G.10 Population Health Management and Care Coordination

REQUIREMENT: RFP Section 60.7.G.10
10. Population Health Management and Care Coordination
a. Describe plan for identifying and coordinating care for those Kentucky SKY Enrollees with the most immediate service needs leading up to and immediately following implementation of the Kentucky SKY program.
b. Describe how the Vendor would identify and monitor new Kentucky SKY Enrollees with high physical or behavioral health needs to assure continuity of care.
c. Describe how the Vendor will stratify Kentucky SKY Enrollees into tiers for Care Management services.
d. Provide a description of the Vendor's targeted evidence based approaches applicable to the Kentucky SKY populations. Provide details on the Vendor's approach for ensuring Network Providers' compliance with evidence based approaches mandated by the Vendor for Kentucky SKY Enrollees.
e. Provide a description of the Vendor's approach for ensuring Network Providers are providing Trauma-informed Care to Kentucky SKY Enrollees.
f. Describe how the Vendor will use telemedicine and telehealth to improve quality or access to physical and Behavioral Health services.
g. Describe how the Vendor will capture data related to Social Determinants of Health and incorporate this information into its Care Management approach.
h. Describe how the Vendor will coordinate with the Department, Department for Community Based Services (DCBS), Department of Juvenile Justice (DJJ), and physical and Behavioral Health Providers to assure each Provider has access to the most up-to-date medical records for Kentucky SKY Enrollees.

Molina's integrated Population Health Management Program meets SKY Enrollees and families at their point of need to provide the right types and intensity of interventions to promote resiliency, foster permanency, and improve their health outcomes.

Molina is focused on addressing the challenges faced by SKY Enrollees, their caregivers, and individuals that serve them. Our staff has been on the ground in Kentucky meeting face-to-face with Foster/adoptive parents, caregivers, and fictive kin (caregivers); Providers; advocates; and other key organizations and agencies. We conducted focus groups with Providers, Enrollees, and caregivers, in two urban (Louisville and Lexington) and two rural (Eastern and Western Kentucky) areas to better understand their needs. We listened carefully and learned what works and what matters. Some of the key themes that emerged from our discussions include the need for: care management support to assist Enrollees and caregivers in understanding available services; a centralized medical record that is readily accessible; better coordination to reduce duplication in services; and timely access to services. Molina's Population Health Management and care coordination programs include the staff, resources, and tools to address these needs.

We have already begun to partner with caregivers and Providers and look forward to collaborating with the Commonwealth and system partners such as schools, courts, law enforcement, Department of Juvenile Justice (DJJ), and Department for Community Based Services (DCBS) to create a System of Care that promotes resilience, permanency, and improved health for SKY Enrollees.

Our System of Care for the SKY program includes the following key components:

- **Trauma-informed care.** Molina's ***trauma-informed approach*** to care recognizes the impact of adverse childhood experiences (ACEs) and promotes healing and recovery. Through our *Fostering Success Academy*, Molina will bring Providers and staff together to promote widespread adoption of trauma-informed practices across our System of Care.
- **Continuity of care for Enrollees.** We will provide a Care Coordinator to serve as the Enrollee's single point of contact throughout their enrollment in the SKY program, regardless of change in placement, facilitating continuity of care for the Enrollee, DCBS Social Service Worker, caregivers, and Providers.

- **Ready access to the Enrollee's medical record.** Molina's proprietary *Health Backpack* is a cloud-based and portable electronic personal health record that is readily available to the Enrollee, caregivers, system partners, and Providers through a secure log-in. As a value-add, ***Enrollees can access their Health Backpack for five years after disenrolling from the SKY program, facilitating transition to independence for transition age youth and continuity in care for Enrollees who are adopted or return to their families.***
- **Integrated care.** Our integrated model of care addresses each Enrollee's physical, behavioral, and Social Determinants of Health needs. Molina's integrated Care Plan incorporates the care management plan, DCBS Service Plan, Integrated Health Plan (for medically complex children), Individual Education Plan, transition to adulthood plan, and other plans developed for the Enrollee. It follows the Enrollee and is accessible to all of their Providers, creating an easy to follow set of goals and interventions.
- **Close collaboration between Molina and system partners.** Molina will designate four System of Care liaisons responsible for establishing positive relationships with system partners. They will develop collaborative agreements that outline our processes for coordination, and providing training on the needs of SKY Enrollees and the SKY program. ***We will also collaborate with DCBS to co-locate some Care Coordinators in DCBS regional offices to improve care coordination for Enrollees, provide immediate screening and assessment, improve outcomes, and reduce system fragmentation.***

We know from our conversations with foster families across Kentucky that Enrollees and their caregivers need a single point of contact for their healthcare needs. All SKY Enrollees will be enrolled in care management and will receive support from a Care Coordinator with the skill and expertise to address their needs and who stays with them throughout their enrollment in SKY, facilitating continuity of care. Our Care Coordinators provide a dedicated source for coordination and facilitation of all healthcare needs (for example, coordination of annual well child visits and specialist referrals, authorizations for durable medical equipment, home healthcare, occupational therapy/physical therapy/speech therapy, and medications) and supportive services (for example, dietary services, medication therapy management for evaluation of complex medication regimens, and dispensing options). This Care Coordinator stays with the Enrollee for the duration of their time with Molina, regardless of their level of care.

As the Enrollee's needs or placement changes, our Care Coordinator will consult with internal experts and the System of Care Team to assure that the Enrollee's needs are being met while continuing to coordinate care. Maintaining a consistent point of contact for the Enrollee, caregiver, and system partners will facilitate continuity of care, promote consistency, and reduce the trauma Enrollees experience when individuals come in and out of their lives. It also enables relationship-building and continued collaboration between Molina and system partners. Molina's Care Coordinator will serve as the single point of contact, work together with the Enrollee's System of Care Team and be responsible to:

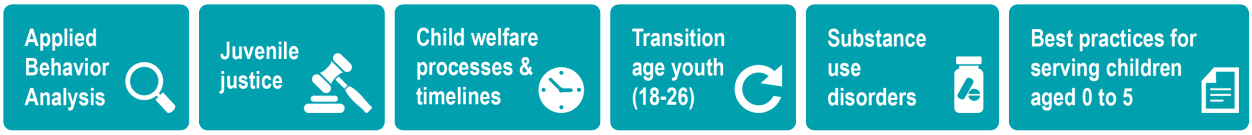
- Conduct the Enrollee Needs Assessment and reassessment annually, or when the Enrollee's health status changes.
- Collaborate with the System of Care Team to develop an ***Integrated Care Plan*** that includes the care management plan, Service Plan, and any other care or treatment plan.
- Coordinate services between Providers and systems.

Understanding Kentucky

Molina highly values Enrollee and family feedback. Recently we facilitated four discussion group sessions, capturing the voices of Medicaid recipients in both urban and rural regions of Kentucky: Louisville, Lexington, Pikeville/Auxier and Owensboro. Families in these focus groups told us that they often considered Care Coordinators their 'partners' or 'friends'. This relationship building is key to our staff's ability to quickly screen, assess and reassess foster youth.

- Review utilization data and ***conduct outreach to fill gaps in care*** or when an Enrollee experiences an emergency department (ED) visit or inpatient admission.
- ***Address social determinants of health.*** We link Enrollees and caregivers to support groups, social supports, and respite care, as well as education and vocational community-based resources. As a value-add, we will provide SKY Enrollees with duffle bags so they have something of their own and don't have to carry their belongings in garbage bags, promoting a sense of belonging.
- ***Provide education and materials on how to stay healthy.*** We provide education on and reminders for Early and Periodic Screening Diagnostic, and Treatment (EPSDT) visits. For example, through our System Navigation Guide we provide Enrollees and caregivers with a resource that outlines key milestones (such as well child visits) and important contact information for the Enrollee's PCP, dental Provider, Care Coordinator, Nurse Advice Line, Behavioral Health Services Hotline, and others. Our System Navigation Guide helps take the guesswork out of caring for a SKY Enrollee.
- Provide services and supports to ***encourage Enrollees in becoming proactive participants*** in their health and well-being and t promote healthy lifestyles. Using a High Fidelity Wraparound approach, we place the Enrollee at the center of their care to develop an integrated Care Plan based on their identified goals, strengths, and priorities.
- Provide a ***transition to adulthood plan*** and transition support for Enrollees aging out of Foster Care. Through our Transition to Adulthood assessment, we will understand the Enrollee's short and long term goals as they move toward adulthood and create a plan to support them in working toward independence.
- ***Support Enrollees during times of transition***, such as a change in placement. Our Care Coordinators will serve as the hub of communication and information-sharing for the Enrollee's System of Care. They will walk alongside Enrollee's throughout their journey, promoting consistency and continuity of care.

Based on input from foster families, we know that caregivers are looking for care coordination support and assistance with navigating the various systems involved with SKY Enrollees—healthcare, child welfare, social services, and juvenile justice. Molina's Care Coordinators will have experience with these systems or will become experts through internally developed career growth and training. We will provide specialized career tracks with opportunities for Care Coordinators to receive additional training and become experts in specific topics related to children and youth as shown below.



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These Care Coordinators will provide advanced internal support (for example, assistance with navigating the court system or school system and connecting with community-based organizations) that will ultimately improve service delivery, promote evidence-based practices, and enhance care coordination.

