G.13 Technical Approach USE CASE 7: JULIE

Our approach to Julie's USE CASE strives to address her needs in both the near and long term. In the near term, our Care Coordination Team (CCT) focuses on instituting those services and supports that address Julie's behavioral needs and use of psychotropic medications, with the aim of stabilizing her so she can live in the community. In the long term, our CCT helps prepare Julie for a transition from foster care, including instruction in independent living skills and coordination of waiver services. Throughout this process, we ensure Julie's goals and preferences inform everything we do and incorporate her desires as much as possible.

a. Care Management

We assign Julie to Rita, a Humana Care Coordinator (CC) and licensed behavioral health (BH) professional. Under **our integrated CCT model, Rita is responsible for managing Julie's BH and physical health conditions**, with the support of a Humana Registered Nurse for any questions or guidance. Our care coordination approach for Julie includes the following steps:

Our approach to managing Julie's care is informed by our experience serving **more than 40,000 Medicaid Enrollees with special health care needs**, including more than 200 pediatric Enrollees with disabilities in our Kentucky Medicaid plan.

1. Acquire Information about Julie's Health History: Rita contacts Julie's Department for Community Based Services (DCBS) Social Service Worker (SSW) to obtain information about her health history, including information from court judicial review documents that may contain further detail. Rita reviews Form DPP-106B, any historic claims information provided by DCBS, and information from court judicial review documents. Upon reviewing this information, Rita notes the lack of detail concerning Julie's medication history. To gather additional information about Julie's history and fill in these information gaps, Rita directly contacts Julie's current providers (and any known past providers) to inquire about her health history, as well as her last health plan (if not Humana) to seek additional information about her care.
2. Conduct the Assessment: Rita works with Julie's DCBS SSW to schedule a face-to-face assessment and care planning session with Julie and her residential facility caregivers. Rita administers the Common Health Risk Assessment (HRA) and Kentucky SKY Pediatric Needs Assessment to capture a comprehensive picture of Julie's needs, including her physical health, BH, and social needs. In addition, Rita coordinates with Julie's providers to complete the Child and Adolescent Needs and Strengths (CANS) tool to gather additional information on Julie's experiences and needs to inform our care plan.

   Using her Humana training on the tenets of High Fidelity Wraparound care planning, Rita leads Julie, her caregivers, and her DCBS SSW in a discussion of Julie's goals and priorities. Julie's caregivers at the residential facility express their ongoing concerns about her disruptive behaviors, including the danger those behaviors pose to the other residents. They are also concerned that Julie is turning 18 soon and what that means for her living situation, including whether she will stay in the foster care system. Rita also notes Julie's goals and preferences and uses those (as well as the input provided by her caregivers and DCBS SSW) to develop her care plan.
3. Assign a Care Coordination Level: Taking into account the results of the Common HRA, Kentucky SKY Pediatric Needs Assessment, Medicaid Severity Score, potential need for a higher level of care, and clinical judgment from her experience, Rita assigns Julie to Intensive Care Coordination. For the duration of Julie's engagement in this risk level, Rita provides, on a monthly basis, the following services (at a minimum): One face-to-face visit per month, one weekly contact, one meeting with Julie and her caregivers, and one care plan update.
4. Convene the Care Coordination Team (CCT): Next, Rita convenes Julie's CCT. Julie's CCT includes Julie, Rita, her DCBS SSW, her primary care provider (PCP), her BH provider, her caregivers at her residential placement, a representative from her school to speak to her education and individualized education plan

(IEP), her Department of Juvenile Justice (DJJ) case worker (if her incarceration was recent), and any other key individuals identified by Julie (with approval from her DCBS SSW) or her DCBS SSW. In the event that parental rights have not been terminated, Rita also works with DCBS SSW to determine their level of involvement on the CCT. The CCT will add or remove other team members as Julie's circumstances evolve.

Rita schedules a CCT meeting to review Julie's assessment, determine appropriate services, and review her care plan. By bringing all of Julie's providers together and providing a forum for the discussion of her physical health and BH needs, the CCT serves an important role in ensuring integrated, multidisciplinary care.

