G.13. Technical Approach USE CASE 2: KIMBERLY

Kimberly has been in the emergency department (ED) for three days pending transfer to a residential facility. Attempts to locate a residential bed have been unsuccessful, and the hospital intends to discharge her. Upon notification of Kimberly's ED visit, a Humana behavioral health (BH) Utilization Management (UM) Coordinator, Erica, jumps into action to alert Kimberly's assigned Care Coordinator (CC), Deb, to begin collaborating to get Kimberly discharged from the ED and into an appropriate level of care.

Deb immediately reaches out to the Department for Community Based Services (DCBS) Social Service Worker (SSW) for Kimberly to get up to speed on the situation that led up to Kimberly being in the ED, status of referrals, and plans for next steps.

a. Care management, including coordination with the foster parents

Kimberly is assigned to Deb, a Humana Care Coordinator (CC) and a licensed BH clinician. Upon notification of Kimberly's ED visit, the emergent need for this case is to get Kimberly in a more appropriate care setting based on her needs. Deb gathers information from the DCBS SSW to determine why providers have denied admitting Kimberly over the last three days and determine if the Provider Relations representative for these facilities can do additional outreach to secure a bed for Kimberly. Deb collaborates with Erica, the Humana UM Coordinator, to ensure the facility and DCBS are working and on the same page for discharge planning.

We will assign a BH UM Coordinator to each inpatient and residential facility in our network to establish relationships and allow us to quickly find beds for our Enrollees. Additionally, because all residential providers in the Commonwealth that service foster children will likely be par with Humana, we will use our information about open beds, upcoming discharges of other Enrollees, and capacity to work with DCBS to determine any options and use our leverage with the provider network to attempt to locate an appropriate placement.

At the point when Kimberly is accepted in a lower level facility, a Psychiatric Residential Treatment Facility (PRTF) Deb continues managing Kimberly's case through admission and beyond. Deb's approach to care coordination for Kimberly includes:

1. Assessment: Deb works with Kimberly's assigned DCBS SSW to schedule a face-to-face assessment and care planning session with Kimberly and her treatment providers upon admission to the PRTF. Using the Enrollee Needs Assessment and following the tenets of High Fidelity Wraparound care planning, Deb and Kimberly discuss her goals, strengths, preferences, and needs. Kimberly expresses apathy about schoolwork and her future goals. She also describes anger toward her mother but expresses her desire to reconnect with her siblings.
2. Care Coordination Level: Deb re-assigns Kimberly to Complex Care Coordination after her ED encounter and admission to a PRTF. For the duration of Kimberly's engagement in this risk level, Deb provides the following services (at a minimum) monthly: two face-to-face visits, one weekly contact, two hours per week of care coordination, one meeting with Kimberly and her foster parents or current caregivers if Kimberly is not returning to the foster home, and one care plan update.
3. Care Coordination Team (CCT): Kimberly's CCT includes Kimberly, Deb, her DCBS SSW, PRTF treatment staff, her Primary Care Provider (PCP foster parents, school counselor, and any other key individuals identified by her DCBS SSW, including any of Kimberly's relatives as appropriate. In addition, under the Foster Child Bill of Rights, Deb invites Kimberly to identify two additional individuals to join her CCT. Deb has regularly engaged Kimberly's CCT throughout her enrollment in Kentucky SKY program. As described below, Deb schedules a CCT meeting for Kimberly following her PRTF admission, ideally concurrent to the facility's scheduled treatment team meetings to engage current providers to review updates to Kimberly's case and ensure all necessary services are in place moving forward. Kimberly's ongoing providers are notified of her admission to a PRTF through our provider portal, Availity.
4. Care Planning: Deb updates Kimberly's care plan with the services she will receive at the PRTF, the projected length of stay, and the discharge plan. Goals may be updated to reflect PRTF's care plan including

treating Kimberly's depression, addressing her self-harm, improving her behavior at school, and helping her foster family feel confident caring for Kimberly to increase the likelihood of return to their home. These include:

