Opportunities to Improve Care Coordination for Vulnerable Populations

HCBS National Conference
September 2013
Agenda

- UnitedHealthcare Care Coordination Model - Kathy Woods, RN, BSN
- UnitedHealthcare Foster Bridge - Innovation for Serving Children in Foster Care - Jennifer Kyle RN, MA
Objectives

UnitedHealthcare Care Coordination Model

1. Long Term Supports Services Population Overview
2. Describe the Integrated Clinical Care Model
3. Identify Opportunities for Improve Care Coordination
LTSS National Picture

Medicaid Long-term Care programs are focused on serving frail, elderly and disabled individuals.

**Membership Population**
- ABD population
  - Fastest growing and most costly Medicaid population
  - Three cohorts
  - ABD Non-HCBS ("community well")
  - Community Nursing Home LOC population
  - Nursing Home Residents
- Have multiple chronic illnesses
- Services typically address functional limitations (assistance with ADLs & IADLs)
- Low income

**Numbers**
- 15 million ABD Medicaid beneficiaries currently in the U.S
- 3.3 million of the 15 million are eligible for LTC services
- 25% of the 3.3 million people eligible for LTC services are currently enrolled in a managed care plan
Integrated Care Approach

Quadrant II:
- MCO Coordinator w/BH expertise
- Locus of care: Behavioral health Provider OR Health Home
- PCP (routine visits, screening, and care)
- Dual disorders treatment/Assertive Community Treatment
- Psychiatry/medication management (Telehealth)
- Illness management and recovery
- 24 hr Crisis Services
- Peer and Recovery Supports (NA/AA, Clubhouse, etc.)
- Family psychoeducation
- Collaboration with community/faith-based organizations
- Supportive Housing and Employment Services

Quadrant IV:
- Locus of care: Medical Home/BH Health Home
- Dual disorders treatment
- Psychiatry/medication management (FTF or Telehealth)
- Integrated care planning with PCP and medical specialists
- Illness management and recovery (Transplant, NICU, INSPIRIS)
- 24 hr Crisis Services
- Peer and Recovery Supports (NA/AA, CCSS, TFC, etc.)
- Family psychoeducation
- Home and Community-Based services (waiver or PCO)
- Supportive Housing and Employment Services
- Hospice & Palliative Care

Quadrant I:
- MCO Health Coach/Navigator OR CHW/Promotora
- PCP (routine visits, screening and care)
- PCP-based BH screening
- Prevention plan and programs (smoking cessation, nutritional counseling, etc.)
- Collaboration with community/faith-based organizations
- Health literacy/education
- Psychiatric consultation and referral
- Consumer portal: Live and Work Well
- NowClinic/Nurse Advise

Quadrant III:
- MCO Coordinator w/ physical health expertise OR
  - Patient-Centered Medical Home
- Comanaged specialty medical/skilled care (Healthy First Steps, Transplant, NICU, INSPIRIS)
- PCP-based BH screening and referral
- Psychiatric consult and/or medication management (FTF or Telehealth)
- Chronic care/illness management (DM, CHF, COPD, Asthma, etc.)
- NowClinic/Nurse Advise
- Home and Community-Based Services (waiver or PCO)
- Hospice & Palliative Care

Risk/Complexity

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Clinical Care Model

- **Member cohort dictates interventions**
  - *Example:* A Care Coordinator will have a different approach for someone living permanently in a nursing home versus someone who is in the community and can remain there.
  - Care Coordination may be delivered over the phone or in-person, depending on functional status, service eligibility, and state program design.
  - Arranging safe, quality services is a vital component of Care Coordination.

- **All members assigned a Care Coordinator**
  - Assesses member, creates a plan of care, coordinates services for the member, maintains member contact.
  - Personal relationship between member and his/her CC is key to a successful Complex Care program.

- **Employ Prior-Authorization and Utilization Management processes**
  - Ensures the services a member is receiving are appropriate for his/her circumstances.
Questions and Thank You!
Objectives

UnitedHealthcare Foster Bridge

1. Describe Challenges For Children In Out of Home Placement
2. Identify Opportunities for Innovative Multi-Disciplinary Electronic Information Exchange
3. Demonstrate UnitedHealthcare Foster Bridge
Foster Care: National Picture

The ~400,000 children in foster care represent a vulnerable group of children that often experience a lack of continuity and loss of connection to a safe and nurturing environment.