5. Care Planning: Rita leads the CCT through High Fidelity Wraparound care planning to create a care plan that contains the services and supports required to meet Julie's needs and goals. Because Humana's secure provider portal, Availity, contains the care plan, **Julie's up-to-date care plan is available at all times to her providers and her DCBS SSW**. Julie and her caregivers can also access her care plan via our dedicated Kentucky SKY Voice & Choice Information Exchange care portal (with DCBS permission). Julie's providers can also access her claims, medication history, and lab results via Availity, enabling them to take these into account when making care decisions.

   Julie's care plan includes the following community-based services, which Rita coordinates and arranges in partnership with Julie's DCBS SSW:

   - Medication Reconciliation and Review: In response to Julie's high number of medications and lack of information concerning their effects or her medication history, Rita conducts a medication reconciliation and review based on the Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care[1], with the collaboration of a Humana pharmacist. This information is shared with Julie's providers, as described below in section I.G.13.c of the RFP, to determine any necessary changes to her medication regimen.
   - BH Services: Julie has a history of explosive and erratic behavior as well as a diagnosis of intellectual and developmental disabilities (IDD) and low IQ. Rita works with Julie's CCT to schedule a behavioral analysis assessment to determine if Julie can benefit from a behavior modification plan from an applied behavior analyst. This behavior plan can address Julie's aggressive behaviors, promote the development of appropriate coping skills, and identify Julie's triggers for her emotional shifts and aggression. Using these triggers as a guide, the analyst can help her providers and caregivers identify steps to take to mitigate triggers and better manage Julie's behaviors. The analyst also provides ongoing monitoring to ensure the plan is having the desired effect. Rita also requests Julie's current treatment plan from her BH provider to include in the care plan. Through a review of the treatment plan, Julie's CCT can ensure she is receiving evidence-based, psychosocial treatment for any BH need. Our approach to promoting psychosocial treatment for Julie is further described in I.G.13.d of the RFP.
   - Primary Care: Rita reviews Julie's available history to ensure regular engagement in primary care and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. In addition, Rita recommends that Julie's visits with her PCP to cover other age-appropriate topics, such as sexual health, family planning, breast exams, HPV immunizations, and cervical cancer screening. Rita also aims to deliver educational content to Julie on these topics, as appropriate for her intellectual functioning and level of understanding.
   - Waiver Services: Julie may be eligible for waivers for IDD, including the Michelle P. Waiver and Supports for Community Living. As described under section I.G.13.f of the RFP, Rita works with her DCBS SSW and her providers to explore the opportunity to apply for these waivers and their appropriateness for Julie's needs.
   - Education and Employment Supports: Working with the representative of Julie's school on the CCT, Rita reviews Julie's IEP and captures its services on her care plan to ensure coverage of IEP services during

[1] developed by the Dept. of Family and Protective Services and the University of Texas at Austin College of Pharmacy

school breaks. If Julie expresses interest in working or participating in community activities, Rita works with her DCBS SSW, and the Department of Vocational Rehabilitation to determine if Julie may benefit from supportive employment services. These services can help Julie develop her social skills and provide her with exposure to her community.

- Aging Out: At 17, Julie is quickly approaching the age of transition from foster care. As Julie has an IDD diagnosis, we must consider the appropriateness and viability of transfer. As described below under section I.G.13.e of the RFP, Rita works with Julie's DCBS SSW to arrange an evaluation that can indicate whether or not transition is viable. Based on the results of the evaluation, Rita engages Julie and the DCBS SSW to support transition activities at the appropriate level for her needs and capabilities.

b. Discharging planning for all levels of care

During Julie's CCT meeting, Rita learns that her DCBS SSW and BH provider are evaluating the appropriateness of treatment in a setting that is at a higher level than a psychiatric residential treatment facility but a lower level than acute care. An Extended Care Unit (ECU) meets these criteria. Julie coordinates with her peer Melissa, a Humana Utilization Management (UM) coordinator, to conduct a review of all available documentation on Julie's case to determine if she meets the ECU level of care using MCG or other appropriate criteria.

