G.13   Use Cases for Kentucky SKY

REQUIREMENT: RFP Section 60.7.G.13
13. Use Cases for Kentucky SKY
Submit a response to the following use cases. The Department encourages the Vendor to provide a thorough response and suggest innovative ways to fulfill the requirements of this Contract.

The use cases represent hypothetical Kentucky Enrollees, families, Providers, or entities. Responses must include, at a minimum, the program and services listed within each use case, but the Vendor is not limited to responding only to those areas. The Vendor should include any limitations or exceptions to providing the programs and services listed.

The Vendor's response may include detailed narratives, diagrams, exhibits, or detailed information specifically tailored for Kentucky SKY to demonstrate its ability to meet or exceed requirements.

Molina's trauma-informed care framework will determine the exposure to, and impact of, trauma on SKY Enrollees. Because children in Foster Care and Adoption Assistance interface with many systems and agencies, we communicate and collaborate with other systems and Providers to complement, not duplicate, efforts. *As a trauma-informed organization, Molina will support SKY contracted Providers, the professionals who serve on an Enrollee's Care Coordination Team, and our Care Coordination staff in acquiring greater awareness and knowledge of trauma.* We will assist those who serve SKY Enrollees to understand trauma's impact on children and hone the necessary skills to effectively support their recovery from trauma.

The responses that follow do not exceed six pages per use case and provide detailed descriptions of how Molina will engage SKY Enrollees and caregivers and connect them to services and supports that promote permanency, build resilience, and lead to improved health outcomes.

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USE CASE 1 FOR KENTUCKY SKY

Molina views our Providers as true partners in the healthcare system. We will work alongside these Providers to support them in adopting trauma-informed care principles, enabling them to reduce Enrollee's exposure to further trauma.

Molina is aware of the challenges that impact providers in the Eastern Mountain Service Region. Specifically, the availability of healthcare professionals in the region, include primary care providers (PCPs), mental health providers, specialty physicians, and dentists, is lower than the rest of the Commonwealth and the nation as a whole. The lack of provider resources is further exacerbated by the high rates of heart disease, cancer, chronic obstructive pulmonary disease (COPD), injury, stroke and diabetes. The rate of chronic health conditions, coupled with high rates of poverty and opioid use contribute to a healthcare system that is stressed. Hospitals and emergency departments (ED) are on the frontlines of this healthcare crisis as many individuals wait until their conditions are emergent before accessing care, particularly in areas where access to preventive care services are limited.

In our experience, overstressed providers struggle with simply treating the basic needs of Enrollees and often do not have the time or resources to apply evidence-based practices to their work. Adopting new evidence-based practices impacts Provider workflows and policies, which will need revision to adhere to best practice approaches.

Molina will work alongside the hospital and their ED staff to assist them in applying trauma-informed care principles which will lead to better care and ultimately a reduced work load as SKY Enrollees receive appropriate care, including fewer ED visits. Further, accessing the Enrollee's medical record to view test results and current medical treatments will reduce duplicate testing.

Our care coordinators will communicate regularly with the Department for Community Based Services (DCBS) Social Service Workers in Eastern Mountain Service Region. During a Care Coordination team meeting, our care coordinator will learn from the DCBS Social Worker that he/she has documented numerous examples of ED staff and physicians/office staff neglecting to conduct and document trauma assessments on children and youth, exacerbated trauma when physical assessments were performed on pre-teen girls, and not seeking medical records before ordering duplicate services.

The following response details our efforts to address these issues through our effort to build a trauma-informed infrastructure in the eastern Kentucky. Specifically, we will offer *hands-on support* and resources to assist providers in the region *in adopting evidence-based tools and practices;* demonstrate to providers how they can easily access SKY Enrollee's medical records through our cloud-based *Health Backpack;* expand our provider network in this region through *telehealth, school-based and pop-up clinics, and contracting with providers in bordering states*; connect providers to trauma-informed resources available through our *Fostering Success Academy*; conduct ongoing provider monitoring; and engage with the community to maintain ongoing dialogue about the effectiveness of our strategies.

a. EVIDENCED BASED PRACTICES AND TRAUMA-INFORMED CARE

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 incorporate trauma-informed assessments into our routine processes, including the Adverse Childhood Experiences (ACEs) Questionnaire, the Trauma Symptom Checklist for Children, and Trauma Symptom Checklist for Young Children. We recognize that ED physicians are not currently using these tools, nor have they been incorporated into their workflows. We will take a multi-pronged approach to encouraging their use:

- Molina's Medical Director contacts each provider's Medical Director to discuss the importance of using trauma-informed assessment tools and the positive impact on children in Foster Care. If the hospital agrees to pilot the use of the ACE questionnaire, our Medical Director agrees to arrange for

their physicians and staff to receive training on the use of the ACE questionnaire through our *Fostering Success Academy*. We will also offer ***Continuing Medical Education/Continuing Education units*** to encourage participation. Our Medical Director checks in with the Medical Director regularly to learn about the status of implementation and offer to conduct in-person coaching and training for ED staff.

- Molina offers to embed a care coordinator in the ED and provider offices once a week on a typically high-volume day to assist ED staff in coordinating care for SKY Enrollees. Specifically, the care coordinator will demonstrate how ***provider staff can review the Enrollee's medical record by logging into our cloud-based Health Backpack*** (discussed later), reducing duplicate testing.

- We connect providers to a local Provider Champion for Trauma-Informed Care—a provider peer we have identified as demonstrating a commitment to trauma-informed principles who mentor other providers and assist in trauma-informed care training and support. Potential Provider Champions in the Eastern Mountain Service Region include Appalachian Regional Healthcare, Baptist Healthcare, KentuckyOne Health, Precision Healthcare Delivery, and the Kentucky Primary Care Association (KPCA). In our experience, peer education is an effective tool for promoting evidence-based practices.

Molina views our providers as true partners in the healthcare system and we will assist them in delivering the best care to Enrollees.

b. UNIQUE NEEDS OF CHILDREN AND YOUTH IN FOSTER CARE

Molina understands that Foster Care placement, and the antecedents of the removal from the home, creates disruption in the natural developmental process. According to the Kentucky Department of Public Health's 2017 State Health Improvement Plan, 59% of Kentucky youth experienced some kind of ACE, which drives poor adult health outcomes. Traumatic experiences can initiate strong emotions and physical reactions that can persist long after the event. Children who experience an inability to protect themselves or who lacked protection from others to avoid the consequences of the traumatic experience may also feel overwhelmed by the intensity of physical and emotional responses.

Molina understands that poor health outcomes for children and youth are the result of the traumas they have faced, including removal from their homes, frequent placement changes, failed attachments, history and consequences of abuse and neglect, and poorly coordinated healthcare due to the loss of information about their pre-existing healthcare conditions with every new transition. Molina works to eliminate duplication of services through coordinated care and accessible medical records.

c. ACCESS TO AND SHARING OF MEDICAL RECORDS

Molina offers a comprehensive care coordination system that will contain Kentucky SKY Enrollee assessment results, Care Plans, and additional information. Social Service Workers, providers and their staff, and stakeholder organizations involved in a child's care can easily access this cloud-based medical record summary to reduce duplicate testing services. The *Health Backpack* is a cloud-based and portable electronic personal health record, with role-based access to promote both coordination of care and privacy. ***Caregivers, SKY Enrollees, and system partners can access the Health Backpack through the web or Molina Mobile, our mobile application to view appropriate and timely information about the Enrollees they serve***, including:

- **Screening and Assessment.** Results from the Health Risk Assessment (HRA), Enrollee Needs Assessments, and evidence-based tools such as the Trauma Symptom Checklist

- **Information regarding the SKY Enrollee's overall health status.** Identifies current conditions under treatment, height, weight, educational level, recent medical visits, current medications and prescribers, allergies, lab results, and immunizations records. 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.** PCPs, specialists, dental providers and behavioral health providers
- **Medications and prescriptions.** Active prescriptions, drug utilization, and prescribers
- **Health alerts.** Upcoming and missed well-child screenings, upcoming medication refills and missed refills, and gaps in care

Molina's provider services representative and our embedded care coordinator demonstrate to provider staff how to securely access an Enrollee's information through the Health Backpack. The hospital's IT department also agrees to include a link to the Health Backpack system in its electronic medical record, facilitating ease of use.

d. PROVIDER CONTRACTING

The lack of access to preventive care and alternatives to ED care contribute to the stress SKY Enrollees and their caregivers may face. Molina will alleviate this burden by offering telehealth options that SKY Enrollees and caregivers can readily access.

General Medicine. Through our parent company's national telehealth vendor, Molina will provide telehealth services to Kentucky SKY Enrollees. This partnership will be particularly beneficial to SKY Enrollees and their caregivers in regions where provider access is a challenge due to the Commonwealth's rural nature. Through Teladoc, SKY Enrollees and caregivers will have 24/7 access to services by web, phone, or Teladoc's award-winning mobile application. Teladoc's General Medical option gives SKY Enrollees' convenient access to quality healthcare when and where they need it. Telehealth services are vital to delivering integrated, whole person care to and reducing health disparities for Kentucky SKY Enrollees who live in rural, urban, or geographically isolated areas; those who face barriers to accessing care in a traditional primary care setting; or those who require specialty care that may not otherwise be readily available. Telehealth also helps eliminate costly ED visits for non-emergency conditions.

In addition to telehealth, Molina will contract with providers to bring services to the Eastern Mountain Region through school-based clinics and pop-up clinics and contract with providers in bordering states.

School-based Clinics. An important part of our network in Kentucky includes school-based services. In our experience, offering well care visits at schools where children and youth spend a large portion of their day improves health outcomes by enhancing access to important preventive care services. Through our partnership with KPCA, Enrollees will have access to their full network of school-based clinics across the Commonwealth, such as Adair County Elementary Healthy Kids Clinic, Grace CHC and SBH Bell Central School. *As a value-add, we will include telehealth services in our local Molina regional One-Stop Health Center, which we plan to locate in Hazard County.*

Pop up Clinics. Molina will partner with local SKY providers and community-based organizations in the Eastern Mountain Region to offer pop-up clinics. These pop-up clinics offer SKY Enrollees and caregivers easy access to services in their communities ranging from preventive screenings to condition-specific treatment. By bringing care closer to SKY Enrollee's homes, we can fill gaps in care; screen for medical and behavioral health needs, facilitating early intervention; and reduce caregiver stress associated with driving long distances and/or to multiple appointments.

Contracting with Providers in Bordering States. To improve access to care and alleviate the burden on local hospitals in the Eastern Mountain region, Molina's network includes key health systems in West Virginia, such as West Virginia University and Barnesville Hospitals, and we are currently negotiating with Cabell Huntington Hospital. By expanding our network into neighboring states, we will increase access to care and reduce drive times for SKY Enrollee caregivers in nearby Kentucky cities and towns.

e. PROVIDER EDUCATION AND ONGOING SUPPORT

We recognize that an effective Kentucky SKY program network requires a strong partnership and collaboration between the providers who serve the children and youth in Foster Care and Molina. We give providers the support and incentives they need to deliver flexible, trauma-informed care using evidence-

based practices and that is coordinated across physical and behavioral health providers serving Kentucky SKY Enrollees that will result in improved quality outcomes.

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 and customized educational sessions for individual practices and 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.

Molina's Fostering Success Academy offers:
- Evidence-based practice toolkits
- CEUs/CMEs
- Webinars
- Learning Collaboratives
- Personalized coaching
- Dedicated Training Manager
- In-person classes
- Peer Consultations
- Online resources

- 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, engage with youth and caregivers, and interact 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 the ***Train the Trainer*** workshop on ACEs. This will enable us to offer monthly and on-demand trainings related to ACEs for PCPs and other 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 SKY 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.

The Care Coordinator also verifies the providers are connected with the Kentucky Project Extension for Community Healthcare Outcomes (ECHO) program. Project ECHO extends specialty care knowledge into the primary care setting so that PCPs can give their Enrollees improved care in their own communities, without the need for a specialist referral. During teleECHO clinics, an interdisciplinary team of experts will videoconference with PCPs interested in learning more about a specific disease state or condition. Subject matter experts present brief didactic presentations and PCPs present cases to the specialist team and to each other, discuss new developments relating to their patients, and determine treatment. Through this case-based learning model, participants acquire new skills and knowledge that enable them to better treat their patients, improving health outcomes within the community.

f. PERFORMANCE MONITORING

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 in the Eastern Mountain Region 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 assure that 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.

g. CULTURAL COMPETENCY

Culturally sensitive trauma-informed care refers to the capacity for healthcare professionals to effectually provide trauma-informed assessment and intervention that acknowledges, respects, and integrates patients' and families' cultural values, beliefs, and practices. We train our providers to understand that families and youth may attribute distress or illness to culturally specific beliefs, may have distinct traditions for decision making and communication, and may be reluctant to seek help outside their cultural community. This is especially important in the Eastern Mountain Service Region where historically people who lived in this Appalachian region had a "closed door" culture that was fiercely independent[1]. Through our *Fostering Success Academy*, Molina provides initial and ongoing training to network providers on culturally competent responsive care.

h. COMMUNITY ENGAGEMENT

To fully understand the unique needs of providers in the Eastern Mountain Service Region and to gain a better understanding of the needs of the youth and children living in those counties, Molina scheduled a regional town hall meeting in Prestonsburg to listen to the concerns of providers, DCBS Social Services Workers, Department of Juvenile Justice (DJJ) staff, and other stakeholders. This town hall gave us an opportunity to gather direct feedback from providers, understand their perspective, offer training and information on trauma informed care, and take information back to Molina to ***develop targeted strategies to bolster trauma assessment compliance, information-sharing, and trauma informed resources*** in the eastern part of the state. Our approach to community engagement includes:

- **Caregiver Advisory Group.** Comprised of foster and kinship families, a Molina representative and a representative from DCBS, this workgroup focuses on identifying and addressing the challenges that face families that care for children in foster care. For example, the workgroup discusses ways to reduce the burden on foster families related to supporting children with complex needs that have numerous appointments or how to best serve children with behavioral health needs. To encourage participation, Molina offers childcare and tele/video-conferencing. This group meets every two months in community settings, in rotating regions of the Commonwealth.

- **System of Care Collaboration Group.** Convened by the system of care liaison, this workgroup includes participants from DJJ, DCBS, courts, Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), law enforcement, and schools to discuss ways to enhance the System of Care for children in foster care. These meetings are held monthly to facilitate a smooth transition and rapidly identify systemic issues are being identified and rapidly resolved. The Workgroup recommends trainings, policy changes, system-wide improvement projects, or initiatives to facilitate coordination between the systems, improving efficiency and quality of care. Our System of Care Collaboration Workgroup serves as a good resource for identifying network gaps, including the need for specialists, specifically in the Eastern Mountain Service Region.

Through Molina's comprehensive approach to building a trauma-informed system of care in Kentucky, we enhance the region's ability to support children and youth with trauma and ACEs. Our provider education strategy, which includes the *Fostering Success Academy*, town halls, live and web-based trainings, Toolkits, and informal education opportunities give providers the resources they need to provide effective care in a trauma-informed manner.

In the months following this coordinated effort, Molina tracked decreased incidences of duplicate tests and services being ordered and an increase amounting to trauma assessments conducted on SKY Enrollees. care coordinators reported fewer incidences of providers re-traumatizing SKY Enrollees during appointments, which they attributed to trauma-informed cultural competency training.

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[1] https://docs.lib.purdue.edu/cgi/viewcontent.cgi?article=1484&context=eandc

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USE CASE 2 FOR KENTUCKY SKY

Kimberly, 15 years old, Liberty, Kentucky

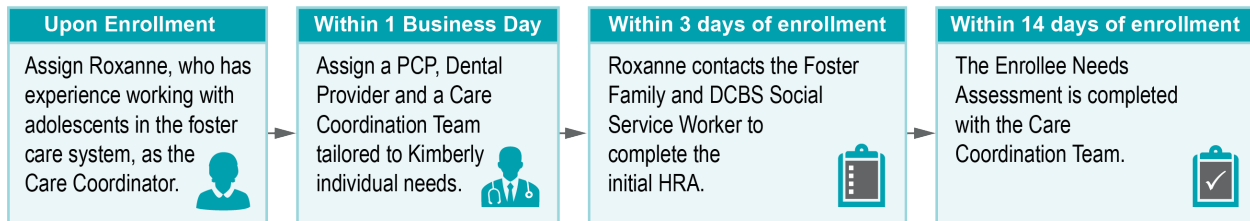| Care Management	Challenges
Level III, Complex Care Management	Multiple placements, behavior issues at school, suicidal thoughts and actions

Kimberly has a history of abuse, neglect, and complex trauma stemming from her family experience that has deteriorated her natural support system. Yet, despite her adverse childhood experiences, she has demonstrated significant resilience, empathy as a caregiver for her younger siblings, and resourcefulness to seek help from her neighbors. Kimberly's experience not only includes trauma but significant loss, grief, and bereavement as she has now become disconnected from her siblings and familiar environments. Molina acknowledges Kimberly's strengths, despite the obstacles she has faced and will engage Kimberly to mitigate her externalizing behaviors, self-injury, and suicide ideation through appropriate pharmacological and therapeutic supports. We will support Kimberly through primary care and family planning services as well as evidence-based trauma therapies to address her past experiences. Based on available information, we will provide Kimberly with Complex Care Coordination services.
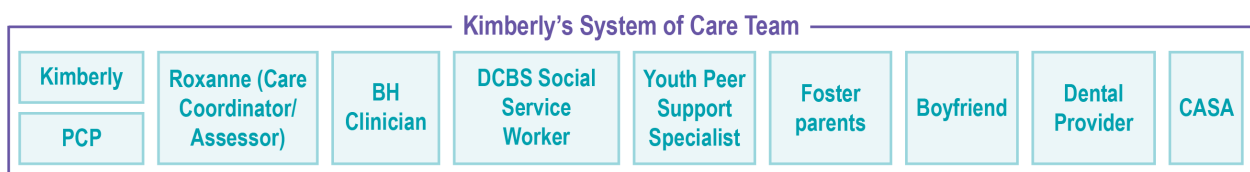
a. CARE MANAGEMENT

Molina's comprehensive and person-centered approach to care coordination will support Kimberly to assess her physical, behavioral health, and social determinant of health needs and connect her to the right services to help her achieve her self-directed goals. As shown in Exhibit G.13-1, we begin to serve Kimberly immediately upon enrollment to quickly understand her needs and provide support.

Upon Enrollment	Within 1 Business Day	Within 3 days of enrollment	Within 14 days of enrollment
Assign Roxanne, who has experience working with adolescents in the foster care system, as the Care Coordinator.	Assign a PCP, Dental Provider and a Care Coordination Team tailored to Kimberly individual needs.	Roxanne contacts the Foster Family and DCBS Social Service Worker to complete the initial HRA.	The Enrollee Needs Assessment is completed with the Care Coordination Team.

