25. Enrollees with Special Health Care Needs (Section 35.0 Enrollees with Special Health Care Needs)

a. Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 “Enrollees with Special Health CareNeeds” including. Include a summary of how the Contractor’s experience in providing services to these populations has informed the approaches.

Drawing upon our extensive experience caring for complex populations, we know that individuals engaged in their health care achieve better health outcomes. For this reason, we designed our care management model in Kentucky to uniquely meet the complex needs that individuals with special health care needs (ISHCN) and their caregivers face. The dual approach of implementing a telephonic care coordination model that empowers our chronic condition and complex enrollees while implementing a multidisciplinary care team (MCT) able to provide direct care to our highest need enrollees positions us to meet our enrollees with special health care needs wherever they and their caregivers are along the continuum of care. Through our collaboration with various Kentucky provider groups and community-based organizations, we know that the eight ISHCN populations designated by the DMS require different levels of attention and care coordination.

Our National Advisory Board (the Board) has helped to inform our approach to serving ISHCN nationally and has had an impact on the design of our care management approach in Kentucky. The Board serves as an independent advisory council providing input to UnitedHealthcare Community Plan of Kentucky (UnitedHealthcare) by actively engaging enrollees, providers, advocacy groups and other key community stakeholders for feedback on the design and delivery of services supporting ISHCN. The Board is vital to our ability to improve enrollee satisfaction, enhance enrollee outcomes and implement programming improvements to better meet the needs of individuals. The Board offers a unique perspective to recommend, develop and champion innovations on enrollee engagement strategies that support clinical approaches for individuals with special needs. The goals of the Board are to:

- Cultivate a consumer-centered culture
- Advance awareness and knowledge of individuals served
- Identify emerging trends or policy issue
- Create a pathway to enable policy advancements
- Develop and recommend innovations for populations with special health care needs

Our Board is comprised of leading experts and aging and disability advocates, a UnitedHealthcare Community Plan member and family members of individuals with SHCN. Some of our current Board members include ***Lindsay Baran,*** National Council on Independent Living; ***Gail Hunt,*** President & CEO, National Alliance for Caregiving; and ***Jennifer Snow,*** Director of Public Policy, National Alliance on Mental Illness.

Innovative Approaches to Providing Services

We recognize that ISHCN often need additional support in accessing appropriate services. Our approach to serving this population and supporting their caregivers involves coordinated care that makes an otherwise complicated health care system more accessible. To make certain our ISHCN receive the appropriate supports, we include them within our risk stratification process and, based upon an analysis of multiple data inputs, designate them into one of our population health management (PHM) risk levels: complex care management (Level 2), management of chronic conditions (Level 1), or health promotion and wellness (Level 0). Within each tier, we have specific programs and interventions to address our enrollees’ special health care needs.

Given decades of experience influencing care for high need enrollees, we have designed our complex care management model to address the most high need enrollees in Kentucky. We focus this model on those in need of intensive stabilization and support using a MCT uniquely positioned to provide direct care for this vulnerable population. These regionally based teams not only provide high-touch care management and coordination, but also have the ability to provide physical and behavioral health care directly to the enrollee. For example, our complex care team includes a nurse practitioner and behavioral health clinician who can provide stabilization services to enrollees after hospital discharge. We support ISHCN enrolled in our complex care management program with a care manager who leads complex care plan development. This care manager serves as a key point of contact, along with other core members of our care team (behavioral health workers [BHWs], RNs, community health workers [CHWs], nurse practitioners [NPs]), who support enrollees for care plan coordination. They verify that the enrollee understands their choices, explains how to navigate access and ways to address their health care goals. Members of an enrollee's care team receive cross training in physical and behavioral health care, along with advanced, evidence-based training to support their relationships with enrollees. These trainings include trauma-informed care, motivational interviewing and crisis intervention. Our approach addresses the physical, behavioral health and social needs of enrollees while fostering recovery and resiliency.

To achieve the best possible outcomes for our complex enrollees experiencing homelessness, we will implement the **Housing + Health pilot in the Commonwealth.** This nationally recognized program supports individuals who are persistent health care users and struggling with homelessness, addiction and transitions from incarceration by providing an evidence-based, biopsychosocial solution that integrates social services, nursing, medicine and behavioral health. The Housing + Health team in Kentucky will use our proprietary ***Hotspotting*** data analytics tool to identify subgroups of enrollees with the most complex needs, including homelessness. The team will use the ADT feeds to meet, engage and activate targeted patients experiencing homelessness at the hospital bedside, in the ED, or at the shelters where they reside.