As shown in Exhibit G.10-1 below, our System of Care puts the Enrollee in the center of their team as a primary partner and driver of their care, in keeping with the Foster Care Bill of Rights. It brings together clinical and non-clinical staff, Providers, system partners, and natural supports to meet the Enrollee at their point of need. Our model includes the Assessment Team and Care Coordination Team per the Draft Contract. Molina will then blend those teams to create a System of Care Team that will support the Enrollee throughout their enrollment with Molina, provide close collaboration between the Enrollee's Providers and involved system partners (for example, DCBS and DJJ), and promote continuity of care.

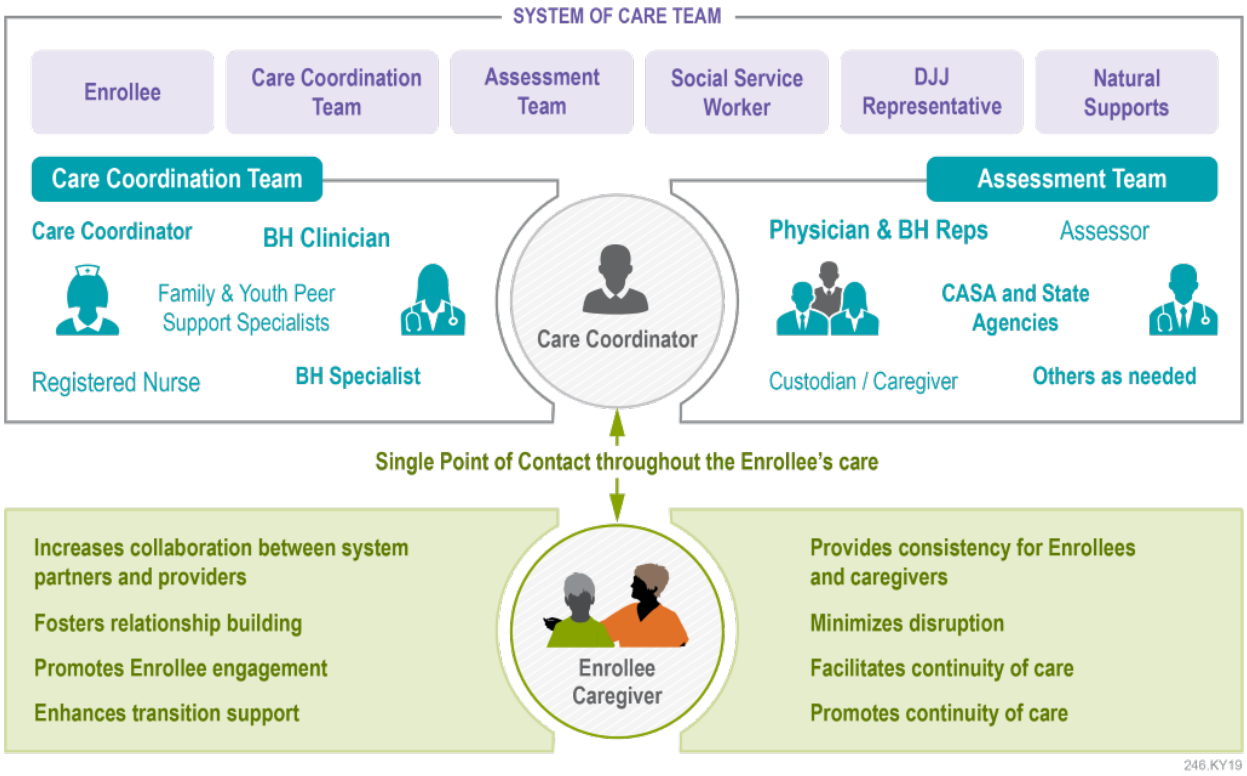


Exhibit G.10-1. Molina's System of Care Provides Wraparound Support to the Enrollee

a. COORDINATING CARE FOR ENROLLEES WITH THE MOST IMMEDIATE SERVICE NEEDS FOLLOWING IMPLEMENTATION

For SKY Enrollees with complex chronic conditions and/or behavioral health needs, a change in Providers can be a potentially overwhelming experience. Our continuity of care approach eliminates potential disruptions for Enrollees through early collaboration with system partners to gather information about Enrollees with complex conditions and immediate needs and the Providers that serve them. We will use this data to prioritize Enrollees for high touch engagement and care coordination during the transition and to bring their Providers into our network. Our processes for identifying and coordinating care for Enrollees with the most immediate service needs will begin before implementation and continue throughout the life of our Contract.

IDENTIFYING AND COORDINATING CARE FOR ENROLLEES WITH IMMEDIATE NEEDS POST-IMPLEMENTATION

Molina will collaborate with DCBS to create a process whereby the Social Services Worker can contact us 24/7 to notify us of the removal of a child or youth with significant or complex needs. Our customer service representatives will document the Enrollee's needs and information, and contact information for the DCBS Social Services Worker and placement. The call and documentation will generate an alert to our Care Coordination Team resulting in a Care Coordinator contacting the DCBS Social Services Worker within 24 hours to begin coordinating services and supports. The Care Coordinator will ask about any Providers the Enrollee is seeing and the need for durable medical equipment and medications, and will begin arranging services. If the Enrollee's need is urgent, such as the need for an asthma inhaler or critical medication, the customer service representatives will contact the on-call Care Coordinator to arrange for immediate access to those services.

We recognize that extra steps are needed to assure a seamless, successful transition between health plans for Enrollees with special needs. When receiving a transitioning Enrollee with special needs, we will reach out to the Enrollee's previous MCO to coordinate the transition and minimize potential service disruption. We will provide new Enrollees with continuity of care, transition of care and discharge planning information, emergency numbers, and instructions on how to continue services directly with us.

b. FACILITATING CONTINUITY OF CARE FOR ENROLLEES WITH HIGH PHYSICAL OR BEHAVIORAL HEALTH NEEDS

In our experience, ensuring continuity of care for Enrollees with high physical or behavioral health needs requires early identification. A primary way we will identify Enrollees with high physical or behavioral health needs is through our initial Health Risk Assessment (HRA) process that we will expedite for the SKY program. ***Our goal is to identify Enrollees' needs from day one of their enrollment.*** As it is our first interaction with new Enrollees and caregivers, we have designed our initial HRA to be a positive experience that facilitates engagement and relationship building. Upon notification of enrollment, our Care Coordinators will begin making attempts to contact the Enrollee and caregiver to complete the initial HRA within three days.

We know that caregivers and foster parents often don't receive information on the Enrollee's medical history, medications, and current treatments, making it difficult for them to complete the HRA. Therefore, our HRA will focus on identifying the Enrollee's immediate medical needs (for example, malnourishment, chronic conditions such as asthma or diabetes, and need for durable medical equipment), screening for behavioral health needs, and assessing trauma. We will gather all information from available sources to develop an understanding of the Enrollee's medical history, gaps in care, and needs. Sources include: interviews with kinship placements or family members and DCBS Social Service Workers; immunization registries; pharmacy data (for Enrollees who have had medications filled at a Molina-contracted pharmacy); claims; and utilization data from the Medicaid program if the Enrollee was previously enrolled.

We will also identify Enrollees with high physical or behavioral health needs through our initial HRA process, predictive modeling, utilization monitoring, self-referrals from youth and young adults, and referrals from their caregiver. Further, we will require primary care providers (PCPs) to assess Enrollees' needs during each visit and notify us if an Enrollee has high physical or behavioral health needs.

ENSURING CONTINUITY OF CARE FOR ENROLLEES WITH HIGH PHYSICAL OR BEHAVIORAL HEALTH NEEDS

Once we determine that an Enrollee has high physical or behavioral health needs, Molina's number one priority is to get appropriate services in place. If the Enrollee's Providers are known, we will verify they are in our network and authorize services immediately. If the Provider is not contracted with Molina, we will contact the Provider to arrange for services and complete any necessary authorizations. Regardless of whether the Provider is in or out-of-network, there will be no delay in service provision. Our provider services representative will complete all necessary steps to assure Provider payment while the Care Coordination Team simultaneously arranges for services and transportation, as needed.

We will prioritize all new Enrollees with high physical or behavioral health needs for completion of the Enrollee Needs Assessment. The Enrollee Needs Assessment plays an important role in helping us fully understand the Enrollee's needs and connect them to services quickly. Therefore, ***our goal is to complete the assessment as quickly as possible and within 14 days of enrollment for Enrollees with high physical or behavioral health needs.*** The assessment results will provide us with a more complete picture of the Enrollee's strengths and needs and inform the Care Coordination Team of any previously unidentified needs, enabling the Care Coordinator to coordinate access to appropriate services and supports.

MONITORING FOR COMPLIANCE WITH SCREENING AND ASSESSMENT TIMEFRAMES

Our Care Coordinators will document HRA and assessment results and the date of completion in Clinical Care Advance, our integrated care management system. Clinical Care Advance will flag new Enrollees and track them throughout the transition timeframe, allowing Care Coordinators to monitor due dates for screenings, assessments, creation of care/treatment plans, and Care Coordinator correspondence based on the Enrollee's eligibility date. The system will generate dashboards and provide real-time feedback on the current status of completion rates, and outstanding screenings and assessments. Using this information, Care Coordinators will prioritize screenings and assessments.

Our care management audit team and supervisors will review monthly reports to verify timeliness of completion. Supervisors will review timeliness reports weekly to validate that all Enrollees are assessed timely. Supervisors will effectively deploy resources, including additional staff or training, to assure Molina's compliance with required screening and assessment timelines.

c. STRATIFYING ENROLLEES FOR CARE MANAGEMENT

Our Population Health Program is driven by our stratification process, which enables us to develop and target individual interventions based on Enrollees' needs and circumstances. For new Enrollees, our initial risk stratification will rely on any flags in the 834 (such as a Medically Complex designation), information gleaned from the HRA, any care records we can obtain, and information from system partners (for example, DCBS, DJJ, and schools). However, we anticipate that most new Enrollees will have limited medical records and historical information. We will update our risk stratification monthly to include information we learn about the Enrollee's needs, risk levels, service utilization, and conditions.

