEALTH PLAN

Chronic pain represents the largest annual health care cost, up to \$635 billion, more than cancer, heart disease, and diabetes. It often presents with behavioral health conditions and is highly prevalent in the top 5 percent of complex patients who account for roughly 50 percent of health care expenditures. To address these major health problems, in 2015, Inland Empire Health Plan (IEHP) formed the Centers of Excellence (COE) using an interdisciplinary, patient-centered approach, based on the biopsychosocial model for treatment of chronic pain. Findings from the Desert Clinic Pain Institute demonstrate significant improvements in emotional and physical health and disability while substantially reducing cost. By providing health education, social support groups, groups on healthy diet and smoking cessation, the COE model takes into account the significant impact of social determinants on health outcomes. Integration into community resources that support healthy living is a key component to sustain success.

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Key Priorities

- Treat the whole person using a multimodal, multidisciplinary approach.
- Enable members to develop a sustainable, healthy lifestyle.
- Improve the following for referred members:
 - Numeric Pain Rating Scale (NPRS)
 - PEG: Pain Intensity and Interference (PEG)
 - Oswestry Low Back Pain Disability Questionnaire (ODQ)
 - Pain Disability Index (PDI)
 - Pain Catastrophizing Scale (PCS)
 - Patient Health Questionnaire-9 (PHQ-9)
 - GAD-7 Questionnaire (GAD7)
 - Patient's Global Impression of Change (PGIC)
 - DAST-10 Questionnaire (DAST)
 - The Alcohol Use Disorders Identification Test (AUDIT)

Geographic Location

Coachella Valley, CA
Rancho Mirage, CA
Palm Springs, CA
Indio, CA
San Jacinto, CA

Population

Complex chronic pain is responsible for high costs, is among the leading causes of disability, and is a root to the nationwide opioid use disorder. The target population consisted of chronic pain sufferers with a pain condition of at least three months in duration, presence of co-morbid psychiatric illness or symptoms, with concurrent high-dose opioid use. These individuals were at high risk of hospitalizations and/or deaths related to opioid overdose.

Since implementation in 2015, roughly 750 Medicaid or Medicaid-Medicare Dual-Choice members have gone through the program. The average age of the members is 51, and approximately 62 percent is female and 38 percent is male. Members reside in San Bernardino and Riverside counties.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Desert Clinic Pain Institute:

- Desert Clinic Pain Institute, led by Dr. Tobias Moeller-Bertram;
- Borrego Health, a Federally Qualified Health Center providing care to IEHP members at several locations close to the COE locations; and
- MFI Recovery Centers, which provide residential and intense outpatient drug treatment.

Frequent in-person and phone meetings between COE leadership and key stakeholders in these institutions are the foundation of these collaborations.

Intervention and Methods

The Desert Clinic Pain Institute - Multidisciplinary Pain Program offered a three-phase, 12-month evidence-based program involving an integrated and multidisciplinary approach to chronic pain. There are four pillars of this program: Medical Treatment, Behavioral Therapy, Physical Reconditioning, and Education. Multiple modalities were utilized based on the patient's specific needs and individualized treatment plan. These included a spectrum of evidence-based interventions delivered on site, ranging from individual and group cognitive therapy, to restorative medicine and conditioning, to alternative therapies such as yoga, mindfulness, medication, massage, acupuncture, and other treatment modalities.

The first phase occurred in the first month of the program. During this time, program staff engaged in a weekly interaction with members to achieve the following goals:

1. Stopping the crisis mode.
2. Re-engaging the patient in taking responsibility for his or her health.
3. Paving the road to recovery.

The second phase consisted of five months of treatment to increase mental and physical health, with the goal of reducing pain and increasing both activities and quality of daily life. In Phase 2, there were clearly defined goals for members, including changes in dietary habits, development of a healthy exercise routine, improvement of flexibility and thereby reduction of the chance of re-injury, and reduction of stress, anxiety, and depression. Members' achievements included the focus on self-help tools as well as reduction of medication.

The third phase occurred in the remaining six months and aimed to continue the healing and recovery process from the second phase with the focus on strengthening members' responsibilities and their integration into their community. The main goal was to empower each member to be able to continue the helpful routines learned during the first part of the COE program.

To match patients with the optimal program, IEHP used location dedication (Integrated Google Maps APIs). The patient population outcomes collected were stored in our own database. Outcome reports were generated in real time and could be displayed for the population as a whole or broken down by clinic. This information is utilized in regular occurring systematic case reviews to adjust the treatment plans and as basis for quality improvement. Specific outcome patterns identified are used to model best treatment options for the individual patient. Social media platforms (Facebook) are used for outreach. To allow for a combination of multiple health providers and services, including services currently not reimbursed, the COE initiative used a case rate per member where payments were triggered when certain milestones were met.

Outcomes

Patient/Family Outcomes Data were analyzed for 184 subjects at the three-month mark with the following findings:

- Physical Health: NPRS showed significant improvement ($p < 0.05$), PEG showed significant improvement ($p < 0.001$), ODQ showed significant improvement ($p < 0.001$), and PDI showed improvement ($p < 0.1$).
- Emotional Health: PCS showed significant improvement ($p < 0.001$), PHQ9 showed significant improvement ($p < 0.001$), and GAD showed significant improvement ($p = 0.001$).
- Patient Satisfaction: PGIC showed significant improvement ($p < 0.001$).
- Substance Use: DAST showed significant improvement ($p < 0.001$), and AUDIT showed significant improvement ($p < 0.05$).

Clinician Outcomes Monthly team experience surveys were conducted to rate satisfaction. The data for the first quarter of 2017 represent a monthly average sample size of five providers per site. Overall satisfaction was measured using a Likert scale, and 100 percent of participants stated that they were likely to stay with the organization in the foreseeable future. Clinicians also scored an average of 9.8 out of 10 in their likelihood to recommend the Desert Clinic Pain Institute to others.

Community Impact No reported outcomes.

Cost Savings Health utilization data of the patients enrolled in the COE initiative were analyzed on an ongoing basis by IEHP, including:

- Emergency room visits;
- Inpatient interventional utilization of pain procedures;
- Morphine Equivalent Dosage (MED); and
- Return on Investment (i.e., total medical costs, including pharmacy, facility, professional, and administrative components pre/post COE initiative).

Initial analysis of a subset of patients revealed a decrease in annualized total cost of care, from \$36,817 before the COE initiative to \$19,671 after the COE initiative, and a reduction in the probability of high total cost in 54 percent of patients.

Lessons Learned

Sustainability IEHP is reimbursing the Desert Clinic Pain Institute using a case rate based on which phase the member is in. This arrangement allows more flexibility to the care team in caring for the individual. A third-party

evaluation team specialized in alternative reimbursement modeling with experience in case-rate development is currently working with IEHP and the Desert Clinic Pain Institute to update the reimbursement agreement.

Challenges Setting up the operating systems to accommodate authorizations and claims payments for a multi-disciplinary program, which includes some services that are not generally covered (i.e. acupuncture and chiropractic care), was a challenge. However, IEHP was able to include all the services offered in this program in a case rate and configure the claims payment system to process automated claims.

Successes The key elements that contributed to the success of the program included program development/support and care management/coordination at the plan level. In terms of program development/support, it was critical to:

- Define core program elements for the COE and identify partners to scale;
- Complete a needs assessment and identify gaps and areas of support for each COE;
- Build internal infrastructure to support the COE; and
- Perform case rate development and maintenance.

As it pertains to care management/coordination at the plan level, it was important to:

- Identify and screen patients for COE referral using a clinical review of the patient's history, RUB score, MED utilization, and BH assessment;
- Hold regular interdisciplinary care team meetings;
- Coordinate care with SUD and Specialty Mental Health care-out programs; and
- Perform concurrent review of outcome data and clinical progress.

Advice If another health plan were to replicate this program, it would be very important for the health plan to maintain engagement with patients before and during treatment. It is also important for health plans to implement a transitional support program after completion of the program for successful outcomes. Longitudinal coordination of care among all treating providers and entities is essential, and non-clinical and clinical support staff should complete training to care for members with complex care needs. Finally, it is important to create a linkage to and coordination with carve-out and community services.

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Kudos to the Team

Team Lead

Dr. Jennifer Sayles, MD, MPH
Chief Medical Officer
Inland Empire Health Plan

Team Members

Desert Clinic Pain Institute
Dr. Tobias Moeller-Bertram, MD, PhD, MAS, Director of Medical Affairs and Clinical Research at Desert Clinic Pain Institute

Inland Empire Health Plan

Dr. Maury Manliguis, DO, MPH, IEHP Medical Director
Peter Currie, PhD, Former Senior Clinical Director of Behavioral Health Integration and Transformation at Inland Empire Health Plan

Contact

Victoria Ostermann
Director of Government Affairs
909-890-4430
ostermann-v@iehp.org

Intercept®: Youth Program to Address Social Determinants of Health

VAYA HEALTH

In April 2013, Youth Villages began providing Intercept® in Vaya Health's southwestern seven-county region of North Carolina. The Intercept® program specializes in providing services to troubled youth and their families; attempting to prevent youth from out-of-home placements; and successfully reuniting youth who are in an out-of-home placement. Family intervention specialists address all systems affecting the child and family, including family, school, peers, individuals, juvenile justice, child welfare, and the community. Other community providers of specific services that are not delivered by Youth Villages are also included when they are clinically indicated.

Intercept® addresses the social determinants of health by coordinating with primary care physicians to ensure that health care is being accessed appropriately. Specialists also link the family to other resources, such as transportation, pro-social activities for youth, food/clothing, and public housing. This initiative was designed to increase services and support for youth and their families who are involved with child welfare and/or juvenile justice.

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Key Priorities

- Reduce the number of children entering out-of-home placement.
- Reduce time in care in institutional setting.
- Reduce separation time between child and parent thus reducing Adverse Childhood Events (ACE) for youth and family.
- Stabilize family unit.
- Increase family supports.
- Improve outcomes for youth.

Geographic Location

Alexander, Allegheny, Ashe, Avery, Buncombe, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Watauga, and Wilkes and Yancey counties in western North Carolina

Population

Community stakeholders and Vaya Health had concerns about lengths of stay for youth in foster care, sibling groups being separated, limited services to prepare families for reunification, and absence of community-based options for diverting youth from custody. The Intercept® program serves youth involved in the child welfare and juvenile justice systems. This population is often faced with issues related to accessing health care and transportation, lower education, and economic instability. The Intercept® program helps link families to long-term supports and resources in these areas to ensure that basic needs are met in order to maintain achieved successes. Successful youth and their families are more likely to contribute positively to their communities.

Since May 2013, 204 children between the ages of five and 18 were served in the western region of North Carolina. Among this group, 60 percent of participants were between the ages of 9 and 14, 59 percent were male, and 41 percent were female. Stratifying by race, 88 percent were Caucasian, 4 percent were African-American, 3 percent were Native American, and 5 percent were unknown.

Key Partners and Community Groups

The following key partners are critical to the implementation of Intercept®:

- Youth Villages, which Vaya Health contracted with as a network provider using fee-for-service case rate
- 23 County Departments of Social Services (DSS) that partnered in the development of unique continuums of care to address the needs of child welfare populations in each county
- NC Department of Public Safety, Division of Juvenile Justice, which partnered in the development of unique continuums of care that address the needs of youth who were involved in juvenile justice in each county

Intervention and Methods

Evidentiary Family Restoration® was the basis for the Youth Villages/Vaya Health Intercept® initiative. Although the Intercept® model has been implemented in other states, this initiative was unique in how it worked with individual county DSS agencies instead of a generic approach that overlooks regional and cultural differences, particularly in rural areas. This approach emphasizes family, community, service intensity, accountability, and measurement and involves delivery of comprehensive, evidence-based/research-informed interventions for the child and family. Core components of the initiative include low caseloads, intensive community-based intervention, single specialist accountability, structured training and supervision, empowerment to help families resolve future problems independently, and 24/7 crisis intervention. Intercept® focuses on collaboration with relevant individuals within public agencies for the formulation of a comprehensive, community-based treatment plan.

The program begins with a clearly defined logic model, use of the most effective evidence-based and research-informed practices in multiple domains, structured supervision and clinical consultation, and initial and ongoing training that provides intensive support to specialists. The model also includes a comprehensive multi-modal review process to assess model adherence in each location in which the service is being delivered. Structured processes to scan literature for new evidence-based practices allow for rapid incorporation of new treatment modalities and for strengthening of interventions.

Multiple program components help address social determinants of health, such as increasing connections to

community resources and developing social support networks. Intercept® specialists fulfill multiple duties, including:

- Teaching parents to advocate for children’s educational needs and to focus on attendance/completion to reduce truancy/drop-out rates;
- Teaching families how to access transportation to promote long-term success, assist in accessing resources, and gain skills to maintain housing;
- Assessing factors that have an impact on the ability to work and teach application/interview skills in order to address employment barriers; and
- Assisting with access to psychiatric services and ongoing medication management and ensure that annual physical and dental visits are completed.

In 2013, Vaya Health’s leadership began working with seven western county DSS directors to expand the child services continuum to address community-identified service gaps, including services needed to support a no-reject foster care setting. This collaboration was essential in developing streamlined accountability for services and structured clinical pathways. The development of the pilot was a joint collaboration between Vaya Health, the county, and providers. Clinical and operational metrics were monitored through weekly and monthly processes using a balanced scorecard approach. Success was measured through post-discharge follow-ups through two years after discharge from treatment to determine long-term outcomes.

Outcomes

Patient/Family Outcomes For families discharged through December 2016, 88 percent reported overall satisfaction with services; 89 percent were satisfied with the quality of services; and 89 percent reported satisfaction with the quantity of services. Ninety-four percent of families were maintained in the program for at least 60 days (minimum intervention dose).

At 12 months after discharge, 84 percent of children were living at home or independently; 91 percent reported no trouble with the law; and 92 percent were attending school, GED classes, or had graduated from high school. Only 8 percent of participants had been placed in a psychiatric hospital, residential treatment, or correctional facility since discharge.

Clinician Outcomes The initial pilot included five staff members serving 16 youth and their families. Currently, the program has expanded to include 17 staff members serving nearly 60 youth and their families. Because of the need for program staff to be experts in family and community engagement to be successful, program expansion and growth can be seen as direct indicators of clinicians’ effectiveness.

Retention rates of these clinicians remained high. For example, the Waynesville office that serves the southwest counties had a 100 percent retention rate in 2015 and 2016.

Community Impact Intercept® has positively affected communities by decreasing the risk of out-of-home placement and trauma in a vulnerable population. Documented and/or reported long-term community impacts include increased educational engagement and completion, increased access to services, decreased episodes of legal involvement and/or incarceration, and strengthened family and community relationships. The program has received praise from stakeholders, including chief court counselors and county directors of Social Services.

Cost Savings Eighty two percent of Intercept® episodes of care (N=140; 6/2013 to 12/2016) were discharged to a non-residential community-based service without a follow-up crisis or inpatient service within 120 days of discharge. The cost saving projection, using a weighted and blended cost of residential services, is \$2.1 million. This approximate saving is based on the average cost of Intercept® (\$15,000 per episode versus weighted cost of residential of \$30,000 per episode). The projected 45 percent increase in utilization of Intercept® in FY 16-17 compared to FY 15-16 will create additional cost savings, allowing for increased capacity.

Lessons Learned

Sustainability Long-term sustainability through Medicaid funding relies on appropriate determination of medical necessity for this service and savings realized from diversion from inappropriate levels of care, including out-of-home, inpatient, and residential. Additional resources to promote sustainability include development of an *In Lieu* of Medicaid Service Definition to formalize programmatic requirements.

Challenges Barriers related to community engagement and school system collaboration were encountered in the initial phases of implementation. Challenges arose from historical relationship difficulties between schools and other treatment providers. Vaya Health engaged in relationship building across stakeholder groups focused on recognizing the importance of transitional relationships with other service providers outside the historic school-based model, and promoting the success of the child as the ultimate outcome. Education on the preventive and reunification impact of Intercept® required time and resources. Educational and training efforts continue in an effort to encourage accessing Intercept® services before out-of-home treatment is needed.

Successes Stakeholder support was essential in the development, expansion, and success of the model. The support of Chief Court counselors, county commissioners, and DSS directors was instrumental in promoting engagement and collaboration with other stakeholders and community members. The utilization of evidence-based models such as the Adolescent-Community Reinforcement Approach (A-CRA), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), Collaborative Problem Solving (CPS), and Community Advocacy Project (CAP) provided a clinical foundation for the success of Intercept®.

