

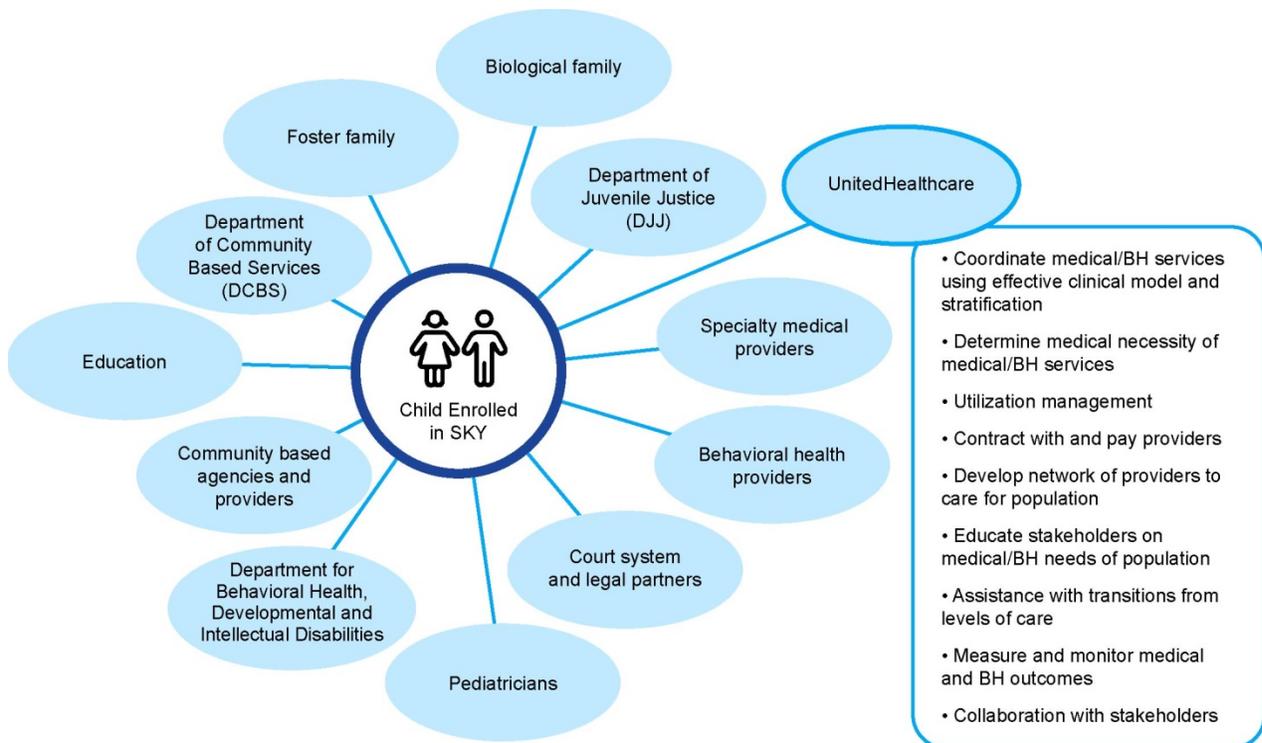
## 8. Covered Services

a. Describe the Contractor’s approach for ensuring the successful completion of required assessments and screenings. Please include a description of the following:

i. How the Contractor will coordinate with Kentucky SKY Enrollees, the Department, DCBS, DJJ, and families. Address the involvement of any other sister agencies in the description.

We know children in foster care require coordination among various entities that wrap around them to provide comprehensive services to improve their safety, well-being and help them achieve their permanency goals. As presented in the figure, our SKY staff will coordinate with the entities that help support children and youth in foster care to complete required screenings and assessments timely, and share assessment and other data needed to deliver integrated, coordinated supports. We have implemented a variety of assessments directly relevant to children in foster care, processes to confirm their timely completion and tools to share assessment findings with each child’s multidisciplinary care team.

We will coordinate with SKY enrollees by assigning a **local** care coordinator, or nurse care manager for medically complex children, to every child or youth who serves as their **primary point of contact to coordinate care** and help them navigate the health care system. We will promote the development of robust partnerships with DMS, DCBS, DJJ and sister agencies in a variety of ways. We will integrate local care coordinators in each of the DCBS service regions to collaborate with DCBS staff. Our SKY behavioral health specialist is the primary point of contact for DMS, DCBS, DJJ and sister agencies. They will be local staff members who will have expertise in the foster care and DJJ systems and Department, DCBS and DJJ policies and procedures.



**Figure 11.** We understand children and youth in foster care receive care and services from a variety of agencies, providers and community-based organizations. We have implemented a variety of assessments directly relevant to children in foster care, processes to confirm their timely completion and tools to share assessment findings with each child’s multidisciplinary care team to promote the delivery of integrated, coordinated care to each foster care child and youth.

## Coordinating with SKY Children, Youth and Families

To develop robust partnerships with children, youth and foster families, we will assign a **local** care coordinator to every child or youth who serves as the **primary point of contact to coordinate care** help them navigate the health care system. We maintain the relationship between the child or youth and foster families and their care coordinator, regardless of placement changes to provide stability for the child or youth and their foster family and allow them and their care coordinator to establish a trusted relationship.

