G.13 Technical Approach USE CASE 8: AMANDA

As Amanda's health plan, we are committed to helping her engage in appropriate, multispecialty care that improves her mental and physical well-being and helps her prepare for surgery and/or a transplant to address her heart defect. This includes addressing Amanda's social needs, including interaction with her peers, exploration of activities she enjoys, and connection with her relatives.

a. Care management, including the assignment of the Nurse Case Manager

Because Amanda is designated as Medically Complex by the Department for Community Based Services (DCBS), we assign her to a Complex Care Coordinator (CC), Liz, within 24 hours of her enrollment in Humana. Liz is a Kentucky-licensed Registered Nurse (RN).

Liz takes the following steps to support Amanda:

1. Acquire Amanda's Health History and Other Information: Liz contacts Amanda's DCBS Social Service Worker (SSW) to obtain information about Amanda's health history. Liz reviews Form DPP-106B, historic claims provided by the Department for Medicaid Services (DMS), and any historic individual health plans. To gather additional information about Amanda's history, Liz directly contacts Amanda's providers to inquire about her health history.
2. Conducting the Assessment: Liz contacts Amanda's DCBS SSW and her foster family to schedule a time for face-to-face administration of the Common Health Risk Assessment (HRA) and Pediatric Enrollee Needs Assessment (within the first 30 days of her enrollment in the plan). In addition, Liz conducts a supplemental home environment assessment to determine if Amanda may benefit from home modifications suited to her condition.
   Through these assessments, Liz learns about Amanda's declining health status and need for further surgery or a transplant; her defiant, impulsive, and disruptive behaviors; her fatigue; and her lack of appetite. Following the tenets of person-centered planning (as covered during her Humana onboarding), Liz leads Amanda, her foster parents, and her DCBS SSW in a discussion of Amanda's goals and priorities. These include building Amanda's strength so she can receive surgery or be listed for a transplant, addressing her lack of appetite, and providing emotional support.
3. Assignment of Care Coordination Level: Taking into account Amanda's complex, co-occurring physical health and behavioral health (BH) needs, along with her high utilization of healthcare services including recent emergency department (ED) visits and inpatient admissions, Liz assigns Amanda to Complex Care Coordination.
4. Care Coordination Team (CCT) and Care Planning: Our next step in Amanda's initial engagement in care coordination is convening the CCT and creating a care plan. As Amanda is Medically Complex, Liz combines these processes with those of the Medically Complex Service team (described under Section I.G.13.b of the RFP) and the development of Amanda's Individual Health Plan (IHP), described under Section I.G.13.d of the RFP. This reduces the burden on Amanda's providers, the DCBS SSW, her foster parents, her aunt, and others involved in the CCT; it also avoids any duplication of effort or overlap between the CCT and Medically Complex Service team.
5. Ongoing Engagement in Care Coordination: As Amanda is in the Complex Care Coordination level and is designated Medically Complex, Liz provides at least two face-to-face visits monthly, one weekly contact, one meeting with Amanda and her foster parents, one care plan update, and at least two hours per week of care coordination with Amanda's providers, community resources, and others involved in her care. In the event that parental rights have not been terminated, Liz works with Amanda, her DCBS SSW and her mother to obtain appropriate consents for necessary procedures.

b. Involvement of Medically Complex service team

Amanda's Medically Complex Service team includes Liz, her DCBS SSW, the Family Services Office Supervisor, the Medically Complex Liaison, Amanda's foster parents, Amanda's aunt and any other kin or fictive kin (if involved), and Amanda's Primary Care Provider (PCP), pediatric cardiologist, BH provider, dentist, and other specialists, such as a dietitian to address Amanda's nutritional needs leading up to her surgery. To promote cohesion with Amanda's CCT, Liz also requests permission to include a representative from Amanda's school to seek to support Amanda's educational experience and her individualized education plan (IEP).). Amanda's joint Medically Complex Service team and CCT assist Liz in reviewing Amanda's assessment results and the development of her care plan and IHP (as described under Section I.G.13.d of the RFP). In addition, meetings of the Medically Complex Service team/CCT provide a forum for Amanda's various providers to discuss her care in a comprehensive and integrated matter, as described in Section I.G.13.i of the RFP response below.