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Exhibit G.13-1. Molina Expedites Engagement to Quickly Meet Kimberly's Needs

When our care coordinator Roxanne receives notification that she is assigned to support Kimberly, she contacts the DCBS Social Service Worker and Kimberly's Foster Parents to learn about her admission. She then immediately contacts the hospital to schedule time to meet with Kimberly. Roxanne understands that Kimberly has experienced significant trauma in her life, has not experienced permanency, and is likely anxious about the potential for another placement move. When Roxanne visits Kimberly, she explains her role and that she will support Kimberly no matter her level or care, placement changes, or if she is moved to a different service region. Kimberly expresses that she doesn't feel she belongs anywhere, and she's tired of being moved around. Roxanne and Kimberly talk about who is important to her and who Kimberly would like to participate in her System of Care team. As Kimberly feels as though her boyfriend is the only person that understands her, she asks that he be part of her team. She also would like to have a youth peer support specialist as someone who has "been there" to talk to; but, she is not ready to include her mother. Kimberly's team includes:

Kimberly's System of Care Team

Kimberly	Roxanne (Care Coordinator/ Assessor)	BH Clinician	DCBS Social Service Worker	Youth Peer Support Specialist	Foster parents	Boyfriend	Dental Provider	CASA
PCP								

Understanding Kimberly's Strengths, Needs, and Priorities

While visiting Kimberly in the hospital, Roxanne completed a HRA, noting the traumatic events that Kimberly has experienced and behavioral health needs as well as the resilience she has displayed. As Kimberly has "told her story" many times during her journey, Roxanne attempts to complete as much of the SKY Enrollee Needs Assessment as possible before meeting with her again. Specifically, Roxanne gathers available information—hospital records, information from the DCBS Social Service Worker, PCP, foster family, historic utilization data, and the HRA results to complete the SKY Enrollee Needs Assessment, which includes the Child and Adolescent Strengths and Needs (CANS) assessment, Columbia Suicide Severity Rating Screen (CSSRS), and Trauma Symptom Checklist for Children.

Roxanne visits Kimberly again in the hospital with her foster family and DCBS Social Services Worker to complete the remaining questions on the SKY Enrollee Needs Assessment, discuss discharge planning, and talk about Kimberly's priorities. During the meeting, Kimberly's foster family states they enjoy having Kimberly in their home as she can be very funny and is kind to the other children in the home; however, they also express concern that they may not find Kimberly in time if she attempts suicide again and that her suicide attempt was traumatic for the other children. Kimberly feels badly that she upset the other children—she was upset at the time and didn't consider the effect of her actions on them. She states that she would like to stay with the foster family and agrees to a safety assessment. Roxanne reports that the results of the CSSRS indicate that Kimberly is not currently having suicidal ideation. The foster family agrees to continue serving her if she gets "the help she needs" and they receive some support. The team develops the following plans for Kimberly's discharge:

- Roxanne arranges for Kimberly to receive a full behavioral health assessment and follow-up services through The Adanta Group Community Mental Health Center (CMHC). The Adanta Group provides telepsychiatry services, trauma therapy, and cognitive behavioral therapy (CBT); provides outpatient psychiatric services; and offers a mobile crisis team that can meet with Kimberly in the community.
- Roxanne schedules a follow-up visit with Kimberly's pediatrician and arranges to share Kimberly's medical records with the CMHC.
- Roxanne connects Kimberly to youth peer supports that engage with her daily after her discharge.
- The DCBS Social Service Worker contacts the school to schedule an evaluation and subsequently develop an Individualized Education Plan (IEP) upon Kimberly's discharge.
- The team develops a crisis plan that identifies the symptoms that may indicate Kimberly is experiencing increased symptoms—withdrawing from the family, expressing negative things about herself, anger, or hostility—actions they can take before the situation it becomes a crisis, the number for Molina's behavioral health hotline, which can connect them to a mobile crisis team.
- Roxanne contacts The Adanta Group CMHC, which agrees to conduct daily outreach and send a weekly mobile team to check on Kimberly and coach her foster family on how to support her.
- Roxanne arranges for Kimberly's medications to be available at discharge and makes sure the foster family and Kimberly understand their purpose and how to take them.

Roxanne checks in daily with Kimberly and her foster family and confirms that they can have eyes on her continuously for at least 48 hours post-discharge. In addition, Roxanne arranges to Kimberly to talk with her siblings daily through video conferencing as that was important to Kimberly. Kimberly reports that this familial connection will significantly help her desire to get better.

Developing Kimberly's Person-Centered Care Plan

Within seven days after Kimberly's discharge, the System of Care team collaborates to develop Kimberly's integrated Care Plan. The team uses High Fidelity Wraparound principles to engage Kimberly, encouraging her to identify her own needs, goals, and preferences and to start to take greater responsibility for her own physical health, behavioral health, and vocational and educational goals. Based on Kimberly's self-identified goals, the System of Care team identifies the following interventions.

Kimberly's Goals	Care Plan Interventions
I want to stop feeling so sad and hurting myself.	• Roxanne coordinates a follow-up visit with Kimberly's pediatrician and child psychiatrist to monitor her antidepressant medications. • Roxanne immediately connects Kimberly with her tele-behavioral health therapist at The Adanta Group CMHC. • Kimberly's youth peer support specialist will connect with her daily for the first two weeks post-discharge. • Roxanne checks in daily with Kimberly and her foster family, and confirms that they will be able to have eyes on her continuously for at least 48 hours post-discharge.
I want to do better in school.	• Roxanne and the DCBS Social Service Worker coordinate with Kimberly's school counselor to identify strategies to support Kimberly educationally. • Roxanne explores with Kimberly and the school counselor the option for her to attend an on-line school or a combination of traditional school with online options. • Roxanne and the DCBS Social Service Worker coordinate to see what supports the foster family need at home to help address her repeated absences.
I want to have friends.	• Roxanne links Kimberly and her foster family to *The Sapling Center*, a local youth drop-in program in Georgetown. • Roxanne arranges for Molina's non-emergency transportation value added benefit to transport Kimberly to *The Sapling Center*. • Roxanne connects Kimberly to Molina's virtual support group, so she can interact with peers from across Kentucky who have similar experiences.
I want to spend time with my family.	• Roxanne arranges for Kimberly to talk with her siblings through videoconferencing. • The System of Care team conducts a family reunification assessment to determine the supports necessary for reunification. • The DCBS Social Service Worker arranges for in-person supervised visitation and family reunification supports. • Kimberly agrees to have her mom participate in Trauma Focused Cognitive Behavior Therapy sessions provided by The Adanta Group via telehealth
I don't want to get pregnant.	Roxanne helps to schedule a PCP appointment to discuss long-acting reversible contraception and make sure that Kimberly is up to date on all EPSDT (EPSDT) services.

The System of Care team also discusses a possible placement change for Kimberly that would put her closer to her mother and siblings once she is stable. Kimberly states she's not yet ready to make a move and would like to stay in her current placement but is willing to consider it in the future. Roxanne coordinates Kimberly's healthcare services and works in concert with the System of Care team to increase Kimberly's sense of control over her life and ability to self-manage.

Educational and Vocational Services. The school determines Kimberly is eligible for an IEP due to her behavioral health needs. They connect Kimberly to an online program overseen by a teacher who provides one-to-one support. This allows Kimberly to stay on track with her schooling while focusing on getting well and stabilizing her behavior. As part of Kimberly's transition to adulthood assessment, Roxanne initiates discussions with Kimberly about her vocational goals and will incorporate strategies for meeting them in the transition to adulthood plan.

Peer Support Services. Molina's youth peer support specialist provides mentoring and coaching to help Kimberly cope with her depression and suicidal ideation and actions. We also link Kimberly to our virtual support group for adolescents, which links her to peers of the same age, gender, or with similar needs (for example, behavioral health issues, teen moms, etc.) via online video conferencing. These groups are led by a trained clinician and offer a valuable resource and source of support for Kimberly.

Transition to Adulthood. Before Kimberly's 16th birthday we will engage her in a transition to adulthood assessment to explore her interests and goals for her future. As part of this process, we will conduct a family reunification assessment to identify if Kimberly is: (a) likely to reunify or (b) likely to age out of the foster care system without reunifying. Based on her assessments, we will help Kimberly identify services and supports for life skills, vocation, education, housing, transportation, food security, and other social determinant of health needs to prepare her to achieve independence in adulthood.

PCP and Family Planning Services. In addition to completing EPSDT screens, Kimberly's PCP will discuss with her long-acting reversible contraception (if she is using another type of birth control now) and will screen for sexually transmitted infections.

Behavioral Health Services. The Adanta Group provides medication management, trauma-focused cognitive behavioral therapy (TF-CBT), and mobile team services.

Foster Family Support. Based on the family's request, Roxanne invites a family peer support specialist to participate on her System of Care team. They check in with the foster family weekly and provide coaching and resources, such as information on local trainings and online materials.

b. DISCHARGING PLANNING BETWEEN LEVELS OF CARE

We implement our discharge planning process, a core clinical competency, as soon as we are notified of Kimberly's inpatient admission. Roxanne consults with Roxanne, and the hospital's discharge planner to ensure that Kimberly has the needed supports to return home instead of a residential care facility. During the discharge planning process and to help Kimberly get the level of care she needs, the System of Care team identifies alternatives to residential care given the lack of available beds. Roxanne confirms with Kimberly's foster family that they will accept her back into their home with additional supports and resources. She also convenes the System of Care team to create a crisis safety plan that outlines specific actions the foster family can take to avoid crisis situations and available resources and supports if a crisis happens. Roxanne integrates the crisis safety plan into Kimberly's comprehensive Care Plan.

c. NETWORK ADEQUACY AND AVAILABILITY OF SERVICES

Distance to providers is an issue for this family and has posed a barrier to accessing services. To assure that Kimberly has access to services, we connect her to The Adanta Group CMHC, which offers services via telehealth and also agrees to send a mobile team to Kimberly's home for routine checks and in crisis situations. When Kimberly stabilizes, it is possible for her PCP to monitor her medications. We will connect the PCP to peer consultation services to enhance their capacity and willingness to serve Kimberly. The availability of residential services is a network gap that Molina will address. Our care coordinator will notify our provider contracting staff of the need for this level of care. They will contact exiting residential treatment centers to gauge their interest in expanding capacity or open new facilities.

d. TELEHEALTH FOR BEHAVIORAL HEALTHCARE SERVICES

Because Kimberly lives more than 45 minutes from a behavioral health specialist, Roxanne links Kimberly and her foster family to a behavioral health specialist through The Adanta Group's telepsychiatry program. ***We will also offer a virtual support group for SKY Enrollees to connect with other SKY Enrollees through web-based platforms.*** The family can also access urgent care services through our virtual urgent care network, including may receive triage, diagnosis, and treatment for common conditions.

e. APPLICABLE EVIDENCE BASED PRACTICES

Based on Kimberly's complex needs, we link her to services and supports based on the following evidence-based practices.

High Fidelity Wraparound Approach	
Description	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 to develop a family-driven plan that promotes self-advocacy. The Enrollee and family's self-identified goals are integrated into a single Care Plan that includes natural supports and services provided through all child-serving systems.
Applicability to Kimberly	• As Kimberly is nearing adulthood, placing her in the driver's seat of her own care is an important step for her to learn self-management. • The System of Care team will collaborate with Kimberly, her Social Service Worker, caregivers, Providers and natural family to create a Care Plan based on Kimberly's self-identified goals and priorities. • Her ongoing System of Care team will provide coaching and education to improve Kimberly's ability to self-manage; connect her to community-based resources; and integrate all services and supports into her Care Plan.
Expected Outcomes	Kimberly will develop appropriate coping skills and learn to manage her services and supports and develop an effective support system as she moves toward adulthood.
John Chafee Independence Program (Chafee Program)	
Description	The Chafee Program assists youth that are currently or formerly in Foster Care to 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 is intended to serve youth who are likely to remain in Foster Care until age 18, youth who, after attaining 16 years of age, have left Foster Care for kinship guardianship or adoption. The Family Preservation Act extends eligibility for these services until age 23.
Applicability to Kimberly	To promote Kimberly's independence and self-sufficiency, Roxanne coordinates with the Independent Living Coordinator to refer Kimberly to the Chafee program.
Expected Outcomes	Kimberly will learn independent living skills to support her successful transition to adulthood.
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	
Description	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.
Applicability to Kimberly	Kimberly receives behavioral health services from a clinician trained in TF-CBT.
Expected Outcomes	Kimberly will learn ways to identify and manage the symptoms of trauma she has experienced and develop strategies for expressing herself.

f. PRESCRIBING PSYCHOTROPIC MEDICATIONS

Any psychotropic medications prescribed for Kimberly must be prior authorized by Molina's internal board-certified child psychiatrist. Our prior authorization psychiatrist will require Kimberly's prescribing provider to document the expected outcome as well as the therapeutic behavioral health services that will be provided in addition to medications. Further, the prescribing provider must document completion of appropriate lab tests when submitting requests for continued authorization. Through these processes, *we will make sure that Kimberly's medication therapies are safe and effective in meeting her needs.*

We measure Kimberly's success on psychotropic medications through concurrent review of her utilization and continued symptoms. Roxanne monitors Kimberly's progress through a minimum of two face-to-face visits, one weekly contact, a monthly meeting with Kimberly and her caregivers and one Care Plan update; and recommends updates or changes to her medication based on clinical presentation and

symptoms. Roxanne reviews claims data and checks in with Kimberly's foster family to confirm she is attending appointments with her PCP and behavioral health provider.

g. COORDINATION OF TRANSPORTATION

Roxanne confirms that Kimberly's caregivers have reliable transportation (a family car) but that getting Kimberly to behavioral health service appointments proves challenging because the provider is 45 minutes away from their home. Roxanne links Kimberly to telehealth services, alleviating the need for the family to drive such a long distance. If transportation becomes a need in the future, Molina will coordinate non-emergency transportation services. Kimberly's DCBS Social Service Worker will arrange for transportation to visits with her mother and her siblings to support reunification efforts.

h. PROVIDER CONTRACTING

Due to Kimberly's geographic location, access to services is a challenge. To make sure she receives the services she needs, we offer behavioral health services via telehealth. If she has limited access to PCP or specialty care, our provider contracting staff contacts all providers in her region to establish agreements, including providers in adjacent states and out-of network providers.

i. PROVIDER EDUCATION AND SUPPORT

Roxanne educates Kimberly's PCP on availability of behavioral health services, community resources in the area, and encourages her to connect Kimberly to services. She also shares information about our *Fostering Success Academy,* which provides information on trauma-informed care and resources for children involved in SKY program. The System of Care team educates Kimberly's behavioral health clinician, PCP, and any other community-based providers on Kimberly's specific needs, history of ACEs, need for continuity of care, and short- and long-term goals. If Kimberly's PCP is uncomfortable serving her due to her recent suicide attempt, we will connect the PCP to a peer consultation with a child psychiatrist.

j. ACCESS TO AND SHARING OF MEDICAL RECORDS

The System of Care team can view Kimberly's assessments and Care Plan via the ***Health Backpack, a digital, cloud-based personal health record that travels with Kimberly throughout her Foster Care journey,*** promoting care coordination and a collective focus on a single set of goals. Roxanne acts as the hub for this information, ensuring providers have the information they need to effectively serve Kimberly and avoid duplication of services. ***Kimberly can access her Health Backpack for five years after she exits the SKY program.*** Her foster family can print information to include in her Medical Passport.

k. MAINTENANCE OF THE CARE PLAN

Roxanne monitors, follows-up, and evaluates the effectiveness of the services provided on an ongoing basis by telephonic and/or face-to-face interventions with Kimberly and her foster family. She works in concert with Kimberly's DCBS Social Services Worker to confirm that services Kimberly receives are not duplicated and that the Service Plan, the school's education plan and any other plan of care from other organizations are coordinated and incorporated in one single Care Plan, per a High Fidelity Wraparound Approach. Kimberly's Care Plan will be available to the System of Care through our *Health Backpack*—a digital, cloud-based personal health record that travels with Kimberly throughout her journey. She can continue to access her medical records for five years after disenrollment from the SKY program. We will also connect Kimberly to the Kentucky Resources for Independence, Success and Empowerment (RISE) Web portal so she can access her records, such as a birth certificate.

Expected Outcomes for Kimberly
In alignment with her stated goals and objectives listed in her care plan, Kimberly is reporting fewer depressive feelings and has had no suicidal ideation for three months. Her acting out behaviors decreased at school. Her interactions with her biological mother have becomes less strained and Kimberly has hope that one day she can return home to be with her siblings. Kimberly's foster family has increased confidence in caring for Kimberly and reports that the telemedicine solution for Kimberly's behavioral health needs have been beneficial for both Kimberly and her foster family. She has made several friends at The Sapling Center, which she visits once a month and talks regularly with her youth peer support specialist.

USE CASE 3 FOR KENTUCKY SKY

Shakira, 16 years old, Bowling Green, Kentucky

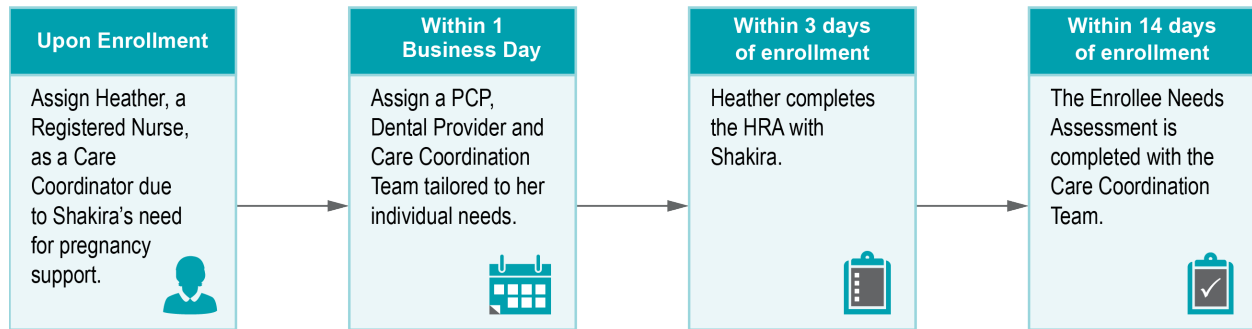| **Care Management**	**Challenges**
Level II, Intensive Care Coordination	Grief from the loss of her grandmother, depression, an unplanned pregnancy and increasing difficulty at school

Shakira has experienced significant loss and trauma. She has lost her grandmother, has been abandoned by her baby's father, been uprooted from her home, and is now suffering depression resulting in difficulty at school. Molina will offer her services that promote continuity of care and stability and that are designed specifically for youth with Shakira's needs. Based on all available information, we identify Shakira as needing Intensive Care Coordination.

a. CARE MANAGEMENT

Molina is highly qualified to support Shakira and her baby through our integrated System of Care. Together with our system partners, we deliver whole-person care through care coordination—facilitating and coordinating the delivery of services to meet Shakira's physical, behavioral health, social determinants of health, and transition to adulthood needs. As shown in Exhibit G.13-2, our process for serving Shakira begins immediately upon enrollment so we can quickly connect her to services and supports such as prenatal care.
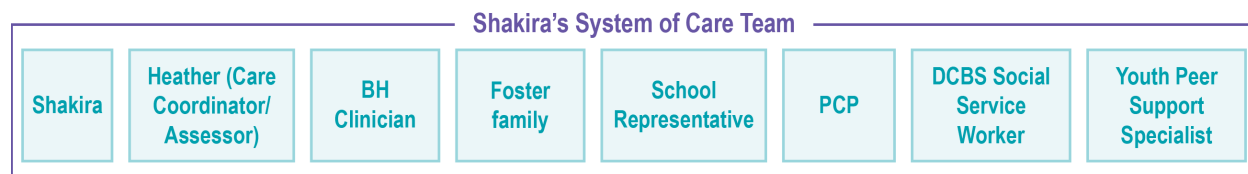
Upon Enrollment	**Within 1 Business Day**	**Within 3 days of enrollment**	**Within 14 days of enrollment**
Assign Heather, a Registered Nurse, as a Care Coordinator due to Shakira's need for pregnancy support.	Assign a PCP, Dental Provider and Care Coordination Team tailored to her individual needs.	Heather completes the HRA with Shakira.	The Enrollee Needs Assessment is completed with the Care Coordination Team.