Completing the initial welcome call for children, youth, or caregivers in the SKY program and completing the initial health risk assessment (HRA) are critical to identifying the tier of care management they belong in and connecting them to resources as soon as possible. The welcome call is often our first live contact with a child or youth and/or their parents, foster parents or legal guardian and the HRA is our opportunity to understand the child and youth's needs in a personal way. We recognize that we are asking children and their foster families to share deeply personal information through the HRA, so we train our *Advocate4Me* member services advocates (MSAs) on person-centered engagement

strategies that build trust and confidence with every interaction. We also train our MSAs on Trauma-informed care, ACEs and crisis intervention knowing children and youth in the SKY program have unique needs compared to their peers.

For children determined to be “medically complex” based upon the DCBS definition, we assign a nurse care manager as the single point of contact for their coordination. For children and youth in the other tiers of care management, we assign a care coordinator to support the care management activities. For those in intensive or complex care coordination, the care coordinator will reach out to the child or youth's team including parents, foster parents, the DCBS social service worker and other key partners to conduct a comprehensive assessment and develop their care plan based upon their care management tier per Attachment C – Draft Medicaid Managed Care Contract, 42.10.1 Care Plans. The care coordinator will engage them in care management services in accordance with Attachment C – Draft Medicaid Managed Care Contract, 42.10.2 Care Coordination Teams. As we discuss in our response to requirement b. later in this section, we use a suite of comprehensive assessment tools most relevant to the child or youth's age and circumstances.

## Coordinating with DMS

Based upon our experience supporting children and adolescents in foster care across many states, and because we have listened to the stakeholders in Kentucky, we understand that robust communication among system partners is critical. We will staff care coordinators in each of the nine DCBS service regions; they will co-locate in the DCBS and DJJ offices in each region. This will allow our care coordinators to develop working relationships with DCBS staff so we can more readily meet the needs children and youth in the SKY program, particularly those children and adolescents with urgent needs or who are in crisis. Through these working relationships, care coordinators will collaborate with DCBS social service workers to coordinate care for

Our SKY behavioral health specialist is the primary point of contact for the Department, DCBS, DJJ and sister agencies. The specialist will have expertise in the foster care and DJJ systems and Department, DCBS and DJJ policies and procedures. They will develop relationships with the Department, DCBS, DJJ and sister agencies. As requested, they will participate for meetings, strategy sessions, conference planning and joint trainings. They will help address concerns and understand how system issues will affect our care coordinators, providers and community organizations. The SKY behavioral health specialist will educate our full SKY team so they understand the nuances of the work they do and when DCBS makes changes to the SKY program.

children in “real time” as they move between risk levels based upon their individual circumstances.

Additionally, our SKY behavioral health specialist will work with DCBS staff to understand changes to the foster care system, resolve issues and confirm our care coordinators SKY team understand how changes that may affect their daily work. Our SKY behavioral health specialist will be the primary point of contact for sister agencies regarding overall strategy and policy setting. They will be available for meetings, strategy sessions, conference planning and joint trainings. Our SKY behavioral health specialist will understand the foster care and DJJ systems.



They will attend meetings to discuss specific outcomes and how system issues will affect the care coordinators (e.g., DCBS implements a new service). The behavioral health specialist will communicate lessons learned to the care coordinators and the full SKY team so they are aware of how these nuances may affect their daily work. They also will provide updated training and information to our provider network quickly and accurately.

## Coordinating with DCBS

We know that children in DCBS care have completed assessments and planning that will be used as part of our assessment process to confirm we have an integrated plan with DCBS, DJJ, and sister agencies for the child and family. All too often, those served through this complex system get bogged down in the number of plans and responsibilities to achieve permanency. We do not want to add to the confusion, but rather use our system to streamline and enhance the care for children and families DCBS and DJJ are supporting. To accomplish this, we will ask the DCBS social service worker to provide vital assessments that can be shared with the MCO, to help in our care assessment and planning purposes. Some examples of these from DCBS may include:

- Initial assessments, knowing some information cannot be shared outside of DCBS. Access to these documents will provide important information about the child and family learned during the DCBS investigation process.
- Case Plan document, which will provide pertinent information related to the permanency goal, goals related to well-being, and provide an inventory of any court ordered services that we can assist DCBS in coordinating, especially related to Medicaid covered services such as therapy, assessments and medical appointments.
- Independent Living Document such as the Ansel Casey Lifeskills Assessment (4.0) completed by the youth. This can assist the care coordinators in understanding areas to focus on with our technology solution On My Way to ensure the child’s SDOH and plans are coordinated to ensure a smooth transition to adulthood.

To develop robust relationships with the Department, DCBS, DJJ and sister agencies, we will integrate **local** care coordinators in each of the DCBS service regions. By co-locating our staff with DCBS staff, we expect to develop working relationships with DCBS staff that will help us proactively engage enrollees by understanding those enrollees who have urgent needs.