If Julie does not meet the criteria, we will forward her case to our Kentucky SKY BH Director and Psychiatrist for additional review and a peer-to-peer review. This review may take into account Julie's extensive medication history, noting that her high level of psychotropic use may contribute to the disruptive behaviors causing her DCBS SSW and BH provider to consider another placement, as well as Julie's lack of psychosocial care to date. Julie's low IQ may also be dulling the efficacy of psychotropic medication.

If the request is denied, Rita helps coordinate the needed psychosocial care and works with Julie's prescribers to address her utilization of psychotropic medications. If Julie's behavior does not change with alterations to her medication regimen, we can revisit the possibility of treating Julie in a higher level of care.

If the request is approved (at the time of the initial request or after other measures have been found to be ineffective), Melissa helps to find an ECU (e.g., The Brook Hospitals) that has an open bed, obtain an evaluation, and (if appropriate) obtain a prior authorization (PA) request from the ECU. Melissa then coordinates Julie's transition from her residential placement to the ECU, including arranging transportation through her DCBS SSW. Humana's integrated clinical platform, Clinical Guidance eXchange (CGX), facilitates the exchange of information about Julie's needs and care to date, including her medications. Using this shared system, all CCT members can see case notes from Julie's care, authorizations, and medications.

After Julie's admission to the ECU, Melissa contacts the facility's discharge planner to discuss next steps for transitioning Julie back to the community. We begin discharge planning upon admission to ensure that the appropriate services and supports are in place when Julie moves to a lower level of care. Melissa participates in concurrent reviews for the duration of Julie's ECU stay to ensure continued appropriateness of care. Melissa and Rita discuss Julie's case, as needed, with our Kentucky SKY Medical Director and Psychiatrist during **twice-weekly joint UM and care coordination rounds** to gather input on Julie's treatment plan and discharge plans, including the appropriate level of care.

Once we determine that it is no longer medically necessary for Julie to stay in the ECU, Melissa consults with Rita to determine if a discharge plan is in place with an identified placement and admission date with DCBS. If Julie's DCBS SSW confirms there is an identified step-down placement able to admit Julie when she is discharged from the ECU, discharge planning with the facility continues. If no step-down has been identified, Julie's Kentucky SKY CC, Rita collaborates with the UM reviewer then issues a decertification notice to DCBS SSW, which we provide three days prior to discharge if Julie is in an in-state facility or seven days prior to discharge if she is in an out-of-state facility. We record all information concerning Julie's ECU stay in CGX to promote communication between all Humana associates.

Following her ECU stay, Julie may be discharged to outpatient care in a community setting or to another level of care, including a partial hospitalization or residential. Regardless of her discharge location, Melissa and Rita help locate a BH provider for her seven and 30-day follow-up visits after hospitalization, arrange continuation of other services needed through her placement, and ensure that any needed prescriptions are authorized and sent to her preferred pharmacy.

Once discharged, Rita notifies her PCP, conducts a reassessment, and works with Julie's CCT to update her care plan. Rita follows up after her scheduled appointments to ensure she attends. If Julie misses an appointment, Rita contacts the BH provider to ensure that it is rescheduled within 24 hours (per our contract with her BH provider) and works with Julie and her CCT to address any barriers that may otherwise prevent attendance at the rescheduled appointment.

c. Prescribing psychotropic meds and documentation in medical records (e.g., rationale)

At the time the USE CASE begins, Julie has been prescribed two antipsychotic, two antidepressant, and two anticonvulsant medications, and lacks a detailed medication history or evidence of psychotherapy. As an enterprise and with close collaboration between our clinical teams and our in-house Pharmacy Benefits Manager (PBM), Humana Pharmacy Solutions, Inc. (HPS), we have instituted measures to ensure appropriate psychotropic use across our Enrollees. **Between June 2018 and June 2019, we achieved reductions in psychotropic medications as the share of all prescriptions issued to our Kentucky Medicaid foster care Enrollees**.

Our Clinical Practice Guideline (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.