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Exhibit G.13-2. Molina's Expedited Engagement Process

The enrollment file identifies that Shakira is pregnant, so we assign Heather, who is a registered nurse and has experience working with young mothers, as her care coordinator. Heather knows the importance of prenatal care so she quickly contacts Shakira's DCBS Social Service Worker to learn more about Shakira and begin to coordinate care. When hearing about the losses Shakira has experienced and the trauma of finding her grandmother dead, Heather gains an understanding of the challenges Shakira has faced. Heather contacts Shakira to introduce herself and learn more about her priorities by completing the Health Risk Assessment (HRA). She is careful to let Shakira guide the discussion to avoid further traumatizing her by making her retell her story.

Shakira is clear that she wants to keep her baby as she feels the baby is the only family she has left. She's upset that her boyfriend does not want to be involved and hopes that will change. Shakira reports that she's been accessing prenatal care and would like to continue seeing her OB/GYN. Heather confirms that her OB/GYN has been assigned as her PCP. Before ending the call, Heather discusses with Shakira who she would like on her System of Care team. Shakira feels like her foster family is a primary source of support although she has developed a positive relationship with her Court Appointed Special Advocate (CASA) who checks in on her and has supported her decision to keep her baby. Heather explains that Shakira can access youth peer support services and she agrees to include them on her System of Care team. Shakira reports feeling lonely as, since her boyfriend is no longer in the picture and she moved away from her friends, she doesn't have anyone her age with whom to socialize.

Shakira's System of Care Team

Shakira	Heather (Care Coordinator/ Assessor)	BH Clinician	Foster family	School Representative	PCP	DCBS Social Service Worker	Youth Peer Support Specialist

Before completing the SKY Enrollee Needs Assessment, Heather reviews Shakira's school records, DCBS assessments and Service Plan, and medical records so she can complete much of the assessment before the meeting. ***Heather meets with Shakira's foster family, Shakira, and the DCBS Social Service Worker in Shakira's home to assess her priorities, strengths and needs, and readiness to transition to adulthood.*** During the meeting, Heather notes that Shakira is comfortable expressing herself, makes healthy choices for herself and her baby (tries to eat healthy, doesn't smoke), is eager to learn how to care for her baby, and is respectful to her foster family. The foster family expresses their concerns about her behavior, which makes Shakira upset. Heather educates the family on the effects of the trauma that Shakira has experienced and explains how they can better support her by making her feel more in charge of her life and focusing on her strengths. Shakira feels like Heather is "on her side", strengthening that relationship. The foster family was unaware that Shakira's behaviors were trauma-related and appreciated learning how they can better help Shakira.

Heather documents the assessment in our comprehensive care management system, Clinical Care Advance, making it available to the System of Care team through our Health Backpack. She contacts the team members to discuss the results and invite them to participate in the Care Plan. Shakira's Care Plan will incorporate her DCBS Service Plan, care management plan, and Transition to Adulthood Plan, giving Shakira and her family a single, integrated plan with common goals and appropriate interventions to help Shakira meet her goals.

DEVELOPING SHAKIRA'S PERSON-CENTERED CARE PLAN

Heather convenes the System of Care team to develop an integrated Care Plan that incorporates Shakira's self-defined goals and preferences. Given that she is 16 years old, the System of Care team will also develop the Transition to Adulthood Service Plan that is incorporated into her Care Plan.

The System of Care team identifies the following interventions based on Shakira's expressed goals.

Shakira's Goals	Care Plan Interventions
I want to feel better about myself.	• Heather refers Shakira to a behavioral health professional trained in grief counseling and trauma informed care at McCoy Counseling. • Heather arranges for a youth peer support specialist to participate on Shakira's System of Care team and maintain regular contact.
I want to learn how to take care of myself and my baby.	• Heather connects Shakira with resources from our Mothers of Molina (MOMs) pregnancy program. • Heather links Shakira to Kentucky Health Access Nurturing Development Services (HANDS) for in-home support services for the first two years of the baby's life. • Heather refers Shakira to the Louisville Teenage Parent Program (TAPP). • Heather assists Shakira in scheduling prenatal appointments and helps her set up reminders in her Molina Mobile app.
I don't want to get pregnant again.	Shakira's current OB/GYN offers family planning services and discusses the use of long acting reversible contraception.
I want to go to the University of Kentucky.	• Heather coordinates services with Shakira's school to support her as a pregnant student and then as a new parent and address her long-term educational goals. • Heather and the DCBS Social Service Worker advocate for a 504-accommodation plan based on her pregnancy and a home-based curriculum once she delivers so she does not fall behind in coursework.

Shakira shares with the System of Care team that she feels these supports will help her get back on track.

Pregnant or Parenting Support Services. Kentucky ranks 5th in the nation for highest rates of teen pregnancy. Molina knows that teens like Shakira need tailored supports for pregnancy as well as appropriate family planning. Guided by expertise from Molina's high-risk OB Care Manager, Heather educates Shakira and her foster family on prenatal care, postnatal care, how to care for her baby once she delivers, and support services available to her as a young mother. Heather coordinates with our High-Risk obstetrics (OB) program to provide Shakira with intensive support to assure she is healthy throughout her pregnancy and is better prepared to care for her baby.

Heather links Shakira to community resources such as HANDS and the Louisville Teenage Parent Program (TAPP). Although Louisville is far for Shakira and her caregivers to drive, this may be a good resource for Shakira to occasionally take advantage of since there are no local support groups specifically for teen moms. Heather links her with needed services such as Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) for nutrition and food insecurity support and enrolls her with Temporary Assistance for Needy Families. Heather also informs Shakira of local Head Start and Early Head Start services (services for pregnant women and families with children up to nearly five years old) and provides information on how to apply for resources that include free education for parents, daycare services, and meal programs.

Physical Health and Family Planning Services. Shakira's current OB/GYN can act as her PCP, continuing to prescribe her antidepressant medication, and offers family planning services, possibly long acting reversible contraception, once Shakira delivers her baby. Her PCP will also assess and closely monitor Shakira for symptoms of post-partum depression upon delivery.

Educational Services. Heather and the DCBS Social Service Worker advocate for Shakira to receive a 504 accommodation plan that allows her to take breaks as needed (sit, stand, walk around, etc.) in the classroom, go to the nurse's office to take prenatal vitamins or rest (as needed), and use a home-based curriculum once she delivers so she does not fall behind in coursework.

b. COORDINATING PHYSICAL AND BEHAVIORAL HEALTH PROVIDERS

Heather serves as the hub of communication for the System of Care team to reduce duplication of services and that all providers are aware of Shakira's unique needs. Heather connects Shakira's OB/GYN with her behavioral health provider to coordinate breastfeeding support since she is on antidepressant medication. Heather assesses Shakira's status during in-home visits and telephone calls and convenes the System of Care team to update her Care Plan monthly and when there is a change in status.

c. ACCESS TO NETWORK PROVIDERS

Heather considers the geographic locations of providers; distance and travel time; and the cultural, ethnicity, language, and other special needs Shakira may have when identifying services and resources. Shakira has experienced significant loss and trauma, including being removed from her home at a young age, abandonment by her boyfriend/baby's father, the death of her grandmother, and now placement in two different Foster Care settings. *We will incentivize smaller, local providers, such as McCoy Counseling, to join our network to provide specialty services and address Shakira's needs related to ACEs.* If Shakira requires the services of an out-of-network provider, we will form single case agreements (SCAs) with qualified providers to assure she receives all needed services.

d. DISCHARGE PLANNING FOR ALL LEVELS OF CARE

Shakira will receive discharge-planning services while in the hospital to deliver her baby. As a participant in the MOMs program, Shakira receives support from a registered nurse during the post-partum phase, as well as in-home visits through the HANDS program. We make sure Shakira has access to a safe crib, a stroller, car seat, diapers, basic baby clothing and nursing support – everything she needs to keep her and her baby healthy at home – procured from community-based organizations. These services help Shakira and her baby stay well during this crucial early time and provide preventive care and education. Heather provides ongoing follow up and support to reduce Shakira's risk of complications from labor and delivery and assure that Shakira and her baby are healthy and have the resources they need. Through these frequent checks, Heather, along with Shakira's providers, monitor for symptoms of continued

bereavement-related depression, post-partum depression, anxiety, or psychosis. Heather coordinates non-emergency transportation services and monitors claims-based utilization data to make sure that Shakira and her baby attend checkups and follow up visits.

e. COORDINATION OF SCHOOL-BASED SERVICES

Shakira may receive preventive and support services through public health departments in schools. Heather and the DCBS Social Service Worker contact the school to assess Shakira for a 504 plan, which authorizes special in-class accommodations given her change in physical health (pregnancy) and behavioral health status.

We will coordinate and align her Transition to Adulthood Plan with her school's post-secondary transition plan to prepare Shakira for graduation and the transition to adulthood. Shakira used to have high educational goals and a desire to attend the University of Kentucky. Although she struggles to maintain hope, together the school and System of Care team develop creative solutions to help her work towards her goals. These solutions may include helping Shakira finish her high school diploma through online programs or supporting her to remain in traditional school so she can stay connected to activities she enjoys that support her mental and physical health, such as music and swimming.

When Shakira reaches her goal of attending university, both the University of Kentucky and Western Kentucky University in Bowling Green have resource centers for student parents like Shakira.

f. COMMUNITY SERVICES FOR PARENTING SKILLS

As described previously in this response, Heather links Shakira to internal and community-based resources that will help her learn to care for herself throughout her pregnancy and as a new mother, as well as care for her new child. In addition to support from Heather, Shakira will be assigned a Molina Community Health Worker to link her to local programs and services (for example, workforce, moms/new families supports, and housing). For example, we connect Shakira to the Her Choice Pregnancy Center's parenting classes. These classes will connect her to new mothers like herself who may become valuable social supports and will also help her learn how to care for her child. The Medical Center in Bowling Green also offers new parent classes free of charge, such as the Newborn Care and Safety Class.

g. APPLICABLE EVIDENCE BASED PRACTICES

We link Shakira to services and supports that offer the following evidence-based practices.

High Fidelity Wraparound Approach	
Description	High Fidelity Wraparound is a structured, team-based process that uses an evidence-based, nationally recognized model to partner with SKY Enrollees and families to use their voice and strengths to develop a family-driven plan that promotes self-advocacy. Shakira's self-identified goals are integrated into a single Care Plan that includes natural supports and services provided through all child-serving systems.
Applicability to Shakira	• The System of Care team will collaborate with Shakira, her DCBS Social Service Worker, foster family, providers, and natural family to create a Care Plan based on her self- identified goals and priorities. • The System of Care team will provide coaching and education to improve the foster family's ability to support Shakira. • Heather connects Shakira to community-based resources and integrates all services and supports into an integrated Care Plan.
Expected Outcomes	Shakira will learn to care for herself and her baby. She will be able to recognize symptoms of depression and be able to reach out to available supports as she transitions to adulthood.

Post-Partum Depression Treatment	
Description	Postpartum depression is a mood disorder that affects women after birth. With more than three million cases each year in the United States, it takes a significant toll on the health and well being of new mothers and their infants.
Applicability to Shakira	• Shakira's behavioral health therapist is trained in addressing grief and loss as well as post-partum depression. • Together with antidepressants, psychotherapy is a powerful evidence-based practice that can help Shakira through her post-partum months.
Expected Outcomes	Shakira will be able to maintain her mental health, engagement in her daily life, and be able to properly care for her newborn baby.
John Chafee Independence Program (Chafee Program)	
Description	The Chafee Program assists youth current and formerly in Foster Care to 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 is intended to serve youth who are likely to remain in Foster Care until age 18, youth who are 16 years of age and have left Foster Care for kinship guardianship or adoption. The Family Preservation Act authorizes services through age 23.
Applicability to Shakira	To promote Shakira's independence and self-sufficiency, Heather coordinates with the Independent Living Coordinator to refer Shakira to the Chafee Program.
Expected Outcomes	Shakira will learn independent living skills to support her successful transition to adulthood.
Trauma-Informed Care	
Description	Trauma-informed care understands 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 staff and our provider network will be trained in trauma-informed care.
Applicability to Shakira	Shakira has experienced the loss of her mother to incarceration, the loss of her boyfriend, gained the stress of raising a newborn alone, the loss of her grandmother when she passed away, and the trauma of being placed into Foster Care. A trauma-informed approach will acknowledge Shakira's experiences and connect her to appropriate providers and services to address the lasting impacts of her loss.
Expected Outcomes	Shakira will learn to cope with her loss, grief, and bereavement, develop new and additional natural supports, and have the skills and resources she needs to achieve her self-defined goals and dreams.

h. COORDINATION OF TRANSPORTATION

Heather confirms that Shakira's foster family has reliable transportation (a family car) that they use to transport Shakira and her baby to and from appointments. If transportation becomes a need in the future, Heather will coordinate non-emergency transportation. At the time of scheduling, Shakira or Heather will inform the scheduler that they will be bringing her child with her (as necessary). This will assist the scheduler to arrange for the appropriate vehicle and accommodations (such as a car seat). We also connect Shakira to supports that can help her obtain a driver's license through the Graduated Driver Licensing program and help her work towards obtaining a car of her own to increase her independence.

i. AGING OUT OF FOSTER CARE AND RISK MANAGEMENT

Heather educates Shakira on her option to continue receiving services from the SKY program after aging out of the Foster Care system. As part of the care planning process, she conducts a transition to adulthood assessment of Shakira's vocational and educational goals related to physical, behavioral, and social determinant of health needs at the time she enrolls with Molina, and annually thereafter. Heather works with Shakira to initiate a Transition to Adulthood Plan to connect her with the services and supports she will need to achieve independence in adulthood. For example, Shakira's Transition to Adulthood Plan includes goals and objectives tied to her desire to attend the University of Kentucky and her interest in

becoming a veterinarian. Heather will connect Shakira with the John Chafee Independence Program to participate in life skills training and receive ongoing support from an independent living coordinator.

j. SOCIAL DETERMINANTS OF HEALTH

Through services and programs like the Chaffee Independence program, Molina connects Shakira to the resources and supports she needs to care for herself and her child. Molina's housing specialist will work with Shakira to identify safe and affordable housing as she transitions from her foster family to independent living. ***We will partner with Transition Age Youth Launching Realized Dreams (TAYLRD), which operates 16 drop-in centers for transition aged-youth across Kentucky, connecting youth to resources and supports they need.*** Resources include food, computer access, recreational and social activities, peer support, care management, employment and education support, and connection to social determinant of health support. Shakira may choose to attend a drop-in center in Leitchfield, to connect with peers and receive additional social determinants of health support. Heather connects Shakira to legal aid to secure her parental rights.

k. PROVIDER EDUCATION AND SUPPORT

Shakira's System of Care team educates her OB/GYN, behavioral health provider, and other providers (including community-based organizations) on Shakira's strengths, needs and preferences. Heather will connect providers and her foster family to trauma informed care training and resources. Providers can also access resources through our *Fostering Success Academy*, which offers multiple interactive training platforms and resources to assist providers in applying evidence-based practices.

l. ACCESS TO AND SHARING OF MEDICAL RECORDS

Heather documents the results of Shakira's HRA, SKY Enrollee Needs Assessment, transition to adulthood service plan and Care Plan in our care management system, Clinical Care Advance. The System of Care team can view the information, via the *Health Backpack,* a digital, cloud-based personal health record that travels with Shakira throughout her Foster Care journey, promoting care coordination and a collective focus on a single set of goals. Heather acts as the hub for this information, making sure that Providers have the information they need to effectively serve Shakira and to avoid duplication of services. ***Shakira will be able to access her Health Backpack for five years after she exits the SKY program, further supporting her transition to adulthood.***

m. MAINTENANCE OF THE CARE PLAN

Heather assesses Shakira's status during weekly contacts, face-to-face visits, and coordination contacts. The System of Care team determines the effectiveness of interventions in addressing the Shakira's needs and update the Care Plan monthly and her Transition to Adulthood Plan annually.

Expected Outcomes for Shakira
Through coordinated, Molina-based and community-based services Shakira delivers a healthy baby girl. Her depression is controlled, although it is exacerbated by her post-partum status. Shakira continues to take antidepressants and is attending a local new mom support group and parenting classes at The Medical Center. Shakira has remained in school with some accommodations and has been able to keep up with her course work at home with support from her caregivers. She is becoming more confident in her ability to take care of her baby and has expressed interest in taking advantage of all the resources available to her so that she can achieve her goal of becoming a Kentucky Wildcat.

USE CASE 4 FOR KENTUCKY SKY

Kirk, 3 years old, Webster County

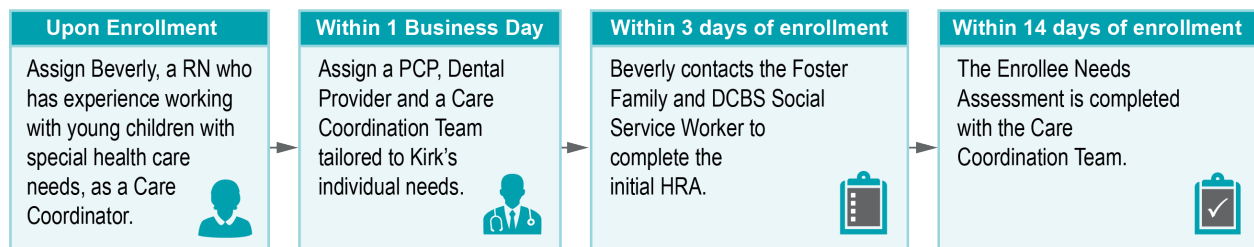| **Care Management**	**Challenges**
Level III, Complex Care Coordination for Children with Special Health Care Needs	Complex medical needs, multiple medications, issues with durable medical equipment and specialty provider access

Molina understands that Kirk is a child with high needs who is involved with multiple systems and Providers. We will work to create a sense of stability and continuity for Kirk and will support his caregivers with his physical health-related and social determinants of health-related needs as they consider adoption. Based on all available information, Kirk is identified as needing Complex Care Coordination.
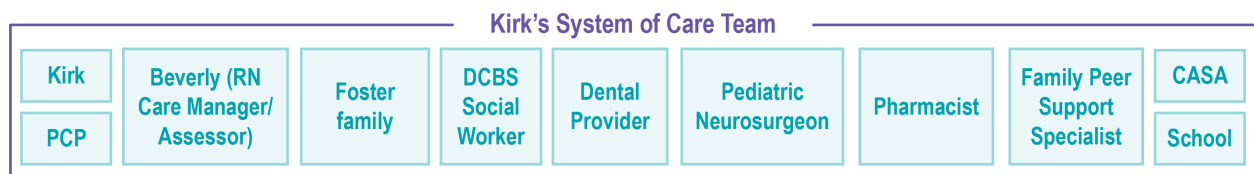
a. CARE MANAGEMENT

Molina's comprehensive and person-centered approach to care coordination will support Kirk and his foster family's desire to have Kirk live a happy and healthy life without further placement disruption. Kirk's medical needs are significant, so we assign a registered nurse, Beverly, as his care coordinator. She quickly starts to gather information about Kirk's medical history, strengths, goals, and needs so he can begin receiving services without delay. We display our timeline of activities in Exhibit G.13-3.

Upon Enrollment	**Within 1 Business Day**	**Within 3 days of enrollment**	**Within 14 days of enrollment**
Assign Beverly, a RN who has experience working with young children with special health care needs, as a Care Coordinator.	Assign a PCP, Dental Provider and a Care Coordination Team tailored to Kirk's individual needs.	Beverly contacts the Foster Family and DCBS Social Service Worker to complete the initial HRA.	The Enrollee Needs Assessment is completed with the Care Coordination Team.