Entry into the Foster Care System

- Children may enter the foster care system due to:
  - Abuse or neglect
  - Voluntary placement as a result of health, social, or economic stresses within the family, and / or
  - Families are not able to cope with the children’s behavioral or emotional issues
- Children in foster care for whom States receive federal reimbursement for foster care expenses are eligible for Medicaid (e.g., behavioral, Rx, acute care)
- Medicaid expenditures for children in foster care are disproportionately large when compared to overall Medicaid enrollment

By the Numbers

- **399,546** U.S. children in foster care (Sept. 30 2012)
- **22.7** average months in foster care
- **9.1** average age of child in foster care

Vulnerabilities of Children Entering Foster Care System

- **90%** have physical health problems
- **55%** have 2 or more chronic conditions
- **~50%** have emotional and/or behavioral health conditions

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1 The Children’s Bureau, a division of the U.S. Department of Health & Human Services reports this data as of July 2013 (AFSCAR Report #20 FY 2012)

What is the opportunity?

Children in foster care receive support and services through multiple state agencies and private programs. These organizations work hard to gather and document important information about the health, education and social service needs for each child in their care. Incompatible electronic and manual processes often make that data difficult to access and share.

To begin to tackle this issue, UHG created

**UnitedHealthcare FOSTER BRIDGE**

- Puts the needs of the child at the forefront
- Provides timely access to information
- Consolidates disparate information into a central location

[https://smashhealth.box.com/s/1eb0ratikk6jdq2eyrgm](https://smashhealth.box.com/s/1eb0ratikk6jdq2eyrgm)
Taking the next step

The value of UHC Foster Bridge is that it **bridges the gap** in information. Foster Bridge is a link that is needed to be able to support the delivery of comprehensive, coordinated care.

**Best Practice**

The careful use of cross-agency and cross-sector electronic information exchange has the potential to transform a fractured system by enabling real-time coordination between the multiple health care and other caretakers of children in foster care* …..


**Current work**

**Where Foster Bridge can take us**
Demonstration of Application

Demonstration
www.uhcfosterbridge.com

Log in: caseworker Password: fcdemo
Care Coordination and Information Exchange

The UnitedHealthcare Care Coordination Model supports vulnerable adults and children in the community through person-centered care planning, care coordination, and linkage with psychosocial supports.

**Foster Bridge** is a UnitedHealth Group innovation that supports electronic information exchange via a web based, secure platform, designed to assist children in the foster care system. Though this tool was built around the needs of children in foster care, without a doubt, timely and accurate sharing of information is relevant for a variety of vulnerable populations.

- Provides web based secure access to information for Care Team members
- Member is the Center
- Information in one central location for improved Care Coordination and Outcomes
Questions and Thank you!
UnitedHealthcare Community & State
Contact Information

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Jennifer Kyle RN, MA
    • Director Population Strategy Children & Families
    • jennifer_kyle@uhc.com
Appendix
Enter Username and Password

Welcome, please login below:

Username

......

[ ] Remember Username  [ ] CONTINUE

Forgot your Username or Password?

*All information contained in these slides is EXAMPLE data for demonstration purposes only
Find your child or Add a new child

Home Page
Change Child

Change to a Different Child by Searching or Sorting
View Unique Information About the Child

Stacy Candice Ritter Not Placed

Medicaid: 714355555  Date of Birth: 10/5/1998  Gender: F  Age: 15

**Personal Information**

<table>
<thead>
<tr>
<th>Religion</th>
<th>Ethnicity</th>
<th>Primary Language</th>
<th>Siblings</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Caucasian</td>
<td>English</td>
<td>Select</td>
</tr>
</tbody>
</table>

Food Requirement
View the Wellness Form for the Child

Stacy Candice Ritter Not Placed
Medicaid: 714355555 Date of Birth: 10/5/1996 Gender: F Age: 15