During the transition, we will integrate historic utilization data, prior authorizations, and any clinical information received from the Commonwealth into Clinical Care Advance to get a full picture of the Enrollee's risks and needs. On an ongoing basis, we will mine data from claims, historical utilization, service authorizations, predictive modeling results, Enrollee self-report, and information provided by the System of Care Team.

Our risk stratification process regularly updates as new Enrollee information is received and our Care Coordinators will modify the types and frequency of interventions as the Enrollee moves up or down in risk level.

Exhibit G.10-2 describes our risk stratification process and care management levels.

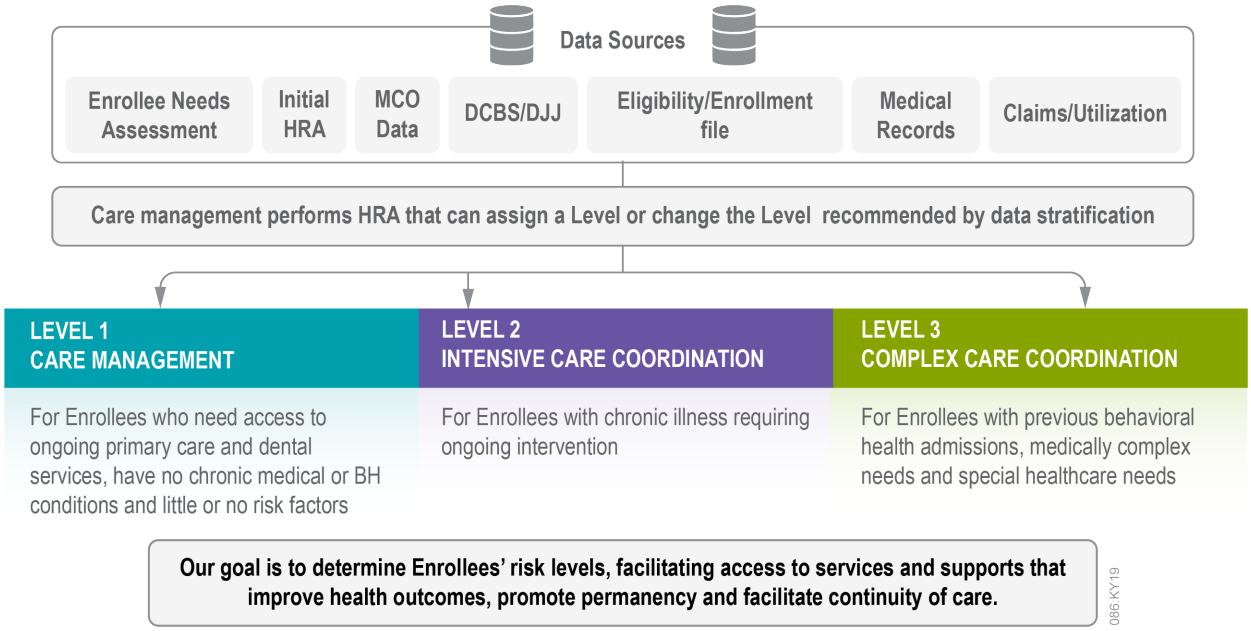


Exhibit G.10-2. Molina's Risk Stratification Process Facilitates Early Intervention

Level I – Care Management

Care Management is for Enrollees who need access to ongoing primary care and dental services, have no chronic medical or behavioral health conditions, and little or no risk factors. Enrollees receiving Care Management will receive support from a Care Coordinator who serves as a single point of contact for Enrollees, the Social Service Worker, family, and Providers that serve the Enrollee. Our Care Coordinators will work with Enrollees, caregivers, and Social Service Workers to create an integrated and coordinated System of Care that reduces duplication in services, reduces care gaps, and results in better outcomes for children, youth, and families.

Level II – Intensive Care Coordination

We provide Intensive Care Coordination for Enrollees with chronic medical needs and/or behavioral health needs that increase their risk for placement disruption or facility-based care. Our Care Coordinators will have more frequent contact with Enrollees and families participating in intensive care coordination. They will conduct monthly face-to-face visits and proactively reach out to the Enrollee and family at least weekly to inquire about the Enrollee's status, verify that services are being appropriately provided, assist the family with navigating the service delivery system, connect them to community resources and available supports, and provide education and coaching, as needed. Care Coordinators will meet with the SKY Enrollee and caregivers at least monthly and complete monthly Care Plan updates.

As Enrollees receiving Intensive Care Coordination have more complex needs, the risk of placement disruption is likely higher than Enrollees in Care Management. To promote permanence, our Care Coordinators will include a family peer support specialist and/or youth peer support specialist as part of the System of Care Team and will facilitate access to in-home supports and respite, as needed. Additionally, the team will develop a crisis plan that outlines potential triggers and specific steps the family can take if the Enrollee's medical or behavioral health symptoms escalate, indicating the potential for a crisis situation. The crisis plan will also include contact information for our Nurse Advice Line, Behavioral Health Services Hotline, Care Coordinator, Providers, and natural supports that can assist in a crisis situation. We will integrate the crisis plan into the Care Plan so that the Enrollee, family, and Providers all have access to the same information.

Level III – Complex Care Coordination

We will provide complex care coordination for Enrollees with previous inpatient behavioral health admissions, Enrollees with medically complex needs, and Enrollees with special healthcare needs that require treatment for a variety of symptoms and conditions from different healthcare Providers, often at multiple facilities. System of Care Teams will be facilitated by the Care Coordinator and include a family peer support specialist and/or a youth peer support specialist. For Enrollees with behavioral health needs, the plan will focus on positive behavior support and strategies for assisting caregivers to implement strategies. For Enrollees with developmental concerns that impact their behaviors, our Applied Behavior Analysis (ABA) specialist will assist the team in assessing the Enrollee's needs and designing interventions.

Care Coordinators for Enrollees with behavioral health needs will be trained in the High Fidelity Wraparound approach. They will have frequent contact with Enrollees and caregivers—two face-to-face visits monthly; weekly contact; a monthly meeting; and monthly Care Plan updates. They will also spend at least two hours per week coordinating care to assure proper communication between Providers and systems, and offer caregivers a single point of contact for their questions and concerns.

Our Care Coordinators will connect Enrollees with multiple conditions to the Office for Children with Special Healthcare Needs' Specialty Clinics and medical homes to reduce the trips that families have to make, decrease the number of tests and procedures Enrollees will have to undergo, increase access to care, and reduce the number of questions/paperwork as these clinics share the information between their staff. They will organize diagnostic tests and procedures in an attempt to limit the number of tests, injections, and doctors' appointments needed, reducing the amount of trauma Enrollees will experience.

Enhanced Support for Children with Medically Complex Needs

Molina will provide additional support for children with medically complex needs as identified by DCBS' Medical Support Section and in accordance with the Draft Contract. Our program for children with medically complex needs supports Enrollees determined to be medically fragile and with intensive care needs that are not easily met by existing healthcare models. In addition to meeting the requirements of the Draft Contract, our approach to supporting children with medically complex needs promotes continuity of care and avoids further trauma by leveraging the Enrollee's System of Care Team participants to coordinate and provide their medical care.

When an Enrollee is identified as having medically complex needs at enrollment, we will assign a nurse case manager as their Care Coordinator. This will facilitate consistency for the Enrollee and his/her caregiver by maintaining a single point of contact within Molina. The nurse case manager will address the Enrollee's whole health needs and reduce the trauma associated with introducing another individual to the Enrollee during a time of significant change such as removal from the home. The nurse case manager will complete all care coordination activities as well as conduct the in-home assessment.

For Enrollees determined medically complex after enrollment, we will leverage the nurse case manager on the System of Care Team to provide support to the Enrollee and caregiver, according to the Draft Contract. As an existing participant in the Enrollee's System of Care Team, the nurse case manager will be knowledgeable of the Enrollee's strengths, needs, Care Plan interventions, Providers, and overall status. The nurse case manager will provide nursing consultation services to the System of Care Team for children and youth in out of home placement, both in-state and out-of-state.

d. EVIDENCE-BASED APPROACHES

Molina's Population Health Management Program uses evidence-based assessment tools and interventions that have proven effective in supporting children and families in achieving improved health, building resilience, and promoting permanency. Our Care Coordinators will use evidence-based assessment tools to evaluate Enrollees' needs and connect them to evidence-based therapeutic interventions as shown in Table G.10-1.