Our **Housing + Health** program involves consistent engagement and measurements to drive action and guide decision-making. We began analyzing our Arizona model in 2017 using pre- and post-intervention utilization and cost medical claims data. This intervention reduced the total cost of care 10% to 20% in states where we have deployed this model. This reduction was based upon eliminating unnecessary use of the ED, skilled nursing facilities, hospital admissions and the lengths of hospital stays.

Serving enrollee adults and children with chronic physical and behavioral health illnesses in other states has shaped the way we support service delivery and engage these individuals and their families/caregivers/legal guardians. In Arizona, for example, we implemented our ***Family Engagement Center*** — an innovative, best practice enrollee-engagement model that assigns family advisors (telephonic, single point of contact) to the family of a child with SHCN. These advisors support issue resolution and address concerns family members or caregivers have related to coordination of their care, including social support needs. The Family Engagement Center focuses on helping families navigate a complicated health system so they can make more informed health decisions across the care delivery system and social services landscape for improved quality of life. We are eager to roll up our sleeves and become involved with Kentucky's ISHCN population to determine if this model is a good fit and we will bring value to the Commonwealth.

Another best practice in our established markets, serving those with SHCN, is our ***ombudsman advocate role.*** These advocates act as a point of contact supporting individuals and their families/legal guardians with issues that do not require a care manager. They listen to concerns, resolve complaints and serve as an information resource in addition to interacting with Commonwealth agencies to solve escalated concerns quickly.

Another approach we are excited to provide in Kentucky involves the pioneering use of technology for virtual visits. ***UnitedHealthcare Doctor Chat*** is a chat-first platform supported by live video to connect enrollees to a doctor by computer or mobile device for non-emergent care. A board-certified ED physician will assess the severity of the enrollee's situation, provide treatment (including prescriptions) and recommend additional care. Doctor Chat helps us engage enrollees, improve access to care, decrease avoidable ED use and reduce health care disparities within traditionally underserved populations.

b. Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:

Facilitating access and appropriate services for ISHCN is pivotal to improving outcomes and helping enrollees progress toward their overall health goals. We facilitate access to appropriate services through providers and community partnerships. The care teams that wrap around these individuals flex to support an enrollee's specific needs. When facilitating services, we consider medical necessity, diagnostic services, preventive services, rehabilitation services, treatment services and other interventions. For example, children with complex needs can require coordination with special therapies, like access to Applied Behavioral Analysis providers and school-based services. For children who are eligible for EPSDT special services and require private duty nursing (PDN), we have a ***PDN navigator*** focused on making sure these children receive appropriate services. Care coordination is monitored and tracked through ***CommunityCare***, our care management platform. *CommunityCare* stores enrollee information and data to facilitate data exchange related to enrollees' conditions, goals and person-centered care plan. Members of the care team, including providers, have access to view, contribute and monitor the components within the enrollee's care plan.

We link ISHCN to providers dedicated to delivering integrated service whenever possible. We support our providers' evolution to integrated care by enhancing reimbursement for care coordination and offering incentives for quality and value, shared savings/risk, condition-specific and/or population-based payment for Accountable Care Organizations and partners capable of proactive, data-driven, person-centered care. We maintain local relationships with community organizations and leading behavioral health and physical health integrated care providers, such as the Office for Children with SHCN. We understand working toward a more accessible community-based system of support is crucial to our enrollees and the families of children with special needs in Kentucky.

The way we share information with providers is also evolving. Aware that pushing and pulling data is an ongoing area for connectivity, we are committed to bringing an integrated health record (IHR) into Kentucky. The IHR compiles and translates disparate data sources from the last 3 years of an enrollee's medical history into a single consolidated view. The IHR revolutionizes how enrollees, providers and care managers access and take action on an enrollee's health and health care. The value of the IHR lies in its ability to combine clinical intelligence from data feeds into a single, complete, secure and easily digestible record. The information becomes meaningful and useful for providers by to enabling a 360-degree view of an enrollee's health. This is especially important for individuals with SHCN who may be accessing multiple providers and specialists. The centerpiece of the IHR from the perspective of

a provider is the Patient Summary, which acts as a dashboard of patient information where information about a patient is brought together in a single understanding and presentation.