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Exhibit G.13-3. Kirk's Medical Needs Prompt Expedited Engagement

Beverly contacts the DCBS Social Service Worker and foster parents to introduce herself; gather information on Kirk's history and status to inform the initial Health Risk Assessment (HRA); learn about any providers serving Kirk and educate them on services available through Molina; and discuss our collaborative approach to care coordination. Beverly learns that Kirk's foster parents would like to adopt him and that making sure they have the knowledge, skills, and supports to care for his complex medical needs is a priority for them. When completing the HRA, Beverly and Kirk's foster family discuss who they would like to have on his System of Care team, which encompasses his Assessment team and Care Coordination team. This team is charged with providing continuity of care, ongoing support, monitoring and reassessment, assuring close communication across providers. Together, they determine the following participants.

Kirk's System of Care Team

Kirk	Beverly (RN Care Manager/ Assessor)	Foster family	DCBS Social Worker	Dental Provider	Pediatric Neurosurgeon	Pharmacist	Family Peer Support Specialist	CASA
PCP								School

Initial Screening and Assessment of KIrk's Unique Needs

Our goal is to understand and begin to address Kirk's and his foster family's needs from day one of enrollment. Beverly review Kirks medical history to better understand his needs and uses the initial HRA to assess Kirk for his strengths, developmental milestones, activities of daily living, physical and

behavioral health needs, durable medical equipment (DME) needs, in-home providers, and community resources.

Using information gathered from Kirk's DCBS Social Service Worker and Foster Parents, the HRA and medical records review, Beverly conducts a SKY Enrollee Needs Assessment using play-based approaches and foster family interviews to assess Kirk's needs and preferences. The foster family expresses that Kirk is a pleasure—he's always smiling and doesn't seem to get upset often despite his significant medical needs. If they receive in-home support and can access services closer to home, the foster family states that they would like to adopt Kirk.

Care Plan Development

Beverly convenes the System of Care team and begins Care Plan development. This meeting is held in Kirk's home, which is the most convenient for him and his foster family, and many of his System of Care team join in person especially his DCBS Social Service Worker. The Care Plan incorporates Kirk's care management plan, DCBS Service Plan, and all plans that may be developed by providers, such as his pediatric neurosurgeon. Having a single, integrated plan simplifies Kirk's care for his Foster Parents as it enables them to track his services and goals in a single document. Kirk's Foster Parents identify the following goals that inform his Care Plan interventions.

Goals for Kirk	Care Plan Interventions
We will be able to get the care that Kirk needs easier and faster.	• Beverly connects the family to the Office for Children with Special Healthcare Needs (OCSHCN) pediatric neurology clinic in Owensboro and to the cerebral palsy multidisciplinary clinic. He can also receive evaluations for therapies—physical, speech, and occupational and the need for skilled nursing. • Beverly applies for Kirk to be designated as Medically Complex according to the 4.10.2 DCBS Medically Complex Placement procedures. • Molina's pharmacist conducts a medication review to assess Kirk's medications and contacts the prescriber to discuss recommendations. • Beverly arranges for DME, such as a power wheelchair. • Beverly and the DCBS Social Service Worker work together to locate community resources to build Kirk a ramp for his power wheelchair so that he can exit the home safely and more often. • Beverly arranges for Kirk's family to take classes on seizure precautions, signs of oncoming seizures, effects of anticonvulsant medications, and signs that Kirk's ventriculoperitoneal (VP) shunt is not working • As a long term goal, the family agrees to consider getting a service dog for seizure alerts
Kirk's family will have the resources and skills needed to adopt and care for him.	• The DCBS Social Service Worker provides the foster family with information on the Adoption Assistance information. • Beverly works with Kirk's DCBS Social Service Worker to identify another foster family who can serve as a respite provider and arranges for planned respite to reduce caregiver stress. As a value-added service, Molina will offer two additional days of respite care each year. • Beverly connects the family to Wendell Family Support, Encourage, and Embrace Disabilities (SEEDS) program in Owensboro to build caregiver support. • Beverly provides Kirk's foster family with our System Navigation Guide, which provides important contact information, milestones and available resources. • The skilled nurse provider offers teaching and education on the care they are providing so that family can provide it in the future. • Beverly connects Kirk's foster family with an online support system for caregivers with children with CP and chronic medical conditions where they can build a support system as well as learn about Kirk's disease progression.

Goals for Kirk	Care Plan Interventions
Kirk will see Dental and PCP providers on a regular and as needed basis.	• Beverly confirms that Kirk has a PCP and a dental provider at the OCSHCN specialty clinic, who will complete mental and physical health screenings, EPSDT or other comprehensive exams, and periodic follow up exams and care. • As needed, Beverly arranges for Kirk to receive transportation to his appointments if the family car is unable to accommodate his wheelchair. • Beverly works with Kirk's speech therapist to identify ways Kirk is using to communicate and help his foster partners learn these methods so they can begin to talk in Kirk's language such as a communication board.

Beverly coordinates all of Kirk's services and works in concert with his DCBS Social Service Worker to make sure he and his family receives all necessary services and supports.

Medical Services. Beverly refers Kirk to the pediatric neurology clinic in Owensboro. In addition, the cerebral palsy multidisciplinary clinic located in Louisville offers multi-disciplinary services, approximately two and a half hours away from Webster County. Kirk can see the neurologist, the orthopedic surgeon, and pulmonologist on the same day. He and his family may also receive support from a nutritionist, Family-to-Family support parent, physical therapist, occupational therapist, speech therapist, and representative for orthotics. The specialty clinic also provides immunizations and all EPSDT services.

Medication Management. Medication review and reconciliation is high-priority in Kirk's assessment and care planning. The System of Care team can draw on the resources of Molina pharmacists and its Medication Therapy Management (MTM) program as needed. Our pharmacist, who participates in the System of Care team, educates Kirk's foster family about the purpose of each of his medications, side effects to watch for, and any contraindications to discuss with his provider. Beverly will also assess at each contact to see if there have been changes to Kirk's medications, evaluate symptoms/side effects and verify that Kirk's foster family knows how to administer his medications properly. She will provide education and medication reconciliation, as needed.

Routine Lab Work. As Kirk is prescribed anticonvulsant medication, and routine lab work is needed to ensure appropriate levels are maintained. The Skilled Nurse can draw this blood work during home visits as prescribed by the physician.

Adoption Assistance. Beverly will collaborate with the DCBS Social Service Worker to educate Kirk's foster family, who has expressed interest in adopting Kirk, on Kentucky's Adoption Assistance program. To facilitate continuity of care, Beverly will continue to serve as Kirk's care coordinator if he becomes eligible for Adoption Assistance and the foster family chooses to continue with the SKY program. As Beverly has a positive relationship with Kirk, his foster family and providers, this makes the family more comfortable in making a decision to adopt Kirk.

Foster family Training and Support. Now that Kirk is getting a little older, his foster family may need training on how to best meet his changing needs such as through the University of Kentucky College of Social Work Training Resource Center. They can also access supports through the SEEDS program in Owensboro, a family support group that offers networking opportunities and social activities for individuals with disabilities and their parents/guardians and siblings.

Assistive Technology such as a communication board or other devices suggested by the speech therapist.

Skilled Nursing. Kirk needs skilled nursing visits in his home at the frequency ordered by his PCP, such as every other week. Beverly arranges her visits on the opposite weeks so a nurse is seeing that Kirk weekly. The Skilled Nurse ensures his medications are administered correctly, Kirk's appetite, monitors seizure activity for an increase in number of seizure, assesses if there is an increase in Kirk's verbal communications, and any signs that his shunt are not working. The Skilled Nurse checks vital signs to monitor changes in blood pressure, pulse, or repository and check for skin integrity issues that could be

caused from wheelchair use or limited bed mobility. The Skilled Nurse also monitors Kirk's weight to see if nutritional supplements are needed.

PCP and Dental Provider Access. Upon enrollment, Molina confirms that Kirk has a PCP and a dental provider who will complete mental and physical health screenings, EPSDT or other comprehensive exams, and periodic follow up exams and care. Although cerebral palsy does not cause oral deformities or abnormalities, it does tend to cause oral issues due to symptoms associated with the disorder. Kirk can receive dental services through the OCSHCN specialty clinic. Since Kirk is on anticonvulsant medication and it is known that this drug type causes significant dental issue that will need to be accounted for in his Care Plan and dental treatments.

b. AVAILABILITY OF SERVICES AND NETWORK ACCESS

Access to services is a challenge where Kirk lives as evidenced by the fact that for his foster family has been driving him to Cincinnati Children's Hospital for specialty care. Beverly uses Molina's online searchable provider directory to identify alterative providers for the family. She presents the foster family with several options for accessing services: 1) the OCSHCN specialty clinic in Owensboro, 2) the Graves Gilbert Clinic in Bowling Green, and 3) the Riley Children's Center which has a clinic in Evansville with developmental pediatricians and pediatric neurosurgeons in Indianapolis (one-half the distance they travel now). These facilities also offer access to orthotics services and physical therapy.

Beverly suggests to the foster family that they access one of these local options for routine care, and perhaps only travel to Indianapolis annually for pediatric neurosurgeon care. Having all of Kirk's care delivered by one or two clinics/providers will enhance continuity of care and reduce burden on the foster family. The family chooses the OCSHCN specialty clinic which contracts with pediatric neurosurgeons, and has telehealth options so that most of Kirk's care is delivered in one location. Beverly coordinates the transfer of Kirk's medical records from Cincinnati Children's Hospital to Kirk's new provider.

c. AVAILABILITY OF SERVICES, SUCH AS SKILLED NURSING SERVICES

Beverly offers the following options for skilled nursing services: Webster Comfort Keepers Home Care Evansfield that also serves Kentucky, MASH Homecare in Webster; Morgansfield Hospital in Henderson, and Methodist Hospital. The foster family chooses to access services through Methodist Hospital as it is close to their home and will provide Kirk's DME as well as in-home skilled nursing.

d. ACCESS TO SCHOOL BASED SERVICES

Beverly contacts the Webster County School District to request an evaulation for school-based services. As Kirk is three years old, he will be eligible for preschool early intervention services. The Webster County Alpha Academy offers a Childhood Development Center preschool for children ages three to five. Through the school, Kirk will be evaluated for early intervention services to prepare him for kindergarten. Beverly will communicate with the school about Kirk's medical history, Foster Care involvement, special needs, and family preferences to aid in the future development of an Individualized Eduction Plan (IEP). Beverly works hand in hand with school to prevent duplication of services Kirk receives and develops a clear plan for the services that will be provided to Kirk under his IEP, the services that will be delivered under Kirk's SKY program benefits and how srevices will be delivered during school breaks. Kirk's Care Plan will list all of these services and include his IEP as an attachment. A school representive will become a part of Kirk's System of Care team.

e. APPLICABLE EVIDENCE BASED PRACTICES

Based on Kirk's complex medical needs, we link him to services and supports that offer the following evidence-based practices.

Physical, Occupational, and Speech Therapies	
Description	To minimize activity limitations, the physical therapist helps children with walking skills. The occupational therapist works on grasping and hand coordination to help with an activity such as dressing and using an assistive device.

Physical, Occupational, and Speech Therapies	
Applicability to Kirk	• The physical therapist addresses Kirk's impairments related to spasticity, weakness, poor postural control, and lack of coordination. • The speech therapist works on oral motor skills to improve enunciation or teaches Kirk to use an augmentative communication device to successfully communicate with others and participate in social interactions.
Expected Outcomes	Kirk's fine and gross motor skills will improve, enabling him to complete activities of daily living as independently as possible. Kirk will be able to communicate with others.
Child-Parent Psychotherapy (CPP)	
Description	CPP is a treatment for trauma-exposed children aged 0-5. CPP examines how the trauma and the caregivers' 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
Applicability to Kirk	CPP will assist Kirk and his foster family to address the trauma Kirk experienced from multiple Foster Home placements and significant medical interventions.
Expected Outcomes	Kirk's foster family will learn to recognize when he shows signs of trauma and strategies for minimizing any future trauma, helping him to heal and adjust to his new family.

f. COORDINATION OF TRANSPORTATION

Beverly confirms that the foster family has reliable transportation (a family car) but if transportation becomes a need in the future, she will coordinate non-emergency transportation services through the Kentucky Transportation Cabinet, Office of Transportation Delivery program. As Kirk requires the use of a wheelchair, the foster family may need to make adaptions to their current vehicle. Beverly will work with Kirk's foster family to identify local resources, such as the Automobile Mobility Modification Reimbursement Programs, and the KATS Network, which provides a guide to assistive technology funding in Kentucky. Wendell Foster in Owensboro, less than an hour from Webster County, partners with KATS as well. Beverly locates community resources that will fund modifications to the family car so they can transport Kirk and his wheelchair to appointments and family outings.

g. COMMUNITY RESOURCES

As part of Kirk's Care Plan, we identify available community resources that can support him and his foster family in achieving their goals. Beverly refers Kirk and his foster family to the nearest Family-to-Family Health Information Center (F2F) in Owensboro. F2F provides guidance and support for families of children and youth with special healthcare needs. F2F offers parents and caregivers the opportunity to connect with another parent or caregiver with a similar situation or special healthcare need.

h. SOCIAL DETERMINANTS OF HEALTH

Primary social determinants of health that impact Kirk include placement permanency, the need for socialization with peers, educational supports for when he starts pre-school, and community-based supports. Beverly incorporates interventions to address these needs in Kirk's Care Plan. For example, ***Beverly connects Kirk to the local Bright Start Early Intervention Program in Owensboro that offers therpeutic playgroups for children ages two and a half to age four.*** She also connects Kirk and his foster family to disabled friendly communities that have "safe" playgrounds. For example, Senarory Park in Webster County is designed for children who have autism or children using wheelchairs.

Kirk has a history of unstable housing. In his first three years of life, he has lived in six foster homes and with his natural parents for a total of seven different environments. Being able to keep him in this foster home with the goal of adoption will address this social determinant as the family lives in a secure, safe home and community. The family is willing to make home modifications to increase his mobility while in the home, such as widening doorways to accommodate his wheelchair and building a ramp to the entrance. Although Kirk's Foster Parents work, there are increasing financial stress due to decrease income from missing hours of work. Luckily, Kirk's Foster Parents have supportive employers who understand their needs and neither are at risk of losing their jobs.

i. PLANNED RESPITE CARE

Molina offers a value-added service for two additional respite days a year for Kirk's caregivers. In addition, Beverly will work with Kirk's Social Service Worker to identify another foster family in the area who are trained to take care of children like Kirk. This trainer foster family can act as Kirk's respite provider. Beverly knows that Kirk may be eligible for the Supports for Community Living (SCL) Waiver. Beverly will work with Kirk's Social Service Worker to explore this option. Once enrolled in the SCL Waiver (which begins at age 3), Kirk and his family will have access to repite services through this program.

j. PROVIDER EDUCATION AND SUPPORT

The System of Care team educates all of Kirk's providers on his individual needs and circumstances. We recognize that an effective Kentucky SKY network requires a strong partnership and collaboration between the providers who serve the children and youth and us, as the program administrator. Through our *Fostering Success Academy*, Kirk's providers can access training, resources, evidence-based practices, and guidelines on how to best serve Kirk. We offer training on trauma-informed care, resources for children with special healthcare needs, and coordinate information sharing between providers so they become partners in the success of SKY Enrollees.

k. ACCESS TO AND SHARING OF MEDICAL RECORDS

Beverly documents the results of Kirk's HRA, SKY Enrollee Needs Assessment, and Care Plan in Clinical Care Advance, our care management system. The information is loaded to our *Health Backpack*, making it readily accessible to his caregivers, providers, and DCBS Social Service Worker. Participants involved in Kirk's care can view the information, promoting care coordination and a collective focus on a single set of goals for Kirk. Beverly acts as the hub for this information, making sure that providers, system partners and Kirk's foster family have the information they need to effectively serve Kirk and avoid duplication of services. Kirk's foster family can access his medical record at any time by securely logging into *Health Backpack* and can print the information for inclusion in the Medical Passport.

l. MAINTENANCE OF THE CARE PLAN

Beverly follows-up and evaluates the effectiveness of the services provided on an ongoing basis through monthly face-to-face visits, weekly telephone contacts, and monthly meetings with Kirk and his caregivers and DCBS Social Service Worker, and conducts monthly Care Plan updates.

If DCBS determines that Kirk has Medically Complex needs, Molina will engage the Medically Complex Service team. As Beverly is a Registered Nurse, she will continue to support Kirk and his family, facilitating continuity of care. She will convene the Medically Complex Service team to complete an Individualized Health Plan (IHP) within 30 days. The IHP will be incorporated into the Care Plan and updated every six months or as needed. Beverly will convene the Medically Complex Service team every three months to review the IHP, Kirk's current needs, and re-evaluate his determination. Beverly will maintain regular contact, complete care coordination, convene the System of Care team and update Kirk's Care Plan as required by our Complex Care Coordination program.

Expected Outcomes for Kirk
Through targeted interventions, care coordination, and evidence-based practices, Kirk's health improves through increased access to specialty and primary care services. His foster family is reporting fewer issues with his VP shunt and have a solid understanding of his medication regime and pharmacy history. Kirk is engaged in early intervention services through community-based resources and his parents are receiving extra education and support through F2F. Kirk's foster family feels more confident about adopting Kirk now that they have the needed supports and services, newly learned skills to care for him, education on Kirk's medical conditions, and can access the appropriate medical care for Kirk even though they live in a rural area of the Commonwealth.

USE CASE 5 FOR KENTUCKY SKY

Enrico, 16 years old, Oak Grove County

Care Management	Challenges
Level II, Intensive Care Coordination	History of violent behavior, difficulty reunifying with family, poor school performance, juvenile justice involvement

Enrico is a sixteen-year-old boy with violent externalizing behaviors and multi-system involvement with the Department of Juvenile Justice and education system. Molina will take a person-centered approach with Enrico to listen to his self-defined goals – which include his desire for family reunification. We will then engage his family to identify what they need in order to be comfortable with Enrico returning home. Finally, we will wrap Enrico with the appropriate medical and behavioral health services, and educational and life skill support to help him achieve his goals. Through our person-centered, family driven approach, we will see Enrico thrive as he works toward independence in adulthood.

a. CARE MANAGEMENT

Molina is focused on High Fidelity Wraparound care for SKY Enrollees and their families through enhanced care coordination across all providers (physical, behavioral health, independent living, and community resources) and system partners (child welfare, juvenile justice, and education) that serve and support SKY Enrollees such as Enrico. Upon enrollment, Molina assigns a care coordinator, William, a Master's level behavioral health clinician who aged out of the juvenile justice system himself and can relate to Enrico's specific experiences. Exhibit G.13-4 depicts Molina's care coordination timeline.
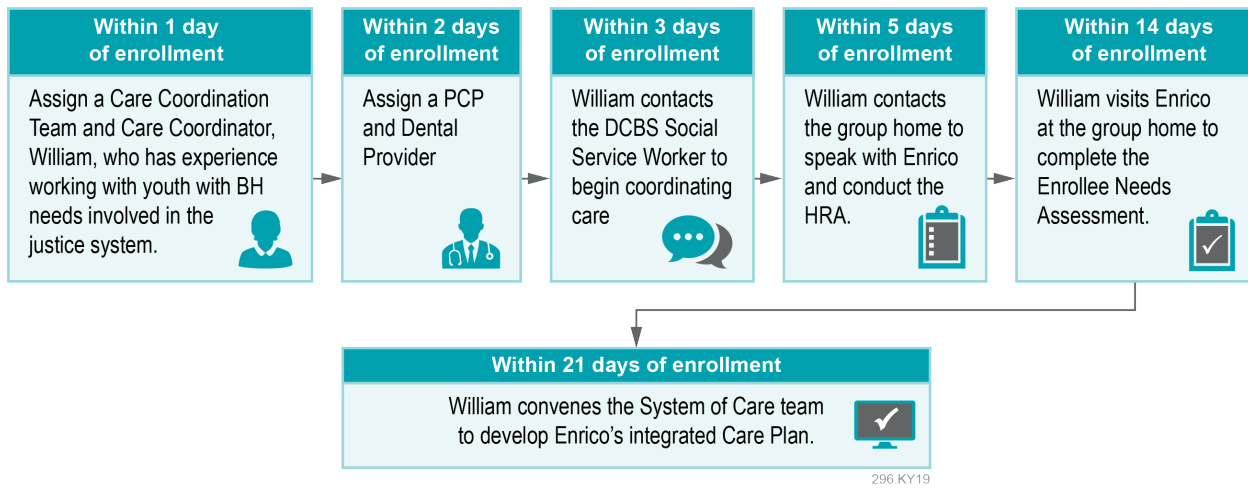

Within 1 day of enrollment	Within 2 days of enrollment	Within 3 days of enrollment	Within 5 days of enrollment	Within 14 days of enrollment
Assign a Care Coordination Team and Care Coordinator, William, who has experience working with youth with BH needs involved in the justice system.	Assign a PCP and Dental Provider	William contacts the DCBS Social Service Worker to begin coordinating care	William contacts the group home to speak with Enrico and conduct the HRA.	William visits Enrico at the group home to complete the Enrollee Needs Assessment.