- Engagement with a BH provider: In anticipation of Kimberly's discharge to the community, Deb works with Kimberly's DCBS SSW to find a BH outpatient provider to provide ongoing therapy. Deb recognizes the foster family's ongoing concern about the distance to the nearest BH provider; therefore, she works with them and DCBS to find the best solution. This may include using telehealth to deliver ongoing care or working with our contracting team to identify out-of-network (OON) providers closer to Kimberly's home who may be engaged under a single case agreement.
- Crisis Planning: We create a crisis plan for each Kentucky SKY Enrollee with BH needs. Kimberly's crisis plan provides her and her caregivers with actions she can take when faced with a potential crisis, including contacting a crisis text line for adolescents, as provided by Pennyroyal and other organizations; contacting Humana's BH Crisis Line for assistance; contacting her DCBS SSW or BH provider; or receiving assistance from her foster family. The crisis plan also includes actions the foster family can take to ensure Kimberly's safety, including securing their medications and monitoring her social media accounts to detect any changes in her mood or behavior that may signal the need for intervention if she returns to the home.
- Primary care: If Kimberly has a gap in care related to a preventive service, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Deb and her PCP are alerted via our integrated clinical platform, Clinical Guidance eXchange (CGX), and provider portal, respectively. Deb then follows up with Kimberly's DCBS SSW and foster parents to help them schedule an appointment to close the gap. Deb consults with the PRTF staff to determine if she needs to see a pediatrician for any current gaps while in the program.
- Family planning and Sexually Transmitted Infection (STI) services: Deb confirms with Kimberly that she received her desired family planning method from her PCP and asks if she has any questions regarding its use. Deb ensures that Kimberly is aware of confidentiality regulations concerning family planning services, including those provided to adolescents, and educates her on the importance and availability of an STI screening, as she is sexually active. In addition, Deb encourages Kimberly to access our KidsHealth library of video and written content for self-paced, adolescent-friendly education on sexual health.
- Education: Kimberly has been suspended from school four times for behavioral issues and has expressed that she has had a hard time focusing during class. Deb discusses Kimberly's educational performance with her CCT (which includes Kimberly's school counselor) to discuss possible solutions, including evaluating Kimberly for an individualized education plan (IEP) or providing tutoring support to help Kimberly get caught up in her classes and offer more one-on-one assistance.
- Coordination with and supports for Kimberly's foster parents: Kimberly's foster parents are members of her CCT, enabling them to stay up to date on and contribute to her care plan. Kimberly's foster parents have expressed their fears about Kimberly's return to their home after her stay in the residential facility. To support her family and maintain this placement, Deb enlists the help of a Humana Family and Youth Peer Support Specialist, who visits the family prior to and after Kimberly's return home to discuss Kimberly's situation and how to best support her as a family. In addition, the Family and Youth Peer Support Specialist discusses the factors that may have contributed to Kimberly's stated desire to run away from home, self-harm, and attempt suicide, and helps the family determine next steps to create a stable home life that supports Kimberly's needs. Deb encourages Kimberly's foster family to visit Kimberly at the PRTF to maintain a relationship during Kimberly's admission and participate in family therapy and discharge planning.
- Family reunification: When Kimberly is ready to revisit reunification with her mother, Deb works with the CCT to arrange family therapy for Linda and Kimberly to address her unresolved anger and hostility toward her mother and work toward family reunification. If in-person family therapy sessions are not possible, we

leverage our relationship with SUN Behavioral Health to use its telehealth platform for family therapy sessions. Additionally, any opportunities for Kimberly to see or interact with her siblings is critical to family connectivity and helping Kimberly adjust to her shift from caretaker to being separated from them. Naturally this is a big transition and Kimberly likely has a lot of anxiety about their well-being.

b. Discharging planning between levels of care

The discharge planning that occurs while Kimberly is in the ED is urgent and requires collaboration between the Humana Kentucky SKY BH UM Coordinator, Erica; Kimberly's DCBS SSW, the hospital staff, and Deb, the Humana Kentucky SKY CC. Once Erica confirms a psychiatric residential treatment facility (PRTF) is the most appropriate level of care for Kimberly, will confirm that a PRFT level of care is appropriate and that Kimberly can be admitted.

After her admission to the PRTF, Erica contacts the facility's discharge planner to discuss next steps for transitioning Kimberly to the community. Erica participates in concurrent reviews for the duration of Kimberly's stay in the PRTF to ensure continued appropriateness of care. Erica and Deb discuss Kimberly's case, as needed, with our Kentucky SKY Medical Director, Ian Nathanson and Kentucky SKY Psychiatrist, Taft Parsons, during **twice weekly joint UM/Care Coordination rounds** to gather input on Kimberly's treatment plan and discharge plans, including the appropriate level of care and updates from the DCBS SSW and foster family. When Kimberly is nearing the end of her treatment, much collaboration is done to prevent a decertification and ensure all parties are ready for Kimberly to return to the foster home with proper supports in place. We record all information concerning Kimberly's stay in the PRTF in our integrated clinical platform, CGX, to promote continuity across associates.