## Coordinating with DJJ

DJJ also will be an integral member of the team, and our care coordinators will participate in meetings at DJJ and be the conduit to the team about the needs of the youth in the juvenile justice system. For instance, we know children that cross over between the DCBS and DJJ systems have unique needs related to coordination. DJJ completes reports and assessments

that will help us coordinate and navigate the system to help the youth be successful. Examples of these assessments include:

- Predisposition Investigation Report (PDI) is a report based upon an investigation concerning the nature of the specific act complained of, and any surrounding circumstance which suggests the future care and guidance which should be given to the youth
- Presentencing Investigation Report collects relevant information on the youth and family to help the Circuit Court in determining a sentencing recommendation for a youthful offender, following conviction

## Coordinating with Sister Agencies

Many sister agencies will be working with our SKY enrollees, and our care team will be prepared to interact with them to obtain assessments and reports pertinent to the child to assist in coordinating their health care needs. For example, for a child that has an individual education plan, having that plan accessible to the team from the education system can only help us better coordinate their care. This can be uploaded to the *CommunityCare* portal for access by the care team.

ii. How the Contractor will ensure assessments are initiated immediately upon a Kentucky SKY Enrollee's Enrollment in the Kentucky SKY program.

## The Initial Health Risk Assessment

In Virginia, we have a 95.5% completion rate of the HRA within 30 days of enrollment.

We use a variety of methods to ensure assessments are initiated immediately when a Kentucky SKY Enrollee's enrolls in the Kentucky SKY program. Additionally, we administer all health risk assessments (HRAs) within the required time frames in Attachment C – Draft Medicaid Managed Care Contract, 42.17 Required Assessments and Screenings and Attachment C – Draft Medicaid Managed Care Contract. 34.3 Population Health Management Program Tools, Section B. Once notified of a new enrollment in SKY, our *Advocate4Me* MSA immediately begins the process of making at least three attempts to complete the welcome call and HRA, calling at different times of the day and on different days of the week to maximize success. We will use the most up to date information received on the 834 file from the state. MSAs document each attempt in *CommunityCare*, our care management platform. To increase completion rates, we:

- **Send a postcard** letting the child, youth, foster parents, or legal guardian know we are trying to reach them with directions to call us back
- **Take advantage of every interaction with the child, youth, or their caregivers** to complete the HRA. For instance, when a foster family calls *Advocate4Me* or *NurseLine*, our systems notify our staff when a child or youth needs an HRA, so they can work with the child or youth and their foster family to complete it.
- **Partnering with DCBS to engage children or youth who may be difficult to locate.** We know these children may move after an initial emergency placement, and may move to a foster home with kin or foster home. Our integrated care managers will allow us to work closely with DCBS social service workers to confirm we have the most up-to-date and accurate information on the child's or youth's placement. If we cannot reach a foster parent, youth or other essential team

By co-locating our staff with DCBS staff, we will be able locate and engage children or youth to conduct an HRA and prioritize those children or youth who may have urgent needs.

members to conduct a new member welcome call and HRA, we will work with the DCBS social service worker to find and engage the correct person.

- **Analyzing data to engage children or youth who may be difficult to locate.** We will review claims and utilization data and use our Hotspotting Tool to determine where children and youth are receiving care, such as visiting a pediatrician or filling prescriptions at a pharmacy. Using this information, our care coordinators will engage these providers to attempt to locate and engage the child, youth, relative or foster parent.

## The Comprehensive Assessment

Upon completion of the HRA, our clinical team will review the findings from the assessment and any other available data we have from the Commonwealth's enrollment file, DCBS staff or the sending MCO to determine the child's or youth's tier of care management. For those children or youth in Intensive or Complex Care Coordination, their care coordinator will reach out to their DCBS social service worker and their foster family to conduct a comprehensive assessment and develop their care per Attachment C – Draft Medicaid Managed Care Contract, 42.10.1 Care Plans. They will engage them in care management services in accordance with Attachment C – Draft Medicaid Managed Care Contract, 42.10.2 Care Coordination Teams. As we discuss in our response to requirement b., we work to understand the child's or youth's behavioral, medical and social needs using a comprehensive assessment tool most relevant to the child's or youth's age and circumstances.

## Facilitating the Timely Completion of Assessments

We monitor compliance to SKY assessment timeliness requirements through **CommunityCare**, our care management platform, and our **Clinical Adherence Program**. **CommunityCare** helps confirm we complete initial HRAs and comprehensive assessments at contractually required intervals using **CommunityCare**, our care management platform, which supports the assessment process in several ways. **CommunityCare**:

- Is highly configurable and allows us to define care management requirements relevant to the SKY Program, such as the required time frames for conducting initial HRAs, initial comprehensive assessments and initial care plans or the required intervals for comprehensive reassessments and care plan updates.
- Incorporates assessment instruments relevant to SKY Program enrollees, providing a single information source and compiling comprehensive assessment results via a single, shared point of access for the authorized individuals involved in a member's care.
- Provides a notification that reminds the care coordinator when it is time to conduct initial assessments, such as the HRA, and reassessments and LOC assessments. **CommunityCare** will create a task that must be completed by the care coordinator and provide a workflow to ensure the task is completed.
- Allows care management staff to closely monitor the completion of assessments.