Within 21 days of enrollment

William convenes the System of Care team to develop Enrico's integrated Care Plan.

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Exhibit G.13-4. Care Management Activities Based on Enrico's Needs

William contacts the Social Service Worker to introduce himself, gather information on Enrico's history and status to inform the Health Risk Assessment (HRA), learn about providers that are serving Enrico, ask about PCP preferences, obtain contact information for the group home, and discuss Molina's collaborative approach to care coordination. William asks the Social Service Worker about Enrico's family's involvement and the long-term plan for Enrico.

William then contacts the group home to complete the HRA, introduce himself and schedule time to complete the SKY Enrollee Needs Assessment. When completing the HRA, William speaks with Enrico and the group home staff to screen for trauma using the ACEs Questionnaire and identify William's immediate physical, behavioral health, and social determinants of health needs. During this call, William works to understand Enrico's concerns and develop a trusting relationship to facilitate engagement.
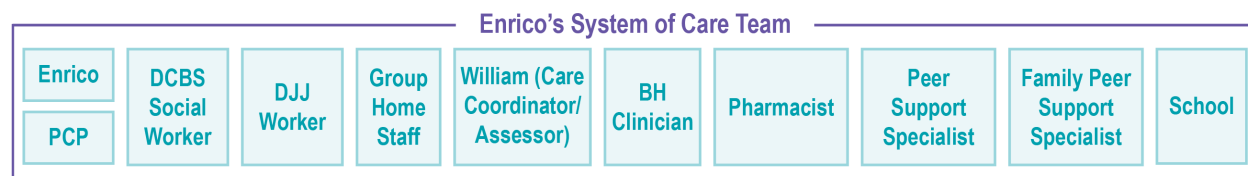
Based on Enrico's risk level as demonstrated by behavioral health needs, physical health conditions (asthma and obesity), history of aggression and need for services, the Care Coordination team determines that he would benefit from Intensive Care Coordination. William contacts the DCBS Social Services Worker to share the results of the HRA and develop a care management plan. He also invites the DCBS Social Service Worker to participate in the SKY Enrollee Needs Assessment and asks for a copy of Enrico's Service Plan. Before completing the Enrollee Needs Assessment, William contacts Enrico's past and current providers and his family (with permission from the DCBS Social Service Worker) to gather a complete picture of Enrico's history and needs. When speaking with Enrico's family, William learns they feel guilty about not having contact with him and relinquishing custody to DCBS, but they are genuinely fearful of him and are not willing to put his siblings at risk by allowing him back in the home.

Understanding Enrico's strengths, needs and priorities

William visits the group home to complete our in-depth Enrollee Needs Assessment using a trauma-informed approach—he explains the purpose of the assessment and how the information will be used, and gives Enrico the opportunity to take breaks and discuss what is important to him. William also uses motivational interviewing strategies to encourage Enrico to express himself and to gain a full understanding of his strengths, goals, needs, and preferences. Because Enrico is 16 years old, William conducts a transition to adulthood assessment to identify his interests and goals upon turning 18 and to connect him with services and supports to accomplish his goals.

Enrico expresses his frustration with not being able to spend time with his family and states that he feels very lonely. He also states that he doesn't have any friends at school and has a hard time concentrating. He's embarrassed about the weight he's gained and is easily frustrated. The group home staff helps him take his medications, but he has not been to a PCP or behavioral health provider in the past year. Enrico states that his priorities include having contact with his family, making some friends, doing better in school, and getting better control of his asthma symptoms.

William explains that his role is to work with the DCBS Social Services Worker and DJJ Worker to arrange for Enrico to receive services. William talks to Enrico about the care planning process and helps him to write down his questions, goals and strengths so he is ready for the meeting. Enrico states that he wants his family to participate in the Care Plan meeting and William invites them. William and Enrico discuss the participants for Enrico's System of Care team, which include the following.

Enrico's System of Care Team									
Enrico PCP	DCBS Social Worker	DJJ Worker	Group Home Staff	William (Care Coordinator/ Assessor)	BH Clinician	Pharmacist	Peer Support Specialist	Family Peer Support Specialist	School

Developing Enrico's integrated Care plan

William convenes the Assessment Team, to review the results of the HRA and SKY Enrollee Needs Assessment process. Once the assessment is complete, his Care Coordination team and Assessment team blend to become his System of Care team. The System of Care team takes a High Fidelity Wraparound approach to supporting Enrico. They encourage Enrico communicate his goals and preferences to drive the Care Plan. Due to Enrico's age and desire to participate in developing his Care Plan, William schedules a meeting with the System of Care team to complete the Care Plan at the group home. The PCP, dental provider and behavioral health provider agree to provide input before the meeting, as they are unable to attend in person. Enrico's family is willing to participate via phone with support from an interpreter. The Care Plan is fully integrated to include the DCBS Service Plan, the care management plan, William's Individualized Education Plan (IEP), and Transition to Adulthood Plan. Enrico identifies the following goals, which guide the interventions in his Care Plan.

Enrico's Goals	Care Plan Interventions
I want to control myself when I get angry.	• William schedules a behavioral health assessment and medication management appointment with the BH provider who previously served Enrico. • Molina pharmacist conducts a medication review to assess William's medication regimen and suggest alternatives to his BH Provider. • The BH Provider offers Multi-Systemic Therapy (MST) to assist Enrico in learning improved coping skills.
I want to be with my family.	• The Care Coordination team collaborates with William, DCBS Social Services Worker and family to conduct a family reunification assessment. • The BH provider includes Enrico's family in MST sessions. • William arranges for an interpreter so that Enrico's family can participate in MST. • The DCBS Social Service Worker facilitates weekly calls with Enrico and his family. • William arranges for the family to receive education on ways to help Enrico manage his frustration and anger.
I want to do better in school.	• The DCBS Social Service Worker agrees to contact the school to request an IEP meeting. • William consults with Molina's IEP expert to learn how to best advocate for Enrico. • William participates in the IEP meeting to advocate for Enrico's needs.
I want to control my asthma symptom and lose weight.	• William assists with scheduling a PCP appointment for EPSDT services and a spirometry assessment of his asthma. • The PCP updates Enrico's asthma maintenance medication, recommends steroids, a rescue inhaler, and routine physical activity to strengthen his lungs. • William connects Enrico to Weight Watchers for Teens for weight management support; Enrico also agrees to sign up for after-school athletics. • Group home staff to receive training on nutrition and healthy meal planning. • PCP assesses whether Enrico's prescribed medications contribute to his weight gain and coordinates with Enrico's BH provider.

Upon completion of the Care Plan, William collaborates with the DCBS Social Service Worker to arrange for all services and supports outlined in the plan as discussed below.

Behavioral Health Services. William verifies that Enrico wants to continue to receive services from the behavioral health provider who previously served him. The behavioral health provider completes a full behavioral health assessment and medication review. Enrico's parents agree to participate in MST with Enrico if sessions are scheduled when they are available and William arranges for interpreter services.

PCP services. William schedules a PCP appointment to re-establish care and get up to date for his EPSDT services. The PCP conducts a spirometry assessment, updates Enrico's asthma medications, and educates Enrico and his group home staff on how to prevent and identify an asthma attack. The PCP also recommends Enrico increase his physical activity and refers Enrico for a nutrition assessment and our online Weight Watchers for Teens program. Enrico feels comfortable participating in an online weight management program as he enjoys spending time on the computer. William educates Enrico about our Healthy Rewards Incentive program, which offers gift cards when Enrollees obtain preventive services. Enrico likes the idea of earning a gift card and is excited to participate.

School Services. William participates in Enrico's IEP meeting with the DCBS Social Service Worker to advocate on Enrico's behalf. Before the meeting, William connects with our designated school-based services expert to make sure he fully understands the IEP process and can advocate for Enrico. William also helps Enrico sign up for the school's basketball team as he expressed an interest.

Dental Care. William assists in scheduling an appointment with Enrico's assigned dental provider. If the group home is unable to transport Enrico to his appointment, he arranges for non-emergency transportation (NEMT) through the Kentucky Transportation Cabinet, Office of Transportation Delivery.

Transition to adulthood. The System of Care team discusses with Enrico his transition to adulthood and helps him to think about his future goals. Enrico agrees to participate in the John Chafee Independence Program.

Family Support. One of Enrico's priorities is to re-establish a relationship with his family. The family states that they are willing to begin having contact with him over the phone and during trauma-focused cognitive behavior therapy sessions. They are clear that all contacts need to be supervised, as they remain fearful of Enrico's behavior. The DCBS Social Service Worker agrees to facilitate monthly phone calls and the behavioral health Provider will supervise visits during MST sessions. Once Enrico's family becomes more comfortable having contact with him, they agree to consider more frequent calls facilitated by group home staff. They request that calls occur when a Spanish-speaking staff member is present so they can observe the conversation and redirect William, as needed.

The System of Care team completes a family reunification assessment to determine whether Enrico is likely to reunify with his family or likely to age out of the foster care system without reunifying with his birth family. The assessment indicates that for reunification to happen, Enrico needs to make significant progress in his behavior management. Enrico states he is willing to change.

b. DISCHARGE PLANNING FOR ALL LEVELS OF CARE

Once Enrico's behavior is stabilized and he no longer displays signs of aggression, William will convene the System of Care team to determine an appropriate living situation for Enrico. They will work together to develop a transition plan that outlines the services and supports Enrico will receive to facilitate a seamless transition to a community setting such as a foster family. William will arrange for ongoing PCP and behavioral health services and community-based supports and update the Care Plan, as appropriate.

c. LANGUAGE ACCESSIBILITY

We considered Enrico's family's language needs when selecting William, who speaks Spanish, as the care coordinator. As necessary, William will arrange for interpreter services to facilitate the family's participation in care planning and therapeutic services.

d. PSYCHOTROPIC MEDICATIONS AND DOCUMENTATION

We will include a pharmacist as a participant on Enrico's System of Care team to evaluate his medications and educate prescribers on alternative medication therapies, as appropriate. Enrico is already receiving a high dose of his current prescriptions without stabilizing his behaviors, so the team discusses alternative medications and therapies.

William's behavioral health provider conducts a complete behavioral health assessment and medication review to determine the most appropriate treatments for him, which includes medications as well as MST. The behavioral health provider submits a request for prior authorization for any psychotropic medications prescribed to Enrico. The request is reviewed and approved by our psychiatrist who determines it includes documentation of the need, purpose for the medication, accompanying therapies (MST), and meets prescribing guidelines. Requests for continued authorization must include documentation of appropriate lab tests (such as metabolic screens) in Enrico's medical record.

e. EVIDENCE-BASED PSYCHOTHERAPEUTIC INTERVENTIONS

Through our network of providers, Enrico will have access to the following evidence-based interventions.

High Fidelity Wraparound Approach	
Description	High Fidelity Wraparound uses an evidence-based, nationally recognized model to partner with Enrollees and families to use their voice and strengths to develop a family-driven plan that promotes self-advocacy. Enrico's self-identified goals will be integrated into a single Care Plan that includes natural supports and services provided through all child-serving systems.

High Fidelity Wraparound Approach	
Applicability to Enrico	• As Enrico is nearing adulthood, placing him in the driver's seat of his own care is an important step for him to learn to self-manage. • The System of Care team creates a Care Plan based on Enrico's identified goals and priorities. • The System of Care team provides coaching and education to assist the group home in supporting Enrico and reduce the triggers for his behaviors; connect Enrico to community-based resources; and include all services and supports in an integrated Care Plan.
Expected Outcomes	Enrico will learn to manage services and supports and develop an effective support system.
Multi-Systemic Therapy (MST)	
Description	The primary goals of MST are to decrease justice involvement and out-of-home placements. Critical features include integration of empirically based treatment to acknowledge the risk factors that may be influencing the behavior, rewards for positive changes in behavior and environment to ultimately empower caregivers, and thorough quality assurance mechanisms that focus on completing objectives set in treatment.
Applicability to Enrico	• The MST therapist will work with Enrico and his family to address his criminal behavior and reduce out-of-home placements. • Using MST, the therapist will identify and address the risk factors that may be influencing Enrico's behavior, educate his family on strategies to reward Enrico for positive changes in behavior, and collaborate with the family to identify clear goals and provide feedback on the family's progress.
Expected Outcomes	The therapist will, identify and address the risk factors that may influence Enrico's behavior, educate his family on rewarding Enrico for positive changes in behavior, and collaborate with the family to identify clear goals and provide feedback on the family's progress.

f. SOCIAL DETERMINANTS OF HEALTH

The System of Care team will incorporate the following interventions to address the primary social determinants of health that impact Enrico as shown below.

Social Determinant	Intervention
Education	William and the DCBS Social Service Worker coordinate with the school to update Enrico's IEP with appropriate accommodations and services to improve his school performance.
Socialization	• The youth peer support specialist coaches Enrico on reading and responding to social cues through phone calls/texting and visits to the group home. • William arranges for Enrico to attend a youth drop-in center with his youth peer support specialist to increase socialization.

g. COMMUNITY RESOURCES

We will identify available community resources in Enrico's Care Plan that can support him in achieving his goals. For example, based on Enrico's preferences, we may connect him to a local Chafee Independence Program location. Enrico can participate in activities and programs that assist with education, employment, financial management, housing, and emotional support. William may also arrange for Enrico to participate in activities at a nearby youth drop in center operated by Transition Age Youth Realizing Dreams (TAYLRD) once his mood is stabilized. The youth peer support specialist will accompany Enrico until he is comfortable attending on his own. As Enrico becomes more comfortable participating in services at the Drop-in Center, we may arrange for him to visit the center more frequently to access their transition support services. If Enrico chooses to transition from Foster Care, William and/or the youth peer support specialist will assist him in applying for community programs that move him toward independence, such as housing, financial support, and educational/vocational programs.

h. AGING OUT OF FOSTER CARE SERVICES

The System of Care team completes a transition to adulthood assessment to determine Enrico's interest in and ability to participate in Aging Out services and assists him in developing short and long-term goals for independence. They explain that he has the option to age out of Foster Care services at age 18 or he can choose to continue receiving Foster Care services until he is 26. Based on his needs, the team develops a transition to adulthood plan that includes:

- The array of services and supports Enrico will need and potential service providers.
- Community resources and supports to address social determinants of health such as housing, food security, and financial resources.
- Potential risks to a successful transition such as medication compliance.
- Recommendation for access for specialized supports including but not limited to positive behavioral supports, medication support, DME and home modifications.
- Options for home and community-based services (HCBS) or other waiver program.

During monthly Care Plan updates, the System of Care team discusses Enrico's options, assess his progress toward self-identified goals, and determine appropriate services to support him in transitioning to adulthood. Through our transition age youth program, we coordinate Enrico's access to employment and vocational services, housing, and ongoing services, based on his readiness and self-identified goals.

i. ACCESS TO AND SHARING OF MEDICAL RECORDS

William documents the results of Enrico's HRA, SKY Enrollee Needs Assessment, and Care Plan in Clinical Care Advance, our care management system and adds the behavioral health assessment completed by the behavioral health provider. All of William's assessments and Care Plan are readily accessible to the System of Care team through our web-based *Health Backpack* tool. Participants can view the information, promoting care coordination and a collective focus on a single set of goals for Enrico. William acts as the hub for this information, making sure providers have the information they need to effectively serve Enrico and to avoid duplication of services. Enrico and his caregivers can access his medical record at any time by securely logging into *Health Backpack*, and can print the information for inclusion in the Medical Passport. ***Enrico will be able to access his medical record through Health Backpack for five years after exiting the SKY program to further support his transition to adulthood.***

j. MAINTENANCE OF THE CARE PLAN

William monitors, follows-up, and evaluates the effectiveness of the services provided on an ongoing basis through monthly face-to-face visits, weekly telephone contacts, monthly meetings with the group home and DCBS Social Service Worker, and monthly Care Plan updates. William communicates findings and Care Plan updates to the team based on Enrico's needs and preference.

Expected Outcomes for Enrico
With appropriate medication, preventive care and social supports, Enrico's aggressive behaviors begin to decrease and his asthma symptoms are under control. He is learning to control his eating with the help of Weight Watchers for Teens and support from group him staff, William, and his Youth Peer Support Specialist, increasing his confidence. Through close coordination with the school, Enrico receives the necessary supports to experience some success in the school setting, increasing his feelings of self-worth and improving his confidence. He is communicating more appropriately with his family and they report feeling less fearful although they are not ready for unsupervised visits. Enrico recognizes that it is unlikely that he will be able to return home and plans to remain in Foster Care until he ages out at 18. The Care Coordinator and DCBS Social Service Worker continue to collaborate so that Enrico receives all necessary services and supports and to prepare him for transition to adulthood and independent living.