DHS-580 WELL CHILD EXAM INFANCY: 1 WEEK
MICHIGAN DEPARTMENT OF HUMAN SERVICES

Well Child Exam Date: Parent (Caretaker Name(s):

Patient Name: D.O.B: Sex:
Stacy Ritter

Allergies:

Allergies

Current Medications:
Complete One of the Screening Tools for the Child

**Stacy Candice Ritter**

- **Medicaid:** 714355555
- **Date of Birth:** 10/5/1996
- **Gender:** F
- **Age:** 15

### Behavioral Screening Tools > PCLC

**POSTTRAUMATIC STRESS DISORDER (PTSD) CHECKLIST - CIVILIAN VERSION**

**Instruct the patient:** Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem in the last month.

<table>
<thead>
<tr>
<th>Response</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?</td>
<td></td>
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<tr>
<td>2. Repeated, disturbing dreams of a stressful experience from the past?</td>
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<td>3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?</td>
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<tr>
<td>4. Feeling very upset when something reminded you of a stressful experience from the past?</td>
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<tr>
<td>5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?</td>
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<tr>
<td>6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?</td>
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<tr>
<td>7. Avoid activities or situations because they remind you of a stressful experience from the past?</td>
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<tr>
<td>8. Trouble remembering important parts of a stressful experience from the past?</td>
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<tr>
<td>9. Loss of interest in things that you used to enjoy?</td>
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<tr>
<td>10. Feeling distant or cut off from other people?</td>
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</table>
Upload, View, or Print a Court Report or Form

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Legal

COURT REPORT

DHS-1280 CFC Initial Court Report:    Add New File: Choose File no file selected

DHS-1281 Updated Court Report:    Choose File no file selected

DHS-3200 Report of Actual or Suspected Child Abuse or Neglect:    Choose File no file selected

CANCEL   SAVE UPDATES
Select One of the Case Worker Page Categories
Bienvenidos!

- Land of Enchantment
- First capitol in 1604
- 47th state in 1912
- 5th largest state in land mass
- 20 elected governors
  (19 tribal; 1 state)
- Population 2.1 million
  - 10.2% Native American
  - 47% Hispanic
  - 39.8% White/Not Hispanic
  - 3% Other
- 24.7% under 18 years old
CYFD ORGANIZATIONAL STRUCTURE

OFFICE OF THE CABINET SECRETARY

- General Counsel
- Inspector General
- Program Planning, Communications and Research
- Office of Community Outreach and Behavioral Health
  - Behavioral Health
  - Licensing and Certification Authority
  - AmeriCorps

EARLY CHILDHOOD SERVICES
- Child Care
- Pre-Kindergarten
- Family Nutrition
- Home Visiting
- Professional Development

PROTECTIVE SERVICES
- Child Abuse & Neglect Reporting/Investigations
- In-Home Services
- Foster Care
- Adoptions
- Youth Services
- Permanency Planning
- Domestic Violence
- Children's Trust Fund

JUVENILE JUSTICE SERVICES
- Secure Facilities
- Reintegration Facilities
- Releasing Authority
- Probation/Supervised Release
- Juvenile Justice Advisory Committee
- Community Corrections
- Youth in Transition

PROGRAM SUPPORT
- Budget/Finance/Background Checks Unit
- Human Resources
- Information Technology

REVISED 08.29.2011
New Mexico’s Vulnerabilities

- Overall rating of 50th in Kids Count
- The highest rate of teen pregnancies in the nation
- Teen death rate nearly double the national average
- The most food-insecure children in the nation
- 54% of children live in low-income families
- 48th ranking in graduation rates
- Some of the highest rates of teen alcohol and drug use
- Teen death rate nearly double the national average
- Highest drug induced death rate in the nation
- Suicide rate consistently among the highest in the nation

- Limited provider capacity
- Workforce shortage
- Lack of community-based services
New Mexico’s Strengths

✓ Abundant natural beauty
✓ Rich history & traditions
✓ **Strong, self-reliant communities**
✓ Caring, compassionate people
✓ Cultural diversity and acceptance
✓ Rural and frontier communities
✓ Temperate climate, clean air
✓ Few natural disasters
✓ Skiing, hiking, climbing, rafting, ballooning…
✓ Robust art/cultural centers