Our **Clinical Adherence Program** monitors the compliance of our care management program with our policies and SKY program-specific care management requirements. This includes metrics, such as timeliness and quality of enrollee assessments and reassessments, timeliness of care plan creation and updates, compliance with required touch points and staffing ratios to member care levels. We conduct ongoing analysis of metrics to achieve clinical goals. If a goal is not met, we take immediate actions such as coaching, balancing caseload(s), developing corrective action plans and reviewing our standard operating procedures and workflows to remedy any issues and improve our metrics.

iii. How the Contractor will meet standards for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening.

Our Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a critical pathway to improving pediatric health outcomes by ensuring timely screening and early intervention to treat any health concerns identified. For children from birth to age 21, this includes physical, developmental and behavioral assessments, and dental, vision, hearing and

Children under the age of 21 make up approximately 70% of UnitedHealthcare's nationwide Medicaid population. As a result, EPSDT is a critical area of focus for communication, training, continuous improvement and assessing disparities in care.

lead screenings. Our comprehensive approach to ensuring access to EPSDT services includes provider education and support, member outreach and ongoing monitoring of performance.

**Education:** The basis of UnitedHealthcare's EPSDT program is the American Academy of Pediatrics AAP/Bright Futures, the Advisory Committee on Immunization Practices, and we will align with the guidelines and periodicity schedules of the Kentucky EPSDT/Health Check program. We will promote Health

Check in Kentucky using targeted enrollee communications, including wellness reminders. Education is a critical component of this communication to verify that SKY children, youth and their guardians understand the availability of the EPSDT benefit and the importance of preventive care in adherence to recommended guidelines. This is the foundation of UnitedHealthcare's early childhood health-promotion strategy.

We use an extensive, multimodal approach to intervene, educate and encourage foster families to obtain and follow up on EPSDT services. Children, youth, and their caregivers will receive education early and frequently throughout enrollment, including wellness reminders that are aligned with recommendations of the AAP/Bright Futures periodicity table. We systematically track where every child is regarding each of the indicated preventive care items. These analytics guide our member educational outreach efforts via a variety of modalities. In each of the Kentucky regions, our goal is to offer the right education and support at the right time within 60 calendar days of the child coming into the SKY program. Education is critical to confirm that foster families understand the availability of the EPSDT benefit and the importance of preventive care according to recommended periodicity.

Culturally competent outreach and communication is a priority. In designing our Kentucky enrollee communications, we understand that a "one size fits all" approach will not be successful in reaching children and youth and their caregivers in the SKY program. We design outreach activities to educate and remind members when they are coming due for an EPSDT service or they become overdue based upon the periodicity schedule.

**Data Analytics:** Based upon the specifications of the CMS-416 national EPSDT report, our business intelligence team analyzes claims and encounter data to identify children who are coming due for EPSDT services, or who have missed services based upon the AAP/Bright Futures periodicity schedule. Furthermore, we use our prospective HEDIS tools to identify gaps in various components of pediatric preventive care, such as

A common barrier that we recognize among children in the Medicaid programs we serve is that elementary school-age children tend to only see their doctor for a sick visit, rather than an annual wellness exam once school screenings and immunizations are complete. Motivating youth and their foster parents to complete annual wellness exams can be even more challenging. We tailor outreach and education to the various age groups, with the aim of engaging parents, kin, foster parents, and guardians of children in addition to children and young adults in their care.

immunizations, lead screenings and dental screenings. We identify gaps from this process through claims and encounter data, and other supplemental data sources, such as laboratory data for lead screenings and supplemental records collected throughout the year.



We provide real-time gap in care information driven by our HEDIS engine, ClaimSphere. ClaimSphere fully integrates with our CSP Facets claims platform, enabling quality reporting based upon pre-adjudicated claims to provide real time gap in care information from claims. By combining this pre-adjudicated data with claims, encounters and supplemental data sources, we anticipate more timely and accurate EPSDT gap data to support our outreach and communication plan. This real time data from multiple sources is then fed daily to our internal and provider facing gap in care status reports. Our provider portal offers online access to gap in care status for our provider partners.

**Partnering to meet EPSDT:** We offer EPSDT related training to our staff and use different modalities to meet the learning style needs of our team. We ensure our trainers are experts, and the content contains the latest information related to the subject being trained. The training of staff on EPSDT benefits varies by role and function. We develop and implement a multifaceted training program that includes in-depth training on the EPSDT benefits and services for both member- and provider-facing staff and subcontractors, when applicable. All stakeholders are reminded of the importance of cultural competency and how critically important it is to respect and honor variations in ethnicity and the culture that our members represent.

The MSAs, who represent one of the first contacts a member has with UnitedHealthcare, receive training on EPSDT to obtain a complete understanding of the preventive care needed by members. Through this training, we empower staff to have a collaborative conversation with the children, youth, parents, kin, foster parents, and guardians to help them understand the benefits and to encourage them to access care per Bright Futures guidelines.

Clinical staff, including UM and care management staff, maintain policies, procedures and clinical protocols to verify that EPSDT services are not denied inappropriately. They also check that care management and coordination includes close monitoring of all the needs of a child including the components of EPSDT care.

Our field-based care coordinators receive at least annual, virtual training by quality leadership on EPSDT benefits and the Bright Futures clinical guidelines, including any changes.