Advice Methods to promote success included small, planned county-by-county rollout to monitor and address barriers before expansion, and clear internal and external education on Intercept® that identify clinical specificity of the model, referral pathways, and expected clinical outcomes. Planning early for community education on the model affected future success. Routine data sharing and collaboration and communication with key partners through joint meetings were effective in maintaining clinical collaboration. In addition, offering an initial training between family intervention specialists and all case managers has proven effective when implementing the Intercept® program in a new community.

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Kudos to the Team

Team Lead

Rhonda Cox
Sr. Director of IDD & MHSU Care Coordination
Vaya Health

Team Members

Jane Kimsey, former Macon County DSS Director
Rhonda Cox, HSP-PA, Sr. Director of IDD & MHSU Care Coordination, Vaya Health
Donald Reuss, Sr. Director Provider Network, Vaya Health
Christy Satterfield, LPC, LCAS, Provider Relations Specialist, Vaya Health
Patrick Betancourt, Macon County DSS Director
Dianne Whitman, Chief Court Counselor District 23 NC
Annie Smith, State Director of Community-Based Programs NC, Youth Villages
Patrick Lawler, Chief Executive Officer, Youth Villages
George Edmonds, Assistant Director, Youth Villages
Brenda Triplett, Regional Supervisor, Youth Villages
Erin Cooke, Clinical Supervisor, Youth Villages
Sierra Kehoe, LPC, Clinical Consultant, Youth Villages
Korri McLaughlin, LCSWA, Family Intervention Specialist, Youth Villages
Gwendolyn Prince, Family Intervention Specialist, Youth Villages
Rhonda Knight, Family Intervention Specialist, Youth Villages
Lesa Bridges, Family Intervention Specialist, Youth Villages
Jamie Leigh, LCSW, Clinical Assessor, Youth Villages

Contact

Rhonda Cox
Sr. Director of IDD & MHSU Care Coordination
828-225-2785, ext. 1141
rhonda.cox@vayahealth.com

Boots on the Ground: Substance Use Disorder Program

CELTICARE CAREPLUS (CENTENE)

In 2015, CeltiCare partnered with Advocates, Inc., a provider of substance use disorder (SUD) services in central Massachusetts, to deliver face-to-face case management services to members in the catchment area. The initiative targeted hard-to-locate members without stable housing and with high risk for substance use because of non-compliance with treatment, frequent visits to emergency departments (EDs), and multiple gaps in care. Integrated medical/behavioral CeltiCare teams collaborated with Advocates staff to create care plans for members and to set case management goals to close care gaps and maintain treatment compliance. The progress toward goals was reviewed in weekly and monthly meetings with both teams. Preliminary results for the program indicate increased use of medical and behavioral health services at lower levels of care and decreased use of emergency rooms for most of the members enrolled in the program.

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Key Priorities

- Engage in case management.
- Decrease readmissions to the higher levels of care.
- Decrease ED use.
- Close the gaps in care.
- Increase compliance with outpatient (OP) treatment.

Geographic Location

Middlesex County, Massachusetts

Population

CeltiCare was focused on members with SUD who had high ED use, low compliance with treatment, and low engagement rates in the case management program. Engagement rates are negatively affected by housing instability and difficulties with telephonic outreach. The initiative was aimed at creating an alternative approach to engaging transient, low-income populations in case management and treatment to address medical, mental health, and substance abuse treatment needs as well as social determinants that exacerbated the ongoing health issues, including lack of stable housing and lack of stable employment and income. Since 2015, the program has served 48 men and women ages 21 to 65 who reside in or receive services in Middlesex County, Mass. A total of 191 members were referred to the program.

Key Partners and Community Groups

The following key partner is critical to the implementation of Boots on the Ground:

- Advocates, Inc.

Intervention and Methods

CeltiCare used behavioral health/medical services utilization data along with a predictive modeling tool (ImpactPro by Optum) to identify members who were appropriate for the program. The list was sent to the Advocates, Inc. staff to perform outreach for case management. The outreach attempts were telephonic, and if a member could not be reached, visits were made to the last known address and family members were contacted to help locate the member.

The identified members were flagged for their potential to successfully remain in the community with appropriate support, including the use of local, community-based, face-to-face, individualized care coordination; integrated care management; clinical outreach; peer support; and engagement in medical, behavioral health, and/or other services and supports. The joint care management team developed and approved a care plan for each identified member based on their ImpactPro risk score. The care plan was the driving factor for the team's ongoing efforts, and the care management level of intensity was individualized and differed relative to type, amount and frequency of contact, and anticipated length-of-stay.

Advocates, Inc. agreed to share data that demonstrated each member's contact type and frequency. The care plan goals mostly focused on addressing mental health and substance abuse treatment needs as well as closing care gaps and assisting members with issues related to socioeconomic factors, such as housing, food stamps, and accessing additional resources in the community. The joint case management team meetings were held weekly to provide updates on major milestones or setbacks in a member's progress, to revise care plans and goals as appropriate, and to identify additional resources to address a member's issues. Members were discharged from the program when it was determined that they had met their goals, upon their request or, in some cases, because of non-participation. In addition, monthly and yearly leadership meetings were held to monitor the on-going work flows and processes, and to identify and implement opportunities for improvement.

Outcomes

Patient/Family Outcomes Available data are considered preliminary because the number of members enrolled in the program at the time of the report's completion and members' different enrollment durations (i.e., some members enrolled for 8-9 months and others for 2-3 months). Of those referred, 25 percent were enrolled. Member churn after referral negatively affected enrollment rates. Most members stayed with the program until their care plan goals were met. The health plan intends to survey members' satisfaction at the time of discharge

from the program.

Clinician Outcomes No reported outcomes.

Community Impact No reported outcomes.

Cost Savings A review of 30 members yielded cost savings resulting from avoided ED utilization. Almost 50 percent (13) showed a decrease in the cost of ED utilization. On the other hand, ten members did not show any changes in pattern, and seven members demonstrated a slight increase in ED utilization. After removing two members who were considered outliers as a result of the severity of their mental health and substance abuse issues, ED utilization decreased by 58 percent.

Lessons Learned

Sustainability The health plan does not anticipate any foreseeable issues in continuing to support this initiative.

Challenges Initially, the health plan found that it was challenging to implement the process and address each organization's needs.

Successes This was a joint effort of medical and behavioral health integrated teams, which enabled the health plan to holistically address the members' needs and contributed to the success of the program. Partners participated in the development of the program, acknowledged and understood the importance of integration, and were open and willing to collaborate with each other. It was also important to have access to a predictive modeling tool and utilization data on both the medical and behavioral health sides.

Advice The health plan identified that it is very important to have a strong, integrated team and support from leadership as well as collaboration from different departments within the health plan, including clinical, medical, network, contracting, and data analytics.

Kudos to the Team

Team Lead

Joann Muldoon
Senior Manager
CeltiCare

Team Members

Audra McKinnon, Manager, CeltiCare
Wilfredo Escobar, Case Manager, CeltiCare
Marianne McCarthy, Case Manager, CeltiCare
Keishana Sanders, Care Coordinator, CeltiCare
Lisa Irving, Program Specialist, CeltiCare
Sarah Tuomenoksa, Program Specialist, CeltiCare
Marcy Morgenbesser, Director of Integrated Care Management, Advocates
Barbara Loonam, Case Manager, Advocates
Calvin Cheung, Case Manager, Advocates

Contact

Julia Linkova
Clinical Director
617-206-6433
julia.linkova@envolvehealth.com



LONG-TERM CARE AND TRANSITIONS OF CARE

Community Transitions for the MLTSS Population



UNITEDHEALTHCARE COMMUNITY PLAN OF KANSAS (UNITEDHEALTHCARE COMMUNITY & STATE)

Because of financial eligibility criteria, many individuals who could benefit from home and community-based services (HCBS) do not qualify and turn to costly nursing facilities (NF). Once in an NF, the individual spends down their assets and becomes eligible for Medicaid. Unfortunately, transitioning back into the community is challenging because many lose their belongings, home, natural supports, and some self-management skills while in the NF.

In 2015, UnitedHealthcare Community Plan of Kansas implemented an initiative to educate, assess, and support transitions from an institutional setting to the community for those who expressed interest in returning to the community. Although supporting members through community transitions has always been a component to UHC's MLTSS program offerings, this initiative leveraged new innovative partnerships with Centers for Independent living, built shared tools to facilitate collaboration with partners, and measured the impact on members through implementation of a Quality of Life survey. This innovative and comprehensive approach has supported more than 600 individuals who have moved successfully and safely into the community within the past two years.

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Key Priorities

- Improved member outcomes measured through utilization post-transition.
- Improved member satisfaction measured through quality-of-life survey metrics.
- Improved provider and community-based organization satisfaction.
- Financial savings for the health plan.

Geographic Location

Kansas

Population

UHC focused on identifying individuals who wanted to transition from institutions into community settings to improve their quality of life, increase member satisfaction, provide members with choice, serve individuals in the least-restrictive setting, and be cost-effective. To accomplish this, UHC evaluated more than 3,000 members living in institutions for appropriateness to transition. Approximately 10 percent were considered to be good candidates for transition to the community.

Key Partners and Community Groups

The following key partners are critical to the implementation of Community Transitions:

- Centers for Independent Living
- Assisted Living Facilities
- Nursing Facilities

Intervention and Methods

In 2015, UHC developed Community Transitions to educate, assess, and support transitions from an institutional setting to the community for those who expressed interest in returning to the community. The goal in implementing this program was to serve individuals in the least-restrictive setting, improve member satisfaction, and reduce costs. The health plan started with a thorough review of the challenges that lead to individuals being served in institutional settings and began to work closely with community partners to develop creative ways to address these barriers to the community, including the following:

- Contracting with Centers for Independent Living for non-traditional services to support transitions;
- Executing single-case agreements for Assisted Living Centers; and
- Developing a “Community Transition Work Book” as a one-stop communication and planning tool to share information among agencies.

Simultaneously, care coordination staff began reviewing patient histories for more than 3,000 members in institutional settings. UHC used member assessments and motivational interviewing to help identify members who would be strong candidates to transition to the community. The health plan reached out to members to discuss available resources to support community living and to determine if a transition would align with the individual’s goals and situation. UHC found that approximately 10 percent of the population would be strong candidates to return to the community. Success indicators included an ability to complete some self-care activities, existing natural supports, established medical and behavioral health care relationships, and a willingness and desire to live in the community.

During this time, UHC also implemented a quality-of-life survey among its LTSS population, which provided vital information about the impacts of transitioning to the community. In the year before this initiative was implemented, nearly 54 percent of individuals surveyed indicated they did not like where they lived. A year post-implementation, nearly 85 percent responded that they like where they live. Survey responses show positive gains on measures related to independence, community inclusion, medication adherence, and happiness.

The implementation of innovative partnerships and contracting strategies helped to ensure that the resources needed to support members were in place in the community. Also, the “Community Transition Workbook” proved to be of benefit in the day-to-day life of internal and external customers, by clearly aligning responsibility to the appropriate party at onset, reducing confusion, missed steps, and duplicative work.

Outcomes

Patient/Family Outcomes In 2015, the program supported 346 members returning to the community, 238 members in 2016, and 20 members in the first three months of 2017. The quality-of-life survey was implemented by UHC to measure the effects of this initiative before and after transition. The survey found the following:

- In 2016, no respondents indicated that they felt unsafe. In 2015, 3.8 percent indicated feelings related to feeling unsafe in their living situation.
- Significant gains in measures of autonomy and independence, with an increase in 42 percent for eating when respondents wanted, 34 percent increase in eating what they wanted, and increases in their ability to watch TV and use the telephone (up 22 percent and 23 percent, respectively).
- A reduction in the percentage of respondents who indicated that they go without taking their medicine when they need it (from 12.3 percent to 2.2 percent).
- In 2016, nearly 90 percent of respondents indicated that they were happy with how they can move about their community and home, up from 56.6 percent in 2015.

Clinician Outcomes No reported outcomes.

Community Impact No reported outcomes.

Cost Savings Although each situation is unique and costs differ based on the needed HCBS to support the member living safely in the community, on average the savings associated with serving someone in the community versus in an NF is approximately \$2,000 per member per month.

Lessons Learned

Sustainability This initiative is sustainable and important to assisting Kansas Medicaid members to live in the setting of their choosing. The health plan did not indicate any foreseeable barriers in sustaining the initiative.

Challenges In a large rural state like Kansas, staffing and access to services are a challenge that the health plan needed to address. Managing relationships with NF and community partners was a significant barrier initially. Over time, dedicated relationship building supported strong collaborations.

Successes The most important element was the engagement of the entire health plan. From the clinical team, to the provider advocates, senior leadership, analysts, medical directors, program managers and administrative staff, everyone had to work together to make this a health plan-wide initiative.

Advice Support for the initiative throughout the health plan is important. The cross-functional partnership to think creatively to address the diverse needs of individuals moving into the community is necessary for success.

Kudos to the Team

Team Lead

Melody Dowling
Director, Medical Clinical Operations
UHC Kansas Community and State

Team Members

Susan Welch, RN, Case Manager Kansas Health Plan
Kathy Blanton, RN, Case Manager Kansas Health Plan
Carolann Wishall, Provider Relationship Services Advocacy
Elaine Malinski,, Senior Clinical Program Manager
Katie Hooks, Associate Director of Case Management

Anna Purcell, Business Analyst Consultant
Amanda Hilton, Manager, Clinical Medical Management
As well as the support and participation of the entire LTSS team and partners

Contact

Kate Paris
Director of Thought Leadership
952-202-4877
katherine_paris@uhc.com

Dual-Eligible Transition of Care Program A Multi-Stakeholder Collaborative Approach

AETNA BETTER HEALTH OF MICHIGAN

The Dual-Eligible Transition of Care Program (ToC Program) was initiated on January 20, 2016, and focuses on approximately 500 dually eligible individuals residing in southwestern Michigan who see primary care physicians (PCPs) affiliated with the Lakeland Care Network, a physician hospital organization (PHO). Through the program, collaborators coordinate transitions of care from inpatient setting to either home or a skilled nursing facility via inclusive weekly rounds and informal communication between health plan, hospital system, ambulatory clinics, behavioral health organizations, and other stakeholders. Results include improved inter-organization communication and coordination; awareness of, and ability to address housing instability; and decreases in emergency department (ED) and inpatient utilization, signaling stabilized health and enhanced knowledge of navigating care systems.

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Key Priorities

- Reduce ED utilization by at least 5 percent.
- Stabilize medical costs.
- Improve care management efficiency for all involved organizations.
- Reduce care management fatigue experienced by the patient.
- Ensure open lines of communication between care managers at collaborating organizations.
- Improve patient experience of health care.
- Enhance integration of behavioral and physical health.

Geographic Location

Southwest Michigan

Population

The target population includes approximately 500 dual-eligible adults residing in southwestern Michigan who are assigned to PCPs within the Lakeland Care Network. Of this population, 57 percent are female, and 43 percent are male. A majority have five or more comorbid conditions, and at least half of have a behavioral health diagnosis. In this target region, poverty affects 57 percent of this population, and 40 percent have less than a high school diploma. Dual-eligible beneficiaries have limited transportation and financial resources, and experience housing and food instability.

Individuals navigate through fragmented care settings, fostering frustrating and dangerous patient experiences. Virtually all dually eligible beneficiaries have a complex mix of comorbidities and psychosocial needs, all of which require coordination.

Key Partners and Community Groups

The following key partners are critical to the implementation of the DualEligible Transitions of Care Program:

- Lakeland Care PHO, including Lakeland hospitals, Lakeland ambulatory clinics (owned and independent clinics, including FQHCs), and Lakeland Home Care
- Southwest Michigan Behavioral Health
- Riverwood Center
- AAA-Region IV
- Aetna Better Health of Michigan
- Aetna Medicaid Innovations

Intervention and Methods

In January 2016, Aetna Better Health of Michigan and the Aetna Medicaid population health team launched a pilot program with Lakeland Care Network. The focus of the ToC Program was to reduce ED utilization, improve access and engagement with the member's patient-centered medical home, and examine strategies to improve care management engagement and the integration of behavioral health. All members who are assigned to PCPs at Lakeland are enrolled in MI Health Link, Michigan's dually eligible demonstration program.

Those who are dually eligible for Medicare and Medicaid experience financial struggles, and are more likely to experience inconsistent transportation, housing and food instability, low levels of health literacy, and more. An important part of this program has been the recognition and resolution of these issues as they arise. Additional participants from the health care ecosystem participate in the program as well. For example, Southwest Michigan Behavioral Health, the region's behavioral health Prepaid Inpatient Health Plan (PIHP), and Lakeland Home Care participate in weekly case rounds, one of the key program communication mechanisms.