Table G.10-1. Effective Evidence-based Approaches

Evidence-based Practice	Applicability to the SKY Program
Screening and Assessment Tools	
Adverse Childhood Experience (ACE) Questionnaire	10-item self-report measure identifies childhood experiences of abuse and neglect. The study posits that childhood trauma and stress early in life, apart from potentially impairing social, emotional, and cognitive development, indicates a higher risk of developing health problems in adulthood.
Ages and Stages Questionnaire (ASQ-3)	The ASQ-3 is a developmental screening tool designed for use by early educators and healthcare professionals. It is easy-to-use, family-friendly and creates the snapshot needed to catch delays and celebrate milestones. The use of the ASQ-3 will enable us to determine the specific areas in which an Enrollee experiences delays and will help us to educate caregivers on how to identify signs of developmental delays as well as milestones.
American Society of Addiction Medicine (ASAM)	Our Care Coordinators and substance use disorder navigator will use our innovative pre-screening tool, which is based on ASAM criteria to determine Enrollees' risks for substance use disorders. Using the results, they will connect Enrollees to appropriate levels of care.
Child and Adolescent Needs and Strengths (CANS)	The CANS assessment is a comprehensive trauma-informed behavioral health evaluation and communication tool. It is intended to prevent duplicate assessments, decrease unnecessary psychological testing, aid in identifying placement and treatment needs, and inform case planning decisions. The CANS assessment will provide all those involved in the Enrollee's care with a thorough understanding of his/her behavioral health needs and make recommendations for the supports and services.
Child Post Traumatic Stress Disorder Symptom Scale (CPSS)	The CPSS is used to measure posttraumatic stress disorder severity in children aged 8-18. It is a useful tool for the assessment of posttraumatic stress disorder (PTSD) severity and for the screening of PTSD diagnosis among traumatized children.
Columbia Suicide Severity Rating Scale (C-SSRS)	The C-SSRS supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Our Care Coordinators will use the C-SSRS to assess Enrollees' risks for suicide. We will also provide this tool to caregivers and train them to evaluate Enrollee's risks.
Child Trauma Screen	This screen is to determine whether the Enrollee has experienced trauma, displays symptoms related to trauma exposure, and/or should be referred for a comprehensive trauma-informed mental health assessment.
Trauma Symptom Checklist for Young Children (TSCYC)	The TSCYC is an easy-to-use instrument for assessing trauma-related symptoms in young children. The scales allow a detailed evaluation of posttraumatic stress symptoms and a tentative PTSD diagnosis, and provide information on other symptoms such as anxiety, depression, and anger. As being removed from the family home is a trauma-inducing event, this tool will assist in identifying the impact of that trauma.
Evidence-Based Treatment Approaches	
Applied Behavior Analysis	Applied Behavior Analysis is a type of therapy that focuses on improving specific behaviors, such as social skills, communication, reading, and academics as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence. Although Applied Behavior Analysis is often used for individuals with autism spectrum disorder, this evidence-based practice is also effective for individuals with intellectual and developmental disabilities. Molina will hire a Care Coordinator who is a certified Applied Behavior Analysis therapist to educate Care Coordination Teams and Providers on Applied Behavior Analysis techniques.

Evidence-based Practice	Applicability to the SKY Program
Chafee Foster Care Independence Program (CFCIP)	To promote Enrollee independence and self-sufficiency, we will connect them to local CFCIP sites. CFCIP offers assistance to help current and former Foster Care youths achieve self-sufficiency. Activities and programs include help with education, employment, financial management, housing, emotional support, and assured connections to caring adults for older youth in Foster Care. The program serves youth who are likely to remain in Foster Care until age 18, or youth who, after turning age 16, leave Foster Care for kinship guardianship or adoption.
Child-Parent Psychotherapy (CPP)	Our Care Coordinators may refer Enrollees to behavioral health services to address ACEs through CPP. CPP is a treatment for trauma-exposed children aged 0-5. CPP examines how the trauma and the caregiver's relational history affect the caregiver-child relationship and the child's developmental trajectory. Treatment also focuses on contextual factors that may affect the caregiver-child relationship
Multi-Systemic Therapy (MST)	We will refer Enrollees for MST, an intensive community-based treatment for serious juvenile offenders with possible substance abuse issues and their caregivers. The primary goals of MST are to decrease youth criminal behavior and out-of-home placements. Critical features of MST include: integration of empirically-based treatment to acknowledge a large variety of risk factors that may be influencing the behavior; rewards for positive changes in behavior and environment to ultimately empower caregivers; and many thorough quality assurance mechanisms that focus on completing objectives set in treatment.
High Fidelity Wraparound Approach	High Fidelity Wraparound is a structured, team-based process that uses an evidence-based, nationally recognized model to partner with Enrollees and families to use their voice and strengths. The goals of the High Fidelity Wraparound process include: • Creating a plan to meet the behavioral health needs prioritized by the youth and family • Improving the youth and family's ability to manage their own services and supports • Developing and strengthening the youth and family's natural social support system • Integrating the work of all child-serving systems and natural supports into one organized and effective plan
Parent-Child Interaction Therapy (PCIT)	Care Coordinators may refer children with behavioral health needs to a behavioral health Provider that offers PCIT. PCIT was developed for children ages 2 to 7 and has been shown to be effective for children who exhibit disruptive behavior or have experienced trauma, as well as those with autism spectrum disorder. This intervention teaches caregivers specific skills they can use to help improve interactions with children.
Trauma-focused Cognitive Behavior Therapy (TF-CBT)	TF-CBT is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple, and complex trauma experiences, including cutting and self-injurious behavior. TF-CBT is a structured, short-term treatment model that effectively improves a range of trauma-related outcomes in 8-25 sessions with the child/adolescent and caregiver.
Trauma-Informed Care	Trauma-informed care recognizes and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize. A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service Providers. Molina will provide ongoing training to our staff and Provider network to foster a trauma-informed System of Care.

Evidence-based Practice	Applicability to the SKY Program
Enrollee Engagement	
Motivational Interviewing	We will train our Care Coordinators to use motivational interviewing to engage with youth in Foster Care who may be ambivalent and resistance of change. Care Coordinators will leverage motivational interviewing techniques to gain a full understanding of the issues that youth face. They will prompt them to share their experiences in their own language and on their own terms, with the goal of establishing a trust relationship that forms the basis of the Enrollee's experience in care.

Promoting the Use of Evidence-based Practices

We will offer Provider training on evidence-based practices and offer resources and toolkits to assist them in adopting effective practices. Molina will implement the *Fostering Success Academy* to provide training on the SKY Program to both our staff and the SKY network Providers. Our *Fostering Success Academy* will specialize in training specific to SKY populations including ACEs, trauma-informed care, Neonatal Abstinence Syndrome (NAS), Six Seconds Emotional Intelligence, crisis intervention services, and evidence-based practices applicable the SKY population.

Our SKY training manager will oversee the Academy and will work with our System of Care liaisons and Molina trainers experienced with children and youth in Foster Care, adoption, and/or involved in the juvenile justice system. We will offer Mental Health First Aid Training and Applied Suicide Intervention Skills Training (ASIST) with opportunities for staff and Providers to become certified. Our approach includes self-paced web-based learning using live webinars delivered by Molina content experts using web-based video and audio technology, and in-person trainings conducted by dedicated clinical and nonclinical trainers as well as trainings conducted by subject matter experts on specific topics. We employ dedicated clinical and non-clinical trainers to conduct routine trainings throughout the year.

Monitoring Provider Adoption of Evidence-Based Practices

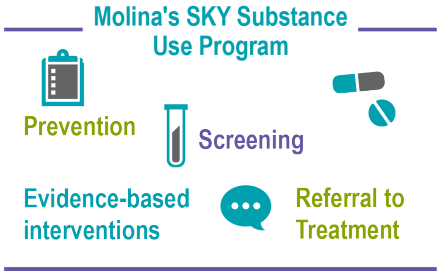
Through our Quality Management program, we will select an evidence-based practice to promote each year, such as trauma-informed care and the High Fidelity Wraparound approach. We will work with Providers to develop trainings, conduct audits to assess for the level of adherence, and implement improvement strategies. Molina's Quality department will lead regular Provider forums on topics selected through performance measures, satisfaction survey findings, and feedback. Through these forums, we will work with Providers to develop regional solutions and best practices to improve the System of Care delivery. Provider Services staff will participate in these forums to inform future Provider trainings, communications, and town hall meetings.

INNOVATIVE CARE MANAGEMENT MODELS TO SUPPORT SKY ENROLLEES AND CAREGIVERS

Molina will fully support SKY Enrollees and their caregivers through our innovative care management programs developed specifically for the SKY program. Our specific programs meet each Enrollee and caregiver at their point of need to provide the right types and intensity of interventions to promote resiliency, foster permanency, and improve Enrollee health outcomes. As described below, these interventions address substance use disorders, transition to adulthood, NAS, pregnancy, and psychotropic

medications. In collaboration with the System of Care Team, our Care Coordinators will include these specific interventions in the Enrollee's Care Plan, as appropriate.

Substance Use Disorder Program



Molina knows and understands that SKY Enrollees are at higher risk for substance use and that the substances used and reasons for their substance use differ from other populations. Adolescent substance use often includes easily accessible substances, such as tobacco, alcohol, and prescription drugs. We also know that it is often a coping mechanism due to increased ACEs, and favorable attitudes towards substances often based on their parent's substance use, limited parental supervision, and living in communities and environments where substances are easily accessible (for example, increased number of liquor stores). For SKY Enrollees, these risk factors are often elevated and without adequate protective and resiliency factors to mitigate them, such as positive parent-child relationships, meaningful community involvement, pro-social peers and supports, appropriate education on the harmful effects of substance use, and/or personal goals.

Kentucky's sociocultural context includes some of the highest rates in the United States for drug overdose fatalities among 12 to 25-year olds. Furthermore, according to Kentucky Youth Behavioral Risk Survey data[1]: 15.5 % of Kentucky youth report trying cigarettes before the age of 13 years and by age 17 this number is 41.5%. More than 17% of youth reported drinking alcohol before age 13, with 58.7% of youth reported underage drinking by age 18.Thirty-two percent of youth under age 18 report trying marijuana at least once, and nearly 1 in 6 youth reported making a suicide attempt in the past year.

Molina's model of care for SKY Enrollee's applies evidence-based practices for adolescent substance use prevention to promote protective and resiliency factors, while mitigating individual risks. We offer Kentucky an integrated approach that meets SKY Enrollees where they are and offers a comprehensive continuum of services and supports to prevent, identify, and treat substance use.