Matching individuals with the right provider is essential to sustaining enrollee engagement. We help ISHCN connect with providers and specialists through our Provider Recommendation Engine (PRE). Our PRE is an intelligent rules engine that systematically matches individuals with preferred providers while respecting the individual's choice and distance standards. Preferred providers include integrated providers, those who demonstrate higher quality scores and lower costs, have value-based payment (VBP) agreements with us, or are recognized as a Center of Excellence. The PRE is applied for preferential auto-assignment for enrollees in need of a PCP and is used by our call center staff when enrollees want a new PCP. It provides a pathway for guiding enrollees to integrated care settings.

For instance, ISHCN may be at increased risk for oral diseases, so it is important to locate dental providers experienced with ISHCN. We look for providers who have specific ISHCN experience and help navigate enrollees toward these providers. If an individual chooses to stay with their out-of-network provider, we have policies in place to maintain continuity of care and provision of services while working to recruit these providers in network or through use of single case agreements. When out-of-network care becomes necessary, our care managers provide hands-on assistance to arrange care that meets an individual's needs.

For individuals with more severe or complex behavioral health diagnoses who may be enrolled in our complex care management program, their care manager will help them to understand our network of psychiatrists and specialty behavioral providers and to choose providers who match their needs and can be accessed for direct service. We are committed to contract with these behavioral health specialists at a level beyond the minimum network requirements. Our contracting approach uses data and analytics to identify areas of clinical risk, treatment variation and gaps in care. Then we use this information to prioritize closing those treatment gaps. We foster long-standing relationships with providers to make certain our enrollees receive uninterrupted care delivery. Most importantly, individuals have access — without needing a referral or authorization — to routine outpatient behavioral care. Individuals and caregivers can use our online *Provider Directory* available on the enrollee portal to locate a provider. In addition to listing providers by geographic location, our directory of behavioral health providers includes their area of expertise (e.g., learning disabilities, crisis diversionary services) to help ISHCN and their caregivers choose the provider best suited to their needs.

i. Approach to identifying Enrollees.

Effective care management and coordination requires identifying health risks in our enrollees with SHCN. Our ***Impact Pro*** identification and stratification tool uses advanced technology, proprietary analytics and clinical expertise to segment enrollees by demographics, diagnoses, utilization and risk upon enrollment. We use sophisticated predictive modeling to produce workable information to identify enrollee-specific care opportunities and prioritize individuals for outreach. Data inputs include:

- ***Behavioral, physical and social determinant data,*** including ICD-10 diagnoses from claims data; continuity of care documents; ADT notifications; historical claims; and behavioral health and other "blind spot" data
- ***Assessments,*** adult and pediatric health risk assessments (HRAs), PHQ-9 for depression and readmission risk assessments for adverse events
- ***Referrals*** from providers, enrollees, families, caregivers and other natural supports, Commonwealth and community service agencies

This information gives care managers, providers and other members of the care team a comprehensive view of each enrollee's specific needs. *CommunityCare*, our care management platform, facilitates the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems. Once an individual's risk level is identified, the information triggers an entry into a queue in *CommunityCare*. This trigger notifies our care teams to begin outreach and support for a given intervention (e.g., transition stabilization, housing supports and disease management outreach). The following table details how we will identify each of populations with SHCN.

ESHCN Populations	Methods to Identify Enrollees					
	834 File	Hotspotting	Health Risk Assessment (HRA)/Enrollee Needs Assessment (ENA)	Claims	ADT Feeds	*CommunityCare*
Children in/or receiving foster care or adoption assistance, if applicable		✓				✓
Blind/disabled children under 19 years of age	✓		✓			✓
Adults over the age of 65	✓		✓		✓	✓
Homeless		✓	✓			✓
Individuals with chronic physical health		✓	✓	✓	✓	✓
Individuals with chronic behavioral health		✓	✓	✓	✓	✓
Children receiving EPSDT special services				✓		✓
Children receiving services in a Pediatric Prescribed Extended care facility or unit				✓		✓

We also identify ISHCN through prior authorization and chart reviews, recognizing there are multiple ways to identify ISHCN. Trained in prior authorization, our grievance and appeals staff, member services staff and inpatient care-management staff can spot diagnoses meeting the standard for ISHCN.