c. Discharge planning between levels of care

Amanda has a recent history of inpatient admissions related to her cardiac and pulmonary function. During each admission, Liz works closely with our Hospital-Based Care Managers and telephonic Utilization Management (UM) Coordinators to provide discharge planning support that ensure a safe transition to the appropriate level of care and decrease her risk of readmission. Our discharge planning processes include:

- Outreach to the inpatient facility by the Humana Hospital-Based Care Managers or another UM Coordinator to begin discharge planning upon notification of Amanda's admission through a daily hospital census; admissions, discharge, and transfer (ADT) feed; or direct notification by Amanda's foster family. In addition, Liz receives a task in our integrated clinical platform, Clinical Guidance eXchange (CGX), prompting outreach to the responsible UM associate and Amanda's providers, DCBS SSW, and foster family.
- Concurrent review process, including application of MCG guidelines to ensure that Amanda is in the appropriate level of care.
- Creation of a discharge plan by the UM Coordinator assigned to Amanda's case in conjunction with Liz and Amanda's Medically Complex Service team and CCT that outlines all needed post-discharge services and appointments. As part of the discharge plan, Liz, assist Amanda with scheduling any follow up appointments or care for outpatient services such as a cardiologist or pulmonologist.
- Frequent UM rounds (twice weekly or more depending on complexity) to review Amanda's admission with Liz, our UM associates, and our Kentucky SKY Medical Director. During these rounds, we discuss the appropriate next steps for Amanda's care, including moving her to a lower or higher level of care depending on her needs, progress, and the findings of the concurrent review. In addition, Liz and the UM team collaborate to ensure that we remove any barriers to safe discharge.

If Amanda is listed for a transplant, Liz coordinates closely with her transplant team at the facility to ensure that Amanda receives all needed services. In addition, Liz draws upon the expertise of Humana's National Transplant team to assist in managing Amanda's transplant care, as needed. Our National transplant team provides transplant benefit approvals, care coordination in collaboration with Amanda's CCT, and UM for our Enrollees from the time they are approved for a transplant through one year post-transplant.

d. Individual Health Plan development and maintenance within specified timeframes

Development: Within 30 days of Amanda's enrollment in the Humana Kentucky SKY program (or her designation as Medically Complex), Liz convenes an initial session with Amanda's Medically Complex Service team to develop her IHP. Amanda's IHP includes information about Amanda's current medical diagnoses, medications, drug allergies, history of hospitalizations, list of providers, therapy and interventional services, and actions for addressing Amanda's needs. Once complete, Liz disseminates the IHP to all Medically Complex Service team associates.

In addition to the IHP, Liz creates a care plan to fully capture Amanda's goals, preferences, and needs, including those related to the Social Determinants of Health (SDOH), including education, overall well-being and quality of

life. Using the care plan and IHP as guides, Liz coordinates with Amanda's providers to obtain orders and prescriptions for all medically necessary services, including any needed durable medical equipment (DME) or home modifications.

Maintenance: Liz facilitates an IHP meeting with Amanda's Medically Complex Service team every three months thereafter to review the IHP, assess Amanda's current needs, and re-evaluate Amanda's Medically Complex determination. Liz conducts two face-to-face visits with Amanda every month and also has weekly contact. Amanda will receive a minimum of two hours per week of Care Coordination and one care plan update per month. Liz updates Amanda's IHP every six months at a minimum, and distributes signed copies to her Medically Complex Service team through our secure provider and DCBS-facing portal, Availity, Humana's Voice & Choice Information Exchange care portal, and any other secure means needed to reach all members of Amanda's Medically Complex Service team. Amanda's care plan is also made available to her Medically Complex Service team through these means.

e. Availability of and access to providers

Availability: Our provider network includes six children's hospitals: Norton Children's Hospital, Norton Women's and Children's Hospital St. Matthews, Norton Children's Medical Center Brownsboro, Shriners Hospital for Children, Children's Hospital Medical Center, and St. Jude Children's Research Hospital. Children's Hospital Medical Center and Norton Children's Hospital provide cardiac transplant services. In addition, our network contains nine pediatric cardiologists, 382 BH providers, 123 dentists, and 87 pediatricians in Eastern Kentucky, which we define as Region 8 of the Commonwealth of Kentucky Medicaid Managed Care Organizations Regions mapped out in I.C.18 the RFP.