Preventing Adolescent Substance Use

Molina will implement evidence-based practices and public health strategies to prevent adolescent substance use within the SKY population, and our MCO population, including:

- **Strategic Prevention Framework.** Molina will implement the SAMHSA's Strategic Prevention Framework model to build community capacity and implement evidence-based practices in each region to address the specific-trends impacting our Enrollees. This model engages community stakeholders to: (1) conduct a needs assessment, (2) implement capacity building, (3) facilitate strategic planning, (4) implement evidence-based strategies, and (5) evaluate outcomes. We will engage the community in each of our regions and facilitate this process.
- **Public Health Education Campaign.** Molina will collaborate with the Department and other MCOs to implement an education campaign on the harmful effects of adolescent substance use that is aimed at reducing favorable attitudes towards substance use and increasing knowledge about its harmful effects. The educational campaign will include a poster series that will be distributed to Provider offices, digital communications strategies, and formal training for family/caregivers, child welfare, juvenile justice, education system, faith leaders, and community-based organizations.
- **Reduce Access to Substances.** Molina will implement a 'Lock it Up' campaign to educate and encourage parents, caregivers, Foster Parents, and extended family to lock up alcohol, tobacco, and prescription drugs to reduce access for SKY Enrollees.

[1] https://education.ky.gov/curriculum/CSH/Documents/2017KYH%20Summary%20Tables_ADA.pdf

- **Prescription Take-back Initiatives.** Molina will implement prescription take-back events no less than quarterly to encourage Enrollee's and their families to appropriate discard expired and un-wanted prescription drugs.
- **Provider Education.** Molina will promote Provider education and training on adolescent substance use—such as the American Academy of Pediatrics-endorsed buprenorphine waiver course—to expand the network of Providers that can address opioid use disorders in adolescents. Molina will also promote educational modules addressing adolescent mental health and treating adolescent Enrollees with co-occurring disorders in an integrated fashion.
- **Screen Enrollees to Identify Risk Factors.** Molina will screen SKY Enrollees using the ACE questionnaire[2] to identify risk factors for substance use. The Enrollee's System of Care Team will then implement appropriate clinical supports to address their ACEs and risk factors.
- **Increase Protective and Resiliency Factors.** The core of our model is strengthening Enrollee protective and resiliency factors. We will provide family stabilization and reunification support, engage Enrollees to promote meaningful community involvement—including participation in our Molina Youth Festival—to establish self-determined goals and provide transition to adulthood services.

We will work closely with DCBS to identify additional programs and services that can be implemented to prevent adolescent substance use in Kentucky.

Adolescent Substance Use Screening

We will collaborate with Providers to appropriately screen adolescents for behavioral health conditions, including substance use, using an evidence-based tool such as:

- **Adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT).**[3] Adolescent SBIRT is a developmentally appropriate adaption of the screening, brief intervention, and referral to treatment evidence-based practice. We will require pediatricians to use adolescent SBIRT within their practice, as indicated, to early-identify adolescent substance use and connect them to appropriate supports and services.
- **Brief Screener for Tobacco, Alcohol, and Other Drugs.**[4] This tool is an empirically validated assessment developed by the National Institute on Drug Abuse to screen adolescents for substance use and to stratify them into risk categories of: (a) no risk, (b) low risk, or (c) high risk. Providers can then appropriately refer SKY Enrollees to appropriate treatment.

Referral to Treatment

Molina will educate Providers on how to access information and make appropriate referrals to adolescent substance use Providers across Kentucky, including through:

- **Molina's Provider Directory.** Our online, publicly available directory offers Providers an easily accessible tool to search and identify local substance use Providers to connect SKY Enrollees and their families to for support.

[2] https://www.ncjfcj.org/sites/default/files/Finding%20Your%20ACE%20Score.pdf
[3] https://pediatrics.aappublications.org/content/128/5/e1330
[4] https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/screening-tools-for-adolescent-substance-use

- **Molina Mobile.** Providers, SKY Enrollees, and their families can use *Molina Mobile* to obtain information and self-refer to substance use Providers. *Molina Mobile* allows Enrollees and caregivers to search our Provider directory and filter search results based on their needs and preferences. Users can also use the app to directly connect with our SKY Enrollee Services Call Center for assistance.
- **SKY Care Coordinator.** Providers, SKY Enrollees, and their families can contact the Enrollee's assigned Care Coordinator to identify local substance use treatment resources, according to their individualized needs and preferences. The Care Coordinator will identify options for formal substance use supports, as well as community-based supports, including support groups, faith-based recovery communities, Foster Care peer support services, social determinant of health resources, and other supports available through FindHelpNowKY.

Evidence-Based Interventions

Molina promotes expanded availability of evidence-based practices to meet our Enrollee's needs where they are. We will promote and authorize the use of a full continuum of interventions, including brief and low-acuity interventions, such as motivational interviewing, over-the-counter tobacco cessation resources, and community support groups, as well as more intensive and clinical advanced methods, including:

- Outpatient substance use behavioral health treatment (for example, cognitive behavioral therapy, contingency management, and motivational enhancement therapy)
- Family-based therapies (for example, brief strategic family therapy and family behavior therapy, functional family therapy, multi-disciplinary family therapy, and multi-systemic therapy)
- Urine Drug Testing and monitoring programs
- Medication assisted treatment (for example, naltrexone and buprenorphine)
- Recovery support services: youth-led substance use support groups and 12-step program(s)
- Virtual support program to connect Enrollees to substance use Providers remotely
- Technology Assisted Care through smart phone applications (for example, True Mobile Health to offer virtual recovery coaches, a daily recovery plan, recovery support education, text messages, and GPS monitoring)
- Intensive outpatient treatment
- Residential treatment
- Inpatient treatment and detoxification
- Intensive Outpatient Programs with co-occurring competency
- Developmentally appropriate substance use disorder counseling in community settings (for example, schools and churches/synagogues)

We will work closely with the Department to further assess and define resources needed to prevent, intervene early, and treat adolescent substance use among SKY Enrollees.

Transition to Adulthood Care Management

Transition age youth in Kentucky are often in Foster Care for different reasons than their younger counterparts; including due to their own unmet behavioral needs that result in externalizing behaviors. We also know that as many as 62% of transition age youth[5] in Kentucky are reunified with their biological families; while 13% of youth ages 16-17 and 50% ages 18-21 will age out of the Foster Care system. Our enhanced model, shown in Exhibit G.10-3, offers a fully integrated approach to quickly screen and assess SKY Enrollee's needs and connects them to the right care.

Exhibit G.10-3. Molina Supports Youth in Aging Out Services to Achieve Independence in Adulthood

As described in our response to RFP Requirement G.12 Aging Out Services, we will provide transition to adulthood supports for all youth in our System of Care and will work closely with DCBS to conduct early family reunification assessments to identify Enrollees who are: (a) likely to reunify and (b) likely to age out of the Foster Care system without reunifying with their birth-family. In our experience, completing a family reunification assessment enables us to provide the right supports and services to meet each SKY Enrollee's specific, individualized needs.

Molina's System of Care Team will conduct a comprehensive assessment of each SKY Enrollees' transition to adulthood needs before their sixteenth birthday or as part of their HRA for Enrollees 16 years or older at the time of enrollment. ***Additionally, we will reassess Enrollees' transition to adulthood needs annually for the remainder of their enrollment in the SKY program.*** We will include additional assessment tools and input from additional system partners, as appropriate, such as youth that are in Foster Care, receiving special education services, and/or juvenile justice involved. These additional tools may assess the Enrollee's need for continued secondary education enrollment, recidivism risk, and other individualized needs. For Enrollees with juvenile justice involvement, we will coordinate with the DJJ Roundtable before initiating any assessments to keep them as the lead in this process.

Using the assessment results, the System of Care Team will assist transition age youth in self-directing a transition to adulthood plan that will facilitate their independence in adulthood. The transition to adulthood plan will address the following areas:

- Access to physical and behavioral health services
- Independent living skills
- Employment/vocational/education interests and supports
- Transportation needs
- Housing
- Food security
- Financial resources
- Continuity of care during the transition

[5] https://www.childtrends.org/wp-content/uploads/2017/09/Transition-Age-Youth_Kentucky.pdf

Molina's Care Coordinators will closely monitor Enrollees' transitions from the children's System of Care or juvenile justice placement. ***We will follow Enrollees until they have fully and successfully connected to their Providers in the community and adult System of Care.*** Molina knows our Enrollee's plans and needs well before they transition out of Foster Care, juvenile justice, and the SKY program because we engage early and engage often in planning their transition to adulthood. Our approach significantly reduces surprises, enabling us to adequately prepare and plan for the Enrollees' needs and preferences.

Care Management for Children with Neonatal Abstinence Syndrome

In calendar year 2016, there were 1,257 unduplicated cases of NAS reported to the Department for Public Health. This represents over 100 new cases of NAS each month in Kentucky. Over one-half (53.8%) of the mothers reported using buprenorphine by history, and 35% of mothers tested positive for buprenorphine[6]. When infants are born with drug dependence, they are at high risk for feeding and developmental issues as well as problems with learning when they reach school age. They also suffer from common symptoms of withdrawal, such as body shakes or seizures, fussiness, poor feeding, slow weight gain, hyperactivity, vomiting, and more.