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We use our innovative ***Hotspotting tool*** to find individuals with social and behavioral complexities and high utilization of services, especially those individuals experiencing homelessness. Hotspotting makes strategic use of data analytics to locate these individuals and then applies a person-centered approach to understand and address the medical, behavioral and social barriers affecting their health. Reaching homeless individuals requires a nimble

approach. Even though we apply analytics and predictive modeling, we know we need more than analytics to engage these individuals and to wrap services and supports around them. With hotspotting, we can pinpoint individuals most likely to benefit from the direct, evidence-based, in-the-community approach to care delivery that we are bringing to Kentucky. Our field-based care teams include CHWs trained to engage individuals directly in place-based interventions, whether at a hospital bedside, at a homeless shelter or on the street.

Identification of enrollees with substance use disorder (SUD)/opioid use disorder (OUD), including those at risk, is essential to connecting them as soon as possible to treatment and resources. Besides our enrollee screening tools and provider education efforts to increase screening for SUD/OUD, we used clinical and analytic insights gained across our enterprise to develop claims-based reporting. We also use our Hotspotting tool to identify and engage enrollees with emerging risk and high risk enrollees requiring an immediate connection to evidence-based care (e.g., recent overdose, inpatient with an OUD related complication such as endocarditis, pregnant women with OUD, those with recent detox and no evidence of medication-assisted treatment [MAT]). Once identified, we work diligently to make sure enrollees struggling with OUD are linked to the right care management supports with a care team tailored to meet their individual needs as soon as possible.

ii. Process for screening and assessing individual Enrollee needs.

Our screenings and assessments for enrollees address holistic needs (medical, behavioral, social). Adults and children with SHCN have separate assessments, but the assessment process is the same. Behavioral health screening tools and questions are embedded in the adult and pediatric HRA and CORE assessments. When clinically indicated, we use supplemental, evidence-based assessment tools. The appropriate health professionals conduct screenings and assessments: an RN, behavioral health clinician or CHW. We enter data gathered from an enrollee's HRA and comprehensive assessments into *CommunityCare*, our web-based clinical care coordination platform. Through *CommunityCare*, we track and facilitate the coordination of services and share enrollee information with the enrollee's care manager, MCT and other providers.

Pediatric assessments: Our pediatric HRA includes the Children with Special Health Care Needs (CSHCN) screener. Supplemental evidence-based pediatric assessments include Child Stress Disorder Checklist – Short Form (CSDC-SF); Care, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for alcohol and drug use and misuse; and Vanderbilt ADHD Diagnostic Parent Rating Scale (VADPRS) for severity of ADHD symptoms.

Adult assessments: Our adult HRA includes these assessments Alcohol Use Disorders Identification Test – Consumption Questions (AUDIT-C) for alcohol use; Single Alcohol Screening Questionnaire (SASQ) for alcohol use; Drug Abuse Screen Test – 10-item test (DAST-10) for drug use/misuse. Additional supplemental adult assessments include Pfizer Patient Health Questionnaire (PHQ-2) for depressive symptoms; Generalized Anxiety Disorder (GAD-2/7) for general anxiety; and Single question drug screener.

Assessments for children and adults: Additional behavioral health assessments for both adults and children include Adverse Childhood Experience (ACEs) Questionnaire for trauma and Bipolar Spectrum Diagnostic Scale (BSDS) to access bipolar (depression/mania) symptoms. Positive screenings trigger referral to a behavioral health clinician for further assessment and possible referral for behavioral health services.

The assessment process requires active listening, motivational interviewing skills and a comprehensive evaluation to understand and help an ISHCN and their family/caregiver think about a vision for the future. The process provides a framework for learning about and gaining a

holistic understanding of the enrollee's needs, goals, values, preferences, choices and priorities, in addition to their medical, behavioral, functional, social, cultural and health literacy circumstances.

We have developed tools to support providers in administering screenings and assessments for behavioral health conditions, including the *Behavioral Health Toolkit for Medical Providers* available on *Link*, our provider portal. In addition, we have integrated a number of behavioral health screeners in *CommunityCare* for provider (and enrollee) administration.

Our standard HRA process generates referrals and identifies ISHCN eligible for care management. We have developed an innovative referral stream based upon screening tools to help detect substance use issues (alcohol, opioids and misuse of prescription medications). Enrollees who are with adult guardianship clients are also identified as ISHCN. We will interface with Department for Aging and Independent Living (DAIL) as outlined in Attachment C – Draft Medicaid Managed Care Contract and Appendices, Section 35.2 DAIL: Adult Guardianship Clients.