Medication reconciliation: Rita performs a medication reconciliation for Julie upon enrollment and a change in condition report (including her recent residential admission) during each reassessment. During this medication reconciliation, Rita notes that Julie is taking six psychotropic medications. Prompted by this finding, she coordinates with a Humana pharmacist to conduct a full medication review to ensure the appropriateness of Julie's medications referencing the Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care developed by the Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, evaluate the potential for any drug interactions, and how they might disrupt her behavior. This review finds that there is not a strong match between Julie's diagnoses and her drug regimen, indicating an opportunity for a re-evaluation and alteration of her medication regimen by her providers, as needed.

Rita shares the results of the medication reconciliation and review with Julie's DCBS SSW, a representative from her residential facility, her BH provider, her PCP, and her ECU providers (if she has been admitted) to discuss next steps. Follow-up actions include further exploring how Julie's medication regimen may not be optimal for her behaviors, addressing any drug interactions that may be exacerbating her behaviors or potentially putting her at risk of suicidal ideation, and discussing how to deliver psychosocial care to Julie, including applied behavioral analysis (as described above).

Monitoring: Our specialized BH drug utilization review (DUR) program monitors Julie's claims for use of multiple, concurrent antipsychotics; appropriate metabolic monitoring; use of psychosocial care as a first-line treatment before being prescribed an antipsychotic medication; and other appropriate follow-up. Any missed care will trigger notification to Julie's DCBS SSW, her prescriber, and Rita to perform appropriate follow-up. Under this model, our system would have flagged Julie's use of multiple, concurrent antipsychotics, as well as her lack of psychosocial care, and alerted Rita through CGX. This alert would prompt intervention from Rita (and a Humana pharmacist, as needed) with Julie and her prescriber.

An important aspect of any prescription medication use (including psychotropics) is ensuring proper adherence. Our in-house PBM, HPS, monitors Julie's pharmacy claims to ensure refill adherence. Evidence of non-adherence (e.g., missed refill) triggers a notification to her prescriber and Rita, informing them of Julie's irregular use of her medication and encouraging intervention.

Documentation and record reviews: Julie's medication history, including psychotropics, is available to her providers through our provider portal, Availity. **Humana's One Medication List tool links CGX, Availity, and Humana's Voice & Choice Information Exchange care portal to enable Julie's providers, her caregivers, and Rita to view, share, and update Julie's medication information, including use of over-the-counter and herbal medications**.

We will periodically review the medical records of providers like Julie's 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. We will measure this against the corresponding CPG for appropriateness in addition to the Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care. When we identify providers with a pattern of missing rationales or possibly inappropriate prescribing, it will prompt intervention by our Kentucky SKY Medical Director, Psychiatrist or our Kentucky Medicaid Pharmacy Director, Joe Vennari, PharmD, as appropriate.

d. Evidence based psychotherapeutic interventions

Evidence-based psychotherapeutic interventions applicable to Julie's care include, but are not limited to:

- Multi-method assessments: Through our Provider Services structure, we encourage our BH providers who assess Enrollees with disabilities to apply integrated, multi-method assessments that use quantitative, qualitative, and ecological data points. This evidence-based practice will enable us to gain a complete picture of Julie's BH needs now and as she ages out of foster care.
- Psychosocial Care for Disruptive-Behavior Disorders: In absence of any record that Julie has received psychosocial services related to her disruptive behavior to date, Rita and our **provider-facing Quality Improvement Advisors** (QIA) work with Julie's BH provider to encourage implementing psychosocial care to manage Julie's behaviors and to accompany and/or replace some of the psychotropic medications she uses. As described above under section I.G.13.c of the RFP, we monitor our membership for evidence of a claim for psychosocial care as a first-line treatment before being prescribed an antipsychotic medication. When we identified Julie's gap in psychosocial care, we notified her DCBS SSW (as her custodian), the responsible prescriber, and Rita to prompt appropriate follow-up and intervention.
- Applied Behavioral Analysis (ABA): As described above, ABA provides an evidence-based, psychosocial alternative to psychotropic medication use that can help Julie's caretakers learn how to manage her adverse behaviors. Our Kentucky Medicaid network includes 44 group and individual providers of ABA.