Neonatal Abstinence Syndrome Program: Promoting Healthy Babies and Families

- Immediate assignment to a Registered Nurse Care Coordinator at enrollment
- Discharge planning coordination with the Neonatal Intensive Care Unit
- In-home assessment and coaching
- Caregiver education: swaddling techniques and maintaining a soothing environment
- Service connections: occupational and physical therapy, feeding, specialists, developmental pediatricians, medications and early intervention
- High frequency, high touch engagement with the child for a year post-birth or until they have achieved established developmental milestones even after the child returns home if the family selects Molina as their health plan

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When a child with NAS is enrolled in the SKY program, we will immediately assign a registered nurse (RN) as a Care Coordinator. The RN Care Coordinator will assist with discharge planning from the Neonatal Intensive Care Unit and provide ongoing support and conduct in-home visits with the child and his or her caregiver. They will connect the child to services, such as occupational and physical therapy, feeding, specialists, developmental pediatricians, and medications. The RN Care Coordinator will educate the caregiver on how to maintain a soothing environment (quiet, dimly lit room) and teach strategies such as swaddling techniques, assess the child's development and growth, and connect with early intervention services as needed. We will provide caregivers with a Guide for NAS that includes easy-to-follow tips on how to care for a child with NAS, common issues associated with NAS and available resources.

Our RN Care Coordinator will continue to be highly engaged with the child for a year post-birth or until they have achieved established developmental milestones. If the child returns to their birth parent during that time, is eligible for Medicaid MCO services, and selects Molina as their health plan, we will continue to support the child and their birth parent through our NAS program, facilitating continuity of care and improved health outcomes for the child.

[6] https://chfs.ky.gov/agencies/dph/dmch/Documents/DPHNASReport2016.pdf

Pregnancy Program

Molina's support for Enrollees begins before conception. Because our Care Coordinators walk alongside Enrollees throughout their journey, regardless of placement changes, they develop trusting relationships, facilitating open communication. In our experience, these relationships are important when discussing topics such as family planning. Care Coordinators will assist Enrollees in preparing for annual well visits by encouraging them to write down any questions they may have, including birth control and sexual health. They will provide web-based and written materials and health coaching to encourage Enrollees to be healthy before conception, promoting lifelong health.

If an Enrollee becomes pregnant, their Molina Care Coordinator will continue to support them. They will educate Enrollees and their caregivers on prenatal care, postnatal care, how to care for the baby upon delivery, and free support services. Our Care Coordinator will leverage resources available through our Moms of Molina (MOMs) program that includes counseling over the phone, educational workbooks, and other resources, including our Pregnancy and Post-partum Care Healthy Rewards incentive program.

We will link pregnant Enrollees to community programs and resources such as the Louisville Teenage Parent Program (TAPP) and the statewide Kentucky Health Access Nurturing Development Services (HANDS) program that provides in-home support services during the first two years of the baby's life. Families begin by meeting with a HANDS parent visitor who will discuss any questions or concerns about pregnancy or a baby's first years. Based on the discussion, all families will receive information and learn about resources available in the community for new parents. We will also connect soon-to-be moms to local, faith-based Pregnancy Care Centers and programs in their local communities.

Care Coordinators also link pregnant Enrollees with needed services such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for nutrition and food insecurity support and assist them in enrolling in Temporary Assistance for Needy Families. In addition, we will inform them of Head Start and Early Head Start services (services for pregnant women and families with children up to nearly five years old) and provide information on how to apply for resources that include free education for parents, daycare services, and meal programs.

We will provide new moms with discharge planning services while in the hospital delivering her baby. New moms will receive support from a nurse during the post-partum phase, as well as in-home visits through the HANDS program. We will make sure new parents have access to a safe crib, stroller, car seat, diapers, basic baby clothing, and nursing support—everything they need to keep themselves and their baby healthy at home. Molina will arrange for transportation to make sure that both mom and baby attend checkups and follow-up visits.

Psychotropic Medication Review

Almost 42% of the children in Kentucky's Foster Care system have been prescribed at least one psychotropic medication, higher than the national average of 26.6%. Molina will take steps to curb over-prescribing of psychotropic medications using best practice guidelines and rigorous monitoring and oversight of prescribing practices. Our goal is to facilitate Enrollee access to safe and appropriate medications.

We will require prior authorization for psychotropic medications prescribed to an Enrollee under the age of 18. All requests will be reviewed by a board-certified psychiatrist and must include evidence of informed consent and a description of therapeutic interventions that will be provided in addition to the medications. The psychiatrist may conduct a peer consultation to educate the requesting Provider on appropriate prescribing practices and alternative medications and services, as needed. Requests for continued authorization must include documentation of appropriate lab tests (such as metabolic screens) in the Enrollee's medical record.

Molina will monitor prescribing patterns to identify Providers that prescribe medications outside of recommended guidelines, use polypharmacy, or do not regularly complete appropriate lab tests. Specifically, we will review pharmacy claims for:

- Enrollees under 18 and on psychotropic medication exceeding recommended dosage
- Enrollees under 18 receiving two or more stimulants, antidepressants, antipsychotic medications
- Enrollees under 18 prescribed psychotropic medication without a DSM 5 diagnosis
- Enrollees aged four or under prescribed psychotropic medications, polypharmacy, concomitant prescribing, and dose in excess of FDA guidelines

These events will trigger a review of the Enrollee's clinical needs and an update to the integrated Care Plan. Our Pharmacy team will educate Providers, as appropriate, to facilitate adherence to prescribing guidelines.

e. ENSURING NETWORK PROVIDERS ARE PROVIDING TRAUMA-INFORMED CARE TO ENROLLEES

Molina takes seriously its responsibility to make sure our Provider network is applying a trauma-informed approach to serving SKY Enrollees. Children in Foster Care need to be supported using a wraparound approach practiced by Providers and caregivers who are trauma-informed and know how to address ACEs. This systemic strategy bolsters children's resilience and makes sure that services address trauma first. We will require our PCPs, specialists, and all Providers serving SKY Enrollees to participate in training on trauma-informed care and work toward incorporating trauma-informed practices in their policies and workflows. We will offer all Providers access to our *Fostering Success Academy*. This convenient and comprehensive Provider training program provides education and resources on evidence-based practices, including trauma-informed care using multiple modalities including in-person classes, personalized coaching, webinars, peer consultation, and online resources. Our dedicated SKY training manager will coordinate system-wide trainings as well as customized educational sessions for individual practices and/or Provider groups.

Through the *Fostering Success Academy,* Molina will bring Providers and staff together to promote widespread adoption of evidence-based practices across our System of Care.

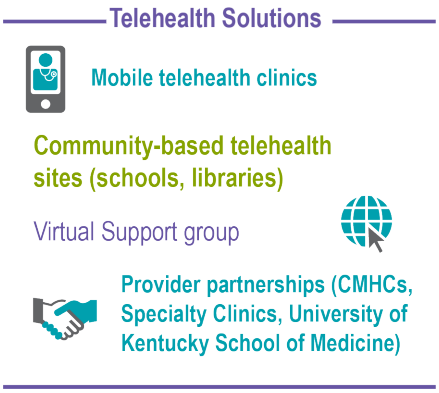
- We will seek ***Provider Champions*** willing to share best practice strategies and offer apprenticeship opportunities to Providers in the training phase, allowing trainees to observe team meetings, engagement with youth and caregivers, and interactions with other team members. In our experience, creating Provider connections to support evidence-based practices is an excellent tool for facilitating consistency in practices across Providers.
- We will participate in a ***Train the Trainer*** workshop on ACEs. This will enable us to offer monthly and on-demand trainings related to ACEs for PCPs and Providers.
- During regular interactions with Providers as part of ongoing care coordination, our ***Care Coordinators***, who will be trained in ACEs, ***will educate Providers*** on trauma-informed care strategies for serving Enrollees and incorporate trauma-informed care interventions in the Enrollee's Care Plan.
- Providers can access self-service tools such as a ***trauma-informed care toolkit*** that gives Providers practical strategies for adopting policies that support trauma-informed care.
- Through ***Learning Collaboratives*** facilitated by the SKY training manager, we will bring together Providers and Molina staff to share strategies and best practices for adopting trauma-informed practices.

We will encourage Providers to conduct an organizational assessment to determine their readiness to implement trauma-informed approaches. Our SKY training manager will connect Providers to resources, such as webinars available through the National Child Traumatic Stress Network, that can assist them in developing and adopting plans to modify their policies to adhere to trauma-informed practices.

Our goal is to make sure SKY Enrollees who have experienced trauma can actively participate in treatment delivered in a non-threatening manner by Providers that respect their needs and preferences.

f. USING TELEMEDICINE AND TELEHEALTH TO IMPROVE QUALITY AND ACCESS TO PHYSICAL AND BEHAVIORAL HEALTH SERVICES.

Molina has effectively used telehealth in other states to improve quality and Enrollee access to physical and behavioral health services. Further, In Puerto Rico, our affiliate's telehealth Provider reports that 92% of issues are resolved after the first visit and 95% of Enrollees are satisfied with the telehealth services delivered. We will leverage our experience to implement an effective telehealth program for the SKY program.



As shown in Table G.10-2, we will offer several innovations specifically for SKY Enrollees who are accustomed to using technology daily. Our offerings bring services directly to Enrollees, increasing their ability to self-manage. We make Enrollees comfortable with accessing healthcare services in readily accessible ways, increase health literacy, and give Enrollees the tools they need to lead a healthy lifestyle, setting the stage for health into adulthood. As described below, we will offer a wide range of options for telehealth services and improve quality access to physical and behavioral health services for SKY Enrollees across Kentucky, including virtual services, community-based telehealth sites, and Provider partnerships.