The collaborative planned for a brief pilot program, followed by an evaluation period that would inform leaders whether or not to continue with and potentially expand the program. After a positive evaluation of progress, organizers chose to commit to this program for the longer term. Collaborators have expanded their partnership beyond the sole focus on ToC interventions to also include high-risk members who use the ED frequently but who do not have an inpatient admission. These programs have contributed to a 10 percent decrease in ED utilization at Lakeland overall, and at some clinics, the decrease has been as much as 21 percent.

The success of this program is enabled through a mix of technology, data, and direct communication. The strategic use of Aetna Medicaid's proprietary predictive modeling data provides insight into utilization patterns. CareUnify, Aetna's web-based population health system, was deployed in this program and is a central communication

mechanism that allows Aetna and providers to share notes, documents, and patient data. However, most important is the concerted effort of all stakeholders to engage in direct communication with one another. In addition to informal contacts, well-attended weekly rounds sessions serve as key collaboration points.

Outcomes

Patient/Family Outcomes This initiative has been successful in ensuring that the care manager who is in most frequent direct communication with the patient is the person with whom the patient has the best rapport and the most trust. As a result, duplicative interactions on the part of the care management team were eliminated and the patient experience improved dramatically. Patients have been more likely to attend these appointments and adhere to treatment recommendations.

Clinician Outcomes The continued decline in ED utilization results from the effort to open communication among stakeholders. This collaboration spans the entire Lakeland system, including three hospitals, more than 30 clinics, and the PHO's home care service area. Some of Lakeland's sites employ care managers, while others do not. Those clinics with on-staff care managers saw a decrease in ED use (a decline of 21 percent in one case) because of improved care coordination, as well as increased communication with patients regarding their conditions, medications, and what to do when certain symptoms arise.

Community Impact Community participants have observed issues with housing and food stability. Conversations regarding how to include shelters, pantries, and other resources in the program are in process. In addition, the Community Development team at Aetna Better Health of Michigan is discussing these issues with government and nonprofit entities.

Cost Savings The Lakeland system overall has experienced a 9 percent decrease in ED use, while one clinic had a 21 percent drop in ED visits. The decrease in ED use occurred within the context of an increasingly high-risk population. Since June 2016, the number of high-risk patients at Lakeland with Aetna coverage who are dually eligible increased by more than 55 percent. Despite this increase in high-risk patients, per-member-per-month medical costs have remained nearly stable for the past year.

Lessons Learned

Sustainability Critical to the long-term sustainability of this program is the active participation and collaboration of partner organizations, including the health system (hospitals, ambulatory clinics, home care services, and more), the PIHPs, and community organizations. In part, the program's sustainability can be attributed to the dually eligible demonstration program's requirement that each participating member have an assigned care coordinator. The demonstration supports this important program feature both financially and in terms of policy. To continue to provide care management services to each member, Aetna would like the demonstration program to be implemented for the long run.

Challenges The greatest challenges for plan care management teams revolve around the time needed to collaboratively meet the needs of complex members, including:

- More intensive work with provider care teams in order to identify barriers to care (e.g., transportation, authorization issues, housing issues, etc.);
- Additional coordination of services to ensure that barriers are addressed;
- Preparation for, and attendance at, weekly case rounds;
- More frequent calls and/or visits with participating members; and
- Meetings with family members to explain care options.

These issues are being addressed by testing alternatives to traditional methods of case assignment, reconsidering workflow, and altering care collaborations as needed.

Successes The most important reason why this program has been successful is the deep dedication of all collaborators to improving care for the most complex patients. Despite growing pains, time intensity, and other challenges, stakeholders continue to participate and demonstrate a willingness to experiment with new ideas. Tools such as CareUnify, risk stratification reports, and other data have also contributed to the success of the program. However, without consistent participation from collaborators, these tools would be minimally useful.

Advice It is important to ensure the team's willingness to adapt the model quickly. Processes that are not working need to be identified and immediately changed. It is also necessary to identify why the process is not working so that the same mistakes are not repeated in future iterations or programs. Also, it is critical to encourage trust among participants and a willingness to be honest if something is not working. Because collaborating organizations function so differently from one another, it is important for everyone to express their experience. Identifying problems as soon as feasible means that care is improved more quickly.

Research

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Kudos to the Team

Team Lead

Shannon Saksewski, MSW, MBA

Population Health Specialist Team Lead
Aetna Better Health of Michigan

Team Members

Samantha Fell, MS, PMP, Director, Lakeland Care Network
Karen Riley, RN, Health Management Advisor, Lakeland Care Network
Kristeen Banish, RN, Care Manager, Lakeland Care Network
Sherrie McNutt, Vice President, Clinical Health Services, Aetna Better Health of Michigan
Mary Spicketts, Director, Clinical Health Services, Aetna Better Health of Michigan
Ruth Adelabi-Julian, Manager, Clinical Health Services, Aetna Better Health of Michigan
Andrea Koenigshof, Manager, Clinical Health Services, Aetna Better Health of Michigan
Latresa McCurtis, Care Coordinator, Clinical Health Services, Aetna Better Health of Michigan
Stacy Meyr, DC, Director, Population Health, Aetna Medicaid
Mark Douglas, JD, FNP, RN, Head of Innovation, Aetna Medicaid

Contact

Shannon Saksewski, MSW, MBA
Population Health Specialist Team Lead, Aetna Better Health of Michigan
734-589-7710
saksewskis@aetna.com



CHILDREN'S HEALTH

A Model of Care: Care Coordination of Health-care for Complex Kids (CHECK)



MERIDIAN HEALTH PLAN

Meridian Health Plan partnered with the University of Illinois College of Medicine at Chicago's Coordination of Healthcare for Complex Kids (CHECK), a demonstration project funded by the Centers for Medicare and Medicaid Services (CMS) to test a model of care for improving the health of children and families affected by asthma, sickle cell disease, diabetes, or prematurity. The goal of the initiative is to improve the overall health and quality of life for this population. Community Health Workers help navigate the health care system and address social needs, with the goal of improving chronic disease self-management, access to resources, and school attendance rates. A team of licensed professionals use a care model that provides direct interventions to patients and their families. Together, each component of this program model works in collaboration to create a valuable pediatric community and population health model. To date, nearly 13,000 families are enrolled, over 5,000 families are engaged, and 70,000 instances of patient contact have been reported.

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Key Priorities

- Reduce health care costs in the first year by 16 percent, 19 percent in the second year, and 23 percent in the third year.
- Reduce absentee rate by 30 percent over baseline for CHECK-enrolled students in Mile Square school-based clinics by the end of the third year of the project.
- Foster greater patient and family engagement and participation in care management by reducing missed clinic visits by 25 percent and increasing patient activation by 25 percent.

Geographic Location

Cook County, Illinois

Population

CHECK focuses on Medicaid-enrolled children with high-cost, chronic diseases. Since Medicaid is the largest health insurer for children and the primary resource for low-income parents, CHECK focuses on filling the gaps in service that this population often faces. Low Medicaid payment rates place an unfair burden on children's providers, which can threaten children's access to high-quality health care.

The target population includes children up to age 18 who reside in Cook County, have a chronic disease, and are enrolled in Medicaid. The program targeted 9,944 enrollees and engaged 5,534 children, half of whom are considered "medium risk." Of this population, 39 percent live below poverty and 47 percent are female. Stratified by race ethnicity, 62 percent are Hispanic and 32 percent African American. A majority (80 percent) have been diagnosed with asthma.

Key Partners and Community Groups

The following key partners are critical to the implementation of the CHECK program:

- Meridian's Care Coordination team
- University of Illinois College of Medicine at Chicago's CHECK

Intervention and Methods

CHECK takes a community health approach to reach participants, whether in their homes or during clinical visits, to ensure that each participant is receiving comprehensive, holistic care. CHECK also works to ensure that participants' health is improving and that unnecessary utilization is being reduced, while outpatient primary care is promoted. Using a comprehensive approach of providing community health, navigation, behavioral health services, and other social service support in the same space, care planning is tailored to participants while also helping participants navigate complex systems and have increased access to social services.

The Care Coordination team comprises health care professionals with extensive training, continued education in the target diseases, and specialized training in nursing, mental health, community health, and physical health. The team is organized by geographic zones and disease specificity and includes a liaison between medical staff and families as well as a presence in community sites to more effectively meet the needs of families. Care Coordinators assist patients with the development of care and management plans and assessments to assist with the improvement of patient self-monitoring and symptom identification. These individualized plans are designed to be patient-focused and goal-oriented to drive tangible results. Also, the assessments analyze and log information related to mental and socially-related health conditions.

Two other teams also support this initiative; the Mental Health Promotion Team and the Technology and Innovation Team. The Mental Health Promotion Team provides support through direct interventions to resolve existing conditions, preventative interventions, referral services for continuation of care, and advisory services to providers. The Technology and Innovation team supports a messenger platform that provides two-way communication between families and staff regarding service needs; a cloud-based community services referral data warehouse; care coordination software for managing and tracking patient engagement; and a web-based disease specific self-education platform that provides educational materials to families.

Geocoding techniques are used to "map out" the eligible population by the services being provided and by level of assigned health risk to tailor services and interventions to an entire ZIP code or neighborhood. Predictive modeling algorithms are currently being tested in order to predict which social service resources are most likely needed and what's the most efficient way to deliver them (human, technology, or a combination of both). Also,

the program is evaluating which of the CHECK Mental Health Promotion Team services are most effective and valued by participants through the use of follow-up assessments.

Outcomes

Patient/Family Outcomes No reported outcomes.

Clinician Outcomes Among the members engaged by CHECK, 95 percent received care and 36 percent of members attended in-person visits. Participation in the CHECK programs resulted in 15 percent fewer weeks of chronic absenteeism, and no-show rates for outpatient visits dropped to 10 percent, compared to a 22-24 percent overall outpatient clinic no-show rate. Twenty-three percent of members received referrals for social services. For behavioral health promotion services, 23 percent received advisory services, 8 percent received direct intervention services, and 93 percent received preventive services.

Community Impact Through the CHECK program, the health plan engaged the community in several ways, including:

- Providing disease-specific sub-specialty trainings for clinical and non-clinical partners;
- Offering community partner teach-in opportunities to market community resources to CHECK team;
- Connecting with a dental mobile van community events;
- Participating in health and wellness social resource fairs and community events; and
- Creating partnerships with non-clinical community stakeholders such as Chicago Public Schools and faith-based organizations.

Cost Savings Using a sliding window analysis, cost per-member-per-month fell over the course of a twelve-month period across all service categories. Prior to engagement in the CHECK program, the per-member-per-month cost totaled \$458.90: ED (\$47.60), inpatient (\$320.20), outpatient (\$31.00), and other (\$69.10). Other is comprised on non-institutional provider services such as dental, transportation, and laboratory services. The utilization rate of ED and inpatient services per 1,000 participants was 738.5: ED (606.3) and inpatient (132.2). After twelve months, the total per-member-per-month cost fell to \$161.80: ED (\$19.40), inpatient (\$63.50), outpatient (\$23.40), *other (\$59.00). The utilization rate of ED and inpatient services per 1,000 participants fell to 502.6: ED (447.1) and inpatient (55.5).

Lessons Learned

Sustainability A request for additional funding has been submitted to the CMS for continued support for this program. Resources are also being provided through partnerships with Meridian Health Plan. The key to sustaining this program is to retain funding and resources for the staffing model of front line staff (i.e., Care Coordination and Mental Health Promotion teams) and their supervisors, as well as to support the technological components of the program. In addition, sustainability requires continued growth of the community-based medical neighborhood to build partnerships and align ongoing initiatives with key stakeholders and connect participants with additional resources.

Challenges It was challenging to implement a program within an academic bureaucracy where additional rules and regulations make it difficult to establish contracts with external organizations. This made for a lengthier process to implement new relationships and products/technology. Also, it was difficult to create job descriptions for staffing as there were no precedents to refer to. The program model had to be adjusted to reflect changes in the ever-changing political and health care environments.

Successes The Care Coordination and Mental Health Promotion teams are the backbone of the success of engaging the participants and connecting them to the care they need. The opportunity to embed these teams into various community-based patient-facing points of care has been instrumental to the program's success as well. The partnership between CHECK and Meridian Health Plan has been key to efficiently monitor and track

participants' health outcomes and identify opportunities for improving care plans, care coordinated services, and utilizations of services.

Advice The health plan noted that it is important to allocate time for planning and operationalizing the program and to monitor political and local influencers for changes that might affect the program. Also, make sure that it is possible for ideas to be operationalized and that the program is aligned with the needs of payers of the program. Create cohesiveness between the varying experience levels of staff, so that everyone feels that they are a part of the team and know their value. You should provide support for staff as this work can be emotionally draining. Lastly, it is important to establish avenues for gathering data from external bodies (i.e., state and federal entities) and to build relationships with providers and other key stakeholders early to get buy-in and support.

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Kudos to the Team

Team Lead

Molly J. Siegel, MS
Executive Director, Coordination of Healthcare for Complex Kids (CHECK)
Department of Pediatrics

Contact

Imani R. Lewis
Senior Manager of Quality Improvement Strategy, Meridian Health Plan
312-980-2366
imani.lewis@mhplan.com



ORAL
HEALTH

Increasing Oral Health Access through the Affiliated Practice Dental Hygienist (APDH) Program



UNITEDHEALTHCARE COMMUNITY PLAN OF ARIZONA

UnitedHealthcare Community Plan (UHCCP) Arizona credentialed and contracted with Affiliated Practice Dental Hygienists (APDH), an integrated program with primary care clinician teams to improve access and address gaps in care. The purpose of this initiative is to increase the proportion of UHCCP enrolled members ages 2-20 who receive an annual dental visit. Rather than waiting for members to go to dental providers, the health plan brings a dental team member to the member's medical primary care provider (PCP) office. APDHs can provide basic screening and fluoride to the full range of preventive services. The APDH provides education and when needed, refers members to their affiliated dentist for comprehensive examination and treatment. Through this additional care option in the primary care setting, there is opportunity to identify social determinants of health (SDOH) and to make referrals into the UHC myConnections program (a network designed to help address SDOH).

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Key Priorities

- Establish credentialing and contracting of a new dental provider type (APDH).
- Increase the proportion of members enrolled in UHC Community Plan ages 2-20 years who receive an annual dental visit.
- Integrate an APDH into a medical primary care provider team to close preventive medical and dental gaps in care concurrently.
- Identify and implement new best practice standards for primary care providers/patient-centered medical homes and dental providers to work as enhanced primary care teams.

Geographic Location

San Luis, Arizona

Population

Yuma County experiences several barriers to oral care, including low health literacy, shortage of oral care providers, transient agriculture jobs, lower household incomes, and non-fluoridated community water supply. In Arizona, the APDH model is an opportunity to increase utilization of dental services and improve Arizona's ADV HEDIS rate by credentialing and contracting with a new oral care provider type that offers services at community-based locations (i.e., schools, medical offices, HeadStart, WIC Centers, etc.). This model adds integrated delivery of medical and oral care services, screening opportunities where SDOH can be identified, and referrals made for social supports that improve health security.

The pilot targeted 1,000 patients between the ages of 6 months and 21 years in Yuma County, a rural area in southwest Arizona adjacent to Sonora Mexico. The majority of patients were Hispanic/Latino residents of San Luis, Arizona, with annual household median incomes near \$30,000 and employment largely in agriculture and manufacturing.

Key Partners and Community Groups

The following key partners are critical to the implementation of the APDH program:

- Dental Benefits Providers (DBP), that manage dental administration and operations through a contractual agreement between DBP and UHC-CS of Arizona
- San Luis Walk-In Clinic (SLWIC), a clinic that provides high-quality, affordable primary care and behavioral health services

Intervention and Methods

Affiliated Practice Dental Hygienists are direct-access providers who were established to address unmet oral health care needs. However, because of the inability to be credentialed and contracted with Medicaid plans in Arizona, the model has been highly underutilized. Through an agreement with an affiliated practice dentist, APDHs can provide preventive and therapeutic dental hygiene services as appropriate without direct supervision by a dentist. In an Affiliated Practice model, an unsupervised APDH can provide dental hygiene services in non-traditional community-based settings and receive direct reimbursement from Medicaid plans.

This initiative integrates medical and dental services to concurrently close preventive medical and dental gaps in care. The APDH at SLWIC provides dental hygiene services in a medical primary care setting. As the medical provider completes an EPSDT visit, the APDH provides an oral screening, education, fluoride varnish, and referral to a dentist. The integration raises awareness of the oral systemic link between poor oral health and medical conditions (i.e., diabetes, cardiovascular disease, pre-term labor, low birthweight). The targeted pilot population has higher risk for and prevalence of oral disease and low attendance of oral care visits. The initiative reinforces the importance of oral health and captures services provided by APDHs to count toward the ADV HEDIS measure.