Following her stay at the PRTF, Kimberly may be discharged to outpatient care or to another level of care, including a partial hospitalization (PHP) or intensive outpatient program (IOP). If she is discharged to outpatient care, Erica and Deb help her locate a BH provider for her seven-day and 30-day follow-up visits after hospitalization, provide any education or support needed to help her return to her foster home, ensure that any prescriptions are authorized and sent to her preferred pharmacy. Her crisis plan is updated and reviewed again to resolve any remaining concerns from Kimberly's foster parents to prevent a readmission to inpatient or inappropriate utilization of the ED.

Once she is discharged, Deb notifies her PCP, conducts a reassessment (prompted by Kimberly's change in condition), and works with Kimberly's CCT to update her care plan. Deb follows up after her scheduled appointments to ensure attendance. If Kimberly misses her appointment, Deb contacts the BH provider to ensure she reschedules within 24 hours (per contractual requirements) and works with both Kimberly and her CCT to address any barriers that may otherwise prevent attending the rescheduled appointment.

c. Network adequacy and availability of services

Humana has contracted, credentialed, and functioning ongoing relationships with **51 residential BH treatment facilities, 133 Behavioral Health Service Organizations, and 25 PRTF locations** in Kentucky. We enter conversations with any willing provider of residential services to ensure a robust network for our Kentucky SKY Enrollees. Erica arranges care for Kimberly at one of the PRTFs in our network that is appropriate for her needs, such as Buckhorn Children's Center, Purchase Youth Village, Maryhurst, Uspiritus (Centerstone), Hope Hill Youth Services, and Ramey-Estep Homes, Inc.

Once Kimberly is ready to be discharged to the community, Deb helps her find a BH provider skilled in treating adolescents and trained in trauma-informed care (TIC). We have contracted with IOP and PHP providers across Kentucky, including all Community Mental Health Centers (CMHC), enabling Kimberly to receive step-down services, as needed, near her foster family's home. In total, we have **3,192 BH providers** contracted in Kentucky. To preserve a continuum of care for our Enrollees with BH needs like Kimberly, Humana is partnering with Springstone to **expand access to IOP and PHP services for Kentuckians**. Springstone is a national provider of

high-quality BH solutions, with a reputation for bringing new services to populations in need of BH and substance use disorder (SUD) support. In addition to BH services for Kimberly, our provider network in Kentucky includes **891 pediatric PCPs**. Our overall PCP network has a ratio of **one PCP to 33 Enrollees**, far exceeding DMS' required PCP ratio of 1:1,500, and ensuring continued access to primary care services.

d. Availability and utilization of telehealth for behavioral health services

Humana's telebehavioral health capabilities can address many of the issues in Kimberly's case, from her initial referral to BH services from her PCP to her prolonged stay in the ED. In addition, our telebehavioral health solutions can provide Kimberly with access to services on an ongoing basis following her admission to a residential facility.

In the Emergency Department: Through technical support and financial assistance [in the form of our one-time **Practice Transformation Incentives (PTI)**], we will work with our network providers to support telebehavioral health consults in EDs. Through this consult, a psychiatrist offers Kimberly a full assessment, confirms her diagnosis, and advises on the appropriate next level of care.

In her PCP's office: Kimberly's PCP was unable to facilitate a successful referral to a BH provider. We recognize our Medicaid Enrollees often face barriers that prevent them from following up on referrals as a result of unclear communication from the referring provider, lack of transportation, or other barriers. To encourage direct referrals to BH services and facilitate access to care, **Humana's partnership with Arcadian Telepsychiatry provides Kimberly with the option of accessing BH services in her PCP's office**. If Kimberly's PCP participates in this program, they receive Humana-funded hardware to link to Arcadian's platform. Kimberly can then receive an appointment with a BH provider right in her PCP's office, avoiding issues with both referral follow-up and travel distance. We will support similar arrangements between our other network BH providers and PCPs through technical assistance from our provider-facing **Practice Innovation Advisors**, who are dedicated to helping our providers improve the delivery of care, and our **PTIs**.

Ongoing engagement in care: We provide Kimberly with two telebehavioral health options for ongoing care: **direct-to-consumer** or **PCP-facilitated**, as described above. Through the direct-to-consumer option, Kimberly can access individual therapy on an ongoing basis via a mobile application. By removing Kimberly's transportation barriers, this platform encourages ongoing engagement in care.