✓ Number of children without health insurance declining
✓ Children’s obesity rate declining
✓ Student test scores improving
✓ **Below national rate for low birth weight babies**
✓ Infant mortality lower than national average
✓ Youth binge drinking declining
✓ DUI fatalities declining
✓ Lower cost higher public education
✓ Lottery scholarships
New Mexico Communities of Care
Communities of Care

Anchor Sites
- Santa Clara Pueblo
- Highland Cluster – Albuquerque
- Grant County

Extension Sites
- Alamogordo
- Catron County
- Dona Ana County
- Las Vegas
- Ohkay Owingeh Pueblo
- San Juan County
- Santa Fe
- Taos
- Tesuque Pueblo
Communities of Care

Communities:
- Have accepted the invitation
- Have attended the Communities of Care Summit
- Are receiving technical assistance and support from their CYFD liaison

TA topics include:
- System development and strategic planning
- NM Cares Wrap Around Model
- Cultural and Linguistic Competence
- Social Marketing
- Anti-stigma
- Mental Health First Aid
- Youth and Family Leadership and
- Other areas as determined by the local team

Communities are refining a plan for their community to support youth and families
- Youth have a strong voice in the process
Vision of New Mexico Community of Care

System Design
(Also referred to as a ‘System of Care’)
A ‘system design’ or ‘system of care’ is how services, supports and people are organized around individuals and their families based on sustainable financial supports.

New Mexico Community of Care Values:
* Individual & Family Voice/Choice
* Community-Based & Community Driven
* Recovery & Resiliency focused
* Culturally & Linguistically Responsive
* Adaptable & Sustainable
* Strengths-Based
* Perseverance

Performance Measures
This is how we measure the achievement of the desired outcomes including increasing individuals’ recovery and resiliency and the quality (not the quantity) of services.

New Mexico Performance Measures Indicators:
* Quality Service Review
* Data, reviews, satisfaction surveys and evaluations
* State Performance Measures
* NOMs (National Outcome Measurements)

Practice
Practice is how services and supports are delivered.

New Mexico Practice Expectations:
* Based on the expressed needs/assessment of the individual/family
* Strengths-based with the individual/family driving their own care
* Teamining with emphasis on natural/community supports
* Holistic planning with emphasis on engagement
* High Quality & Outcomes-informed

Array of Care
An ‘array of care’ consists of individuals and families, providers and community partners that offer a full range of services and supports, given funding, availability of services, and development of natural supports.

New Mexico Array of Care Components:
* Community & Natural supports
* Behavioral Health Providers including CSA’s
* Physical Health Providers including PCPs
* Other System Partners (i.e. statewide Family Organization, State agencies, schools, community resources)
Communities of Care
CYFD Coordination of Care Protocol
Target Population

A Community of Care is primarily designed for children and youth and their families who are:

- In an out of home placement;
- At high risk of out of home placement;
- Involved in either protective services or juvenile justice services or both;
- Have received a behavioral health diagnosis that qualifies them for services as delivered by Core Service Agencies; or
- Meet the medical necessity criteria for residential treatment.
Vision of New Mexico Community of Care

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Quality Service Review (QSR)

- QSR is an ORGANIZATIONAL LEARNING PROCESS
- QSR observes the PRACTICE MODEL
- QSR connects RESULTS to local FRONTLINE CONDITIONS
- QSR supports TEACHING & LEARNING PROCESSES
- QSR stimulates NEXT STEP ACTIONS taken to improve practice and results at all levels of the organization

Organizing Functions of Practice

1. Engagement
2. Teamwork & Coordination
3. Assessment & Understanding
4. Long-Term View/Pathway to Safe Case Closure
5. Planning
6. Implementing Supports & Services
7. Tracking & Adjustment
Communities of Care - Goal

Improve our system so that we support our children, youth and families to:

Get Better
Do Better
Stay Better
Contact Information

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Office of the Secretary
Children, Youth & Families Department

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Phone: (505) 827-7625

NMSOC.org

Digital Stories:
http://www.mcsystemofcare.org/stories/