Our model of care builds upon tools and assessments to determine transition of care needs. For instance, assessments for individuals residing in institutional settings include questions that trigger additional, more specific assessments for enrollees residing long term in nursing facilities, behavioral health facilities and residential programs. In addition to assessing the enrollee's health status — including their physical health, behavioral health, medication and social needs — our care managers work with these enrollees to gauge their desire, ability and readiness to transition back into their community. When an individual receiving complex care management wants to transition, the complex care team sends a CHW to the facility to engage the enrollee and assist them through their transition. The CHW works with the enrollee to stabilize their health and identify additional social supports.

iii. Approach to providing education to Enrollees and caregivers.

Once we identify an ISHCN for care management, we engage the enrollee, along with their family/caregiver/legal guardian, in a person-centered, strengths-based care planning process. We align care delivery from the enrollee's point of view and engage them in care interventions keeping with their personal health and wellness goals.

We understand navigating the health care landscape can be challenging for families and caregivers of children with SHCN and foster care children. To alleviate frustration, we provide families, caregivers, other natural supports and legal guardians with as much information and education as possible. We engage families and caregivers with member advisory councils, community partners and advocacy groups for education on how to successfully navigate complex issues and find support. We invite them to participate in listening sessions and educational Lunch & Learn events. They have access to caregiver toolkits with the potential for improving quality of life for themselves and their children. We also use caregiver self-assessments to determine the need for extra supports.

In Arizona, we conducted caregiver listening sessions for individuals with DID and their families to learn their concerns and gather more information on their needs. We will commit to conducting similar listening sessions in Kentucky.

We prepare, encourage and empower ISHCN and their caregivers to participate in the comprehensive assessment and care planning processes by providing clear and concise information before the assessment. Additional tools and resources we

introduce throughout the process:

Enrollee goal form: Included in our Welcome Kit, UnitedHealthcare's My Whole Health Tracker, is a worksheet offered to enrollees to complete before the comprehensive assessment. It gives individuals an opportunity to think about their short- and long-term goals.

Member Handbook: Every enrollee receives a *Member Handbook* that contains written information about the assessment and care planning process. It also describes how we support the enrollee in leading their care team and engaging the services, supports and providers they prefer. The *Member Handbook* is available on our enrollee portal and in alternative formats, such as large print or Braille for individuals with visual needs. The handbook is translated into other languages upon request.

Communication access: Before the assessment, we encourage enrollee participation by making sure all of their communication access needs are met. This includes arranging for a translator/interpreter, acquiring informational materials in alternate formats, or securing adaptive/assistive equipment through community-based organizations.

Reminder calls: We contact the enrollee and their care team members before the scheduled in-person meeting to remind participants of the date, time and location.

Staff training to assure appropriate communication: To promote enrollee engagement, clinical and non-clinical staff who have direct contact with enrollees receive internal disability-competent care training. Topics include:

- Types of needs common to populations served in Kentucky, including functional limitations and behavioral health needs
- Best practices for engaging and building trust: motivational interviewing and active listening techniques, ACEs interviewing, trauma-informed care approaches, mental health and SUD interviewing and disability etiquette practices, such as speaking directly to the enrollee in clear and concrete language and giving them sufficient time to respond
- Communication access skills for working with individuals with disabilities: understanding care options, cultural health beliefs and practices, preferred languages, health literacy and other communication preferences and needs

We train our providers to help guide enrollees/caregivers/legal guardians navigate the health care system and access community resources. We encourage individuals with SHCN to take an active role in self-managing their health care through health promotion and disease prevention education and outreach. We offer these tools through our websites, mobile apps, texting programs and telephonic support. Our Advocate4Me call center is staffed with member services advocates (MSAs) ready to respond to inquiries and concerns with the goal of addressing all enrollee issues during the initial call. Our MSAs take pride in supporting our enrollees by offering prompt and positive call center experiences. MSAs have training and access to enrollee's information across our systems, which support an integrated and comprehensive approach to meeting the unique needs and providing education to enrollees with health concerns. Enrollees can also manage their health questions through NurseLine, which provides telephonic access 24 hours a day, seven days a week to RNs who can educate enrollees about chronic conditions, such as asthma or diabetes.

iv. Approach to providing transition support services.

Our person-centered transition planning process can be aligned to fit the needs of ISHCN moving from one care setting to another. Not every case is the same, which is why we have processes and transition supports in place to enhance discharge-planning activities. ISHCN in

care management and their caregivers have one point of contact for referrals and requests — streamlining the process and making it more effective. Continuous communication with the enrollee and caregiver throughout transition activities encourages enrollees to take an active role in their transition planning and care.