Access: Amanda is currently engaged with a number of specialists in addition to her PCP. When Amanda became a Kentucky SKY Enrollee, Liz would have taken steps to ensure continuity of care in the event that her providers were out-of-network (OON), including coordinating with our Provider Contracting team to bring the providers in-network or execute a single case agreement.

Transportation poses a challenge to Amanda's foster family in helping her attend appointments with her various specialists. In addition to the transportation support described under Section I.G.13.h of the RFP, Liz also educates Amanda's foster parents on our telebehavioral health options. Through this service, Amanda can receive BH care in her own home or can receive it in her PCP's office. This service may mean one less trip for Amanda's foster family and can increase access to needed care.

f. The Medical Passport

Liz maintains Amanda's Medical Passport, ensuring all appointments for medical, BH, vision, and dental care are included, along with records of immunization and other relevant clinical history. Liz also ensures that Amanda's DCBS SSW has access to the scanned electronic version of the Medical Passport. This extra step ensures that if a hard copy of medical records is ever misplaced, there is an electronic version to which to refer.

For a child with complex and long-term health concerns like Amanda, the number of medical records and documents to keep track of can become overwhelming for caregivers. Liz will be there to support Amanda and her family or caregivers by compiling the various documents from a wide array of providers to ensure despite any transitions in caregivers or living situations, the Medical Passport remains accessible, up to date, and intact.

g. Training and support for caregivers

Liz provides ongoing training and support to Amanda's caregivers (including her foster parent, her aunt, and paid caregivers) in the form of direct education, digital supports, referrals to community resources, and value-added services. If, during the initial IHP planning meeting, permanent relative placement with Amanda's aunt was identified as an outcome, Liz helps plan for this transition. She serves as a resource to both Amanda's aunt and

DCBS SSW to coordinate the transition of Amanda's care whenever her aunt, Amanda, and DCBS SSW feel comfortable making that switch. Liz provides the following training and support to Amanda's caregivers:

- One-on-one education: During her monthly face-to-face visits with Amanda and her foster parents, Liz reviews any training provided by Amanda's providers, answers questions about Amanda's care or treatment plan, and identifies other needs to be addressed in the home. When possible, Liz includes Amanda's paid caregivers in these sessions. In addition, Liz helps them come up with ideas to keep Amanda's spirits up and improve her behaviors, including coping and self-soothing techniques, and finding safe activities that interest Amanda but do not adversely affect her health. With the consent of Amanda's DCBS SSW and foster parents, Liz includes Amanda's aunt in these sessions so she can learn the same skills and techniques, if Amanda were to be placed back in her home.
- Individual therapy: Amanda's foster parents can access our value-added service of **12 individual therapy sessions** for caregivers. By providing this benefit, we aim to prevent caregiver burnout and promote stability in Amanda's placement.
- KidsHealth: Liz teaches Amanda and her caregivers how to access **the library of video and written educational content, KidsHealth**. KidsHealth contains content tailored for children, adolescents, and parents about pediatric conditions, supporting self-management, and caregiver assistance.
- myStrength: Liz educates Amanda's foster parents on how to access **myStrength**, a digital platform designed to improve self-management of BH and physical health conditions, including depression and anxiety. As caregivers, Amanda's foster parents can use this solution to better understand and manage Amanda's BH needs, as well as access caregiver-specific resources in myStrength's caregiver library.
- Support groups: Liz helps Amanda's foster parents find caregiver, transplant, and foster parent support groups to provide additional support and learning as they manage Amanda's complex needs. In addition, Liz encourages Amanda's foster parents to sign up for mentoring support through the University of Kentucky if they are new to the role.
- Support for her foster siblings: Amanda's foster siblings may also benefit from a support group or other activities targeted for siblings of children with special needs. Linkage with these services can help them better understand Amanda's needs and feel more comfortable with Amanda as a member of their family. In addition, Liz provides direct education on how they can help Amanda stay healthy, including training on proper handwashing and infection prevention. Liz understands with the high needs of Amanda's care and the amount of attention that is needed from her foster parents to meet those needs, the other children in the home may demonstrate increased negative behaviors as a result and unconscious attempt to receive equal attention. This could potentially be a risk for disruption for Amanda as well as her foster siblings. Liz spends time educating the foster parents on how to prevent such issues (using respite for Amanda while devoting time to the other children, involvement in activities to strengthen relationships with the other children, etc.) and what to do if any changes in behavior are noted, such as increasing services.

h. Coordination of transportation, as needed

During the Enrollee Needs Assessment, Liz learns of the challenges Amanda's foster parents face in transporting her to her many medical appointments. To help them overcome this barrier and reduce the burden on their family, she works with the family on travel and lodging services that may be available through local community resources and provider-based organizations. In addition, Liz teaches her foster parents how to obtain reimbursement for transporting her to medical appointments when applicable.

i. Coordination of physical and behavioral health services

Our approach to the coordination of Amanda's physical health and BH services emphasizes actions taken by Liz (as Amanda's CC and by Amanda's providers.