The Health Plan Dental Clinical Practice Consultant (CPC) engages medical and dental offices in developing integrated APDH models. Currently, UHCCP is working with several community partners throughout Arizona to implement 21 APDH models. The Dental CPC connects community partners, assists in determining strategies for delivery of dental services, provides resources, and guides the medical and dental practices in establishing the APDH provider for reimbursement. As outlined in their business agreements, medical and dental offices coordinate patient care and referrals.

The Health Plan worked with DBP to develop a process for credentialing and contracting with the APDH. State,

regional, and national leaders from Quality Management, Dental Operations, Government Dental Clinical Programs, Legal Counsel, and Networks worked together to develop a provider contract, a credentialing application and process, standards of operation, and company policies. The Health Plan identified regions and patterns of low ADV rates to guide the selection of the target population. As the initiative is expanded and incorporated into other primary care offices, this technique will continue to be used to identify additional target populations throughout Arizona.

Outcomes

Patient/Family Outcomes The ADV HEDIS score for SLWIC was 4 percent higher than UHCCP's overall score for services provided from October 2015 to August 2016. In September 2016, the ADV HEDIS score was 59.5 percent, meeting the 60 percent goal. As of February 2017, the SLWIC had an ADV score of 32.7 percent. Approximately 51 percent of patients did not have an established dental home from December 2015 to September 2016. Members expressed satisfaction with integration of a dental visit because it allowed them an opportunity to ask dental-related questions and to receive preventive treatment at their EPSDT visit.

Clinician Outcomes The APDH provided services for 1,134 Health Plan members between December 2015 and September 2016. Medical providers and staff are comfortable with the integrated dental services and have developed a workflow that is least disruptive to the medical providers' schedules.

Community Impact Regularly scheduled meetings are held to facilitate ongoing communication between the Health Plan, SLWIC, and other community dental providers. The initiative has gained the attention of other medical and dental offices in Yuma County. Also, Sunset Community Health Center has started to establish an APDH model of care, and the Yuma Multi-Specialty Integrated Care Clinic has requested future meetings to plan for integration of dental services with an APDH provider.

Cost Savings As medical accountable care organizations accomplish the ADV rate in their value-based contract and dental providers encounter more patients, the overall ADV rate for UHCCP should increase. This could position UHCCP with the opportunity to become eligible for an incentive payment from the state Medicaid regulator for accomplishing an ADV rate of 70 percent or higher. Also, as there is an increase in utilization of preventive dental services, members will require fewer costly restorative and surgical dental procedures; this will be better assessed over time.

Lessons Learned

Sustainability An increased demand for APDHs to be integrated into medical teams will most likely be driven by an increase in medical practices that engage in value-based contracts that include the ADV measure and by providing direct reimbursement for APDH services. Currently, there are incentives for medical providers to increase the ADV rate among their assigned member population. Testing an incentive program for dental providers to increase the ADV rate among their assigned member population could be considered. A dental provider incentive program has the potential to support the Health Plan's goal of accomplishing an ADV score of 70 percent.

Challenges The health plan noted that it was challenging to ensure that APDHs became a provider type that UHCCP could contract and reimburse for services within their license. After that, it was necessary to develop a credentialing processes, contract, fee schedule, and claims payment process. To address this, UHCCP needed executive support, persistence, regular meetings, project management, and accountability. Another challenge encountered was that SLWIC was beginning to see repeat patients who have additional preventive dental needs, outside of oral screenings and fluoride varnish. UHCCP is currently working with SLWIC to expand APDH services to include dental sealants, cleanings, and radiographs.

Successes Support from UHCCP Arizona leadership and Government Dental Clinical Programs helped to make this program a success. In addition, teamwork, stakeholder engagement, value-based contracts, and ADV

HEDIS scorecards contributed to implementing the program. Finally, it is important to establish positive, innovative relationships between UHCCP and providers.

Advice The health plan shared that it is important to involve leaders from quality management, dental operations, clinical programs, legal, and network to develop credentialing and contracting processes for a new provider type. It is helpful to use existing resources (i.e., credentialing documents; policies as templates). When developing a medical-dental integrated care model, it is important to credential, contract, and reimburse direct-access dental hygiene providers and employ a dental CPC to manage project and develop strategies. Also, include ADV HEDIS measured in value-based contracts and understand the state Dental Practice Act and collaborate with state dental hygienists' association, oral health coalitions, and practices. Finally, consider the target population's needs, resources, and barriers to oral health care.

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Kudos to the Team

Team Lead

Michelle Gross-Panico, RDH, DHSc
Dental Clinical Practice Consultant
United Healthcare Community and State (UHC-CS) of Arizona

Team Members

Mike Weitzner, DMD, MS, UnitedHealthcare Government Dental Clinical Programs
Tara Mattingly, DMD, Dental Director, United Healthcare Community Plan Arizona
Dental Benefits Providers (DBP)
Craig Newton, Ph.D., Vice President, Quality Management and Performance, United Healthcare Community Plan Arizona
Dan Jansen, MSW, MA, CPHQ, Clinical Quality Manager, United Healthcare Community Plan Arizona
Stephen Chakmakian, DO, Chief Medical Officer, United Healthcare Community Plan Arizona
Denise Clemente, BSHA, Sr. Network Development and past Dental Manager for United Healthcare Community Plan Arizona

Contact

Kate Paris
Director of Thought Leadership, UnitedHealthcare Community & State
952-202-4877
katherine_paris@uhc.com



BEHAVIORAL
HEALTH

PROMISING INITIATIVES

While initiatives outlined in the previous categories represent programs with demonstrated outcomes, Medicaid managed care organizations are actively designing, implementing, and testing new programs for their members. These programs do not yet have data on outcomes but are considered potentially promising on the basis of their robust, evidence-based design and responsiveness to members' needs.

Navajo Nation's Community Initiative to Raise Awareness of Depression

UNITEDHEALTHCARE COMMUNITY PLAN OF NEW MEXICO

Depression is among the most prevalent and treatable mental health disorder and has a serious impact on physical health, including the prevalence and outcome of chronic diseases. In 2016, a coalition of stakeholders, including the Diné Council of Elders, the Hozho Center, and UnitedHealthcare came together to begin work to improve outcomes for individuals experiencing depression. The goal of the coalition was to support the tribal communities throughout McKinley County in their ability to recognize, screen, refer, and obtain treatment of depression for their community member. From the identification of the need, through outreach to build the coalition, to the structure and direction of the initiative, the community led the initiative. UnitedHealthcare offered support with logistical assistance and skilled, culturally responsive facilitation to identify and implement action steps that fostered community ownership, engagement, and long-term sustainability.

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Key Priorities

- Work collaboratively with the community on a health-related issue of importance to them.
- Bolster the community's own ability to respond to the health issue.
- Improve UHC's strategies for engaging with communities and develop culturally responsive strategies to address pressing health concerns.
- Understand the "depression problem" from the community perspective and increase community awareness of depression.
- Increase depression screening and access to care for depression through settings delivering primary care, behavioral health, substance use treatment, human services, peer-support services, and Native American traditional medicine.
- Grow provider multicultural capabilities to enhance culturally competent care and positive member experiences.

Geographic Location

McKinley County, New Mexico

Population

There is no word for “depression” in the Navajo language, which illustrates the complexity of addressing this health issue. The project sought to empower the community to take the lead and action through educating community members to recognize, get screening, and obtain treatment using mental health providers and traditional healing, community education and training, and develop the use of Navajo peer-support specialists who can provide support and care coordination activities while awaiting to see a mental health professional.

Eighteen people participated in community outreach and focus groups, and approximately 90 percent of participants were Native American tribal members. Focus group participants were tribal community members, leaders, health plan members, providers, and advocates. Future efforts will have the potential of affecting 3,600 Native American health plan members in the county.

Key Partners and Community Groups

The following key partners are critical to the implementation of the APDH program:

- UnitedHealthcare
- Dine Council of Elders, a Native American traditional provider and peer-support agency
- Dine Veterans Program
- Hozho Center, a peer-support agency
- Bureau of Indian Affairs
- Be Well New Mexico
- Synergy Behavioral Health, a local network provider
- Presbyterian Medical Service
- Community advocates
- Health plan members

Intervention and Methods

In 2016, a coalition of stakeholders including the Diné Council of Elders, the Hozho Center, and UnitedHealthcare, came together to improve outcomes for individuals experiencing depression in the community. The goal of the coalition was to support the tribal communities throughout McKinley County in their ability to recognize, screen, refer, and obtain treatment of depression for their community member. The coalition recognized that to develop an initiative that resonated with the community and had long-term sustainability, it must be informed and led by the community.

Awareness and recognition of depression within the Navajo community is a considerable barrier to recovery. The term “depression” is not directly translatable in the Navajo language and as a result, is often not fully understood in the Navajo culture. To bridge the Navajo and Western perspectives, this initiative began and was guided by the creation of a visual depiction of a tree. This illustration represented the roots of depression and through the course of eight stakeholder focus groups, participants explored what the roots of the tree meant to their community.

The focus group discussions of “depression” led to understanding, from the Native American perspective, to help explain the impact of historical trauma (often referred to as “ch’ee’nah” in the Navajo language), and understand difficult challenges of domestic violence, suicide, and substance abuse. “Ch’ee’nah” can be best described in the English language as meaning “depression,” which historically comes from the “Long Walk of the Navajo” when people were forcibly removed from the reservation and became prisoners in a foreign encampment. The hopelessness, helplessness, and painful missing of a place, animals, or person are embodied

by this phrase. This project supported concerned and committed community members to clarify and apply their understanding of depression to problems and solutions concerning their own health and the health of their community. Cultural traditions were honored through facilitation of the focus groups—including deference to elders, introduction of clan, and the opening prayer.

Eighteen people participated in the focus group and identified themselves as either Navajo, Pima/Hispanic, Caucasians, Choctaw, or Hispanic adults. Three identified themselves as consumers of services, three as social worker interns, two as administrators, four as staff members, two as managed care employees, and two as traditional healers from Navajo Nation. There were eight questions developed for the focus group. For each question, qualitative analysis was conducted by identifying content themes and grouping the specific responses within those themes.

Outcomes

Patient/Family Outcomes Initial findings from piloting the depression initiative, two health plan members received care coordination and increased engagement with community providers. Associated outcomes were regaining custody of children from protective custody; improved social determinants of health, including housing, employment, reduced social isolation; and increased social support and expressed need for environmental modification to support physical mobility. One family reported improved communication, reduced relationship conflicts, and reduced depressive symptoms.

Clinician Outcomes No reported outcomes.

Community Impact The participation rates have varied from month-to-month, but meeting participants have been consistent and engaged. Also, members are taking action on items identified by the group, including a “Depression Conference” held on May 5, 2017, at Crownpoint Navajo Technical University, interweaving Western Mental Health and Traditional Healing. In addition, members of the group made special handbags that signify “Understanding your roots and finding Happiness through Hope” – “Sei baa Shi’l Hozho doo.” Special cups and bookmarkers with positive messaging will be inserted in handbags made by the group through donations by various entities.

Cost Savings No reported outcomes.

Lessons Learned

Sustainability By using collective community planning and contributions, the cost of this event was covered. The first depression event was held in May 2017, with a second event planned for a neighboring community. From the beginning of this project, UHC staff communicated to the gatekeepers our intentions to empower the group to sustain the project so that the group can carry on the work to save lives of community members. Project staff will assist with the focus group, communicate findings, and assist with some of the implementation activities.

Challenges As the project was implemented, we discovered that the participants had ideas that were different from the original intention. Because this was a community-based, culturally-responsive initiative, staff worked to be flexible and amenable to the priorities and needs of the community and gatekeepers. Although this required an adjustment, collecting information benefitting the tribal community and implementing findings to make it meaningful and successful from their perspective was in line with the project’s goals.

Successes Having community nonprofits participating in the initiative encouraged others to join the effort. The creation of a safe, bilingual environment in which participants perceived that their ideas were truly valued enabled them to fully and openly share their observations, opinions, and personal experiences. The use of focus groups provided effective and efficient structure for obtaining the needed information to appropriately align the depression project plans. The UHC Health Plan supported the entire initiative by contributing valuable staff time and the cost of their travel to a rural part of the state, along with modest contributions for food and other

essentials.

Advice The health plan noted that it is important to be sensitive to the needs and preferences of the community and to see the strengths in the diverse perspectives of the culture. Empowering the community and being ready to adapt project goals to the expressed needs of the community can change the course of the project. Taking the needed time to establish such relationships is vital because they are the foundation for trust when working with communities of color and other underserved groups.

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Kudos to the Team

Team Lead

Carolyn Morris, Ph.D.
 Director, Behavioral Health for Native American
 UnitedHealthcare Community Plan of New Mexico

Team Members

Carolyn Morris, Ph.D., Director, Behavioral Health for Native American UnitedHealthcare Community Plan/
 New Mexico
 Laura Valdez, RN, Manager Clinical Medical Management UnitedHealthcare Community Plan/New Mexico

Amilya N. Ellis, LCSW, MPH, CHES, UnitedHealthcare Community Plan/New Mexico Clinical Program
Manager
Hozho Center

Contact

Kate Paris
Director of Thought Leadership, UnitedHealthcare Community & State
952-202-4877
katherine_paris@uhc.com

Access Point Behavioral Health Screening & Education

TRILLIUM HEALTH RESOURCES

Access to behavioral health services in rural communities is a challenge for members, families, and health care providers. Trillium Health Resources' Access Point is a three-pronged behavioral health screening and education initiative to reach members in rural eastern North Carolina. Through interactive kiosks, a robust web presence, and responsive programming on multiple mobile devices, Trillium is reaching members who might otherwise not know about or seek services for mental health and substance use conditions that are affecting their lives. In 2015, Trillium launched this initiative in partnership with local rural communities with a staggered startup of the website and ten kiosks over six months. More than 1,800 people have used the technology and nearly 100 have interacted with Trillium staff directly through the warm line available from the kiosks. These are members who would likely not have been connected without this technology available in their community.

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Key Priorities

- Provide access to screenings and services for those living in rural areas within Trillium's catchment.
- Provide all people with 24/7 access to anonymous, online, evidence-based, self-administered behavioral health self-screenings, educational resources and referral information in English and Spanish.
- Strengthen connection to rural communities by offering a local presence.

Geographic Location

The North Carolina counties of Beaufort, Bertie, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, and Washington

Population

Trillium's catchment area is largely underserved, rural, and remote in coastal eastern NC. Lack of local resources and stigma around admitting to and seeking behavioral health services prevent people from receiving the help they need. Despite a high prevalence of mental health and substance use problems, too many people go without treatment, in part because their disorders go undiagnosed. By facilitating private, anonymous screening for individuals in areas and communities with a large number of risk factors (e.g., low income, unemployment, and geographic isolation), Trillium believed that people at risk for behavioral health diagnoses could be identified, connected to services/resources, and avert crises.

Access Point serves people living in Trillium's 24-county eastern North Carolina catchment. To date, more than 1,800 individuals have used the system, including 99 who engaged Trillium via a kiosk dedicated phone line. Members who used kiosks are typically younger than 55 years of age; 46 percent were between ages 18 and 34, 42 percent were between ages 35 and 54, and 13 percent were age 55 or older.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Access Point program:

- Local social service agencies, health departments, federally qualified health centers, schools, and community centers

Intervention and Methods

This initiative was the first of its kind in North Carolina to address the unique nature of the coastal area, where remote and rural communities have either low population density or seasonal population fluctuations. The Access Point concept was inspired by the use of a computer tablet in a Boston-based public drug store, to destigmatize mental health issues. Trillium tailored this approach to provide a private Access Point kiosk where people could access screenings and other resources, including a phone in the privacy booth that would connect them to a trained professional in Trillium's Call Center.

Targeting counties where there is a shortage of providers and a higher risk of behavioral health needs, Trillium looked at available evidence-based screening tools and chose to contract with Screening for Mental Health for the kiosks and website. Trillium approached key stakeholders in communities with the concept and readily secured public locations in health departments, social service offices, libraries, and local government buildings. Kiosks were designed with Trillium branding and community ceremonies were conducted to launch placement of the kiosks.

Access Point was designed to provide all people with 24/7 access to anonymous, online, evidence-based, self-administered behavioral health self-screenings; educational resources; and referral information in English and Spanish. Voice over IP (VoIP) provides immediate assistance and direct support to users at the Community Kiosk by connecting them with a trained Call Center agent. This connection is a dedicated warm line that goes directly to the Trillium Call Center. For those who access via the website, a provider directory and phone number also connect the community to behavioral health services and resources.