Finally, we will provide local partners and other stakeholders with a routine overview of UnitedHealthcare EPSDT initiatives and additional detail regarding geo-mapping of opportunities through our Hotspotting Tool in an effort to augment and assist with children in foster care getting services and closing gaps in care. This will assist in supporting existing partner programs, building community awareness and sharing best practices. We verify that they understand the importance of EPSDT services and pediatric preventive health overall. This training is provided virtually or in-person at the start of a new relationship and then ongoing as needed.

iv. Any challenges that the Contractor anticipates in completing required assessments and how it will mitigate these challenges.

Based upon our experience working with children who are part of populations like that of the SKY program, the most significant challenges to completing required assessments include:

- An inability to connect with the child, youth, kin, foster parent, or guardian due to the child or youth frequently changing placements or their foster parents moving, which may mean the contact information we have for the child or youth is no longer valid
- Foster parents will not discuss the child or youth's health with our care coordinator because they are not the child's legal guardian, and they do not understand the purpose of our outreach

We have learned that to mitigate these challenges, we must have our care coordinators in the offices of DCBS social service workers to engage them in our outreach process. Being on-site, we will be able to gather the most up-to-date information about where the child or youth lives, any needs they have and be part of the case planning process. Our care coordinators will collaborate with DCBS social service workers to help us connect with foster families, such as explaining our role and giving foster families permission to discuss the child or youth's care with our care coordinators.

v. Provide examples of how the Contractor has succeeded in providing assessments to individuals similar to those required for the Kentucky SKY Enrollees.

Having served more than 65,000 children and youth in foster care across 13 markets in 2018, we have experience providing assessments to individuals similar to SKY enrollees and consistently demonstrate a high success rate. For example, in our latest report of our Virginia market, we **completed 95.5% of our assessments for new enrollees within 30 days** of enrollment to our plan.

We know for our health plans where staff is integrated in the offices with state/county workers, our ongoing assessments are completed at a higher rate. For example, in Ohio, we have care coordinators in county offices certain days of the week. During those days in the office, the care coordinator sets up time to complete assessment no matter what the child or youth's risk level is. The assessment toolkit we use for children is important and based upon the child's condition and age. We use motivational interviewing techniques to gather information from the state/county caseworker, and review documents provided by them to complete our assessment. When a caseworker or care coordinator determines having the care coordinator at a team meeting would be helpful with the family, or a face to face in-person visit is warranted, our staff ride with the state/county foster care case manager to help complete our assessments.

Another example is our work in Nebraska, where in meeting with the state caseworkers it became apparent that each entity was identifying high-risk members, but the lists did not always match. Therefore, on a weekly basis, a list is gathered both from the MCO and the state for children for whom they would like to hold an interdisciplinary team meeting about. This occurs weekly via phone, and next steps are discussed between the state caseworker and the care coordinator to ensure the child's care is well coordinated and effective. This has produced a systematic approach to completing timely assessments and coordinating care for the highest risk members.

vi. Include examples of Trauma assessment or screening tools the Contractor would recommend the Department consider for the use in identifying Trauma in Kentucky SKY Enrollees.

We use a variety of assessment and screening tools to identify trauma among our children and youth in foster care. Some examples include:

- Child Stress Disorders Checklist – Short Form (CSDC-SF) used as part of our Pediatric Core Assessment. We have included a sample of this assessment as Attachment G.8.a.vi.-1 CSDC-SF.

- Primary Care Post-traumatic Stress Disorder screener (PC-PTSD) – recommend incorporated into all pediatric/PCP practices as a standard two-question screener for all youth. We have included a sample of this assessment as Attachment G.8.a.vi.-2 PC-PTSD.
- Post-traumatic Stress Disorder Checklist (PCL-5) – more comprehensive assessment to be administered when trauma is suspected, but the origins and severity are not yet known. Use by our staff and available for provider use through our provider portal. We have included a sample of this assessment as Attachment G.8.a.vi.-3 PCL-5.
- Pediatric Symptom Checklist (PSC-35) – used by our staff and at the provider level to determine the underlying issues leading to aberrant behaviors that may be indicative of past/present trauma. We have included a sample of this assessment as Attachment G.8.a.vi.-4 PSC-35.

We look forward to working with DMS to support them in identifying an appropriate set of screening tools based upon our extensive experience to meet the needs of children and youth in the SKY program.

b. Submit the proposed screening tool the Contractor will use to develop the Kentucky SKY Care Plan. Include a description of how the Contractor will use the results of assessments that sister agencies have conducted in developing the Care Plan.

We use four primary assessment tools to gather pertinent information about a child or youth to develop a comprehensive plan of care.

### **Pediatric Core Assessment (Under 18 years of age)**

New members entering a UnitedHealthcare Community & State health plan are screened for case management programs using a health risk assessment (HRA) tool. Members identified as foster care, adoptive assistance or other out of home placement, are referred for case management services and assigned to the appropriate care coordinator. The assigned care coordinator will complete the initial Pediatric Core Assessment as quickly as the member's condition requires within the timeframes established by regulatory requirements, but no later than 30 calendar days from identification of the member as appropriate for care management. The assessment is completed telephonically or face to face based upon the member's condition and regulatory guidance.