As soon we learn an enrollee may be interested in or is at risk for experiencing a change in care setting, we implement a person-centered discharge planning process based upon the appropriate care setting (e.g., from hospital or nursing facility to community). Our care team makes certain the right supports are in place before discharge to establish a successful transition of care. This includes referrals and other services and supports that are in line with the enrollee's care plan and physician requests. The transition process maintains continuity of the care during an individual's move to the safest, least restrictive setting of their choice.

CommunityCare, our care management platform, brings members of an enrollee's MCT together to view transition care plans, monitor discharge planning and track services and supports post-discharge. *CommunityCare* helps the care manager confirm the continuity of the enrollee's care between care settings and among the medical, behavioral and specialty providers and community organizations delivering services and supports to the enrollee.

For behavioral health transitions, we layer on peer support specialists who work with high-acuity enrollees during transitions. These peers meet with enrollees at the facilities and follow them into the community. They attend appointments with the enrollee and work with them to create their personalized My Whole Health Tracker or Wellness Recovery Action Plan (WRAP) and crisis plan for self-management. Peers support specialists and members of the care team promote recovery and resiliency by introducing ways to help enrollees build their social support network and engage in support groups. We also offer additional resources, such as Daily Strength, an online support resource with more than 500 support communities comprising people facing similar life challenges, medical conditions and mental health issues.

Supporting Successful Transitions in Washington State

We recently contracted with three transitional housing "campuses" in Spokane, Washington. Each provides the full continuum of services for a step-down housing process to support people transitioning out of Eastern State Hospital. We help them develop independent living skills as they transition from structured housing to semi-independent living to independent living. This includes transitional and supported housing providers, such as Catholic Charities. The behavioral health needs of the population requiring transitional housing, including people who are homeless, individuals exiting out of institutions and individuals exiting out of jails, are significant. Our teams coordinate with transitional housing providers and supportive services to make each transition successful.

Once the transition of care is complete, our care manager performs a reassessment with the HRA, conducts an enrollee interview for additional inputs and uses the findings to inform the enrollee's care plan. Before discharge, our care team, in conjunction with the facility, arranges services aligned to the individual's needs and preferences. Follow-up appointments after hospitalization occur as quickly as possible, but no later than seven days from discharge to align with HEDIS Follow up after Hospitalization requirements. We review and authorize services requiring authorization as a part of the transition process.

Our care teams work closely with the enrollee to address additional social supports and wraparound services, such as housing, nutrition and transportation. As an example, we contract and work with a broad range of transitional housing providers, including emergency shelters, who meet individuals where they are and move them toward better care and recovery. We will employ a ***housing navigator*** in Kentucky whose focus is to help us build and strengthen

capacity with housing providers and work directly with enrollees, their care teams and community work groups.

Our care teams help individuals use state-covered transportation for non-emergent medical transportation. Transportation companies have specialized vehicles for people with special transport needs; we work with the enrollee and their family to confirm this service is a part of the care/transition planning process. We will have a ***local mobility coordinator*** in Kentucky who will resolve care management issues created by transportation barriers. In addition, the mobility coordinator will lead efforts to build upon existing community-based transportation services to support enrollees and manage transportation pilot programs.

Discharge and Follow-up Planning for Children and Adolescents: Care interventions and discharge planning are based upon an enrollee's risk level and are designed to be both effective and meaningful. Whether it is a telephonic CHW or a MCT member conducting outreach and care management, each one is trained to work with the child or adolescent and their family/caregiver/guardian to develop a care plan that supports their needs and preferences. During discharge transitions and follow-up planning, we use the enrollee's care plan to track progress. The care plan is documented in *CommunityCare*, where the enrollee's entire care team has access to the information in real time. Using our platform in this way allows care managers, providers and enrollees to view up-to-date information related to the enrollee's goals and needs, coordination of services, care transitions, discharge planning and associated progress. Both CHWs and MCT members maintain weekly contact and connect families to community-based resources once the child with SHCN returns home. If necessary, our PDN navigator will focus on making sure these children have appropriate services. Other special considerations for children and adolescents transitioning include making sure they maintain EPSDT screenings in line with the periodicity schedule and progress toward their educational goals. We work with school-based programs to address the needs of children with SHCN outside of a clinical setting.