Family therapy: We have partnered with SUN Behavioral Health to leverage their telebehavioral health capability for **family therapy**. Kimberly can benefit from family therapy to build her relationship with her foster family, which has expressed anxiety about her well-being, and to promote dialogue with Linda to move closer to reunification with her birth family.

e. Applicable evidence based practices; including psychotherapeutic interventions

Evidence-based practices (EBP) applicable to Kimberly's case include, but are not limited to, those published by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA):

- Trauma-focused cognitive behavioral therapy (TF-CBT): Incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. Application of TF-CBT in Kimberly's care can help Kimberly learn how to regulate her behavior, thoughts, and relationships; process the trauma she experienced in her childhood; and enhance her ability to develop safe, trusting relationships with her foster and birth family. TF-CBT also includes interventions for Kimberly's foster parents or birth mother (depending on need), emphasizing parenting skills and family communication.
- Dialectical behavioral therapy (DBT): Used to help individuals with patterns of self-harm, like Kimberly. Application of DBT by Kimberly's provider can help Kimberly learn the linkage between positive thoughts and feelings, with an emphasis on using mindfulness in times of conflict.

- Deb uses resources available to her including clinical consultation, Humana's **Healthwise library** of condition-specific resources to inform management of Kimberly's case. Our **QIAs** provide face-to-face education to her providers on these practices through quarterly visits to our PCPs and high-volume specialists.

f. Prescribing psychotropic medications and documentation in medical records (e.g., rationale, follow-up assessments and monitoring, etc.)

Our clinical teams have worked with our in-house Pharmacy Benefits Manager (PBM), Humana Pharmacy Solutions, Inc. (HPS), to implement assessment, monitoring, and follow-up procedures that ensure safe and appropriate use of psychotropics among our Medicaid Enrollees. These approaches cover Kimberly's psychotropic use from the time of her first prescription of an antidepressant to any additional psychotropics prescribed during her PRTF admission.

We plan to incentivize Kimberly's PCP for their performance on the antidepressant medication-monitoring HEDIS metric.

Medication reconciliation: Deb performs a medication reconciliation for Kimberly upon enrollment, a change in condition (including her recent residential admission), and during each reassessment. Deb shares the results of the medication reconciliation with Kimberly's DCBS SSW, foster parents, PCP, and BH provider (once engaged) to determine appropriateness of use, adjust treatment as needed, and prevent possible duplication or drug-drug interactions.

Monitoring: HPS monitors Kimberly's pharmacy claims to ensure refill adherence. Evidence of non-adherence (e.g., missed refill) triggers a notification to her prescriber informing them of Kimberly's irregular use of medication. If Kimberly were to be prescribed additional psychotropic medications, including antipsychotics or stimulants, we would also monitor her claims through our BH drug utilization review (DUR) program to monitor use of multiple, concurrent antipsychotics, and look for evidence of appropriate metabolic monitoring and first line psychosocial care. Any missed care or potentially unsafe prescribing practices triggers notification to Kimberly, her prescriber, and Deb to prompt engagement.

Clinical Practice Guidelines (CPG): Our CPG committee will review and establish a CPG for psychotropic medication use among children and adolescents to advise our providers on appropriate prescribing practices. We will use our enterprise-wide CPG Adherence report to evaluate provider adherence to this CPG once in place.

Documentation and record reviews: We make Kimberly's medication history, including her antidepressant prescription and any other psychotropic medication use, available to Kimberly's providers through our provider portal, Availity. We periodically review the medical records of providers with evidence of potentially inappropriate psychotropic prescribing practices (as identified through pharmacy claims and medication reconciliations) to ensure documentation of the rationale for psychotropic use, and measure it against the corresponding CPG for appropriateness. Identification of providers with a pattern of missing rationales or possibly inappropriate prescribing will prompt intervention by our Kentucky SKY Medical Director or a Humana pharmacist, as appropriate. These reviews will incorporate the Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care; we address any analysis that indicates over-prescribing with Kimberly's prescribers and potentially review them with the DCBS SSW and clinical support teams.

g. Coordination of transportation, if needed

Deb is able to support by providing education on how to obtain reimbursement for transporting her to and from medical appointments through DCBS based on their role as foster parents. If the family experiences temporary barriers in transportation, they can reach out to the rest of Kimberly's CCT for potential connection to resources to assist based in their community.

h. Provider contracting

As described above, we have built a robust Kentucky Medicaid network and are partnering to expand the availability of IOP and PHP services for children, adolescents, and adults in the Commonwealth. We apply an "any willing provider" approach to our provider network activities, in compliance with 907 KAR 1:672 and KRS 304.17A-270. To ensure network adequacy in the near and long-term for Enrollees with complex BH needs like Kimberly, Humana employs an aggressive recruitment plan, including encouraging PCPs to employ BH providers through our PTIs; incentivizing PCPs and BH providers who offer extended hours; leveraging our relationships with national providers, like **Springstone**, to expand their services for Kentuckians; and investing in telehealth solutions, as described above.