Table G.10-2. Molina Offers Innovative Telehealth Solutions

Virtual Services	
Virtual Support Group	Molina proposes to create a virtual support group for youth in Foster Care. Youth in the SKY program would be linked via online video conferencing to other SKY youth the same age, gender, or with similar needs (for example, behavioral health issues and teen moms) These groups will be led by a trained clinician and will offer a valuable resource and source of support for youth. This virtual networking will offer support to youth in rural areas with limited community-based resources. The group will also act as a networking base for youth as they age out of the Foster Care system, providing them with social connections with people who have similar lived experiences.
Community-based Telehealth Sites	
School-based Services	Molina proposes to partner with school-based clinics to improve access to preventive care, such as dental screenings and well child visits, for children and youth. In our experience, bringing services to schools where the children we serve spend a majority of their time, increases adherence to preventive care services and improves Enrollee and caregiver satisfaction.

Provider Partnerships	
Community Mental Health Centers (CMHCs)	Through our contracts with CMHCs across Kentucky, we offer SKY Enrollees access to a full array of psychiatric and behavioral health services offered in person and via telehealth. We will partner with CMHCs to increase their telehealth offerings by linking to other Providers that offer specialty and preventive care, expanding our network and increasing access to an integrated approach to care.
University of Kentucky College of Medicine	The University of Kentucky College of Medicine maintains telehealth clinics that offer specialty services relevant to SKY Enrollees, such as child psychiatric, pediatric endocrinology, developmental pediatrics, and others. We will work to include them in our Provider network, giving SKY Enrollees access to an available network of skilled Providers to meet their needs.
Office of Children with Special Healthcare Needs Specialty Clinics	Molina is working to contract with the Office of Children with Special Healthcare for multispecialty services available through their 11 regionally-based clinics. Through this partnership, our SKY Enrollees will have access to specialty services without having to travel to other states or nearby communities.

As a component of our value-based programs, we will encourage the use of telehealth by incentivizing Providers to establish a telehealth platform and/or designate clinic space for Enrollee consultation.

g. ADDRESSING SOCIAL DETERMINANTS OF HEALTH THROUGH OUR CARE MANAGEMENT APPROACH

We know that social determinants of health have a significant impact on how Enrollees' prioritize, engage with, and access to healthcare services. For Enrollees in Foster Care, social determinants of health play an even bigger role as they likely contributed to the child's removal from the parental home. These children have experienced abuse, household substance use disorders, and poor living conditions. They are more likely to have behavioral health disorders, developmental challenges, and chronic health conditions.

Some of the prevalent social determinants of health in Kentucky that contribute to the high rate of children in Foster Care include[7]:

- 25% of children in Kentucky live in poverty
- 96 of Kentucky's 120 counties experienced an increase in their unemployment rate
- 11 per 10,000 households (4,538 people) in Kentucky are homeless family households—sleeping outside, sleeping in emergency shelters, or staying in transitional housing programs
- 13.5% of all Kentuckians have not graduated from high school
- NAS has increased from 179 cases in 2006 to 1,092 in 2015, a more than six-fold increase
- 20% of Kentucky children are food insecure (202,050 children) and 11 Kentucky counties have childhood food insecurity rates of 30% or higher
- The Centers for Disease Control and Prevention (CDC) ranks Kentucky third overall in the number of opioid overdose deaths as of 2015

In addition to the social determinants of health that led to their removal, SKY Enrollees may experience social isolation when moved to unfamiliar settings and other regions, leaving them feeling unsupported and lonely. They may also be placed in rural areas far away from other family members and friends. Enrollees exposed to these social determinants of health experience ACEs that disrupt the safe and nurturing environments that children need to thrive, contributing to unhealthy lifestyles. To mitigate the effects of ACEs and social determinants of health Molina's approach includes gathering data to facilitate

[7] https://chfs.ky.gov/agencies/dph/Documents/StateHealthImprovementPlan20172022.pdf

early identification and incorporating interventions into our Care Management program through collaborations with community organizations.

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH

Molina will gather information on social determinants of health that directly impact individual Enrollees and address those needs through our Care Management program. Additionally, we will work to improve the health of the communities we serve by leveraging our powerful data analytics tools to assess community needs. We demonstrate our approach below.

Identifying Enrollee-specific Social Determinants of Health

For Enrollees in the SKY program, we will identify social determinants of health during the initial HRA, the Enrollee Needs Assessment, and during regular contacts with the Enrollee and caregivers. Our Care Coordinators will identify barriers to care by closely listening to the Enrollee and caregivers' needs, when conducting initial and ongoing screening and assessments, and through developing the Care Plan. We will document barriers and strategies to address them in the Care Plan. During regular interactions with Enrollees, caregivers, Providers, and partners our Care Coordinators assess the effectiveness of our strategies for addressing barriers and update the Care Plan, as needed.

Leveraging Data Analytics to Assess Community Needs

We will use our robust data analytics tools to identify community-level social determinants of health and work with community partners to solve the local issues that lead to disparities in access to healthcare services. For example, the Appalachia region in Kentucky is plagued by poverty due to a lack of employment and educational options. Housing options are limited and community members report feeling stressed and hopeless. As a result, many have adopted unhealthy coping skills such as smoking or the use of alcohol or drugs (for example, opioids) to ease the pain, leading to addiction, disability, and premature death[8].

We will use community health assessments completed by local hospitals and available data to identify the needs of the local population, their expectations about healthcare, and key drivers of satisfaction related to access and receipt of healthcare within the system and community. Our detailed analysis of the community will include stratification of analysis for specific, high-volume populations by race, ethnicity, language spoken, and high prevalence disease states in a single area. The analysis will identify specific actionable concepts that can be applied to policy and program development to enhance the delivery of high quality care in the region.

Addressing Social Determinants of Health through our Care Management Program

The Enrollee's System of Care Team will coordinate resources across community-based organizations and systems to assure Enrollees and caregivers receive the necessary supports to become healthy and well. Through relationships we have already developed in Kentucky, we will connect Enrollees to employment and vocational services, safe housing, transportation, food security organizations, financial services, and other resources they can rely on even after they are no longer eligible for the SKY program.

Molina will leverage the experience of our Ohio affiliated health plan, which also serves children in Foster Care and involved in the juvenile justice system, to offer effective programs for addressing the challenges faced by Kentuckians. Several of our initiatives in Ohio serve as a guide for us as we prepare to enter Kentucky, including:

Housing Assistance Program. We will dedicate a full-time staff position in Kentucky to a care manager who specializes in helping Enrollees resolve housing concerns. This position will provide housing-related assistance to youth participating in the Aging Out services program. As a value-add, they will support

[8] https://uknowledge.uky.edu/cgi/viewcontent.cgi?article=1209&context=frontiersinphssr

System of Care Teams if unstable housing is a barrier to family reunification. Molina's Ohio Housing Assistance Program began in May 2018. Housing specialists gather information regarding an Enrollee's current living situation, urgency of the housing need, safety concerns, income, and any barriers to housing. The housing specialist assists Enrollees with housing applications and other matters until housing is secured or rent and utility payment disputes are resolved. Our housing specialist in Kentucky will receive training on how to help Enrollees with behavioral health/substance use disorder concerns or other special needs access specialized housing assistance funds and recovery housing resources.

Family and Youth Peer Support Specialists. We employ certified peer support specialists who have real life experience in recovery from behavioral health and/or substance use disorders. In Ohio, we found that the adherence rate for outpatient appointments was 80% among those Enrollees who received assistance from a peer support specialists. These specialists are skilled in motivational interviewing and in serving as role models and inspirations for long-term recovery.

Connections to Social Supports. Molina is building a system of supports to address the isolation that SKY Enrollees may experience. We recognize that children and youth need to connect with same age peers and we offer those opportunities. For example, we will connect SKY Enrollees with an array of local community organizations, such as the Transition Age Youth Launching Realized Dreams (TAYLRD), Boys and Girls Clubs, after school programs, Head Start, and others. We will also offer a virtual support group that connects adolescents to Enrollees with similar lived experiences. Facilitated by a trained clinician, our virtual support group links peers of the same age through video conferencing, offering a valuable source of support.

Improving the Health of the Communities We Serve

Safe, stable, nurturing relationships and environments are essential to preventing child abuse and neglect. To promote relationships and environments that can help create neighborhoods and communities in which children are safe and supported, we support the Essentials for Childhood Framework. The framework has four goal areas and suggests strategies based on the best available evidence to achieve each goal. The four goal areas include:

- **Goal 1: Raise awareness and commitment to promote safe, stable, nurturing relationships and environments and prevent child abuse and neglect.** We will work alongside local community and government organizations to adopt a vision for protecting children from maltreatment. Molina will offer our expertise and resources to support a community-wide campaign to raise awareness of this vision.
- **Goal 2: Use data to inform actions.** We will leverage our data analytics tools and resources to help identify issues that contribute to disparities and share this information with our system partners.
- **Goal 3: Create the context for healthy children and families through norms change and programs.** Molina will partner with local communities and governments to provide parenting skills training and prevention supports and programs that support healthy families.
- **Goal 4: Create the context for healthy children and families through policies.** We will provide decision-makers and community leaders with information on the benefits of evidence-based strategies.

We will partner with state and local governments and community organizations to support local employment, housing, and education initiatives. We provide examples of organizations in Kentucky with whom we have developed relationships in Table G.10-3.