Rita uses resources available to her including clinical consultation, Humana's Healthwise library of condition-specific resources and evidence-based psychotherapeutic clinical practice guidelines (CPG) to inform management of Julie's case. In addition, we educate Julie's providers on these practices through interventions from our **QIAs**, who visit our network PCPs and high-volume specialists each quarter.

e. Viability of aging out of foster care

Given her diagnosis of IDD and a low IQ, any discussion of aging out of foster care for Julie must include an assessment of whether it is viable for her to leave the Cabinet's custody. In coordination with Julie's DCBS SSW, Rita helps arrange a competency evaluation of Julie from an appropriate provider. This competency evaluation can aid in determining Julie's ability to give informed consent and help her DCBS SSW determine whether to recommend Julie's commitment with the Cabinet be extended by court order if there are concerns for her safety and protection.

In preparation for aging out, we initiated transition planning with Julie when she turned 12 (or at whatever age after 12 that she became a Humana Kentucky SKY Enrollee) to help her prepare for adulthood. This includes developing independent living soft skills (e.g., problem-solving, anger management, decision-making) and daily living skills (e.g., cooking, household responsibilities, laundry, and money management), in collaboration with her DCBS SSW, her residential facility, the Independent Living Coordinator for her region, her school, and her BH provider. Rita encourages Julie to participate in independent living skills courses, works with the Department of Vocational Rehabilitation to initiate a transition plan for employment services (including supportive employment), and ensures that Julie's IEP contains information about her transition needs.

Rita offers the option of reconnecting with her family or fictive kin for additional support after Julie ends her commitment (if it is viable to do so) or to serve as her guardian once she turns 21. If Julie does end her commitment, Rita also educates Julie on the choice to recommit within one year (before Julie turns 21).

f. Option for transitioning to an applicable waiver

Rita confirms that Julie was placed on the Supports for Community Living (SCL) future planning list when she entered foster care a decade ago, per DCBS procedure. If she was not, Rita takes action to help her apply for the SCL waiver, including working with her DCBS SSW to complete the application, confirm that Julie meets an intermediate care facility/moderate to severe intellectual disabilities (ICF-IID) level of care, and secures a statement from Julie's provider or a Qualified Mental Health Professional (QMHP) that Julie meets medical necessity for active treatment.

If Julie is determined to have the ability to give informed consent, she may choose to end her commitment at age 18; alternatively, her commitment will end at age 21. Six months prior to her transition, Rita ensures that a request has been submitted to the SCL Waiting List Coordinator to move Julie onto the emergency waiting list.

g. Access to and sharing of medical records

Humana is committing to furthering interoperability of data systems within the healthcare industry. We educate vendors 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 Julie'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 and assessment through Availity and Humana's Voice & Choice Information Exchange care portal
- Clinical inferences and gap in care information delivered via bi-directional data feed connections with **all eight top Electronic Health Records (EHR) systems** in the country
- Proposed delivery of Julie's care plan and assessment information via a bi-directional feed with The Worker Information SysTem (TWIST) and the Juvenile Offender Records Index (JORI), with agency agreement

h. Maintenance of the care plan

As Julie is enrolled in Intensive Care Coordination, Rita assesses her progress on her care plan goals and updates her care plan at least monthly. She also conducts a reassessment and updates the care plan, as needed, following a change in condition (e.g., after Julie's admission to an ECU) or upon request of her DCBS SSW. Rita shares these care plan edits with Julie's CCT for their input and guidance and to ensure that she obtains all necessary orders and prescriptions. The most up-to-date care plan is available on Availity for ready access by Julie's providers and DCBS SSW. It is also on the Enrollee portal as well as our Voice & Choice Information Exchange care portal for Julie and her caregivers to use (with DCBS SSW permission). Rita provides a printed copy of the care plan upon request.

Recognizing that maintaining Julie's records (and particularly her medication history) has posed a problem in the past, Rita maintains Julie's Medical Passport, ensuring all documentation of all appointments for medical, BH,

vision, and dental care, as well as immunizations and relevant clinical history. Additionally, Rita will make sure that Julie'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.