Trillium produces a data dashboard monthly for both internal and partner use. The data collected do not contain Health Insurance Portability and Accountability Act (HIPAA)-protected identifiers and does include demographic information, usage of kiosks, and screening outcomes.

Outcomes

Patient/Family Outcomes More than 1,800 people have used the self-service Access Point kiosks in rural communities in eastern NC. Kiosk users might otherwise not have known how to interface with Trillium to gain access to mental health or substance abuse treatment.

Clinician Outcomes No reported outcomes.

Community Impact Our community partners at local social services department, health departments, and other settings have expressed a great deal of satisfaction in knowing that they can have a person use the kiosk for screening for mental health and substance use disorders. Many of our essential partners have used the system to help them make referrals for care.

Cost Savings No reported outcomes.

Lessons Learned

Sustainability Trillium made the initial one-time investment of hardware and software development. The kiosk locations cover the ongoing cost of utilities and internet services along with the cost of their base operations as an in-kind contribution. The long-term sustainability of the program is accounted for in the administrative cost of operations for Trillium to maintain access to care to members in the service area.

Challenges The biggest challenge for Trillium was internet access in very rural areas. The internet connections in the more-rural areas were unreliable at times. Working closely with local Information Technology staff was key to being able to anticipate the need for internet boosters and, in some cases, hardwire the kiosks.

Successes Success is measured by the impact on both the community and Trillium members. Trillium developed a training program to educate partner staff about the importance and purpose of the project and shared ways to encourage people to utilize the screenings. Martin County Health Department nurses expanded the program to hand-held tablets for individuals to use in the exam rooms while waiting for the doctor and then discuss during their appointment, thus taking the concept a step further. The Gates County Sheriff's Office referred someone to the screening who was able to receive treatment after the screening, rather than proceeding through the legal system. Law enforcement as a whole would like to see how the project could expand into their arena. Other managed care organizations (MCOs) serving rural areas in North Carolina replicated this model, following Trillium's lead.

Advice The health plan noted that preparation and involvement of partners is extremely important. Trillium developed a training program for partner staff to educate them about the importance and purpose of the project and to share ways in which they could encourage people to utilize the screenings. Public awareness and marketing are other keys to success. Trillium has a robust electronic mailing list for newsletters that include information about Access Point, as well as using Facebook, Twitter, and an Access Point web page on the Trillium website and engaging in local community events.

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Kudos to the Team

Team Lead

Cindy Ehlers
Vice President of Clinical Operations
Trillium Health Resources

Team Members

Bobbie Lowe, BS, Project Coordinator
Dave Peterson, MA, Regional Director Central
Bland Baker, BS, Regional Director Northern
Deanna Campbell, BS, Regional Director Southern

Contact

Cindy Ehlers
Vice President of Clinical Operations, Trillium Health Resources
252-670-0199
cindy.ehlers@trillimnc.org

Comprehensive Health Assessment for Teens (CHAT)

TRILLIUM HEALTH RESOURCES

Comprehensive Health Assessment for Teens (CHAT) is a clinically validated instrument created for adolescents ages 13-18 that addresses mental health and substance use conditions and medical problems, and social determinants of health (e.g., housing barriers, employment, and education-related challenges). Comprehensive Health Assessments such as CHAT play a critical role in the service delivery system and help prevent kids from falling through the cracks. In using CHAT, Trillium Health Resources provided earlier and more effective interventions that truly have an impact on adolescents who might develop serious mental and/or substance use conditions that often require high-cost, long-term treatment. Preliminary findings showed that during the pilot phase, mental health only and substance use only diagnoses decreased, while co-occurring diagnoses increased from 2.37 percent to 23 percent. The efficiency created by use of the electronic assessment tool helps to free up clinician time, which is critical in the rural area Trillium covers.

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Key Priorities

- Improve accurateness of assessments for adolescents accessing services, specifically to decrease missed substance use diagnoses among assessed adolescents.
- Improve the current choices among assessment tools for clinicians working with adolescents with minimal training.
- Provide access to a comprehensive tool that has valid measures and assesses the whole person.
- Increase access to aggregate data related to adolescent assessment for Trillium.

Geographic Location

The North Carolina counties of Greenville, Ahoskie, Jackson, Elizabeth City, Nags Head, and New Bern.

Population

Before this initiative, providers were using an assessment that was not based on evidence, and, commonly, substance disorders or other social determinants of health were overlooked in the assessment process. Early identification of the challenges a person faces will lead to better outcomes. The assessment was piloted with 230 individuals, both male and female adolescents, with a substance use diagnosis in 2014 within the (then 19-county) Trillium Health Resources catchment area. Among those who completed the assessment, 45 were referred to intensive alternative family therapy (IAFT).

Key Partners and Community Groups

The following key partners are critical to the implementation of the Access Point program:

- Inflexxion, Inc., developer of the CHAT assessment, which provided technical support and training.
- Trillium network providers, including PORT Health Services, Access Family Services, and Integrated Family Services.

Intervention and Methods

CHAT is a clinically validated instrument created specifically for adolescents between the ages of 13 and 18, that was developed by Inflexxion. By using CHAT, Trillium Health Resources is seeking to provide earlier and more effective interventions that have an impact on adolescents who are at risk for developing serious mental and/or substance use challenges that often require high-cost and long-term treatment. This tool is used to guide treatment planning for adolescents who are in treatment or in the juvenile justice system or a youth treatment facility. CHAT follows a developmental approach that emphasizes the varying needs of young people; uses engaging multimedia (audio) to facilitate adolescents' self-administration; and assesses strengths as well as problem areas, providing a more-comprehensive portrait for guiding treatment.

CHAT is an electronic assessment tool that allows for individuals to respond in private and ranks highly in self-disclosure. It provides the same type of anonymity that teens experience in other on-line social media platforms, though it is completely private and HIPAA-compliant. The tool is also cost-effective in rural clinics that have fewer-than-usual staff available to meet the needs of their patients.

The tool addresses key health issues in the Medicaid population, including sexual health, TB screening, HIV risk factors, and linkages with primary care and social determinants of health (for example, it asks about living arrangements and stressful events such as homelessness, employment, peer relationships, family relationships, and romantic relationships). CHAT also addresses resiliency factors, hobbies, interests, and motivation to address identified challenges. The substance use section of the assessment provides detailed questions that include pictures and slang terminology to help adolescents accurately identify substances they have been using.

The narrative report provides graphs and charts for easy visualization of the challenges reported and motivations to address them. The report is immediately available to the clinician for review with the enrollee. The additional ability to report trends in aggregate allows Trillium and each provider to monitor new drug trends. This has been of particular importance because of the opioid epidemic in Eastern North Carolina.

Outcomes

Patient/Family Outcomes Patient and family outcomes are not yet calculated for this project. However, the pilot data do demonstrate the greater attention and resources given to adolescent health. This was accomplished by increasing the visibility and knowledge base for adolescent health issues through better data collection at the

local level with the use of this tool. This tool also standardized and improved measurement and collection of data on adolescent health conditions and behaviors. In addition, preliminary data suggest higher satisfaction results from patients and their families and other referral sources.

Clinician Outcomes During the pilot, mental-health-only and substance-use-only diagnoses decreased, while co-occurring diagnoses increased from 2.37 percent to 23 percent. Early identification of opioid use will lead to better outcomes among members. Adolescents reported high levels of self-disclosure and satisfaction with the tool during the pilot as well. Clinicians felt they were able to make more-accurate diagnoses and in turn better treatment recommendations.

Community Impact Community stakeholders such as juvenile justice and social services were pleased to see implementation of an evidence-based tool. The standardized assessment report helps stakeholders to have a clearer picture of not only behavioral health, but also important social determinants, strengths, and resiliency. Partners provided regular feedback and after implementation, they felt that use of the electronic assessment tool created efficiencies that improved their ability to serve people in rural areas.

Cost Savings Future and current cost savings will be realized as a result of CHAT implementation. Use of CHAT leads to accurate diagnosing and treatment planning, which in turn leads individuals to the right service, in the right amount, and at the right time. This also allows individuals to receive more-appropriate services earlier in the treatment process, leading to future cost savings.

Lessons Learned

Sustainability Following the pilot initiative, the CHAT tool is now purchased by clinicians and reimbursed through a billing rate enhancement, which makes this sustainable for future use. All clinicians who participated in the pilot chose to continue use of the tool. CHAT promotes better outcomes for the individuals that the health plan serves. Maintaining engagement through a partnership with stakeholders also has been at the forefront of this implementation for sustainability. We have aimed to foster an open-door policy and have encouraged feedback. Through the use of analytics, we are able to monitor trends from CHAT and use outcomes to predict care needs.

Challenges This initiative asked our network providers to change their business practice model. Another implementation challenge was shifting the assessment culture for clinicians. As a result of the rural geographic coverage, we also experienced some concerns about internet connectivity. In an attempt to make this transition smoother, we provided ample training sessions, IT support, tablets to providers through a grant, and technical assistance for providers as they made this shift in their operations. We allowed a three-month soft launch of the CHAT that allowed providers to move at a pace that made the most sense for their organization.

Successes Trillium has an innovative approach to advancing technology solutions with network providers, vendors, and enrollees. Without support from Trillium's executive management team, this initiative would not have occurred. Providers' partnership, participation, and acceptance of this new assessment process aided significantly in the success of this initiative. Use of an evidence-based, self-administered on-line tool was key to gaining providers' buy-in and enrollees' participation. Trillium increased the capacity, through advocacy and training of behavioral health care providers and others to appropriately and effectively identify and respond to adolescents' health needs. Trillium also strengthened the voices and participation of young people to empower them to shape their own health.

Advice The health plans noted that use of technology in the assessment process leads to more-accurate diagnoses, high levels of self-disclosure, and better outcomes. Partnership with providers is key in this type of implementation, and having a vendor of the tool who can provide high-quality customer service is important. It is important to plan for staff turnover at provider organizations so that this can be sustained in each implementation site. Also, consider the use of tablets for community-based services.

Kudos to the Team

Team Leaders

Christie Edwards, MS, LPC, LCAS
Project Manager
Trillium Health Resources

Team Members

Cindy Ehlers, MS, LPC, Vice President Clinical Operations
Maegan Veillette, CSAC, Project Coordinator
Kimberly Greer, PhD, Staff Psychologist
Jason Rice, Contracts Manager
Michelle Martin, Senior Accountant

Contact

Christie Edwards
Project Manager, Trillium Health Resources
252-670-0199
christie.edwards@trilliumnc.org

Vaya Total Care for Physical & Behavioral Health

VAYA HEALTH

Vaya Total Care (VTC) is a complex care initiative targeting an identified Medicaid and dual-eligible Medicare and Medicaid population with complex physical, behavioral health, and social determinant needs. The primary goal is to improve the overall health of members through an integrated care coordination platform, national practice standards, and individual and population stratification to create acuity-based workflows and a shared care plan. Additional goals include reduction of unnecessary expenditures; improved physical, behavioral, and social outcomes; better experience of care; and improved provider satisfaction. A care coordinator is the face of a multidisciplinary care team consisting of licensed behavioral health clinicians, peers, registered nurses (RNs), primary care providers, and pharmacists to assist a member in navigating their health care and personal goals. The initiative has a foundation of training that includes population-specific, integrated, person-centered care; health disparities; and member self-management.

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Key Priorities

- Proactively identify members who are at risk for high service utilization and/or poor health and quality-of-life outcomes associated with non-coordinated service delivery.
- Address member needs across life domains.
- Standardize care coordination practices and protocols across traditional disability groups.
- Develop shared care plan utilized by the entire care team, including providers of non-medical services, to ensure inclusion of social determinants of health.
- Real-time data sharing among all providers and across all care settings.
- Alignment of the Vaya Health care coordination model with the North Carolina Section 1115 Waiver application and other Medicaid Waiver requirements nationally, so that it is portable to other states.
- Develop a care platform, learning collaborative, and joint partnership among Vaya Health, Mission Health Systems, Inc., Mission Health Partners, and Mountain Area Health and Education Center (MAHEC).

Geographic Location

McDowell County, North Carolina

Population

VTC addresses health disparities in Medicaid populations, lack of integration across the health spectrum, and poor engagement, as well as the social determinants of health, including employment, housing, and other conditions that might be barriers to accessing care. A comprehensive Health Risk Assessment, relevant screenings, and risk stratification are used to develop a single care plan and coordinated interventions, customized to a member's needs, and shared across a multidisciplinary team through the VTC platform. This initiative is important to the target population because high utilizers are frequently involved with a variety of social service agencies, have disjointed health care provision, and struggle to navigate multiple service systems.

The target population includes children in foster care; individuals with an intellectual/developmental disability participating in the 1915(c) Innovations Waiver; and dually eligible Medicare/Medicaid members with high-risk indicators in physical and behavioral health, acuity, hospitalization, ambulatory care, claims cost, pharmacy utilization, and/or pharmacy cost.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Vaya Total Care program:

- Mission Health Systems and affiliates
- MAHEC, contracted for program evaluation
- NC DHHS
- McDowell DSS
- RHA & Daymark Recovery Services, a contracted provider
- InfoMC, a software vendor
- Cansler Collaborative Resources, contracted consultants
- Healthcare Perspectives LLC, contracted consultants

Intervention and Methods

VTC represents a collaboration in western North Carolina between the largest regional health care system, Vaya Health, and the regional area health education center for medical and psychiatric residents to address needs of children and adults with complex care needs living in a rural setting. Other key collaborators include mental health, substance use, and intellectual and developmental disability (MH/SU/IDD) providers and the local Department of Social Services (DSS). VTC demonstrates the impact of shared data, clinical and social needs, and integrated person-centered planning on improving efficiency, health care, and quality-of-life outcomes while meeting the requirements of Medicaid waiver(s).

VTC uses technology and clinical pathways to create member dashboards, drive work flow according to the needs of the member, and ensure consistency and accountability of the care coordinator. This allows the care coordinator to focus on members' needs while technology maintains and tracks the tasks of care coordination. Coordination of care among behavioral health, primary care, and social support agencies for members with MH/SU/IDD needs and co-occurring chronic health conditions bridges a long-standing gap between systems and promotes patient accountability.

The next phase of VTC will use Admission, Discharge, and Transfer (ADT) data, clinical summary and claims data to create a near-real-time picture of a member's health. This snapshot will be used to create care alerts within the platform to inform the team of needed interventions and follow-up activities (e.g., emergency department (ED) admission). ADT and clinical summary data will be added to the stratification process to provide timely risk scoring based on most recent health care visits of behavioral health, primary care, and pharmacy adherence

(i.e., point of sale, medication review/reconciliation).

VTC uses a shared member data platform and data analytics that stratify and identify member risk level based on physical, behavioral, acuity, hospitalization, ambulatory care, claims cost, and pharmacy utilization and cost. These indicators predict members who are at risk for significant life events. The initiative uses a train-the-trainer model to train staff in best practices of complex care coordination such as transitional care and self-management education to improve the quality of interventions delivered to the members and our partners. Pharmacists, RNs and peer support are embedded as additional levels of support.

Outcomes

Patient/Family Outcomes From January to March 2017, 71 percent of children in foster care were engaged, with 12 percent in the process of enrollment and 17 percent no longer in DSS custody. In addition, 67 percent of members with primary IDD were engaged, although 27 percent refused to participate; 3 percent were in the process of enrollment; and the health plan was unable to reach 3 percent. Finally, 25 percent of adult members with primary MH/SU were engaged, with the health plan unable to reach 44 percent and 31 percent refusing to participate.

Clinician Outcomes No reported outcomes.

Community Impact The McDowell DSS Director is now requiring participation for all children in foster care. Staging primary care implementation with regional practice champion and hospital systems is also in place.

Cost Savings No reported outcomes.

Lessons Learned

Sustainability Long-term sustainability of this initiative is linked to the overall North Carolina Medicaid Reform proposal, which is dependent on both federal and state legislative and policy developments. This project can also be a solution for those states that are evaluating interventions for complex Medicaid beneficiary populations with chronic health conditions. Success will be contingent on complete integration between the physical and behavioral health provider communities and implementation of North Carolina's Health Information Exchange (HIE) system, including provider electronic health record (HER) capability to communicate real-time information between systems, utilization of health care analytics to drive care, and continuation of a capitated model for management of Medicaid behavioral health services.

Challenges Staff are needed to shift to a more-robust model of coordinating services and supports based on the "needs of a member across all life domains" addressed by intensive training to facilitate staff developing new skills and knowledge. Members and stakeholders required education about the importance of being more proactive in providing information for a data-driven system. Coordinating multiple systems to one platform has proven challenging, as partners had to make changes to their current platforms and system mandates in order to move to a more integrated environment where all providers have access to a member's care plan.