USE CASE 6 FOR KENTUCKY SKY

Mary, 5 years old, Louisville, Kentucky

Care Management	Challenges
Level III, Complex Care Coordination	Possible cognitive delays, communication difficulties, poor dental health, flat affect

Mary's preventive and routine medical care has been neglected, as has her social and developmental needs. Molina will work with DCBS to follow-up on Mary's EPSDT periodicity schedule, immunizations, and developmental needs. We will connect Mary to the appropriate supports and services, in collaboration with her foster family, school and specialty providers. Our primary concerns for Mary are to address her need for preventive EPSDT, dental, and developmental services. We also need to coordinate care for Mary to develop her communication skills. In our experience, individuals who have difficulty communicating may be considered cognitively delayed or display negative behaviors due to not being able to convey their needs. As demonstrated in this response, Molina's person-centered, creative approach to care will address Mary's needs in a holistic manner.

a. CARE MANAGEMENT

The DCBS Social Service Worker assigned to Mary may have contacted our 24-hour Call Center to notify us of Mary's pending eligibility. This call will prompt swift action by our Care Coordination team and her assigned care coordinator, Emma, will contact the Social Service Worker the next day to begin engaging with Mary and identifying her needs. This early notification process, which we develop in collaboration with DCBS, expedites the assessment process and facilitates access to services for Mary, who has immediate needs. Exhibit G.13-5 outlines our timeline and process for connecting Mary to services.
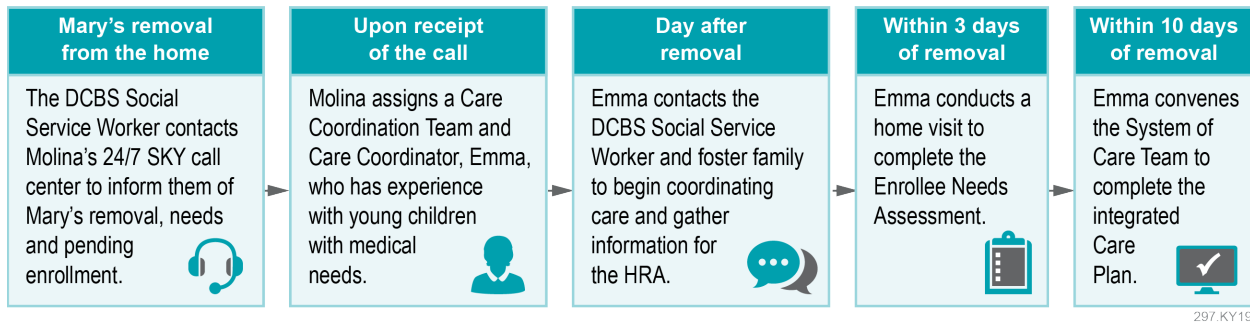
Mary's removal from the home	Upon receipt of the call	Day after removal	Within 3 days of removal	Within 10 days of removal
The DCBS Social Service Worker contacts Molina's 24/7 SKY call center to inform them of Mary's removal, needs and pending enrollment.	Molina assigns a Care Coordination Team and Care Coordinator, Emma, who has experience with young children with medical needs.	Emma contacts the DCBS Social Service Worker and foster family to begin coordinating care and gather information for the HRA.	Emma conducts a home visit to complete the Enrollee Needs Assessment.	Emma convenes the System of Care Team to complete the integrated Care Plan.

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Exhibit G.13-5. Molina's Early Notification Process Facilitates Access to Care

We assign Emma as Mary's Care Coordinator due to her experience in working with young children with cognitive delays, is accustomed to using alternative forms of communication, and can recognize ways that Enrollees who are non-verbal attempt to express themselves (such as hand gestures, facial expressions, noises). Emma's first step is to get existing information collected by our care coordination team at the time of the referral. Emma then outreaches to the Social Service Worker to collect additional information to inform Mary's HRA and get contact information for Mary's foster family. The DCBS Social Worker can provide some information on Mary's history as this was her second placement in foster care in the past year. It was during the previous placement that she was assessed for cognitive delays and was prescribed hearing aids. The DCBS Social Service Worker can provide names and contacts for the providers who previously served Mary as well as the developmental assessment. They are also able to access Mary's immunization records through the Kentucky Immunization Registry. Emma contacts previous providers to request her medical records. Having Mary's assessment, immunization, and medical information decreases the number of services and assessments she needs, reducing future trauma.
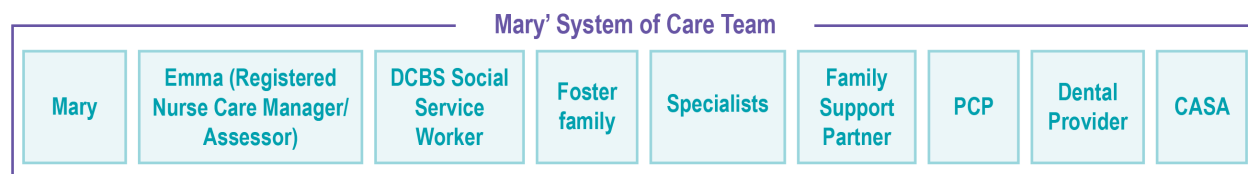
Emma contacts the foster family to complete the HRA, introduce herself and schedule time to complete the SKY Enrollee Needs Assessment. When completing the HRA, Emma speaks with the foster family to

assess for ACEs and the impact on Mary's functioning (Is she withdrawn? Does she display certain behaviors such as outbursts?). During this call, Emma asks about methods the foster family is using to communicate with Mary and her immediate, physical, behavioral health, and social determinants of health needs. They report that they are using hand gestures and facial expressions, which sometimes appear to frighten Mary. As Mary is malnourished and there is lack of documentation of medical care, Emma assists the foster family in scheduling an urgent appointment with Mary's PCP, which will occur the next day. Emma asks the foster family to contact her after the PCP appointment to arrange for any follow up care or services, such as nutrition supplements. Emma prioritizes completion of the Enrollee Needs Assessment to faclitate care planning and access to services. Based on Mary's risk level as demonstrated by her physical health conditions, functional impairment and need for services, the care coordination team determines that she would benefit from Complex Care Coordination.

Emma contacts the DCBS Social Service Worker to share the results of the HRA and develop a care management plan. She invites the Social Service Worker to participate in the SKY Enrollee Needs Assessment and asks for the assessment that resulted in Mary being determined to have cognitive delays.

Understanding Mary's Strengths, Needs and Priorities

Emma and the DCBS Social Service Worker meet with Mary and her foster family in their home to complete the SKY Enrollee Services Assessment. Due to Mary's obvious signs of trauma—flat affect and lack of expression, Emma is sensitive to signs that Mary is feeling overwhelmed when completing the Enrollee Needs Assessment, which includes the Child and Adolescent Strengths and Needs Assessment, the Ages and Stages Questionnaire, and the Trauma Symptom Checklist for Young Children. Emma completes the assessment by observing Mary, her responses to stimuli, and interactions with her foster family and incorporates information she received from Mary's previous providers and the DCBS Social Service Worker. The foster family expresses their concern about being able to care for Mary. Emma and the DCBS Social Service Worker agree to arrange for services to begin immediately. They also work with the family to develop a medical crisis plan that includes key contacts and resources the foster family can access if Mary displays symptoms that are concerning to them. Finally, the DCBS Social Service Worker, Emma, and foster family identify the following System of Care participants.

Mary' System of Care Team

Mary	Emma (Registered Nurse Care Manager/ Assessor)	DCBS Social Service Worker	Foster family	Specialists	Family Support Partner	PCP	Dental Provider	CASA

Developing Mary's Person-Centered Individual Health Plan

Given the need to immediately start services for Mary, Emma convenes the System of Care team two days after the assessment to develop her Care Plan. They identify the following goals and interventions.

Goals for Mary	Care Plan Interventions
Mary needs medical care.	• Due to Mary's multiple medical needs and the trauma she has experienced, Molina assigns a pediatrician and dental provider at Open Arms, a multispecialty clinic in Louisville. • Mary's pediatrician will initiative referrals and information sharing between her audiologist, her developmental psychologist, and children's rehabilitative services Provider. • Emma helps the foster family schedule an initial EPSDT visit, including a nutrition assessment and developmental screening within two days of enrollment.

Goals for Mary	Care Plan Interventions
Mary needs to be able to communicate with others.	• Through Open Arms, Mary receives a hearing assessment and appropriate follow up, such as hearing aids or communication devices. • Open Arms can provide Mary and her foster with communication cards and teach them how to use the cards to communicate with each other. • Open Arms can provide speech therapy and communication devices, as needed. • Emma also coordinates a sign language instructor for Mary.
Mary's services need to be coordinated between Providers and system partners.	• Emma will complete two face to face visits each month; weekly contacts; monthly meetings with Mary, her foster family, and DCBS Social Service Worker; maintain regular contacts with Mary's pediatrician and specialty Providers; and complete monthly Care Plan updates. • Emma will document Mary's assessment results and Care Plan in Clinical Care Advance, making it available to Mary's foster family, DCBS Social Service Worker, and providers through Molina's Health Backpack.
Mary's foster family needs support to care for her needs.	• Mary's System of Care team includes a Family Support Partner who connects her Foster Parent with local resources, such as support groups, and education for families of children who are deaf or hard of hearing, such as Hands and Voices or the Lexington Hearing and Speech Center. • Emma arranges for planned respite care to give Mary's foster family a break. As a value-added service, Molina offers an additional two days of respite each year.

Upon completion of the Care Plan, Emma collaborates with the DCBS Social Service Worker to arrange for all services and supports outlined in the Care Plan as discussed below.

Primary Care. Mary receives an initial EPSDT visit, including a nutrition assessment and developmental assessment within two days of enrollment due to her immediate medical needs. Mary's pediatrician updates her vaccines and assesses her achievement of developmental milestones. Mary's PCP is a developmental pediatrician trained in trauma-informed care and with experience in serving children with cognitive delays and communication needs. We gather information on PCP's specialties and areas of expertise during the initial credentialing process, and incorporate it into our Provider Directory, facilitating PCP assignment. When completing Mary's EPSDT services, the PCP applies trauma-informed strategies. For example, the PCP will take their time when examining Mary and look for signs that she is feeling overwhelmed or fearful. They will take extra time, as needed, to reduce the stress that Mary feels when participating in the exam.

Dental Care. We will assign a dental provider with experience in serving children with developmental delays. As Mary has not received dental care, she may be uncomfortable with this service. Emma arranges for a "get-acquainted" visit where Mary can sit in the chair and experience the office environment without receiving treatment, familiarizing Mary with the office and exam routine.

Specialty Services. Emma connects Mary to the Open Arms clinic in Louisville, which is operated by Home of the Innocents, a provider with whom Molina has a strong partnership. With services located in a single clinic, Mary can see a doctor, dentist, or behavioral health therapist by simply walking from one exam room to another. Open Arms also provides pediatric audiology services as well as outpatient physical, speech, and occupational therapies, and an on-site pharmacy. In addition to reducing the trauma Mary may experience, connecting her with a specialty clinic reduces the foster family's burden related to scheduling and transporting Mary to multiple appointments at several locations, and improves care coordination. Further, if the plan is to reunite Mary with her family, she can continue to receive services through a specialty clinic upon return home, facilitating continuity of care. Through the clinic, Mary can receive hearing aids and communication devices, as needed. She and her foster family can also learn sign language and how to use communication cards.

Care Coordination. Emma is responsible for collaborating with the Social Service Worker, providers, and her school to verify that Mary receives all services she needs without duplication. Emma will complete two face-to-face visits each month; weekly contacts; a minimum of two hours per week of care

coordination; monthly meetings with Mary, her foster family, and DCBS Social Service Worker; regular contacts with Mary's PCP and specialty providers; and monthly Care Plan updates.

Due to Mary's needs, she may be determined 'Medically Complex'. Emma will make a referral to the DCBS Medical Support Section for determination. If she is detremined to be Medically Complex, Emma can continue to support her as as she is a registered nurse, facilitating continuity of care and reducing the potential to retraumatize Mary by introducing more professionals into her life. Emma will provide nursing consultation services, home visits, and develop an Individual Health Plan—which will be integrated into the Care Plan—and coordinate with the Medically Complex Service team.

Mary may also be eligible for the Supports for Community Living Waiver if she is determined to have an intellectual disability. Emma contacts the DCBS Social Service Worker and she agrees to apply for waiver services. If Mary is determined eligible, Emma and the DCBS Social Service Worker will work together to transition her to that program without any disruption in care.

Family Support. Mary's System of Care team includes a Family Support Partner who connects her foster family with local resources such as support groups and education for families of children who are deaf or hard of hearing. Depending on location, Emma can link the family to Hands and Voices or the Lexington Hearing and Speech Center. As we learn more information about Mary's needs, the Family Support Partner walks alongside her foster family, connecting them to community resources and supports so they feel comfortable caring for Mary in their home. Emma provides the foster family with our System Navigation Guide, which identifies key milestones for EPSDT services and includes contact information for Mary's PCP, Emma, and DCBS Social Service Worker. The Guide places key information at the foster family's fingertips, to help them meet Mary's multiple needs.

Respite. Emma notes that respite care for the foster family will support Mary's placement stability and potential permanency with this family. Caring for a child with significant medical needs and disabilitis, such as Mary's, can be stressful for her foster family. Emma arranges for planned respite care to give them a break. Due to Mary's medical and communication needs, disabilities, and the trauma she has experienced, it will be important for the respite care provider to be trained to communicate with her and provide appropriate supports. If possible, Emma arranges for Mary to visit the respite home before any scheduled respite so that she feels comfortable in that setting.

The Care Plan also incorporates the care management plan, DCBS Service Plan, and IEP to facilitate care coordination and keep the System of Care team and providers focused on a consistent set of goals.

b. DISCHARGE PLANNING FOR ALL LEVELS OF CARE

Mary may experience a number of transitions while enrolled with Molina, including a transition to waiver services, transition to a new placement if her foster family is unable to care for her, or return to her mother's home. Emma will continue to serve as Mary's nurse care coordinator while she is enrolled in the SKY program. During any transitions, the System of Care team develops a transition plan that facilitates continuity of care. The transition plan will include steps to reduce Mary's stress during any change by allowing her time to visit any new placement or home, as appropriate. We will arrange for any new caregivers to receive training on Mary's individual needs, what works for her, what triggers frustration, and methods she uses to communicate. If Mary needs to be assigned to a new PCP based on accessibility standards, Emma will work with the placement and Social Services Worker to select a new PCP who is trained in trauma-informed care and is experienced in serving youth with complex medical needs and cognitive disabilities. The transition plan will be incorporated into Mary's Care Plan and updated monthly, as appropriate.

c. APPLICABLE EVIDENCE-BASED PRACTICES

The evidence-based practices we will leverage to support Mary and her foster family include:

Parent-Child Interaction Therapy (PCIT)	
Description	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.
Applicability to Mary	• This intervention will teach her foster family specific skills they can use to improve their interactions with Mary. • PCIT has been shown to be effective for children with developmental delays, making it an appropriate intervention for Mary.
Expected Outcomes	Mary's foster family will learn to communicate with Mary without triggering a trauma-related response, improving their relationship and ability to communicate and reducing the risk for placement disruption.
Trauma-Informed Care	
Description	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.
Applicability to Mary	• Mary has been exposed to significant trauma, which impacts her interactions with others. • Due to her need for extensive medical services, she is at risk for being re-traumatized. • Providers who take a trauma-informed approach when serving Mary and take extra time and read her non-verbal cues will obtain more accurate information on her needs while developing a trusting relationship.
Expected Outcomes	Mary will receive the medical care she needs and accurate diagnoses to inform interventions and services without being exposed to further trauma.
Picture Exchange Communication System (PECS)	
Description	Picture Exchange Communication System, or PECS, allows people with little or no communication abilities to communicate using pictures. People using PECS are taught to approach another person and give them a picture of a desired item in exchange for that item. By doing so, the person can initiate communication.
Applicability to Mary	Mary is currently unable to speak or use alternative forms of communication, such as sign language, and needs a mechanism to communicate.
Expected Outcomes	Mary will be able to communicate her needs and wants to her foster family, improving their ability to care for her.

d. SCHOOL-BASED SERVICES

The DCBS Social Service Worker agrees to contact the local school district to evaluate Mary for school-based, special education services, including speech therapy, occupational therapy, cognitive skills development, and assistive devices. As needed, Emma can seek guidance from our designated school-based services expert for information on available services and strategies for advocating for Mary. Emma will work with the school, DCBS Social Service Worker, and foster family to participate in IEP development and coordinate services to reduce duplication and make sure that Mary does not experience gaps in care such as when schools are on break.

e. SOCIAL DETERMINANTS OF HEALTH

Mary has clearly experienced the effects of social determinants of health, including food security, access to regular healthcare services and likely, poverty. While she is in care, we will coordinate with the Social Service Worker, foster family, and providers to address these needs. We will assure Mary has access to proper nutrition through nutritional services provided by specialty clinics, and receives age-appropriate EPSDT screenings and specialty services to address her medical needs and any behavioral health needs that arise.

If Mary's mother is eligible for Medicaid services, our System of Care team will work with the Social Service Worker to address the social determinants of health that may have led to Mary's removal from the home. They will connect Mary's mom to appropriate supports to address poverty (financial assistance through TANF and SNAP benefits), employment/vocational training as appropriate, education to improve her health literacy, family education (such as learning sign language) and support that enhances her ability

to care for Mary, and transportation to appointments, as needed. Having these supports in place will lead to better care for Mary if she returns home.

f. COMMUNITY RESOURCES

Our Family Support Partner will connect Mary's foster family to local resources such as support groups and education for families of children who are deaf or hard of hearing, such as Hands and Voices in Louisville. We will also link the foster family to supports available through the Kentucky Special Parent Involvement Network (KY-SPIN) Parent Center. The Parent Center provides training and information and support for children and youth with disabilities, their parents, families, and professionals. For example, the foster family can participate in community workshops on education laws, rights, and listening and community skills.

g. ACCESS TO AND SHARING OF MEDICAL RECORDS

Emma documents the results of Mary's HRA, SKY Enrollee Needs Assessment and Care Plan in Clinical Care Advance. The information is loaded to our *Health Backpack*, making it readily accessible to Mary's foster family, providers, and Social Service Worker. Providers involved in Mary's care can view the information, promoting care coordination and a collective focus on a single set of goals for Mary. Emma acts as the hub for this information, making sure that providers have the information they need to effectively serve Mary and avoid duplication of services. The *Health Backpack* facilitates access to needed care and services through alerts when services are needed. Because it will store screenings and assessments, providers and other caregivers with appropriate access will be able to view important information about Mary when determining appropriate courses of treatment. Mary's foster family can download information from *Health Backpack* to include in her Medical Passport.

h. MAINTENANCE OF THE CARE PLAN

Emma monitors, follows-up, and evaluates the effectiveness of the services provided on an ongoing basis through monthly face-to-face visits, weekly telephone contacts, monthly meetings with the group home and Social Service Worker, and monthly Care Plan updates. Molina works in concert with Mary's Social Services Worker so that the services Mary receives are not duplicated. Together, they integrate the DCBS Service Plan, the school's IEP, and any other plan of care from other organizations in one single plan for ease of use by Mary's foster family, providers, and System of Care team. Emma communicates findings and Care Plan updates to the team as appropriate based on Mary's needs and strengths.

Expected Outcomes for Mary
We anticipate that gathering a full understanding of Mary's needs and connecting her with appropriate interventions and services will have a significant, positive impact on her life. Specifically, teaching Mary how to communicate with others will enable her to develop social skills, increase her ability to perform in school, and learn appropriate coping skills. Further, through regular access to preventive services and dental care, we can reduce the risk of Mary developing serious, chronic health conditions. Connecting Mary's foster family with supports and resources allows them to continue caring for her, reducing placement disruption and minimizing further trauma. If Mary returns home to live with her mother, our transition plan will facilitate continuity of care through continued access to appropriate services and supports. Additionally, we will assist the Social Service Coordinator in connecting Mary's mother to community resources that can assist her in properly caring for Mary, promoting permanency and resiliency for this family.