Table G.10-3. Molina's Community Partnerships

Organization	Program Name	Purpose
Dare to Care	Prescriptive Pantries	Health clinics will screen for food insecure individuals and families and provide food assistance boxes.
Kentucky's Heartland	Diabetic Food Boxes	Molina will provide a nutritionist to work with the food bank to design and develop diabetic meal boxes containing a variety of healthy foods commonly available through the pantries.
Family Scholar House	Healthcare Pathways	Community outreach, workshops, and other activities to help single mothers pursue careers in healthcare-related fields.
Louisville Urban League	"It Starts With Me!"	Molina Community Health Workers will engage in outreach campaign to identify and address barriers to employment in families with and social determinants of health assessment.
Boys and Girls Club	Healthy Habits	Molina will fund a program to teach young people about healthy meals and snacks through experience. Funding will also provide resources to hire part-time gardener for club garden.
Audubon Area Community Services	Pop-up Clinics	Audubon locations will be used to expand health services outside their immediate footprint. Molina's support will fund costs to operate the pop-up clinic, including supplies. Audubon will target back-to-school and other events. The program will include behavioral health screening and referrals for social determinants of health at pop-up clinics.
God's Pantry Food Bank	Pop-up Clinics Prescriptive Pantries	Pop-up clinics at distribution sites during high-demand periods when visitation is the highest as well as back-to-school events. Health clinics will screen for food insecure individuals and families and provide food assistance boxes.
United Way of Northeast Kentucky	Social Determinants of Health Assessment in Rural Areas	Molina will fund additional resources and refine outreach and assessment of social determinants of health of individuals living in rural areas, and to enhance the existing 2-1-1 program to address services needed in rural communities.

h. ENSURING EACH PROVIDER HAS ACCESS TO THE MOST UP-TO-DATE MEDICAL RECORDS FOR SKY ENROLLEES.

Molina will meet with DCBS staff quarterly to identify, discuss, and resolve any healthcare issues and needs of Molina's Kentucky SKY membership, including issues related to specialized Covered Services, community services, whether the child's current Providers are enrolled in the network, and sharing of medical records. In our meetings with Providers that serve children in Foster Care and foster families, Molina heard clearly that access to up-to-date medical records is a critical need for the SKY program. Molina listened when Foster Parents noted the difficulty they face when trying to determine what medications a child or youth may need or whether he or she is due for an appointment with a healthcare Provider, especially when a child has recently transitioned to a new placement. Lack of current medical information often leads to Enrollees receiving duplicate tests, further traumatizing them; or a lack of needed care for Enrollees with unidentified conditions. Molina offers multiple approaches and tools to facilitate access to Enrollee medical information, as described next.

Facilitating Data-sharing through Collaborative Agreements

Molina will develop Collaborative Agreements with DCBS and DJJ that include regular processes for electronically sharing data and Enrollee-specific information. We will incorporate this information into Clinical Care Advance that also houses the HRA, Enrollee Needs Assessment, and integrated Care Plan.

Encouraging Provider Participation in the Health Information Exchange

We will encourage Providers to participate in the statewide Kentucky Health Information Exchange (KHIE) so they can electronically provide us with updates on the Enrollee's status and services. Molina's HIE platform enables us to share health-related information with external entities, such as pharmacies, hospitals, and other MCOs. We also interface with required operational systems, such as KHIE, to access, inquire, and bi-directionally share information such as Enrollee eligibility and enrollment, claims and encounters data, and Provider profiles and demographic data.

Integrating Enrollee Information from System Partners

We will load Enrollee records from DCBS, DJJ, Providers, and our Care Coordinators into our Enrollee, Provider, and stakeholder portals, making it readily accessible to the caregiver, Providers, and DCBS Social Service Worker. Providers involved in the Enrollee's care can view the information, promoting care coordination and a collective focus on a single set of goals. The Molina Care Coordinator acts as the hub for this information making sure that Providers have the information they need to effectively serve Enrollees and avoid duplication of services.

Molina's Health Backpack Provides Easy Access to Enrollee's Records

Molina's System of Care recognizes the importance of providing person-centered services that are easily accessible to the Enrollee and portable based on life events. The *Health Backpack* enables caregivers, Enrollees, and system partners to access through the web or *Molina Mobile*, our mobile application, appropriate and timely information about the SKY Enrollee, including:

- **Screening and Assessment.** Results from the HRA, Enrollee Needs Assessments, and evidence-based tools such as the Trauma Symptom checklist.
- **Immunization records.**
- **Current medications and prescribers.**
- **Information regarding the Enrollee's overall health status.** Current conditions under treatment, height, weight, recent medical visits, allergies, and lab results. It provides an easy to understand glimpse of the Enrollee's current health status while also providing the ability to drill down to past utilization data.
- **Providers that serve the Enrollee and their contact information.** PCP's, specialists, dental Providers and behavioral health Providers.
- **Medications.** Active prescriptions, drug utilization, and prescribers.
- **Health alerts.** Upcoming and missed well-child screenings, upcoming medication refills and missed refills, and gaps in care.

This information will help the DCBS Social Services Worker and caregivers understand the Enrollee's current health status, medications, and other important information. Identifying the Enrollee's PCP and specialist also allows the caregiver the ability to interact with both current and past Providers to discuss issues of concern, medications, and current medical conditions. DCBS Social Services Workers and caregivers can download information from the *Health Backpack* and include it Enrollee's Medical Passport. ***Enrollees can access their Health Backpack for five years after disenrolling from the SKY program, facilitating transition to independence for transition age youth and continuity in care for Enrollees who are adopted or return to their families.*** Exhibit G.10-4 provides a sample of the *Health Backpack*.

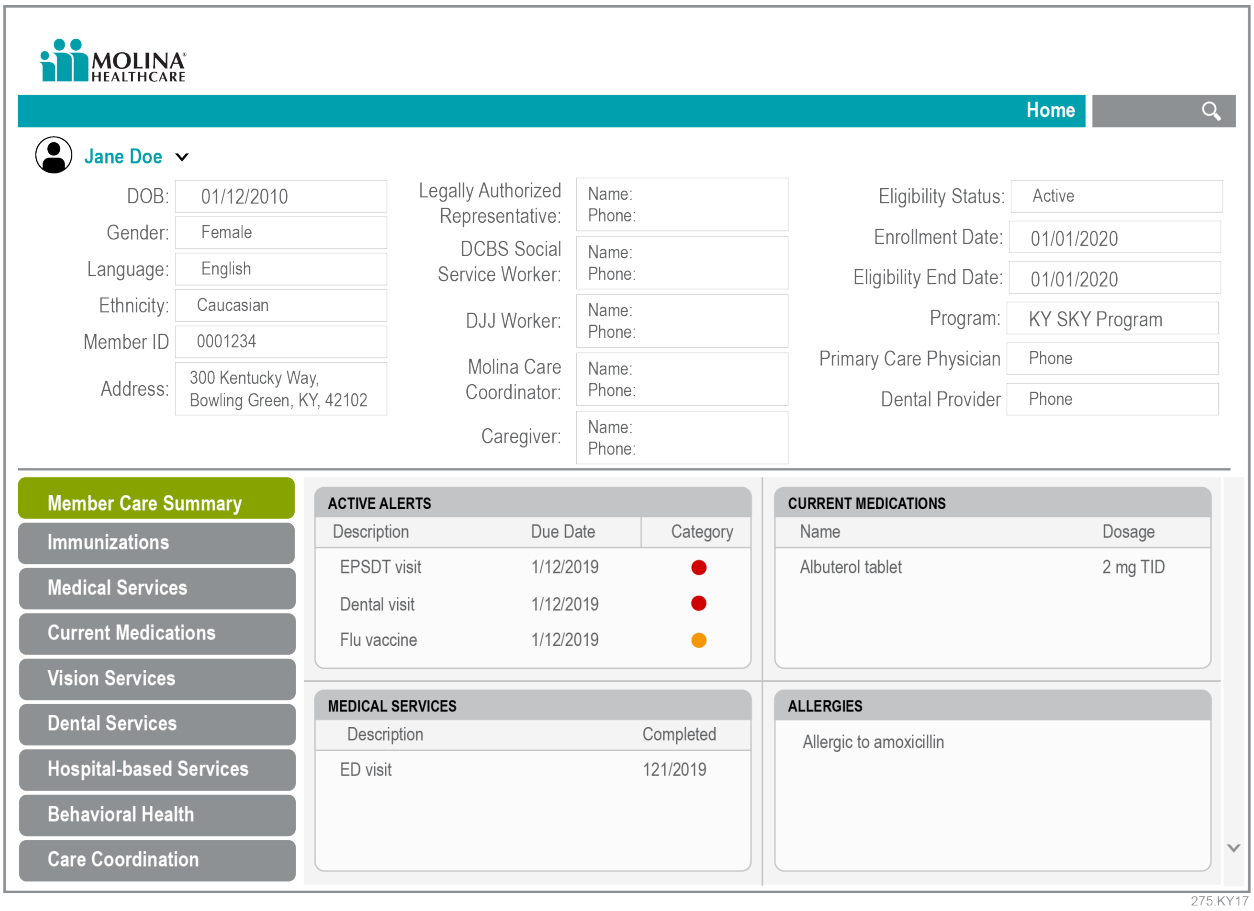


Exhibit G.10-4. Molina's Proprietary Health Backpack Offers Enrollee's Ready Access to their Medical Record

Molina's System of Care model promotes continuity of care for SKY Enrollees and caregivers. It brings together the right team members and system partners at the right time to connect Enrollees to the right services and supports to meet their needs. Our Care Coordinators walk side-by-side with Enrollees, caregivers, Providers, and system partners to facilitate access to trauma-informed approaches, evidence-based interventions, innovative programs, and community resources that lead to improved health outcomes, support resiliency, and encourage permanency.

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