Successes Key to the success of VTC is the partnership between Mission Health Partners (the largest Medicare ACO in North Carolina) and Vaya Health (with support of NC DHHS). Working within the parameters of the current system, the stakeholders in VTC have created more-effective ways to gather information and work toward common outcomes. The role of care coordination has been greatly improved using a shared plan that all stakeholders can access and is based on information from all parties including the member. Utilizing data for predictive analysis has been successful in engaging members, improving outcomes, and sharing data.

Advice The health plan emphasized that a strong partnership with clinicians and stakeholders that share the same vision for the initiative and implementation is key to the success of the project. A training plan that encompasses care-coordination staff and primary care and behavioral health providers should incorporate and

identify the differences among the systems to encourage a smooth transition. The training focus should be on foundation terminology, national standards, and best practices across disciplines. Development of a strong communication plan that addresses the individual nuances of each stakeholder is critical to increase awareness and understanding of each role within the system.

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Kudos to the Team

Team Lead

Brian Ingraham
Chief Executive Officer
Vaya Health

Team Members

Craig Martin, M.D., Chief Medical Officer, Vaya Health
Christina Dupuch, MSW, Chief Operations Officer
Robert Webb, CIO, Chief Information Officer
Rhonda Cox, HSP-PA, Sr. Director, IDD & MHSU Care Coordination
Tracy Hayes, JD, CHC, General Counsel & Chief Compliance Officer
Jody Hill, MSW, LCSW, MHSU Care Coordination Director - Eastern Region, Vaya Health
Christy Pruess, MA, LPC, IDD Care Coordination Director - Eastern Region, Vaya Health
Dustin Burluson, LPC, LCAS, MHSU Care Coordination Manager, Vaya Health
Kaitlyn Callahan-King, LCSW, IDD Care Coordination Manager, Vaya Health
Judith Collins, HSP-PA, Care Management Director, Vaya Health
Jana Aitken, LCAS, Customer Services Clinical Director, Vaya Health
Ron Sanga, PMP, Senior Project Manager, Vaya Health
Don Petit, Business Solutions Director, Vaya Health
Wayne Godfrey, Enterprise Analytics Director, Vaya Health
Jesse Smathers, MSW, LCSW-A, LCAS-A, Network Development Director, Vaya Health
Allison Inman, Sr. Marketing and Communications Director, Vaya Health
Tara R. Larson, Senior Healthcare Policy Specialist, Cansler Collaborative Resources
Stephen A. Wood, FHIMSS, Healthcare Perspective LLC

Contact

Rhonda Cox
Sr. Director of IDD & MHSU Care Coordination, Vaya Health
828-225-2875 ext 1141
rhonda.cox@vayahealth.com

Compassion Reaction: A Behavioral Health Program for Children

TRILLIUM HEALTH RESOURCES

Trillium Health Resources' Compassion Reaction is a behavioral health educational and interactive preventive health initiative designed to reach all public-school children (1st through 12th grades) in rural eastern North Carolina. The first year of our Compassion Reaction program was presented to students in middle and high schools, and year two was presented to students in elementary schools. The components of our Compassion Reaction initiative include Rachel's Challenge, Youth Mental Health First Aid, myStrength, Youth M.O.V.E. (Motivating Others through Voices of Experience), Mobile Crisis, and other digital trainings. These components were introduced to our communities through regional launch programs designed specifically to target community stakeholders.

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Key Priorities

- Provide informational programs to the adult stakeholders to be brought directly to the school-age children and adolescents in the place where they are: schools.
- Deliver interactive, age-appropriate programming designed to change the culture within each school.
- Encourage students to open up about the challenges they face, including bullying, substance use, and thoughts of self-harm.

Geographic Location

The North Carolina counties of Greenville, Wilmington, Elizabeth City, Manteo, Jacksonville, Williamston, and New Bern

Population

Trillium's catchment is largely underserved, rural, impoverished, and remote. Lack of local resources and increased stigma around behavioral health conditions prevent youths from accessing treatment. Suicide among adolescents devastates small communities, especially schools. By facilitating awareness, addressing the isolation, and empowering youth and adults to confront difficult situations, improvement in the culture of these communities can be achieved. Empowering families who have a large number of risk factors, including low income, unemployment, and geographic isolation addresses these needs within the community.

The Compassion Reaction program included all students in public elementary, middle, and high schools within the health plan's 24-county area. Opening the initiative to all individuals, whether or not enrolled in the health plan, served to expand the culture of kindness, compassion, and connectedness. In the first year, grades 6 through 12 were targeted; in the second year, grades 1 through 6 were targeted. The program has reached more than 140,000 people.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Compassion Reaction program:

- Rachel's Challenge, who trained presenters and facilitators
- Drs. Robert Marzano and Tina Boogren
- myStrength
- Mobile Crisis
- School representatives from 24 counties, including teachers, guidance counselors, school board chairs, county superintendents of public instruction, interested county commissioners, parents, and law enforcement representatives
- YMHFA facilitator from UNC-CH
- Youth/Move adolescent and young adult members

Intervention and Methods

With the high prevalence of behavioral health and substance use disorders, many children and adolescents go without treatment, in part because they are unaware that resources exist to assist them. School is often one of the major contributors to stress in young people. With the funding cuts in the educational systems, most schools have limited access to nurses, counselors, social workers, and therapists. Some school administrators are hesitant to fully identify the problems of suicide, bullying, behavioral problems, and substance use that are present in their schools because they have limited resources to address such problems.

Several partners contributed to the development of Compassion Reaction:

- Rachel's Challenge is the foundation of the Compassion Reaction initiative. Rachel's Challenge provides a school assembly that integrates mental health with positive peer interactions and is accepted in school systems of varying cultures. It links wellness, educational performance, discipline issues, and self-esteem.
- Youth Mental Health First Aid is an educational certification program sponsored by the health plan to interested stakeholders, including teachers, law enforcement personnel, and emergency response teams. This program was included in the program to introduce this evidenced-based training to stakeholders who might otherwise not know about this resource.
- Youth/M.O.V. E is a peer-run, self-help resource group for young people between the ages of 12

and 22 with mental illness or interested in learning ways to support their peers with mental illness.

- The myStrength program is an application-based cognitive behavioral therapy program for people with mental illness or chronic pain.
- Marzano Educational Seminars help participants explore the vast array of resources and strategies available to increase motivation and inspire students. Based on a comprehensive model of the nature of motivation and inspiration, participants delve deeper into the six levels of Maslow's hierarchy by exploring specific strategies that have the potential to awaken our learners.
- Mobile Crisis service was highlighted as an emergency crisis resource for families, schools, and communities.
- Trillium utilized data from the North Carolina Department of Public Instruction (DPI) and the Department of Health and Human Services (DHHS) to identify problem areas. Teachers were asked to identify a subset of disparate student types to establish service clubs. Rachel's Challenge trainers worked with school counselors and teachers to continue the program through service clubs. To evaluate the program, Trillium utilized surveys with in-school care coordinators to evaluate program progress and identify problems.

Outcomes

Patient/Family Outcomes No reported outcomes.

Clinician Outcomes No reported outcomes.

Community Impact Most counties had almost 90 percent involvement of schools, and catchment-wide school participation was about 80 percent in 2015. In 2016, 97 percent of schools catchment-wide were involved. Trillium community care coordinators report significantly increased access to schools. Compassion Reaction influenced the increased use of Columbia Suicide Rating Scales by school counselors.

Cost Savings No reported outcomes.

Lessons Learned

Sustainability Compassion Reaction is designed to be sustainable without continued funding from a health plan. Sustainability is promoted by establishing service clubs within schools to promote a message of kindness and compassion, use of myStrength app where age-appropriate, training adults serving kids with YMHA, and introducing the YouthMove self-help program.

Challenges It was challenging to identify contacts within multiple schools within 24 counties. Trillium had to utilize care coordinators in the communities to engage schools. School system calendars are tight, and early engagement of school officials eased access. It was difficult to promote the program and publicize success, including through video documentation, in the community. The large geographical area of the catchment area presented travel and scheduling difficulties. It was challenging to overcome school personnel turnover; however, saturation of the program in the school systems reduces the impact of turnover.

Advice Health plans interested in replicating this program should obtain community buy-in and commitment for the project earlier in implementation. It is also important to promote multiple county school system awareness of the program by continued focused marketing. Sustainability will rely on school, county, and community involvement.

Kudos to the Team

Team Lead

Michael Smith, MD
Associate Medical Director
Trillium Health Resources

Team Members

Jackie Beck, LPC, NCC, LCASA, Director, Transitions to Community Living

Kate Hanley, Administrative Assistant

Dave Peterson, MA, Central Regional Director

Ashley Matthews, RN, Integrated Care Nurse

Contact

Kate Hanley

Administrative Assistant, Trillium Health Resources

252-670-0199

kate.hanley@trilliumnc.org



LONG-TERM CARE AND TRANSITIONS OF CARE

PROMISING INITIATIVES

While initiatives outlined in the previous categories represent programs with demonstrated outcomes, Medicaid managed care organizations are actively designing, implementing, and testing new programs for their members. These programs do not yet have data on outcomes but are considered potentially promising on the basis of their robust, evidence-based design and responsiveness to members' needs.

A+Plus: Aetna and the Ohio Area Agencies on Aging

AETNA BETTER HEALTH OF OHIO (AETNA)

Recognizing the importance of robust local community-based services to prevent or delay institutional care, Aetna Better Health of Ohio developed a partnership with three regional Area Agencies on Aging (AAAs). Each AAA is delegated care management for Aetna members who receive home and community-based (HCBS) waiver services within the MyCare Ohio program, a Centers for Medicare and Medicaid Services (CMS) dual demonstration. The AAAs utilize Aetna's care management tools and technology to provide comprehensive care management for HCBS members of all ages. Since the Ohio AAAs use Aetna's care management system, each member's interdisciplinary team accesses a single record that includes all care coordination and clinical information. Through this partnership, Aetna and partners collectively achieved a 14 percent increase in the number of members receiving HCBS versus nursing home services over the past year, with 80 percent of all newly enrolled managed long-term services and supports (MLTSS) members receiving HCBS, as opposed to institutionalization.

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Key Priorities

- Establish credentialing and contracting of a new dental provider type (APDH).
- Increase the proportion of members enrolled in UHC Community Plan ages 2-20 years who receive an annual dental visit.
- Integrate an APDH into a medical primary care provider team to close preventive medical and dental gaps in care concurrently.
- Identify and implement new best practice standards for primary care providers/patient-centered medical homes and dental providers to work as enhanced primary care teams.

Geographic Location

The Ohio counties of Fulton, Lucas, Ottawa, Wood, Butler, Clermont, Clinton, Hamilton, Warren, Delaware, Franklin, Madison, Pickaway, and Union

Population

This initiative and its associated rebalancing effort enabled Aetna to focus on the high-cost, high-acuity waiver population and to help ensure members remain in their respective communities. Leveraging the partnership with the AAAs in Ohio and their experience providing waiver service coordination, Aetna drew upon trusted local community partners to collectively address the biopsychosocial and LTSS needs of members.

The target population is 5,750 dual-eligible individuals receiving home and community-based waiver services in the southwestern, northwestern, and central regions of Ohio. Three percent are ages 18-44, 24 percent are ages 45-64, and 73 percent are ages 65 and older. Ethnicity is 62 percent Caucasian, 34 percent African American, and 4 percent other.

Key Partners and Community Groups

The following key partners are critical to the implementation of the A+Plus program:

- Council on Aging of Southwestern Ohio
- Area Office on Aging of Northwestern Ohio
- Central Ohio Area Agency on Aging

Intervention and Methods

Aetna Better Health of Ohio participates in the MyCare Ohio program, where it serves 22,000 Ohioans who qualify for both Medicaid and Medicare. The Ohio AAAs have a 30-year history of managing home and community-based waiver services for Medicaid members. Through the integrated care model, coupled with the local community knowledge of the AAAs, Aetna formed a partnership to best serve Ohio members. Aetna contracted with three AAAs to fully delegate care management of members receiving HCBS. Aetna supplies the technology and analytics to the AAAs, along with medical and behavioral health expertise, to collectively coordinate member care. Each AAA utilizes Aetna's care management tools and systems, and follows the health plan's care management model. Furthermore, Aetna provides the care management technology platform and data analytics to identify gaps in care and high-need members.

To implement this partnership, the AAAs employ more than 138 dedicated licensed clinical social workers and nurses to meet the demand of this contract with Aetna. The AAAs provide care management in accordance with Aetna's contract with the State, while also accessing community resources within each AAA region, thus affording access to local funding for housing, transportation, food, and caregiver support. An Aetna manager assigned to each AAA region serves as the single point-of-contact between the plan and each AAA. This manager oversees the daily interaction of the AAAs, conducts quality reviews, charts audits, and attends clinical process meetings, in addition to serving on joint operation committees. Aetna's local supervisor uses train-the-trainer approaches to expand the reach of the model and technology across the AAAs' care management staff. AAA staff members also participate in case rounds with Aetna's clinical resources to address the needs of complex members.

Outcomes

Patient/Family Outcomes Member market share is an indicator of satisfaction with available services. Since the formation of Aetna's partnership with the Ohio AAAs, 70 percent of waiver members selected Aetna in the central region, 60 percent in the northwest region, and 62 percent in the southwest region, respectively.

Clinician Outcomes No reported outcomes.

Community Impact Since its inception, Aetna’s partnership with the AAAs in Ohio has resulted in 80 percent of new members with LTSS receiving home and community-based services. This represents an improvement over the previous level of service in the HCBS waiver.

Cost Savings From January 2016 to January 2017, the percentage of long-term care members served by home and community-based waivers compared to nursing facilities increased from 48.4 percent to 55.3 percent, representing a 6.9 percentage point improvement. Rebalancing the care delivery system toward community service is more cost effective compared to institutional levels of care and results in improved quality whenever individuals are in the most appropriate setting. Appropriate use of care, such as emergency department visits for non-emergent care, is another indicator of cost savings and quality of care. Between 2015 and 2016, emergency department visits for behavioral health care for this population decreased by 10 percent.

Lessons Learned

Sustainability The delegated care management partnership between Aetna and the Ohio AAAs is considered sustainable. Aetna’s decision to delegate care management functions uses the historical role of AAAs as service providers and community resources. This extends Aetna’s capability to use the fully integrated care model through established community providers.

Challenges Establishing system access for all of the AAA staff members posed a challenge and required extensive privacy protections through provider agreements. It was necessary for Aetna to establish and implement clear care management policies, processes, and technology tools to enable external providers to follow our standard care model. Furthermore, it was necessary to ensure adequate oversight of the AAAs’ implementation of the care management model through chart reviews, delegation audit procedures, and measurement of quality outcomes.

Successes Preliminary results have demonstrated that the initiative has supported meaningful collaboration to improve the health outcomes and experience of dual-eligible members. Through a clear management and communication structure, the AAAs are authorized to deliver care management to Aetna members while also taking advantage of the unique resources within each community. The investment in local communities has resulted in improved health outcomes, such as rebalancing home and community-based services, as well as increased jobs, thus resulting in a positive economic impact.

Advice AAAs can be effective partners in the delivery of services to Medicaid populations, particularly for dual-eligible members. Such a partnership requires a deep, long-term commitment of health plans, along with a willingness to help build and foster capacity in the AAAs. Full delegation might not be the optimal first step for AAAs with limited care management capabilities. Health plans may begin with limited delegation of care coordination roles, move toward a fully delegated model, and support capacity building. In addition, health plans must implement a delegated model with clear oversight and specific care management protocols.

Kudos to the Team

Team Lead

Jason Smith
Chief Executive Officer
Aetna Better Health of Ohio

Team Members

Suzanne Burke, Chief Executive Officer, Council on Aging of Southwestern Ohio
Billie Johnson, Chief Executive Officer, Area Office on Aging of Northwestern Ohio
Cindy Farson, Director, Central Ohio Area Agency on Aging

Contact

Janet Grant
Head, Great Plains Region, Aetna Medicaid
602-686-6189
GrantJ4@aetna.com

Justice Reach In: An Incarceration Transition Program

UNITEDHEALTHCARE COMMUNITY PLAN OF ARIZONA (UNITEDHEALTHCARE COMMUNITY AND STATE)

The Justice Reach In program is designed to facilitate transition of members being released from jails and prisons into their communities. UnitedHealthcare Community Plan (UHCCP), an Arizona Healthcare Cost Containment System (AHCCCS) managed care organization (MCO), implemented this program to (1) provide care coordination for members incarcerated in the adult correctional system for 30 days or more, and (2) have an anticipated release date and will become a member with our plan upon release. Strategies have been developed to pro-actively identify needs, assist members on overcoming barriers to accessing physical and behavioral health services, address social determinants of health, and help identify essential services. Joint meetings with various county jail systems has helped to develop a robust Justice Reach In program, which will provide medical and behavioral health and social services to members through collaboration with community providers. Early intervention will reconnect members back into their community, providing a stronger connection to services that can meet their needs.