USE CASE 7 FOR KENTUCKY SKY

Julie, 17 years old, Bowling Green, Kentucky

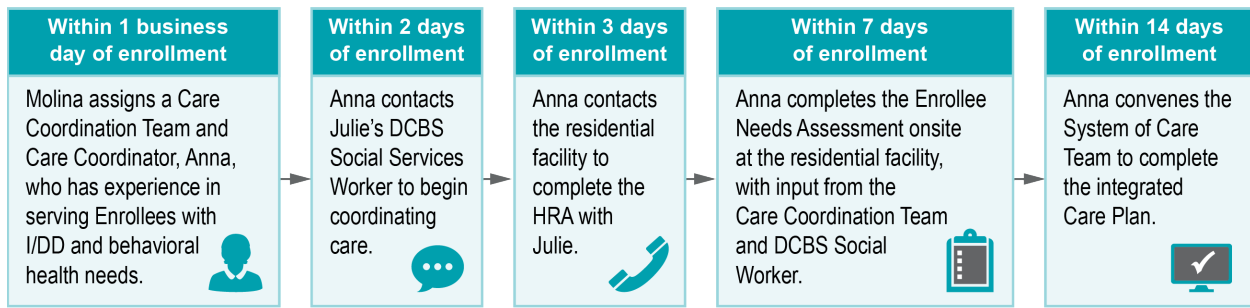| Care Management	Challenges
Level III, Complex Care Coordination	Intellectual disability, little to no contact with family, behavior challenges, multiple psychotropic medications

Julie has been in care for 10 years and her team has yet to identify the right care to help her be successful. Molina will take a detailed history, and will collect all available information on Julie's decade of care to identify her unique strengths and interests to construct a Care Plan that she directs. Julie has been in care for a long time and is accustomed to others making decisions for her. We will help Julie to find her voice, identifying her strengths and goals. We will also work closely with Julie to plan her transition to adulthood and encourage her to remain in the SKY program beyond her 18th birthday.

a. CARE MANAGEMENT

We will focus Julie's care on providing her with the right type(s) and intensity of services, based on her successes in the past and evidence-based practices with the goal of assisting her to develop the skills she will need to live as independently as possible as she becomes an adult. Exhibit G.13-6 depicts our care coordination timeline and how we will engage Julie once we receive notification of Julie's enrollment.

Within 1 business day of enrollment	Within 2 days of enrollment	Within 3 days of enrollment	Within 7 days of enrollment	Within 14 days of enrollment
Molina assigns a Care Coordination Team and Care Coordinator, Anna, who has experience in serving Enrollees with I/DD and behavioral health needs.	Anna contacts Julie's DCBS Social Services Worker to begin coordinating care.	Anna contacts the residential facility to complete the HRA with Julie.	Anna completes the Enrollee Needs Assessment onsite at the residential facility, with input from the Care Coordination Team and DCBS Social Worker.	Anna convenes the System of Care Team to complete the integrated Care Plan.

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Exhibit G.13-6. Molina's Timeline and Process for Engaging Julie

Julie's assigned care coordinator, Anna, contacts the DCBS Social Service Worker to introduce herself, gather information on Julie's history and current needs, which will inform her HRA. Anna gets the name of Julie's PCP and requests medical records to learn about the providers that have been serving Julie. Anna contacts Julie's providers to obtain her medical records and inform them that she will be coordinating Julie's care.

Anna contacts the residential facility to complete the HRA with Julie and the residential staff. She also screens Julie for ACEs, physical, behavioral health and social determinants of health needs. Anna also obtains a list of Julie's medications for review by our pharmacist. During this call, she works to gain an understanding of what is important to Julie, her functioning level, needs, and strengths. Julie states that she doesn't like living at the residential treatment facility and would like to live somewhere she has her own room and a family. She says that when she turns 18, she's "out of there." Anna explains that her role is to help Julie identify her goals for the future and arrange for services and supports to meet those goals. Julie likes the idea of being in charge of her own life and promises to think about what she wants to do.
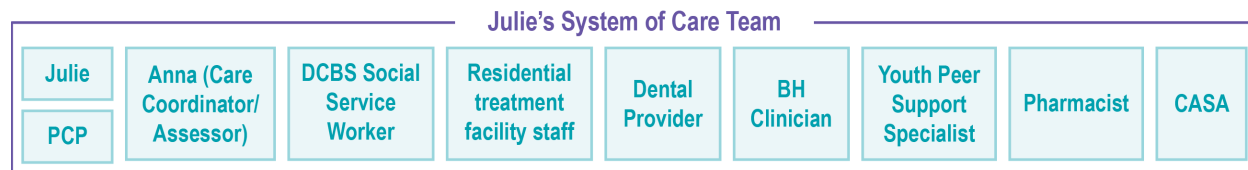
Anna shares the results of the HRA with the Care Coordination Team. Based on Julie's risk level as demonstrated by her significant behavioral health needs and history of inpatient treatment, history of aggression, complex medication regimen and intellectual disability, the Care Coordination team determines that she would benefit from Complex Care Coordination.

Understanding Julie's Strengths, Needs, and Priorities

Before her visit with Julie, Anna reviews all available medical records received from Julie's providers as well as information provided by the DCBS Social Service Worker to complete portions of the SKY Enrollee Needs Assessment, reducing the number of questions she needs to ask Julie. Anna and the DCBS Social Service Worker meet at the residential treatment facility to complete a face-to-face Enrollee Needs Assessment, which includes the Child and Adolescent Strengths and Needs (CANS) assessment, and the Trauma Symptom Checklist. When completing the Enrollee Needs Assessment, Anna employs a trauma-informed approach—she explains the purpose of the assessment and how the information will be used, allowing Julie to select the order of the topics to be discussed, and discuss what is important to her. Anna conducts a transition to adulthood assessment to identify Julie's interests and goals upon turning 18.

During the Enrollee Needs Assessment, Anna recognizes that Julie becomes easily frustrated when she doesn't understand specific questions or terms and is unable to attend for more than 20 minutes at a time. To encourage Julie's participation, she has the opportunity to take breaks, as needed. Anna also observes Julie's behavior and interactions with staff and peers to obtain a complete picture of her functioning level, socialization skills and emotional variability. She notices that Julie is very friendly with the others and accommodating when staff or other residents ask her to do something. Julie seems to enjoy being able to speak with Anna and participate in the assessment. When asked about her goals for adulthood, Julie states that she's not sure about what services area avilable and how she would take care of herself. Anna explains that she is eligible for Aging Out services and that she can apply for waiver services to access additional supports. Julie agrees to discuss transition to adulthood at her care planning meeting.

Anna, Julie, and the DCBS Social Service Worker discuss who should be on Julie's System of Care team. Julie states that she would like to include a staff at the residential treatment facility that she is close to and her Court Appointed Special Advocate (CASA), who visits her and calls to check in. Julie also likes the idea of having a youth peer support specialist on the team who understands what she is going through. Together, they determine that the following participants should be on Julie's System of Care team.

Julie's System of Care Team

| Julie / PCP | Anna (Care Coordinator/ Assessor) | DCBS Social Service Worker | Residential treatment facility staff | Dental Provider | BH Clinician | Youth Peer Support Specialist | Pharmacist | CASA |

Developing Julie's Person-Centered Integrated Care Plan

Anna schedules a meeting to complete the Care Plan at the residential setting and invites all participants from the System of Care team. The PCP agrees to provide input before the meeting, as they are unable to attend in person. During the care planning meeting, Julie explains her goals and the System of Care team works together to identify the following interventions.

Julie's Goals	Care Plan Interventions
I want to live somewhere else.	• The System of Care team reviews Julie's needs and recommends placement in a Therapeutic Foster Care home. • Anna and the System of Care team identify potential Therapeutic Foster Care homes located in an area of the Commonwealth where she is familiar. • The System of Care team develops a transition of care plan to facilitate continuity of care and assist Julie in transitioning to the Therapeutic Foster Care home. • Anna uses our Transition Checklist to verify that Julie's records have been transferred and services and supports are in place.
I want to control myself better when I'm upset.	• A Molina psychiatrist conducts a medication review to assess Julie's medication regimen against best practice prescribing patterns and works with her psychiatrist to determine medication options to address her symptoms with the least risk for negative side effects. • Anna refers Julie for Applied Behavioral Analysis (ABA) at the Community Mental Health Center (CMHC) where she is receiving medication management.

Julie's Goals	Care Plan Interventions
I need help with understanding services.	• Anna collaborates with the DCBS Social Service Worker and providers to verify that Julie receives all services she needs without duplication. • The System of Care team completes a transition to adulthood assessment to determine Julie's desire and skills to transition to independence and coordinates with her school's transition plan. • Anna serves as Julie's single point of contact and completes weekly contacts; two face-to-face visits each month, and has monthly meetings with the System of Care team. She explains available benefits, provides coaching, answers questions, and addresses her needs as they arise. • Julie's System of Care team includes a youth peer support specialist who connects her to community resources and explains available benefits.

Upon completion of the Care Plan, Anna collaborates with the DCBS Social Service Worker to arrange for all services and supports outlined in the Care Plan as discussed below.

Placement setting. The System of Care team determines that an alternative placement setting may be more appropriate. When conducting the Enrollee Needs Assessment, Anna noted that Julie appears to be over-stimulated by milieu and that being in groups of people was a trigger for Julie's behavior. Therapeutic Foster Care offers a less restrictive environment in a home-like setting and offers a more flexible approach to care, which may reduce the stimuli that triggers Julie's aggression.

Primary care services. The residential setting is currently transporting Julie to a PCP who is convenient to their location for EPSDT services, so she continues to receive services through that provider. If Julie needs to be assigned to a new PCP based on accessibility standards, Anna will work with the foster home and DCBS Social Service Worker to select a new PCP who is trained in trauma-informed care and is experienced in serving youth with intellectual disabilities and behavioral health needs.

Dental Care. Julie will benefit from receiving dental care from a provider with experience in serving Enrollees with complex needs and disabilities. Anna will identify a dental provider near the Therapeutic Foster Care home. To ease Julie's anxiety due to the number of changes she is experiencing, Anna offers to arrange for a "get-acquainted" visit with the dental provider. During this visit, Julie can become familiar with the office and the exam routine before an actual visit.

Medication Therapy Management. Molina's psychiatrist completes a medication review to assess Julie's medication regimen against best practice prescribing patterns and completes a peer consultation with her treating psychiatrist to determine the most appropriate medications to address her symptoms with the least risk for negative side effects.

Behavioral health services. Julie requires behavioral health services to reduce her level of aggression, improve her coping skills, learn to recognize an increase in symptoms, and develop strategies for self-management. Anna refers Julie for Applied Behavioral Analysis (ABA) at the Community Mental Health Center where she is receiving medication management. A licensed, certified ABA therapist fully evaluates Julie's needs to identify the underlying causes for her aggression and coordinate with the System of Care team to develop a Behavior Support Plan. The Behavior Support Plan will identify proactive and positive interventions providers and staff can employ to reduce the frequency and intensity of Julie's behaviors. The ABA therapist will also provide training to the staff at the Therapeutic Foster Care home so they can reinforce positive behaviors and use de-escalation techniques to mitigate a crisis.

School-based services. Once Julie is transitioned to Therapeutic Foster Care, she will receive educational services at a local school. Before discharge, the DCBS Social Service Worker will contact the local school district to inform them of Julie's move, request an educational evaluation and begin the process of developing an IEP. The System of Care team will work with the school to identify the education-related services and supports they will provide for Julie.

Care Coordination. Anna is responsible for collaborating with the DCBS Social Service Worker and Providers to verify that Julie receives all services she needs without duplication. Anna will engage with Molina's System of Care liaison to educate local law enforcement on the needs of SKY Enrollees, Mental Health First Aid, and the availability of our 24/7 Behavioral Health Hotline to support emergent situations. The liaison encourages them to contact us when managing situations that include SKY Enrollees with behavioral health needs or intellectual/developmental disabilities so that we can provide appropriate resources, reducing their risk involvement with the justice system.

Julie's Care Plan will incorporate her DCBS Service Plan, care management plan, and any other service plans from providers that are accessible to Anna.

b. DISCHARGE PLANNING FOR ALL LEVELS OF CARE

Upon completion of Julie's Care Plan, Anna will identify Therapeutic Foster Care settings that may be appropriate. She will coordinate with the Social Service Worker to schedule time for the Foster Care staff to visit Julie in the residential placement to determine if they have the skill and expertise to meet her needs. Once a placement is identified, Anna will convene the System of Care team to develop a transition plan. The transition plan may include opportunities for Julie to visit the Foster Home to become familiar with the home and staff. If she is unwilling or unable to visit the home, Anna will show her pictures to ease her anxiety with the transition and assist her in becoming comfortable with a new environment.

As part of the transition, Anna will arrange for the Therapeutic Foster Care Home to receive training on Julie's specific needs, including triggers for her behavior, what works and what doesn't work, and strategies for de-escalating behaviors. This training will be provided by our Master's level licensed Behavioral Health Clinician or the residential staff, if they are available. Anna will also arrange for Julie to receive ongoing primary care, dental care, and behavioral health services and community-based supports, as appropriate. Any required follow-up services, EPSDT appointments, and ongoing care will be scheduled before Julie's discharge from the residential setting.

c. PRESCRIBING PSYCHOTROPIC MEDICATIONS

A primary concern is Julie's medication regimen since she is taking more than four psychotropic medications. Through our Psychotropic Medication program, any psychotropic medications prescribed for Julia must be prior authorized based on review by a board-certified child psychiatrist. Our psychiatrist will require Julie's psychiatrist to document the expected outcome as well as the therapeutic behavioral health services that will be provided in addition to medications. Further, the psychiatrist or prescribing Provider must document completion of lab tests when submitting requests for continued authorization. Anna will update's Julie's medication list and include it in our *Health Backpack*, from which the foster family can print and include in Julie's Medical Passport.

d. EVIDENCE-BASED PSYCHOTHERAPEUTIC INTERVENTIONS

Through our network of providers, Julie has access to the following evidence-based services.

High Fidelity Wraparound Approach	
Description	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 to develop a family-driven plan that promotes self-advocacy. The Enrollee and family's self-identified goals will be integrated into a single Care Plan that includes natural supports and services provided through all child-serving systems.
Applicability to Julie	• As Julie is nearing adulthood, placing her in the driver's seat of her own care is an important step for her to learn to self-manage. • The System of Care team creates a Care Plan based on Julie's goals and priorities. • The System of Care team provides coaching and education to improve the Therapeutic Foster Home's ability to support Julie and reduce the triggers for her behaviors, connect Julie to community-based resources, and integrate all services and supports into an integrated Care Plan.
Expected Outcomes	Julie will develop the skills to advocate for her needs and priorities and learn self-management strategies as she moves toward adulthood.

High Fidelity Wraparound Approach Trauma Informed Care	
Description	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.
Applicability to Julie	• Julie was exposed to significant trauma, which impacts her ability to interact with others. • Julie's System of Care team and providers will apply a trauma-informed care approach, building trust and encouraging her to actively participate in services.
Expected Outcomes	Julie will actively participate in treatment delivered in a non-threatening manner by individuals that respect her needs and preferences, building her confidence.
Applied Behavior Analysis	
Description	ABA 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 ABA 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 ABA therapist to educate System of Care teams and Providers on ABA techniques.
Applicability to Julie	• ABA will help Julie and her caregivers to identify the reasons for her behavior and develop a Positive Behavior Plan to replace her aggression with appropriate responses. • ABA will help Julie to transfer skills and behavior from one situation to another, controlling situations where negative behaviors arise and minimizing negative behaviors.
Expected Outcomes	Julie will learn appropriate responses to situational and environmental triggers, reducing her episodes of aggression.

e. VIABILITY OF AGING OUT OF FOSTER CARE

As part of Julie's Enrollee Needs Assessment, the System of Care team completes a transition to adulthood assessment to determine Julie's interest in and ability to participate in Aging Out services. The System of Care team explains to Julie that she has the option to age out of Foster Care services at age 18 or she can choose to continue receiving Foster Care services until age 26. Julie is unable to decide whether she wants to stay in Foster Care or exit the system. The team is concerned that, due to her intellectual disability and impaired functioning, that Julie may need a guardian. They assess her needs and develop a transition plan that includes:

• The array of services and supports Julie will need and potential service providers.
• Community resources and supports to address social determinants of health such as housing, food security, and financial resources.
• Potential risks to a successful transition such as medication compliance and impaired functioning.
• Recommendation for access for specialized supports including but not limited to positive behavioral supports, medication support, DME, and home modifications.
• Options for transitioning to HCBS or another waiver program, as discussed below.
• An assessment of Julie's need for a guardian.

During monthly Care Plan updates, the System of Care team assesses Julie's interest in aging out of Foster Care and the services and supports she will need and update the transition plan, as appropriate.

f. OPTION FOR TRANSITIONING TO AN APPLICABLE WAIVER

Julie may be eligible for services through the Michelle P. Waiver, which offers individualized community-based service to individuals who have intellectual or developmental disabilities. If Julie is found eligible for this waiver, she will have access to a full array of community-based services and supports such as therapies, natural supports training, transportation, assessment/reassessment, community transition, consultative clinical and therapeutic service, environmental accessibility adaptation, person

centered coaching, and positive behavior supports. These services and supports will be important for helping Julie to live as independently as possible in the community.

Anna requests that the CMHC complete a Michelle P. Waiver assessment to determine Julie's eligibility. If she is determined eligible, the Care Coordinator will collaborate with the System of Care team to transition her from the SKY program. Anna will facilitate the sharing of Julie's medical records and make sure there is no lapse in services during the transition.

g. ACCESS TO AND SHARING OF MEDICAL RECORDS

Anna documents the results of Julie's HRA, Enrollee Needs Assessment and Care Plan in Clinical Care Advance, making it available to the System of Care team through Molina's *Health Backpack*, a portable digital personal health record. Providers involved in Julie's care can view the information, promoting care coordination and a collective focus on a single set of goals for Julie. Anna acts as the hub for this information, making sure that System of Care team members have the information they need to effectively serve Julie and avoid duplication of services.

As part of Julie's transition plan, Anna will obtain her medical records from the residential setting and her current PCP and behavioral health and dental providers. They will assure the Therapeutic Foster Care home and all providers involved in Julie's care receive pertinent information through *Health Backpack*, our cloud-based, portable medical record. Providers involved in Julie's care can view the information, promoting care coordination and a collective focus on a single set of goals for Julie. The DCBS Social Service Worker or caregiver can download and print pertinent documents to be included in Julie's Medical Passport. Julie can continue to access her *Health Backpack* for five years after disenrolling from the SKY program, facilitating her independence as she transitions to adulthood.

h. MAINTENANCE OF THE CARE PLAN

Anna monitors, follows-up, and evaluates the effectiveness of the services provided on an ongoing basis through face-to-face visits, weekly telephone contacts, monthly meetings with the Therapeutic Foster Care home and DCBS Social Service Worker, and monthly Care Plan updates. Anna works in concert with Julie's DCBS Social Services Worker to confirm that the services she receives are not duplicated and that the DCBS service plan, the school's IEP and any other plan of care from other organizations are coordinated and incorporated in one single plan for ease of use by Julie, providers, and Therapeutic Foster Care home. Anna communicates findings and Care Plan updates to the System of Care team as appropriate based on Julie's needs and preference.

Expected Outcomes for Julie
Julie's needs are complex and she will likely require intensive supports to successfully transition to a community-based setting. With proper medication therapies, positive behavior supports and close care coordination, we expect that the frequency and intensity of Julie's aggressive outbursts will decrease. As she develops appropriate coping skills and experiences an environment with less stimuli, her ability to interact appropriately with others will increase and her functioning level will improve, enabling her to live in the community with appropriate supports.