If Erica cannot find Kimberly an in-network PRTF for treatment, she would work with our contracting team to obtain a single case agreement with an OON provider. Erica also informs our provider contracting team of issues encountered in finding a placement to inform future provider contracting opportunities. **Our provider contracting team routinely reviews single case agreements to identify opportunities to bring providers in network**.

i. Provider education and support

Trauma-Informed Care (TIC): As we address Kimberly's crisis, our TIC Program Director works with her providers to offer TIC training (if not yet received). This training can help her PCP, BH provider, and other specialists that Kimberly may visit to provide services that accommodate Kimberly's history of emotional trauma. Through our **TIC Provider Recognition Program**, Kimberly's providers can receive "preferred quality provider" status in our Provider Directory and an indication that they have completed TIC training. This enables our Enrollees and associates to quickly identify providers best suited to care for those who have experienced trauma.

Integration: Kimberly's PCP is kept up to date on her situation through the CCT and information provided through Availity. To support Kimberly's PCP in the screening, diagnosis, and treatment of BH conditions, we offer the following supports, discussed by their Provider Relations representative during monthly check-ins:

- Her PCP has access to our Relias provider education library, which offers more than 340 modules targeted at both physical health and BH providers managing the care of Medicaid Enrollees. Most modules are accredited by at least one professional organization and are eligible for continuing education credit. We have made a concerted effort to include courses in our Relias library that build the capacity of PCPs to understand, screen for, and treat the BH needs most common in our Medicaid beneficiaries, including depression.
- Deb educates Kimberly's PCP on how to request a psychiatric consultation for assistance in treating Kimberly and other Kentucky SKY Enrollees with BH needs.
- While Kimberly's PCP did refer her for additional BH services, this referral was ultimately unsuccessful. To avoid a situation like this, our Provider Relations representatives educate our PCPs on available BH services and how to refer Enrollees to these services. In addition, we provide access to our Care Decision Insights (CDI) platform, which provides data on specialists' effectiveness and efficiency to PCPs to support referral decisions. To further promote closed-loop referrals to BH providers, our Practice Innovation Advisors work with interested PCPs and BH providers to establish referral pathways and data-sharing arrangements.

To promote screenings, referrals, and delivery of ongoing care for depression, we plan to reward network PCPs for their performance on the HEDIS metric "Depression Screening and Follow-Up for Adolescents and Adults."

j. Access to and sharing of medical records

Humana is committing to furthering interoperability of data systems within the healthcare industry. We educate subcontractors of data systems about payer needs and pay these systems to build solutions for both inbound

and outbound data feeds. Using this robust data infrastructure, we will offer Kimberly's providers and her DCBS SSW access to the information needed to address her clinical and non-clinical needs, including:

- Access to her care plan (including her crisis plan) and assessment through Availity
- Clinical inferences and gap in care information delivered via bi-directional data feed connections with all of the top eight Electronic Health Records (EHR) systems in the country
- Proposed delivery of Kimberly's care plan and assessment information via a bi-directional feed with The Worker Information SysTem (TWIST), with agency agreement
- In addition, we will promote innovative methods of coordination through use of Humana's Voice & Choice Information Exchange care portal for the Enrollee and their care team to be equal partners in care planning.

k. Maintenance of the care plan

As Kimberly is enrolled in Complex Care Coordination, Deb updates her care plan at least monthly. In addition, Deb updates the care plan, as needed, following a change in Kimberly's condition (e.g., Kimberly's suicide attempt and admission to a residential facility) or upon request of Kimberly's DCBS SSW. These care plan edits are shared with Kimberly's CCT for their input and guidance and to ensure all necessary orders and prescriptions are obtained. The most up-to-date care plan is available on Availity for ready access by Kimberly's providers and DCBS, and on the Enrollee portal for use by Kimberly and her caregivers (with DCBS permission). Deb also provides a printed copy of the care plan upon request.

Deb supports maintenance of Kimberly's Medical Passport, ensuring documentation of all appointments for medical, BH, vision, and dental care, as well as immunizations and relevant clinical history. Deb also ensures Kimberly's DCBS SSW has access to the scanned electronic version of the Medical Passport. This will allow for safe, protected storage of these important documents, rather than relying solely on paper copies of her records. These crucial documents will also be stored with DCBS SSW permission in the Humana Voice & Choice Information Exchange care portal for the Enrollee and their care team to access.