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Key Priorities

- Ensure that our members who are involved in the adult criminal justice system, and who have physical and/or behavioral health chronic and/or complex care needs are identified before the member's release and that coordination of services begin in a timely and effective manner.
- Connect the member to their community service providers and a medical home.
- Identify social needs that have a material impact on health outcomes and recidivism.

Geographic Location

Arizona

Population

Connecting members back into their community in a timely manner after release from jail/prison is critical. This initiative identifies members and provides them with resources before release. Released inmates often do not know who their primary providers are and thus are not seen when they should be. This initiative provides new members with information of their assigned primary care physician and an initial appointment time. The program has an initial assessment to identify immediate social needs and help access to medical, behavioral, and social supports to better ensure adequate and timely care/services that might reduce the rate of recidivism.

Individuals over the age of 18, with heightened biopsychosocial risks who have been incarcerated in the adult correctional system for 30 days or longer, have an anticipated release date, and will become a member of our plan upon release are part of the targeted program. In the first six months, 73 members were identified.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Justice in Reach program:

- UHCCP Justice Liaison
- UHG myConnections program
- Community Health Workers (CHWs)
- RNs and Medical Directors
- AHCCCS,
- Jail and prison facilities
- ACOs, FQHCs, and RBHAs

Intervention and Methods

The Justice Reach In Program was developed to identify members while still in a correctional facility, connect with them prior to release, and establish community supports to assist with coordination of services post-release. UHCCP's designated Justice Liaison is the single point of contact for all County/ Prison facilities and/or state Behavioral Health Programs. An outreach effort is made and an assessment completed to identify individual needs. A provider communication sheet is given to the member at initial contact, outlining the primary care physician's name, phone number, and date of the first post-release appointment. Health education materials given to the members are based on the member's health needs.

The CHWs have diverse backgrounds, including but not limited to LPN (Licensed Professional Nurse), Behavioral Health, Crisis Intervention, Substance Abuse, Addictions, Justice Programs, Social Work, Counseling, Certified Nurse Assistants, Medical Assistants, and know the communities of Arizona. The CHWs work in collaboration with UHC myConnection program, a dedicated team focused on addressing the social determinants of health, to support members accessing community resources. The CHWs utilize the Community Resource Tool, a web-based mobile-enabled resource that allows CHWs to connect members to relevant and available community resources, such as food, utility bill assistance, support groups, childcare, and clothing. In addition, the CHW will provide referrals and collaborate with myConnections team members who specialize in programs related to transportation, financial management, housing, and employment.

The use of CHWs and myConnections resources are designed to link to a community-wide collaborative approach to reintroducing incarcerated individuals back into the community, support appropriate service utilization, and improve health outcomes of individuals receiving services.

Outcomes

Patient/Family Outcomes As a relatively new program, UHCCP continues to develop member education materials on preventive health care measures (e.g., immunization, health care screening) that will:

- Educate members on health and wellness information related to disease processes;
- Educate members on disease-specific signs and symptoms of a worsening condition and action to take if any of these occur;
- Educate member on appropriate utilization of services based on need (e.g., PCP vs. ER); and
- Work to create a culture of health and wellness that promotes member health.

Clinician Outcomes No reported outcomes.

Community Impact No reported outcomes.

Cost Savings UnitedHealthcare Community Plan will conduct cost analysis for the members involved in the Justice Reach-In. Data will be reviewed six months prior to and six months post-release to compare each member's utilization patterns.

Lessons Learned

Sustainability UHCCP is committed to the Justice Reach In Program. The health plan will continue to dedicate a liaison, acting as the single point of contact as well as clinical, nonclinical, and social supports. UHCCP continues to assess the volumes of inmates being released who meet the program requirements to determine staffing and resource demands. If volumes of members increase, additional resources and/or redeployment of existing resources might be needed. UHC is continuing to evaluate the myConnections program and how to best ensure that the initiative will be self-sustaining.

Challenges The correctional facilities are not funded to provide additional support to the health plan, which makes it difficult to establish coordination of care and obtain the medical records needed. Reporting platforms were not compatible, which also makes it difficult to exchange member information. Reaching members who are incarcerated is difficult to obtain engagement. Continued collaboration with the jail and prison systems has improved the exchange of member information; UHC is now receiving daily feeds. Building relationships with the liaisons within the prison and jail facilities has improved our ability to request and receive medical records, which help identify members' needs and post-release service needs.

Successes Collaboration with the state Medicaid agency and correctional facilities has helped to outline expectations for the coordination of care with the health plans. Policy changes made by the state to pend rather than terminate a member's eligibility upon entry into a correctional institution have been helpful. This allows the health plan to monitor the membership and know the member will be reassigned to the same Health Plan upon release. Community partners have been very engaged in helping collaborate with the health plan to provide additional support to this population.

Advice Identify a point of contact to interface with the correctional facilities. This liaison develops relationships with the community partners and provides stability in baseline goals for the program. Creating a multidisciplinary team increases specialty clinical and social knowledge to manage and support the Justice Reach In Program.

Research

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Kudos to the Team

Team Lead

Linda Downing
UHCCP Director Medical Clinical Operations
UnitedHealthcare Arizona

Team Members

Mary Krawczyk, UHCCP Care Coordinator
Gemma O'Donnell, UHCCP Associate Director Clinical Operations
Dr. Steve Chakmakian, UHCCP Senior Medical Director
Dr. Steve Ibrahim, UHCCP Medical Director
Sue Williams, Optum Manager Medical Clinical Operations
Courtney Soto, UHCCP Service Account Manager
Linda Downing, UHCCP Director Medical Clinical Operations

Contact

Kate Paris
Director, Thought Leadership, UnitedHealthcare Community and State
952-202-4877
katherine_paris@uhc.com

Play Together - Creating an Inclusive Community Playground

TRILLIUM HEALTH RESOURCES

Trillium's Play Together accessible playground initiative created inclusive environments for adults and children with long-term support needs in extremely rural areas of eastern North Carolina. Regular physical activity for all people with chronic disabilities has been shown to help in controlling the occurrence of chronic disease, improving overall health and function, and mediating the psychosocial impact of disability on people and their families. Trillium's Play Together is a community-based, wellness, and inclusion program led by the carve-out plan in collaboration with local counties, hospitals, cities, towns, and community-based organizations. This project launched in 2015 and ended in June of 2017 with the completion of 30 accessible playgrounds

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Key Priorities

- Create an inclusive environment for children and adults with significant disabilities to enable them to interact in their community alongside non-disabled children and adults to address the social determinant of isolation for this population.
- Build collaboration with community partners and create awareness of the needs of this long-term support population at the local community level.
- Inspire community leaders and stakeholders to engage in community improvements that are inclusive for all members of the community.
- Improve access to physical activity for children and adults with long-term, chronic health conditions.
- Engage people with chronic needs with the community.

Geographic Location

The North Carolina counties of Beaufort, Bertie, Brunswick, Camden, Emerald Isle, Carteret, Morehead City, Carteret, Chowan, Craven, Currituck, Dare, Gates, Hertford, Martin, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, and Washington.

Population

Inclusive, accessible playgrounds are safe activity venues for people of all ages and abilities. They are places where typically developing children and children with disabilities can interact in a social setting and de-construct the social norms and stereotypes about people with disabilities. The idea is to reduce the stigma around individuals with long-term support needs by bringing people together, creating awareness, and giving everyone a level playing field.

Trillium's Play Together project targeted 7,500 people in rural eastern North Carolina with long-term support needs, including adults and children. Participants have mobility challenges, intellectual and/or developmental disabilities, autism, and chronic health conditions. These inclusive playgrounds contain workout equipment for adults and accessible equipment for children with all types of chronic needs.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Play Together program:

- Thirty (30) local cities, towns, or counties in eastern North Carolina that provided matching funds through in-kind contributions of land and a commitment for ongoing maintenance.

Intervention and Methods

Trillium engaged local community parks and recreation departments throughout its 24-county catchment area to tell them of the Accessible Playground project and invite them to apply for a Play Together grant. To be considered, applicants had to meet the following qualifications:

- The playground has to be on city- or county-owned land.
- The playground will be maintained by current city or county maintenance staff.
- Must be able to start construction within six months of the approval notification.
- If the request is only for a piece of equipment such as a wheelchair swing, the swing must be located in a county or city-owned public park.
- The playgrounds must be open to the public.

Equipment varies in each playground and might include a Liberty Swing (accessible while in a wheelchair), Cruise Line, and zip line. Playgrounds include a rubberized surface to ensure safety for children and adults with mobility challenges, as well as for wheelchair accessibility. All accommodations provide an opportunity for people of all ages and abilities to play together outside. Each playground is designed for multi-generational use.

Social opportunities are one of the most important benefits of play for child development. The social-emotional domain of child development includes the child's experience, expression, and management of emotions and the ability to establish positive relationships with other. Inclusive playgrounds like these built by Trillium address the developmental needs for all children, but especially children with disabilities and chronic health conditions in these extremely rural areas, by intentionally providing opportunities for physical, social-emotional, sensory, cognitive, and communicative benefits through play.

There is a strong need for innovative approaches in rural areas to address social determinants of health. Trillium created a project that focused on the physical activity needs and social inclusion of people with long-term

support care needs. This project is unique because of the population served as well as its focus on supporting members and families to create awareness of different abilities and to increase inclusive activities.

Outcomes

Patient/Family Outcomes Trillium deployed people counters at several parks over a six-month period. Attendance at the playgrounds in the smallest area was 214 and in the largest area, 15,000 visitors. A community survey and a member survey are planned for fall 2017. The health plan is also working with a university researcher on a qualitative study for the targeted population.

Clinician Outcomes No reported outcomes.

Community Impact The Play Together project has increased access to the community for this long-term support population that otherwise is extremely isolated in many of the rural areas. This project has helped communities become aware of children and adults with long-term support needs that were otherwise out of sight. It has received several local, state, and national awards. Utilization rates at every park suggest that people are enjoying the playground and being outdoors more now than ever before. Counters indicate that children who use a wheelchair for mobility frequently use the Liberty Swing in all 30 parks. In June, Trillium will be honored by the American Association on Intellectual and Developmental Disabilities for this project and the impact it has made on creating inclusive communities in rural eastern North Carolina.

Cost Savings No reported outcomes.

Lessons Learned

Sustainability The inclusive playgrounds created under the Play Together project were built on county-owned land with an agreement that the counties would maintain these as inclusive playgrounds into perpetuity. Trillium is working with local communities and advocacy groups to take on the maintenance, enhancement and sustainability of the playgrounds as a community project.

Challenges The only challenge identified as part of this project was dealing with the impact of flooding related to Hurricane Matthew. Eastern North Carolina is a target for hurricanes every year. In addition to the focus on inclusion, the equipment and locations of the playgrounds had to take into account hurricane winds, storm surge, and rainfall. Despite the best planning, several of the playground areas did flood during Hurricane Matthew; however, there was no long-term damage.

Successes The largest predictor of success of this project is participation by the target population. The project helped overcome isolation for children and adults with disabilities. The number of people in every community who use the playgrounds is overwhelming.

Advice Engage the local community, members, parents, and other stakeholders from the beginning of design through opening day for ongoing sustainability and support of this effort.

Research

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Kudos to the Team

Team Lead

Cindy Ehlers, MS, LPC
Vice President Clinical Operations
Trillium Health Resources

Team Members

Amy Corbitt, BS Project Manager
Melissa Whisnant, BS Project Coordinator Southern Region
Kisha Darden, MA Project Coordinator Northern Region
Bobbie Lowe, BS Project Coordinator Northern Region
Maegan Veillette, BS Project Coordinator Central Region

Contact

Cindy Ehlers, MS, LPC
Vice President Clinical Operations, Trillium Health Resources
252-670-0199
cindy.ehlers@trillimnc.org



CHILDREN'S
HEALTH

PROMISING INITIATIVES

While initiatives outlined in the previous categories represent programs with demonstrated outcomes, Medicaid managed care organizations are actively designing, implementing, and testing new programs for their members. These programs do not yet have data on outcomes but are considered potentially promising on the basis of their robust, evidence-based design and responsiveness to members' needs.

Adolescent Screenings Workgroup (ASW) Collaborative Well-Child Screening Campaign

UNITEDHEALTHCARE COMMUNITY PLAN OF TENNESSEE (UNITEDHEALTHCARE COMMUNITY AND STATE)

The Adolescent Screenings Workgroup (ASW) Collaborative Well-Child Screening Campaign was held in September 2016 as a pilot to increase well-child screening rates among adolescent TennCare (Medicaid) members in the Memphis/Shelby County area. The pilot project was a collaborative effort that used intense promotion, incentives, and a focused time frame to create a surge of awareness and participation from the target population. The collaborative included the state Medicaid oversight organization, all managed care organizations, the Medicaid-contracted child dental provider, the Tennessee Department of Health, and a major federally qualified health center (FQHC). Preliminary findings show a dramatic increase in screenings among the target population for the participating provider in the test area.

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Key Priorities

- Significantly increase the well-child screening rates among adolescents served by the FQHC in Memphis/Shelby.
- Test the potential to sustainably scale and replicate an ongoing collaborative effort with other providers in urban and suburban areas of the state.

Geographic Location

Memphis, Shelby County, Tennessee

Population

Engaging adolescents in their health is often challenging, and screening rates among this population are lower than in other age groups. The CMS 416 non-compliance rates among this group are particularly high. They are hard to reach, and hard to motivate toward developing habits for preventive health, including annual well-child screenings. This project utilized incentives and attractions along with increased promotion to reach the group and motivate them to get their screenings and to hear health messages concerning consistent preventive health care.

The project targeted approximately 9,000 Medicaid enrollees assigned to the FQHC at its service locations in Shelby County who had gaps in care. Ages ranged from 13 to 21 years and included a diverse racial mix of male and female members in this urban setting. An emphasis was placed on engaging the large African-American and Hispanic communities within the target population.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Adolescent Screenings Workgroup (ASW) Collaborative Well Child Screening Campaign:

- All three Tennessee Medicaid managed care organizations (MCOs)
- Division of TennCare Services
- Tennessee Department of Health
- DentaQuest, the child dental services provider for TennCare
- Christ Community Health Services, a major federally qualified health center in Memphis/Shelby County, Tennessee

Intervention and Methods

The ASW Collaborative Well-Child Screening Campaign was the culmination of months of researching, brainstorming, strategizing, and planning by representatives of all the collaborators to create an opportunity to increase the screening rates for this provider in this locality. The project also considered whether this pilot could be replicated.

The group determined to conduct a month-long campaign with Christ Community Health Services to invite all 9,000 of their adolescent members experiencing gaps in care to schedule and complete their screenings. A \$10 American Express gift card was offered as an incentive to complete screenings. The campaign included a kickoff event on August 31, 2016, that featured attractions such as a video game truck and hourly drawings for a Fitbit Blaze provided by the participating MCOs. All of the MCOs had staff on hand to distribute school supplies for their members.

Promotion for the event and campaign included mailed invitations to each member, automated or live phone calls by the MCOs, warm transfer to the provider scheduling staff, and follow-up calls from the provider to schedule appointments. Throughout the month, the provider staff increased their efforts to educate the members about the importance of establishing a medical home, participating consistently in preventive screenings, and taking responsibility for their own health care.

Outcomes

Patient/Family Outcomes The project has the potential to significantly affect HEDIS scores and CMS 416 non-compliance rates. The project can be expanded to include other age groups outside the adolescent

populations. Roughly 301 UHC members were seen through our calls and invites, and 602 gaps were closed. Each member received the well-child exam and immunizations.

Clinician Outcomes The project will increase participation in well-child screenings. It has the potential to increase rates of engagement with members, many of whom the provider might never have seen before. It also has the potential to result in more billable hours for the provider, lower emergency room utilization, and lower hospitalization costs.

Community Impact No reported outcomes.

Cost Savings No reported outcomes. However, the project will help health plans meet quality targets related to well-child screenings.

Lessons Learned

Sustainability The pilot is moving to a multi-location provider in Nashville, Davidson County, Tennessee, in spring 2017 and then to a similar provider in Knoxville, Knox County, Tennessee, in fall 2017. This will ensure that the pilot is replicable in urban and suburban setting across the three areas that feature vastly different populations in terms of socio-economic and racial mix. Should the outcomes continue to be favorable, the pilot will be expanded. The only additional resources will be continued expenses for staff time, incentives, and promotions.