USE CASE 8 FOR KENTUCKY SKY

Amanda, 10 years old, eastern Kentucky

Care Management	Challenges
Level III, Complex Care Coordination for Children with Medical Complexity	Failing health, multiple medications, complex health needs, depression, and eating issues

Amanda is a young girl who has experienced significant trauma in her life related to her multiple medical issues, exposure to her mother using substances, and being removed from her home and moved to non-familial care. Her medical condition is worsening, she has no contact with her biological family, and her foster family is having difficulty caring for her. Molina will connect Amanda to the right services, closely coordinating across systems and providers. We will work to ease the burden on Amanda's foster family to reduce the risk of placement disruption, while arranging for Amanda to receive proper medical care.

a. CARE MANAGEMENT

Amanda's complex medical issues are compounded by her reaction to the separation from her family. Molina will focus on coordinating physical, behavioral, and social supports for Amanda and her foster family. Our person-centered care coordination services for Amanda are based on the High Fidelity Wraparound Approach and the Medically Complex Service team model, and connect SKY Enrollees to services and supports in a timely manner—as shown in Exhibit G.13-7.
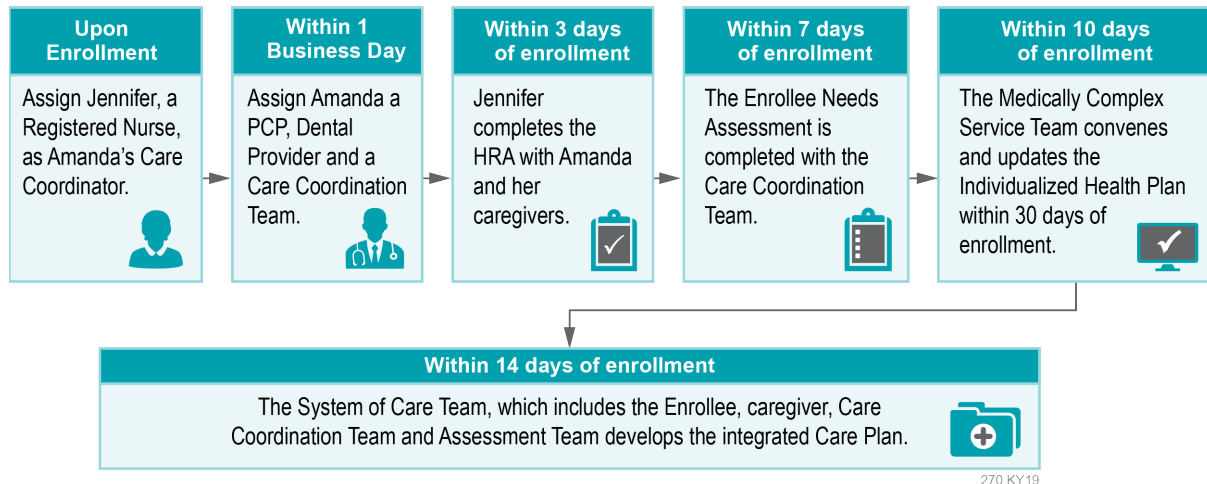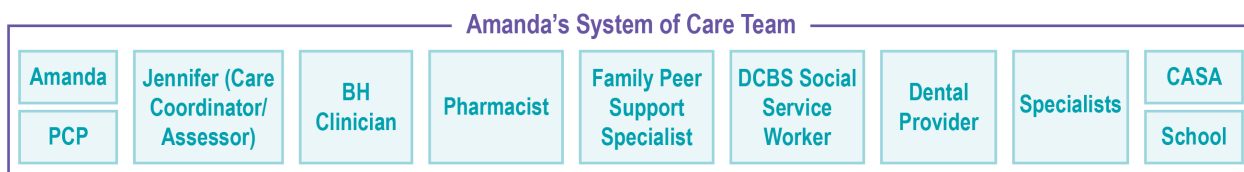
Upon Enrollment	Within 1 Business Day	Within 3 days of enrollment	Within 7 days of enrollment	Within 10 days of enrollment
Assign Jennifer, a Registered Nurse, as Amanda's Care Coordinator.	Assign Amanda a PCP, Dental Provider and a Care Coordination Team.	Jennifer completes the HRA with Amanda and her caregivers.	The Enrollee Needs Assessment is completed with the Care Coordination Team.	The Medically Complex Service Team convenes and updates the Individualized Health Plan within 30 days of enrollment.

Within 14 days of enrollment

The System of Care Team, which includes the Enrollee, caregiver, Care Coordination Team and Assessment Team develops the integrated Care Plan.

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Exhibit G.13-7. Molina Quickly Assesses Amanda's Needs and Provides Services

Amanda is identified as having a designation of Medically Complex on the enrollment file. This prompts Molina to assign Jennifer, a registered nurse who has worked her entire career supporting children with multiple medical needs, in Kentucky as her care coordinator. Jennifer contacts the DCBS Social Service Worker to gather information on Amanda's history and to gather information for her HRA. Amanda's medical needs have been well documented so the DCBS Social Service Worker can provide Jennifer with complete records as well as contact information for all of Amanda's providers. Jennifer contacts them to request any additional information on Amanda's status. Jennifer makes sure that Amanda can continue receiving services through her current PCP if they meet time and distance standards.

Jennifer then contacts Amanda's foster family to explain her role in coordinating Amanda's care and to explain the services available through Molina. She also speaks with them about Amanda's behaviors and conducts an ACEs questionnaire to get a clearer picture on the amount of trauma Amanda has experienced and the effects. Amanda is not feeling well and is unable to talk on the phone. Jennifer asks the family to hold the phone for Amanda so she can introduce herself. She tells Amanda that she will visit

her at home in the next week. Amanda's foster family explains that Amanda's medical needs are overwhelming to them and they are concerned that they will be unable to continue caring for her. Amanda hears that discussion and breaks into tears. Jennifer assures the family and Amanda that she will be available to support them and, with the DCBS Social Service Worker, will connect them to the right services. The foster family, Amanda, and Jennifer discuss who will be on Amanda's System of Care team. In addition to the providers that serve her, Amanda likes the idea of having a youth peer support specialist. She spends all of her time surrounded by adult caregivers and doctors and feels she has no one to talk to that understands. Amanda's System of Care team includes the following participants.

Amanda's System of Care Team

Amanda	Jennifer (Care Coordinator/ Assessor)	BH Clinician	Pharmacist	Family Peer Support Specialist	DCBS Social Service Worker	Dental Provider	Specialists	CASA
PCP								School

Jennifer convenes the System of Care team to develop Amanda's Care Plan. During the meeting, she encourages Amanda to express herself and share what she wants with the team. Amanda expresses that her primary goal is to feel better and that she doesn't want to die. She also states that she wants to be able to make some choices for herself. Guided by Amanda and her foster family's priorities and needs, the Care Plan includes the following goals and interventions.

Goals for Amanda	Care Plan Interventions
I want to feel better.	• Jennifer arranges for transportation so Amanda can continue to receive services through her current cardiologist. The foster family can also choose another provider such as the Specialty Clinic at the Highlands Regional Medical Center. • Jennifer can assist the foster family to schedule an EPSDT well-child visit at the Specialty Clinic on the same day as her cardiology appointment, reducing their travel. • The Medically Complex Service team reviews and monitor Amanda's medication needs. • Jennifer coordinates authorization of DME for oxygen or current prescriptions. • Jennifer continues to assess Amanda's changing DME needs. • The System of Care team arranges for a hospital bed to assist with her oxygen needs as she needs to sleep evaluated or with a wedge pillow. • Pharmacist conducts a medication review to determine if the anti-depressants Jennifer is taking have an impact on her heart condition. • Jennifer requests that a Respiratory Therapist assess for DME to address oxygen needs. • Jennifer provides education, additional training, and monitoring to support her foster family in providing oxygen and to ensure DME is delivered and being utilized appropriately. • PCP to assess for malnutrition • Jennifer connects with Amanda behavioral health therapist at Mountain Comprehensive Care Center to help her cope with the trauma she has and continues to experience. • Jennifer arranges for continued skilled nursing services to check Amanda's oxygen levels, weight, cardiac status, medications and mental status.
I want to have a say in my life.	• Jennifer arranges for Amanda to receive supports through a youth peer support specialist who will call and visit with Amanda throughout the week, and who Amanda can contact when she wants to talk. • The team assists Amanda in creating a menu of food options that she likes and her foster family agrees to keep those foods in the home. Amanda agrees to eat if she can choose her meals. • Amanda provides input on the providers and caregivers that serve her. The team works with the skilled nursing provider to have Amanda's favorite caregivers on when she is most likely to be awake.

The System of Care team is responsible for assuring that all the services and support referrals have been made within the documented time frames in the Care Plan and that visits have been scheduled.

Specialty Services. Jennifer connects the Family to the Specialty Clinic closest to where Amanda lives – the Prestonsburg clinic at the Highlands Regional Medical Center provides cardiology services. Amanda and her foster family may also see a nurse, social worker, nutritionist, Family-to-Family support parent, physical therapist, or occupational therapist at the clinic.

Medication Management. Medication review and reconciliation will be high-priority for Amanda's assessment and care planning. The Medically Complex Service team reviews Amanda's medication as an integral part of all care management and coordination. This includes coordination of medications across clinical providers, assessment of adherence from prescription fill data and other sources, issues of consent for psychotropic medication, medication refusals, and educational needs of caregivers. The Medically Complex Service team and her System of Care team can draw on the resources of Molina pharmacists and its Medication Therapy Management program as needed.

Behavioral Health Services. Jennifer discusses with the pediatrician Amanda's depression and connects with her behavioral health therapist at Mountain Comprehensive Care Center to provide the most recent medical and psychosocial information available and to schedule a reassessment. This therapist has significant experience with treating children with eating issues and children with depression. The behavioral health provider also offers trauma-focused cognitive behavior therapy (TF-CBT) that Amanda can participate in with her foster family.

Durable Medical Equipment (DME). Jennifer ensures there is no gap in authorization of DME for oxygen or current prescriptions, which are noted in her Individual Health Plan and Care Plan. If a provider recommends a change or addition in Amanda's DME (hospital bed, wheelchair), Jennifer follows up on outstanding authorizations. She provides education, additional training, and monitoring to support her foster family in providing oxygen and positioning Amanda. She assures that Jennifer has back-up and portable oxygen tanks as well as a plan if a power outage.

Primary Care services. Amanda can receive EPSDT services through the Highlands Regional Medical Center, reducing the number of trips she and the foster family must make to assure she receives timely well child services.

Dental Care. The System of Care team connects Amanda to make sure she has no infections or oral health conditions that may exacerbate her heart condition.

b. INVOLVEMENT OF THE MEDICALLY COMPLEX SERVICE TEAM

Jennifer serves as the primary contact for the foster family and coordinates services across the System of Care team, Medically Complex Service team and all providers that serve Amanda. Jennifer provides nursing consultation services to Amanda's DCBS Social Service Worker and foster family. Jennifer incorporates a medical assessment into the Enrollee Needs Assessment, which she conducted in Amanda's home, reducing the number of assessments that Amanda receives. She convenes the Medically Complex Service team to review the results and inform the Individual Health Plan. Amanda's Medically Complex Service team consists of a Field Services Office Supervisor, Social Service Worker, Medically Complex Liaison, Amanda's caregivers, a pharmacist, and Amanda's pediatric cardiologist. Jennifer convenes a meeting, at minimum, every three months with the Medically Complex Service team to review the Individual Health Plan, Amanda's current needs, and re-evaluate her Medically Complex determination.

c. DISCHARGE PLANNING BETWEEN LEVELS OF CARE

If Amanda is admitted to a hospital for another open-heart surgical procedure, Molina will begin discharge planning on day one of Amanda's admission. Her discharge plan will address all services and supports she needs to recover, including medication reconciliation, weekly skilled nursing, surgical wound care, and education for the foster family on how to care for her. For example, the foster family will

need to be able to recognize signs and symptoms of infection and rejection of the transplant. The team will evaluate Amanda's needs for DME such as a walker before discharge. As needed, Jennifer will arrange for in home therapies and other services.

d. IHP DEVELOPMENT AND MAINTENANCE WITHIN SPECIFIED TIMEFRAMES

Due to Amanda's significant medical needs, we prioritize completion of the Individual Health Plan. Within 10 days of Amanda's enrollment, Jennifer facilitates a meeting with the Medically Complex Service team to assess her ongoing needs and update the Individual Health Plan that was created when she first received the designation of a Medically Complex child. Jennifer invites all Medically Complex Service team members to the planning meeting to:

• Develop an Individualized Health Plan

• Review current medical services and medical providers

• Incorporate Amanda's current and potential medical and rehabilitative and long-term needs into her care and treatment

• Identify additional services to meet the Amanda's needs

• Assess whether the Amanda's needs continue to warrant a medically complex designation

• Outline steps the foster family can take if Amanda has increased symptoms or an urgent situation

Jennifer updates Amanda's Individual Health Plan every six months and distributes signed copies to members of the Medically Complex Service team and the System of Care team, in alignment with the High Fidelity Wraparound Approach. If Amanda receives a transplant or her needs change before six months, Jennifer will convene the Medically Complex Service team to update the Individual Health Plan,

e. AVAILABILITY OF AND ACCESS TO PROVIDERS

Because Amanda and her family live in rural eastern Kentucky, an area with limited access to services, the team considers all available options for providers. If she needs additional services beyond what is provided at the Specialty Clinic, she can access those via telehealth at the clinic. We may connect Amanda to services in a bordering state such as Virginia or West Virginia. Jennifer may refer her to behavioral health services at a CMHC with telehealth capabilities for counseling services. Our goal will be to connect Amanda and her foster family to the nearest provider with the expertise to meet her needs.

f. THE MEDICAL PASSPORT

Jennifer confirms with the foster family that they have a Medical Passport for Amanda. Amanda helps the foster family add relevant information and provides education on any component of the Medical Passport they may not understand. Amanda's *Health Backpack* is readily available to her foster family and helps them maintain up-to-date information in the Medical Passport.

g. TRAINING AND SUPPORT FOR CAREGIVERS

The Skilled Nurse trains Amanda's foster family on how to manage the oxygen tank, properly administer her medications, and address any other care needs. The System of Care team connects them to online caregiver resources and the virtual support group for foster families available through the University of Kentucky. Jennifer and the Skilled Nurse trains providers coming into the home to care for Amanda, including DME providers and personal care attendants on trauma-informed care and qualifications to care for Amanda and are well versed in her needs and preferences.

h. COORDINATION OF TRANSPORTATION

Jennifer confirms that the foster family has reliable transportation (a family car) but getting Amanda to her appointments proves challenging because of her multiple appoints and the family only having one vehicle (her foster father works out of the home and uses the car to get to work). Jennifer works with the family to schedule all appointments for Amanda on one day. The OCSHCN Specialty Clinics offers multiple providers, including telehealth providers, in one location, limiting the need for transportation.

i. COORDINATING PHYSICAL AND BEHAVIORAL HEALTH SERVICES

Molina's Medically Complex Service team model complements the High Fidelity Wraparound approach and promotes a seamless and integrated system of care and coordination of services among the providers, caregivers and agencies involved in an Enrollee's life. The Medically Complex Service team and System of Care team can access Amanda's Enrollee information to support care coordination activities, monitoring and follow-up with providers, school, social services, or other agencies. Molina is responsible for coordinating Amanda's care, ensuring continuity of care, and supporting our stakeholder partners to provide the complex care Amanda needs.

j. COMMUNITY RESOURCES

Jennifer refers Amanda and her foster family to the nearest Family-to-Family Health Information Center (F2F) in Prestonsburg. F2F provides guidance and support for families of children and youth with special healthcare needs. F2F helps families navigate healthcare systems, work with their child's medical home and advocate for a child in the healthcare system. Jennifer connects Amanda's foster family with a local support parent with lived experience caring for children with medically complex needs. She provides information on the virtual support group for foster families and local foster family support groups.

k. ASSISTANCE WITH THE INDIVIDUALIZED EDUCATION PLAN

Jennifer connects with Amanda's DCBS Social Service Worker who agrees to contact the home-based school provider to review the IEP to ensure Amanda has the necessary supports to be successful in school. Jennifer advocates on Amanda's behalf with assistance from our designated school-based services expert. The school agrees to increase the number of hours of school support, as Amanda feels better. Information from the IEP is incorporated into Amanda's Care Plan.

l. SOCIAL DETERMINANTS OF HEALTH

Primary social determinants of health that impact Amanda include the need for community-based supports to help her with coping skills, and socialization with a friend group. Jennifer coordinates with the school to ask if she can attend school with other children for a few hours a day or once a week. The foster family may choose to have Amanda attend the Kidz Club. Kidz Club is Medicaid Licensed Prescribed Pediatric Extended Care Center in Lexington. This may give the family some respite while Amanda enjoys the company of children her age who are also living with chronic complex illnesses. Jennifer and Amanda's foster family assist her in connecting with a new friend that she has through Kidz Club via face time, texting and phone calls.

m. PLANNED RESPITE CARE

Jennifer notes that respite care for the foster family will support Amanda's placement stability. The Social Service Worker identifies other foster families in the area who are trained to care for medically complex children. These families can act as a respite provider for Amanda. Jennifer reaches out to Amanda's aunt, her former foster caregiver, to see if she would be willing to care for Amanda for short periods of time. This would help maintain Amanda's relationship with her biological family and provide some time off for Amanda's foster family. ***Amanda's foster family can access an additional two days of respite through Molina's value-added service***. As needed Jennifer may increase Amanda's skilled nursing hours for a limited time to give the family additional time away or if there is a family emergency. Having a plan for breaks and emergent situations helps to reduce the foster family's stress.

n. APPLICABLE EVIDENCE-BASED PRACTICES

Due to Amanda's complex needs we apply a High Fidelity Wraparound Approach that puts her at the center of her care and facilitates close coordination of services.

High Fidelity Wraparound Approach	
Description	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 to develop a family-driven plan that promotes self-advocacy. The Enrollee and family's self-identified goals are integrated into a single Care Plan that includes natural supports and services provided through all child-serving systems.

High Fidelity Wraparound Approach	
Applicability to Amanda	• The System of Care team will collaborate with Amanda, her DCBS Social Service Worker, caregivers, providers and foster family to create a Care Plan based on Amanda's self-identified goals and priorities. • Her ongoing System of Care team will provide coaching and education to integrate all services and supports into her Care Plan.
Expected Outcomes	High-fidelity coordination of care will close care gaps, connect Amanda to the right services and minimize duplication of care.

o. SHARING AND REVIEW OF MEDICAL RECORDS

Jennifer documents the results of Amanda's HRA, SKY Enrollee Needs Assessment, and Care Plan in Clinical Care Advance, our care management system. The information is loaded to Amanda's *Health Backpack*, making it readily accessible to her caregivers, providers, and DCBS Social Service Worker. Participants involved in Amanda's care can view the information, promoting care coordination and a collective focus on a single set of goals for Amanda. Jennifer acts as the hub for this information, making sure that the System of Care team and Medically Complex Service team have information to effectively serve Amanda and avoid duplication of services. The DCBS Social Service Worker and foster family can print the information from Amanda's *Health Backpack* to include in the Medical Passport.

p. MAINTENANCE OF THE CARE PLAN

Jennifer monitors, follows-up, and evaluates the effectiveness of the services provided on an ongoing basis. At minimum, Jennifer updates the Care Plan monthly. Jennifer distributes signed copies of the comprehensive Care Plan to members of the System of Care team and DCBS. Jennifer communicates findings and Care Plan updates to the Medically Complex Service team based on Amanda's needs and preferences. As her care coordinator, Jennifer is the single point of contact for Amanda's care and is responsible for ensuring the Care Plan includes all updated IHP, care management and DCBS Service Plans and that all information regarding Amanda's care is in Clinical Care Advance and Amanda's *Health Backpack*.

Expected Outcomes for Amanda
Through targeted interventions, care coordination and improved access to care, evidence-based practices, Amanda's health improves. She has not experienced an ED visit in two months. Through Molina's MTM program, we have reduced the number of medications she is taking. After being given the option to select her own menu, Amanda has started to gain some weight and is eating a wider variety of foods. She has made a new friend at Kidz Club and looks forward to occasional visits there, and connects with her friend via videoconferencing. Amanda also enjoys chatting with the youth peer support specialist as having friends makes her feel "more normal." Her family has been able to enjoy some time off due to Amanda's aunt being willing to offer occasional respite care. Amanda's cardiologist reports that Amanda may be able to undergo another open-heart surgical procedure that will help Amanda feel healthy and function at a higher level.