Integrated Care Coordination: Through our integrated CCT model, Liz manages all of Amanda's services, including her physical health, BH, and social needs. If Liz requires specialized support for the management of Amanda's BH or social needs, she receives guidance from a BH-specialized Care Coordinator (CC), a Community Health Worker (CHW), or a Family and Youth Peer Support Specialist on her CCT. Liz remains Amanda's single point of contact for care coordination services, which promotes continuity of care between specialists and implant teams with various providers and reduces the burden of communication and coordination on Amanda, her foster family, and her providers.

Integrated Care at the Provider Level: Humana's commitment to integrated care extends to our provider relationships. As Amanda is engaged with various providers and has co-occurring physical health and BH needs, it is particularly crucial that her providers communicate to prevent duplication and provide consistent care messaging. Through the Medically Complex Service team and CCT, her providers collaborate on Amanda's overall care plan and IHP, inclusive of her Cardiac Care and Transplant team; BH care; and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. In addition, these teams provide an avenue for providers to stay up to date on developments in Amanda's life that should be addressed in her care (e.g., emotional trauma or open-heart surgery). For example, medications prescribed by her pediatric cardiologist or PCP may be contributing to her disruptive behaviors or lack of appetite. These forums offer an opportunity to discuss and address these issues. In addition, Liz ensures that Amanda's providers know how to access her health history, medications, care plan, assessments, gaps in care, and lab results through our provider portal, Availity, providing a complete picture of Amanda's needs across physical health and BH. We also require Amanda's BH provider to provide her PCP with a quarterly summary of services rendered to ensure consistent communication.

j. Community resources

As an integral part of our care planning process, Liz leverages the resources of the Humana Community Resource Directory (CRD), as well as her own knowledge of resources available in Eastern Kentucky (as a resident of that region herself), to identify those community supports that can help Amanda, her foster family, and her aunt achieve her goals (including permanent relative placement) and address her needs. Resources that may benefit Amanda and her foster family include:

- Organizations for children with congenital heart defects and their families: Through organizations such as Kids with Heart, Little Hearts, Inc., and Mended Little Hearts, Amanda and her foster parents can connect with families in similar situations across the country, lending support and guidance as Amanda manages her condition and prepares for her transplant.
- The Center for Courageous Kids: With the permission of Amanda's providers, Liz helps Amanda and her family apply for a summer camp experience at the Center for Courageous Kids in Scottsville, Kentucky. Whether Amanda attends alone or with her foster family, this camp can help Amanda engage in safe activities with her peers, under the supervision of staff that have been trained to care for her special needs.

k. Assistance with the Individualized Education Plan

Amanda currently receives homebound school services provided by the public school system. Liz works with her school system to evaluate Amanda for an IEP to provide additional supportive services. For example, Amanda may qualify to receive instruction in special subjects (e.g., art and music) in her home by a licensed teacher. Liz requests a copy of the completed IEP to include in Amanda's care plan to ensure coverage of school-based services during school breaks and avoid duplication of care.

If Amanda's health improves after receiving surgery or the transplant, she may re-enroll in traditional public school. At this time, Liz works with the school system to update her IEP, as appropriate, to account for any additional services that Amanda requires to attend school in-person (e.g., attending for half days).

l. Social Determinants of Health

Liz collects and shares information on Amanda's SDOH needs through the Common HRA, Pediatric Enrollee Needs Assessment; and ongoing interactions with Amanda, her foster parents, and the Medically Complex Service team/CCT. Liz captures CCT identified needs on Amanda's care plan and works with her caregivers to identify appropriate community resources that can address these needs. These include:

- Socialization: Socialization is an important element of Amanda's development and contributes to her mental well-being. However, Amanda's fatigue, tachycardia, and cyanotic episodes restrict her ability to participate in many social activities and attend traditional school. Liz works with a Humana CHW to find social opportunities for Amanda. In addition to linking Amanda with affordable art classes, music classes, or other non-strenuous activities, our CHW Worker also helps find unique enrichment opportunities for Amanda, such as working with a local movie theater to create a special screening for Amanda and her family and friends.
- Maintaining kinship connection: If Amanda expresses interest in maintaining ties with her aunt (who previously cared for her), Liz works with her DCBS SSW and foster parents to arrange opportunities for them to interact. Whether or not Amanda is ultimately able to move in with her aunt, maintaining family ties can support Amanda's well-being. If face-to-face visits are not possible due to distance or other restrictions, Liz encourages Amanda and her aunt to speak on the phone on a regular basis. To the degree it is appropriate, Amanda's aunt will be involved in care planning and meeting with Amanda's care providers to feel confident and informed about the care Amanda will require in the event she is to return to the aunt's care.
- Travel and housing support: Amanda may be required to take extended trips to Louisville or Cincinnati while she is assessed for the transplant and then, once she is listed, to wait for her new heart. Liz helps Amanda's foster parents arrange for lodging, transportation, and food coverage upon relocation, including setting up housing at a Ronald McDonald House, if possible.

m. Planned respite care

As a health plan with extensive experience serving children and adults with special healthcare needs through our Medicaid, Dual Eligible Special Needs Plans (D-SNP), dual demonstration, and Medicare plans, we recognize the importance of respite care to caregiver and Enrollee well-being. During her routine interactions with Amanda's foster parents, Liz assesses how they may best benefit from planned respite care. She coordinates with Amanda's DCBS SSW to arrange access to an approved respite care provider trained in medical respite. As Liz support all the Medically Complex-certified foster homes in this area of Kentucky, she can leverage relationships between properly trained foster homes to potentially provide respite for one another.

n. Applicable evidence-based practices

Evidence-based practices (EBP) applicable to Amanda's case include, but are not limited to:

- Parent Management Training: Parent management training recognizes the importance of empowering parents and caregivers in addressing the behavior of adolescents who display anger, irritability, and aggression. This EBP emphasizes rewarding and reinforcing positive behavior instead of punishing negative behaviors. The provision of parent management training to Amanda's foster parents can help them deal with Amanda's challenging behaviors more effectively.
- Cognitive Behavioral Therapy (CBT): CBT can help Amanda learn how her emotions, behaviors, and thoughts influence one another and how she can challenge distorted cognitions and change destructive behavior patterns.

Liz uses resources available to her including clinical consultation, Humana's **Healthwise library** of condition-specific resources and EBPs to inform management of Amanda's case. In addition, Liz encourages Amanda's caregivers to use our KidsHealth library to promote compliance with her treatment plan and self-management of her conditions. In addition, we educate Amanda's providers on these practices through interventions from

our provider-facing Quality Improvement Advisors (QIA), who visit our network PCPs and high-volume specialists each quarter.

o. Sharing and review of medical records

Humana is committing to furthering interoperability of data systems within the healthcare industry to promote better sharing of Enrollee information (in compliance with privacy requirements). We recognize the particular importance of data-sharing in cases like Amanda's, where multiple providers are involved in care. 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 Amanda's providers and her DCBS SSW access to information needed to address her clinical and non-clinical needs, including:

- Access to her care plan and assessment through Availity
- Clinical inferences and gap in care information delivered via bi-directional data feed connections with **all eight top Electronic Health Record (EHR) systems** in the country
- Proposed delivery of Amanda's care plan and assessment via a **bi-directional feed** with The Worker Information SysTem (TWIST) and with agency agreement

p. Maintenance of the care plan

As Amanda is enrolled in Complex Care Coordination, Liz updates her care plan at least monthly. In addition, she conducts a reassessment and updates the care plan, as needed, following a change in condition (e.g., after an inpatient admission) or upon request of Amanda's DCBS SSW. These care plan edits are shared with Amanda's Medically Complex Service team and CCT for their input and guidance and to ensure that all necessary orders and prescriptions are obtained. The most up-to-date care plan is available on Availity for ready access by Amanda's providers and DCBS SSW and our Voice & Choice Information Exchange care portal for Amanda and her caregivers (with DCBS SSW permission) to use. Liz also provides a printed copy of the care plan upon request.