As part of the Pediatric Core Assessment, a trauma screening is completed. This screen provides valuable information related to the traumatic experiences the child has faced. When the screening tool is complete, the care coordinator will refer the child or youth for additional assessments by a provider, provide education information to the foster parent, and refer for specific trauma based treatment interventions to meet the child or youth's needs. They are also responsible for performing additional assessment(s) of the member's needs (when appropriate) and implementing an integrated care plan.

The Pediatric Core identifies each member's social, behavioral, medical and functional needs and desired outcomes in the following four domains:

- **Medical/Behavioral Domain** identifies issues related to the individual's physical, mental or emotional health or issues related to SUD or OUD. Some examples include developmental milestones, EPSDT well checks and behavioral health issues.
- **Social determinants Domain** identifies issues related to the individual's social determinants of health, such as living situation, caregiver support, risks related to housing and food security, community and personal safety, awareness of available community resources, transportation concerns and health literacy.

- **Functional Domain** identifies issues related to the child's ability to maximize independence. Some examples include the child's ability to perform activities of daily living (ADLs); available caregiver and natural supports.
- **Quality of Life Domain** identifies what is important to the child's quality of life, what he/she needs, and any high-risk behaviors the child is engaged in. Some examples include where and with whom to live, daily life activities in which the individual would like to engage, and relationships that are important to them.

We have included a sample of this assessment as Attachment G.8.b.-1 Pediatric Core.

### **Adult Core Assessment (18 years of age or older)**

The care coordinator completes this assessment within 30 days of enrollment for youth who have turned 18 years of age who are in the SKY program. It provides a holistic view of the member's overall health state. The Adult Core helps determine the need for additional condition-specific assessments and helps to determine health outcomes to inform the member's plan of care. The assessment identifies key high-risk conditions, family history, family supports, current/past medical history, personal behaviors, social history and environmental risk factors. It triggers condition-specific assessments based upon evidence-based clinical guidelines and the member's individual condition (e.g., diabetes). We have included a sample of this assessment as Attachment G.8.b.-2 Adult Core.

### **Pediatric to Adult Transition Assessment (Ages 14-18 Years)**

The care coordinator will complete this assessment with youth or the youth's foster parent/guardian to assess the member's needs and barriers that may affect their ability to achieve a seamless transition to adult services. The member is reassessed annually, or more frequently as needed based upon their risk level. The information gathered supports the development of a comprehensive, person-centered Transition Plan of Care. Areas assessed include counseling and education, employment and training opportunities, school and academic services, health and wellness education, transition to adult health care services, self-management including, independent living training (work, finance, housing, transportation available community resources. We have included a sample of this assessment as Attachment G.8.b.-3 Pediatric to Adult Transition.

### **Healthy First Steps (Maternity Assessment)**

This assessment is completed when we initially engage with a foster child who becomes pregnant. The care coordinator will complete the assessment to ascertain risk factors, identify barriers to care and provide immediate assistance to help resolve barriers. Higher risk members (includes those whose initial barriers cannot be resolved) will be monitored closely by the care coordinator and connected with the Maternal Child registered nurse care managers. We have included a sample of this assessment as Attachment G.8.b.-4 Healthy First Steps.

### **How We Will Use the Results of Assessments that Sister Agencies Have Conducted in Developing the Care Plan**

We provide an integrated care management experience that does not duplicate efforts or leave children or youth with gaps in care. We align our mission and program development closely with the vision and efforts of DCBS and our provider partners. Our partnerships include clear operational workflows to confirm we align on details, such as the content of enrollee assessments or the frequency of touchpoints. Our clinical team monitors outcomes and offers support to our partner case managers through case rounds and joint operating committees. We

continue evaluating and refining these partnerships to best meet our enrollees' preferences and match them with programs that will be locally based and in line with enrollees' desires.

Using the example assessments from earlier, our care coordinator gathers these documents and uploads them into the *CommunityCare* portal. With the DCBS social service worker's permission and appropriate release form, we will share these documents with anyone who the DCBS case manager says is appropriate: this could include the foster parent, other sister agencies, and the youth themselves. This will be on a case-by-case basis. Our care coordinators will use these assessments in conjunction with motivational interviewing techniques to ensure our assessment questions are not duplicative of information already available to us.

We will gather assessments from sister agencies to include in our assessment process. Once our care coordinator obtains the assessments from our sister agencies, we will incorporate the information into our assessment with a citation to the source of the information. This will help us narrow our focus to questions and information not already gathered. In addition, our findings and assessments will be vital to DCBS completing their case plans, our care coordinators also will be able to pull up real time data from our Hotspotting Tool to provide the most up to date information to the DCBS caseworker about recent medical appointments to incorporate into their case plans and court reports.

Provide examples of prior tools the Contractor has used for other similar programs and detail how these tools have contributed to the Contractor achieving program goals.

Nationally, we use the suite of assessment tools, discussed previously in Section a.vi., for this population across the 13 states where we work with children in foster care. Using these tools has allowed our staff, providers and stakeholders to identify and address trauma symptoms through a variety of means and meet our goal of ensuring members receive the right care, at the right time and in the right amount.