Challenges Coordination of collaborators and partners was an initial challenge because each organization had different ways of doing business and competitive interests. These challenges were resolved through on-going collaboration and dialogue. Initially, getting the provider to free up enough appointment slots so that all the members who wanted to get their screenings was challenging, but the provider was able to serve interested members throughout the project.

Successes The collaborative was successful in engaging members and motivating them through financial incentives. Collaboration among all MCOs and the state agencies to create and maintain group momentum was another indicator of success. The collaborative was also able to garner participation of providers in the outreach and promotion process. Finally, approximately 1,000 members from the three MCOs have been screened, roughly about 300 members per MCO.

Advice The health plan recommends that an organization has talked through all of the program elements and aligned the specifics across all of the collaborators so that each is engaging, promoting, and incentivizing its members in the same way. Also, be sure that providers can actually accommodate the number of members who want to participate during the time frame of the kick-off event and/or the campaign.

Kudos to the Team

Team Lead

Gregory Fisher
LAPSW, Director of Community Outreach
UnitedHealthcare Community Plan of Tennessee

Team Members

Kathy Janutolo, EPSDT and Preventive Health Clinical Quality Analyst, UnitedHealthcare Community Plan of Tennessee
Caprice Morgan, Community Outreach Coordinator, UnitedHealthcare Community Plan of Tennessee
Gina Dudley, MD, Associate Medical Director, UnitedHealthcare Community Plan of Tennessee
Allison Strohm-Seeds, TennCare Kids EPSDT Program Manager, Amerigroup
Stephanie Holaday, Pediatric Case Manager, Amerigroup
Gail Winton, Manager, Member Support Services, BlueCare

Patty Howard, Manager, Clinical Quality Improvement, BlueCare
Ashley Hathaway, TN EPSDT Outreach Coordinator, BlueCare
Jeremy Strom, Manager, Community Outreach, BlueCare
Rachel Hardaway, Statewide Community Outreach Director, Primary Prevention Impact Services, Tennessee Department of Health
Brad Blair, Call Center Manager, Primary Prevention Impact Services, Tennessee Department of Health
Mary Katherine Fortner, Assistant Director, Quality Oversight, TennCare
Katy Blasingame, TennCare Kids/EPSTD Outreach Director, Quality Oversight, TennCare
Marti Coleman, TennCare Kids/EPSTD Outreach Coordinator, Quality Oversight, TennCare
Dr. Andrew Nearn, Pediatrician, Christ Community
Darnecia Garner, Director, Practice Management, Christ Community
Lydia Crivens, Manager, Clinical Outcomes and Outreach, Christ Community
Vivian Tyler, Outreach Specialist, Christ Community

Contact

Katherine Paris
Director, Thought Leadership, UnitedHealthcare Community and State
952-202-4877
katherine_paris@uhc.com

Partnership to Increase Adolescent Well Visits

UNITEDHEALTHCARE COMMUNITY PLAN OF TENNESSEE (UNITEDHEALTHCARE COMMUNITY AND STATE)

The Adolescent Screenings Workgroup (ASW) Collaborative Well-Child Screening Campaign was held in September 2016 as a pilot to increase well-child screening rates among adolescent TennCare (Medicaid) members in the Memphis/Shelby County area. The pilot project was a collaborative effort that used intense promotion, incentives, and a focused time frame to create a surge of awareness and participation from the target population. The collaborative included the state Medicaid oversight organization, all managed care organizations, the Medicaid-contracted child dental provider, the Tennessee Department of Health, and a major federally qualified health center (FQHC). Preliminary findings show a dramatic increase in screenings among the target population for the participating provider in the test area.

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Key Priorities

- Increase member awareness about the importance of preventive screening and opportunities to have preventive screenings completed.
- Make the care convenient and timely to meet the members' needs by bringing the care to where members are seeking services.
- Increase access to sites that can assist members in getting preventive screenings completed.
- Facilitate partnerships between urgent care sites and providers' offices.
- Increase HEDIS scores for well visits.

Geographic Location

The Pennsylvania counties of Greene, Allegheny, Westmoreland, Fayette, Lancaster, Blair, and York.

Population

Engaging adolescents and busy families in preventive care can be challenging. This initiative works to make care as convenient and timely as possible by bringing it to where members are seeking services. Although the initiative had broad application on UHC membership, the program targets adolescent members ages 12-21, with gaps in preventive screenings. Members of all of races, genders, and ethnicities are affected. Common to those engaged in this pilot was their use of urgent care facilities. Currently, the health plan has 38,502 Medicaid children and 9,076 CHIP children ages 12-21 in this Healthcare Effectiveness Data and Information Set (HEDIS) population.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Partnership to Increase Adolescent Well Visits:

- MedExpress

Intervention and Methods

In June 2016, UHC began working with MedExpress on a program to offer members who access urgent care services the opportunity to complete preventive screenings (e.g. adolescent well visits, BMI screening, nutrition screening) during their visit. The goal of the initiative is to increase access to preventive services and make receiving care convenient for busy families. MedExpress typically sees members within 45 minutes of their home or place of work, has extended office hours every day of the week, is located in convenient locations near bus stops and shopping centers. Frequently, members were approaching MedExpress centers to have physicals required for school sports, so collaboration with MedExpress was expected to result in increased compliance in areas with the highest level of noncompliance for the well-visit measure.

To begin the collaboration, UHC leveraged its online enrollment system to share with MedExpress information on members with HEDIS gaps in care. If MedExpress saw a UHC member, MedExpress could pull up member information to see what if any preventive measures should be offered to the member. MedExpress can offer the member the opportunity to complete the preventive screening at the same time that they are being treated for their urgent-care appointment.

The program was implemented in counties that had the highest volume of members who were not completing their preventive screenings as well as where the MedExpress sites are located. Seven counties were identified, and staff at those sites were trained on the enrollment system as well as how to complete and document the screenings. After the screenings are completed, a summary of the visit is sent to the members' primary care providers to review and follow up on any open issues or concerns.

A dedicated staff person from the UHC quality department works with MedExpress on any open issues and can assist in identifying members who need additional assistance such as a referral to our special-needs department. Regular meetings between UHC and MedExpress are held to review the program and identify opportunities to improve.

Outcomes

Patient/Family Outcomes UHC has seen an increase in overall gap closure. In January 2017, eight months into implementation of the pilot, UHC realized 324 gaps in care closures within the seven counties. Every month UHC found increases in gap closures for Adolescent Well Visits and are able to see movement in the plan's HEDIS results tracking. The opt-out rate is 25-35 percent among patients offered preventive screens.

Clinician Outcomes No reported outcomes.

Community Impact No reported outcomes.

Cost Savings No reported outcomes.

Lessons Learned

Sustainability UHC is looking to expand the program to other services in the MedExpress centers, including diabetes lab testing. UHC will continue to study its marketplace and assess whether to expand this service to other counties in Pennsylvania.

Challenges The rate at which members opted for the offered preventive services has room to improve; however, UHC is optimistic that trends will continue to increase as awareness of the program grows.

Successes UHC worked diligently with MedExpress to organize and finalize documents that would be used in the centers for the well-visit completion; this included information on coding, charting, reviewing the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedules, clinical guidelines, and process flow once a member was seen. This diligence and forethought helped to ensure success.

Advice The health plan recommends reviewing where members are receiving services and try to bring the preventive screenings to that location, whether that location is an urgent care center, a school-based clinic, or a community clinic. It is very important to study where members receive care and try to set up services so that the members can receive any preventive screenings they can when seeking medical care. It is also important to explain and promote this service to your primary care community as this helps with continuity of care and any access issues a provider may be experiencing.

Kudos to the Team

Team Lead

Janae Smith
BS- Senior Quality Director-Pennsylvania
UnitedHealthcare Community Plan of Pennsylvania

Team Members

Denise Puskaric RN, BSN- Regional Quality Director
Janae Smith, RN, BS- Senior Quality Director-Pennsylvania
Kim Falkenstern, RN- Associate Director of Clinical Quality
Joyce Hay, RN, BSN- Quality Manager-Pennsylvania

Contact

Katherine Paris
Director, Thought Leadership, UnitedHealthcare Community and State
952-202-4877
katherine_paris@uhc.com

Child First®: A Program to Address Behavioral Health & Social Determinants of Health

TRILLIUM HEALTH RESOURCES

Trillium Health Resources manages behavioral health services for eligible Medicaid recipients and the uninsured in a 24-county rural area in eastern North Carolina. Trillium is leading the first statewide replication of the Connecticut-based Child First® Model that addresses the social determinants of health of a child. This two-generation early childhood intervention serves children prenatal to 5 years. Average length of treatment is six to 12 months. It is embedded in a system of care that works to promote child and parent mental health, improve development and learning, enhance parent and child executive functioning capacity, and decrease child abuse and neglect. Since October 2015, Trillium has supported the establishment of 35 clinical team teams within the 24 counties of Eastern North Carolina and has served 286 children and families. The current serving capacity in Trillium's catchment is up to 420 families at a time.

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Key Priorities

- Fewer gaps in the behavioral health continuum of services for children in North Carolina.
- Increased partnership and collaboration within the broader early childhood system of care and among key community partners in North Carolina.
- Increased accessibility of services and sustainability of evidence-based programs with provider choice offered to Medicaid enrollees and the uninsured.
- Expansion in the behavioral health workforce in eastern North Carolina, offering opportunities for advanced learning and continuing education.
- Decreased socio-emotional disturbance, developmental and learning delays, and long-term chronic behavioral health conditions.
- Increased use of valid and reliable screening tools and clinical assessment measures to increase accuracy of identifying possible conditions, occurring disorders, strengths and supports, and needs of the children and families to better inform treatment plans and coordination of care.

Geographic Location

The North Carolina counties of Beaufort, Bertie, Brunswick, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Hertford, Hyde, Jones, Martin, New Hanover, Northampton, Onslow, Pamlico, Pasquotank, Pender, Perquimans, Pitt, Tyrrell, and Washington

Population

Trillium's region comprises a large rural geographical area with some extremely remote communities. It serves 14 of the most economically distressed counties in North Carolina and 16 counties below the state's poverty level. These communities have the potential for higher rates of abuse, trauma, neglect, strained parent-child relationships, and crime. Child First® provides intensive home-based services to the most vulnerable children and their families, facilitating the development of responsive, nurturing parent-child relationships, promoting cognitive development, and connecting the family to resources to decrease toxic stress and providing growth-enhancing opportunities for the child and family.

The program targets children prenatal to five years, who reside in Trillium's rural 24-county catchment area in eastern North Carolina and have behavioral and/or emotional delays as assessed using ICD-10 or DSM 5 criteria that affects or is related to social-emotional well-being and children experiencing adverse life circumstances.

Key Partners and Community Groups

The following key partners are critical to the implementation of the Child First® program:

- Child First®
- Stakeholder group including a variety of local, state, and community agencies focused on early childhood services

Intervention and Methods

Research has shown that responsive, early nurturing relationships are able to prevent damage to the developing brain, buffer the brain from adversity, and prevent the rise of the chemicals that are harmful. In fact, whether the foundation of the architecture of the brain will be strong and solid, or weak and fragile is determined by the child's early relationships. The goal of this program is to identify children at the earliest possible time and intervene.

Using a two-pronged approach focused on decreasing adversity and building protective relationships, Child First® takes a holistic look at the health and development of the child, focusing on early relationships and the social environment in the community in which the child lives. Special attention is paid to parental challenges such as unstable housing, food insecurity, lack of employment, and physical illness, the impact of past and present trauma, depression, domestic violence, and substance use.

A Child First® clinical team is comprised of two individuals:

- Masters-prepared, licensed Mental Health/Developmental clinician to facilitate responsive, nurturing parent-child relationships, which protect developing brains and promote behavior, health, and cognitive development; and
- Bachelors-prepared Family Resource Partner that connects the family with needed services/supports, which decrease toxic environmental and psychosocial stress, and provide growth-enhancing opportunities for child and family.

The unique element of Child First® is the intensity of the reflective, clinical consultation that is provided, not just during the training period, but ongoing as a required element of model fidelity. An essential component of the

model is having local Community Advisory Boards, to promote collaboration and improvement of services for families. In eastern North Carolina, many areas do not have sufficient access to preventive services and lack true comprehensive assessments at initial contact to guide treatment planning. In the clinician setting, few evidence-based treatment models or interventions are being offered with high-fidelity monitoring, and there is a lack of reporting and evaluation on the effectiveness of treatments (individual, agency, and system-wide). Trillium selected non-profit agencies geographically located across the area to partner and implement services. The process included non-UCR (invoice based) contracts to cover start-up, innovative training methods to defray costs and extensive staff selection processes to ensure that the most qualified candidates were hired.

Outcomes

Patient/Family Outcomes Since the start of the program, 286 children and primary caregivers engaged in this service and received other referrals to help improve their desired outcomes.

Clinician Outcomes No reported outcomes.

Community Impact Trillium's Child First® implementation increased its partnership and referrals to and from community groups and pediatricians. Trillium and partner agencies created new linkages to expand services and supports available to young children and their caregivers and the systems that support these populations.

Cost Savings No reported outcomes. However, children who experienced early trauma and toxic stress have shown better outcomes when intervention was provided early and often. Studies of this model have yielded cost savings.

Lessons Learned

Sustainability Sustainability is dependent on the development of an "in lieu of," or alternative service definition, that supports appropriate Medicaid service rates. For the three- to five-year-old population ineligible for Medicaid, services will be supported by state mental health block grant funds, county dollars, or private pay. For the prenatal to two-year-old group ineligible for Medicaid, services could be supported by county mental health dollars or private pay. In addition, private funding was sought from the Duke Endowment, Kate B. Reynolds Charitable Trust, North Carolina Blue Cross Blue Shield Foundation, and other philanthropic persons or organizations.

Challenges Medicaid reimbursement does not cover the full expenses, and initially, non-profit agencies were missing the necessary taxonomy code(s) to submit claims. Associate-level licensed professionals were not able to complete service orders independently. Also, individuals credentialed only as licensed clinical addiction specialists were unable to be included. Other challenges, including costs for assessment tools and annual accreditation, were not factored in original expenses; slow development of a functional electronic health record; difficulties marketing the service; and frequent staff turnover. Ongoing access to training must be provided to ensure fidelity to the model as well as ongoing monthly implementation meetings that focus on problem solving.

Successes Key to the success of the program was Trillium's supportive Executive Management Team and Advisory Board and its sound financial management to provide the start-up costs to train and support the affiliate agencies and clinical teams. Also, active involvement and flexibility of Child First® National Program Office CEO and staff were helpful to the implementation of the program. It also was important to have supportive and active involvement of the Key Partners Advisory Board and the development of the state office, staffed with a program director and regional clinical director, with local oversight by the North Carolina Council of Community Programs. Trillium was able to work with enthusiastic and committed non-profit agencies and actively engaged community stakeholders that were committed to the model and goal for this initiative.

Advice It is important for health plans to complete a formal needs assessment and workforce assessment prior to implementation and plan for possible barriers to implementation. If possible, have investors for start-up costs

and/or grant funding available to supplement internal resources. Maintain an open and collaborative relationship with key community partners in prevention, early childhood intervention, and state agencies serving the population. It is also important to use non-profit agencies contracted with a physician or licensed psychologist. Finally, review the research studies to understand the targeted population and treatment settings and establish a user-friendly data collection platform from the beginning.

Research

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Kudos to the Team

Team Lead

Cindy Ehlers, MS, LPC
Vice President Clinical Operations
Trillium Health Resources

Team Members

Kimberly Greer, PhD Senior Staff Psychologist and Program Manager for 2020 Child Vision Initiative
Fonda Gonzales, MS, LPC, NCC Appeals Coordinator and Project Manager for Child First
Michelle Martin, Senior Accountant Trillium Health Resources
Darcy Lowell, MD CEO and Developer for Child First National Program Office
Mary Peniston, COO Child First National Program Office
Hope Newsome, MSW NC Child First State Program Director
Diane Britz, LCSW NC Child First Regional Clinical Director
Rebecca Parilla, PhD, IMH-E (IV-C) National Clinical Director for Child First National Program Office
Kim De-Bella-Farber, LMSW National Data and Quality Officer Child First National Program Office
Anne Davino, Director of Data and Quality Enhancement

Contact

Cindy Ehlers, MS, LPC
Vice President Clinical Operations, Trillium Health Resources
252-670-0199
cindy.ehlers@trillimnc.org



INSTITUTE FOR MEDICAID INNOVATION
1150 18TH STREET, NW
SUITE 1010
WASHINGTON, DC 20036
INFO@MEDICAIDINNOVATION.ORG