The CSHCN Screener and CSDC-SF have been incorporated into our standard health risk assessment nationally administered to pediatric members (under 18 years) upon enrolling with us and re-administered during changes in members' status prompting reassessment and revision to the member's care plans. The CSHCN Screener is a biopsychosocial assessment endorsed by AHRQ and NCQA and is a high-level tool to identify medical, behavioral and social issues the child/youth may be experiencing. This alerts us through screening that additional assessment is warranted and a referral to a behavioral health provider may be warranted. The CSDC-SF provides information as to the type(s) of trauma endured, when it occurred in the child's life, and the severity of symptoms the child is experiencing. This provides us with additional information that can be incorporated into the care plan and the interventions appropriate to meet the child's needs.

c. Describe its comprehensive approach to providing Crisis Services, including in home services, to Kentucky SKY Enrollees.

**COLLABORATE**

Providing crisis services is an essential part of meeting the needs of children and youth in the SKY program. Whenever possible, we want to avoid children and youth being in crisis, based upon our experience, the best way to do that is to develop crisis support, and safety plans for children in the highest risk categories. In collaboration with DCBS, DJJ, and sister agencies, our care coordinator will help develop these plans with the child, youth and caregivers.

As part of the care plan, we will ensure the caregivers for children and youth in SKY have access crisis services and crisis supports in real time.

Crisis services will be built into our continuum of care for children and youth in the SKY program. Our network will be comprised of providers who will be willing to provide services including wrap around services for children at risk of high rates of ED visits and inpatient hospitalization in their family home, kinship home or foster home. For example, in Tennessee we contract and pay for the CAST program Community-based Assessment, Stabilization and Treatment Team. The purpose of the program is to provide rapid and intensive community-based interventions for children and families experiencing acute and chronic behavioral health issues in an effort to prevent unnecessary inpatient psychiatric hospitalizations or out of home placements.

The services as part of this program include:

- Rapid crisis intervention response and/or respite placement, 24 hours a day, seven days a week
- Family and individual psychosocial skill development
- Academic/vocational training and support
- Parent education, training and support
- A&D relapse and recovery support
- Family and peer support services
- Family and individual counseling
- Care coordination
- Psychiatric consultation, diagnostic assessment and interim medication management if needed

Of the children at high risk and in need of this service, 71% had an inpatient event before the program, while only 8% had an inpatient stay while in CAST, and 6 months after the CAST program, that only rose to 18%. This shows the vast improvement when these important crisis supports are available.

In Kentucky, we will build these programs with local providers, and incentivize them to reach outcomes using crisis supports when appropriate. We have already received a proposal from the Children's Alliance IPA for a wraparound program model, which is similar to the CAST model. We will work expeditiously to implement these programs to ensure crisis supports are available to children in the SKY program who need them.

In addition to services, we will ensure children in the SKY program and their caregivers have access to crisis supports 24 hours a day, seven days a week. These supports include:

- **NurseLine** is available 24 hours a day, seven days a week and staffed with RNs to address enrollee questions and triage immediate health concerns. The nurses are trained on unique needs of children in foster care, and therefore are the first point of contact for children, youth, family, relatives, and foster parents if they are in need.
- **Behavioral Health Services Hotline**, staffed by masters level licensed clinicians, is available 24 hours a day, seven days a week to triage enrollee crisis calls. Clinicians triage enrollees who are experiencing life-threatening emergency issues to 911. Our clinicians further assess enrollees who are experiencing non-life-threatening emergency and urgent issues and refer them to a network provider for additional support.
- **Care Coordinator On Call**: To meet the needs of children and youth in foster care and their caregivers, we will provide a care coordinator who will be on call 24 hours a day, seven days a week, 365 days per year. When calling the number after-hours, a child,

youth or their caregiver will be prompted on the IVR to select a specific option if they want to talk to the care coordinator on call. The call will be routed to an experienced care coordinator who has been working with SKY members in the field. The care coordinator will triage the issue and ensure the child or youth's needs are met.

d. Describe the Contractor's experience in providing services through a holistic, person-centered approach, utilizing a High Fidelity Wraparound approach.

High Fidelity Wraparound is a structured, team-based process that uses an evidence-based, nationally-recognized model that partners with families to use their voice and strengths to develop a plan that promotes self-advocacy and produces outcomes.

Our advanced foster care clinical model is person-centered, goal-oriented and culturally relevant to providing a holistic model of care for children and youth. As such, our model is complementary to the High Fidelity Wraparound model. While we don't currently use a High Fidelity Wraparound approach, we do use some of the same principles in our model of care, as described below. If we are awarded the contract, we will work with DCBS to implement this evidence-based approach. Below, we provide information about our framework and how it is similar to the high fidelity wrap-around approach.

Our framework emphasizes prevention, health promotion, and continuity and coordination of care and services. It advocates for and links members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting. Similar to a High Fidelity Wraparound (HFW) program, our model uses a team-based approach to support our SKY children and youth. The child's or youth's care team is led by a care coordinator and includes licensed mental health professional (LMHP) clinical consultant who provides behavioral expertise to address each enrollee's behavioral concerns and an RN case manager who provides clinical expertise to address their medical concerns.

The team focuses on the child, youth, and families expressed needs, goals, desired outcomes, preferences and choices. It implements a planning process that encourages the member, supported by their multidisciplinary care team (MCT), to actively participate as a full partner in assessment and care planning processes, to make decisions about their care and services in meaningful ways, and to direct the development of a care plan that includes the services and supports. The goal is to meet the member's needs and help the member achieve their goals and desired outcomes.

As presented in the table, we empower children, youth, their families and their foster families using person-centered principles that inform our care management programs, processes, tools and approach to working with children and youth in foster care.

Person-centered Principles that Inform our Care Management Approach
<b>Understand the Child or Youth</b>
<ul style="list-style-type: none"> <li>▪ Identify the child's or youth's needs, goals, outcomes, preferences and choices for care delivery</li> <li>▪ Assess and consider the child's or youth's medical, behavioral, functional and social needs and circumstances</li> <li>▪ Identify risks specific to the child or youth and develop risk mitigation strategies</li> <li>▪ Identify and engage paid and unpaid natural supports available to the child or youth</li> </ul>
<b>Monitor and Evaluate</b>
<ul style="list-style-type: none"> <li>▪ Confirm the delivery of services in a manner that reflects personal preferences and choices and contributes to the assurance of the child's or youth's health and welfare</li> <li>▪ Encourage the child or youth to ask for a meeting to discuss a change to their care plan</li> </ul>

**Person-centered Principles that Inform our Care Management Approach**

**Engage the Child or Youth and Their Foster Family**

- Communicate information to the child or youth and foster family in a manner or language that promotes effective communication and reflects cultural considerations
- Empower the child or youth and foster family to direct all aspects of the care planning process
- Include people chosen by the child or youth to participate in the care planning process
- Accommodate the child’s or youth’s and family’s preference for the style of interaction and the time and place for the care plan to be developed
- Educate the child or youth and foster family on the services for which they are eligible and the options for selecting a provider to ensure informed choice
- Identify services and supports that help the child or youth achieve their outcomes in the most integrated community setting
- Provide a mechanism for the child or youth to identify providers who render the services they receive
- Develop a care plan that is prepared in-person-first, singular language, written in plain language and accessible to children or youth and families (with consent), including children or youth with disabilities and those with limited English proficiency
- Understand the setting in which the child or youth and foster family chooses to reside and explore housing options
- Document alternative home and community-based settings that the child or youth and foster family considered during the planning process
- For youth transitioning out of foster care, explore employment outcomes, such as seeking meaningful work opportunities, maintaining current employment and career advancement

e. Describe how the Contractor will develop and provide interventions that will help develop resiliency in Kentucky SKY Enrollees who have been exposed to Trauma and ACEs.

We know assessing children and youth to understand their exposure to trauma and adverse childhood experiences (ACEs) is essential. Our Pediatric Core assessment asks questions related to the trauma children have experienced. We have also developed online training and the Foster Care Corner, so providers can be trained and use the most up-to-date assessments and screening tools with children and youth in the SKY program to determine the severity of the trauma they have been exposed to.

We use the 7 C’s Model of Resilience endorsed by the American Academy of Pediatrics. They provide the skills we want to develop through our interventions for children and youth in SKY. We want the interventions to teach them self-management, and give them opportunities to build on their strengths. The 7 C’s Model includes building the following: competence, confidence, connection, character, contribution, coping and control. It is a plan to help children develop the skills they need to be healthy after traumatic events.

We will develop a network to provide interventions to assist children and youth in SKY build resiliency, as indicated above by the AAP. This will include building a network of providers who are trained in evidence-based practices, including family functioning therapy, peer support, motivational interviewing, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Multisystemic Therapy, NAMI Family-to-Family and EMDR. In addition, we know ensuring these children receive these interventions in settings that best meet their needs. Therefore, we will work to build robust partnerships and contracts with school-based behavioral health providers. We also will work with providers to develop outcome-based contracts to deliver these interventions in family-like settings, rather than in office settings. We know children and youth healing from trauma need to feel safe in the environment they are receiving treatment.

f. Describe the role of non-medical factors (e.g., placement changes) that may drive inappropriate utilization of medical resources and how the Contractor will account for those factors in the delivery approach. As part of the

response, include how the Contractor will identify and leverage non-Medicaid resources that may be available in a community environment, including how it will assist such community-based resources that may serve an important role in the Kentucky SKY Enrollees' overall physical and Behavioral Health care needs and goals even if they are not traditional Medicaid services. Provide examples of any community organizations that the Contractor anticipates involving to provide services to support Kentucky SKY Enrollee' needs and goals.

Based upon our experience in other markets and our review of ED visits and hospitalizations due to behavioral and physical health issues, we know non-medical factors can play into service utilization. Because we understand these trends, use of these services is something we will keep watchful oversight on as the MCO of choice for children in the SKY program. Some non-medical factors that may drive utilization of these services include:

- Delayed reunification: the child may think they are going to go home, and if the plan is delayed for any reason, this could cause feelings of hopelessness, which can manifest itself in many symptoms, which could lead to an ED visit and inpatient hospitalization.
- Placement changes: when a child or youth has a disruption in those who care for them, the instability can lead to physical and behavioral health symptoms that foster parents believe need immediate intervention.
- Removal from the family home post-reunification: once a child is placed back in their family home after an episode of foster care, to once again be removed through no fault of their own can lead to feelings of being overwhelmed. The symptoms resulting from this can cause urgent issues that need immediate attention.
- Disrupted safety plan: during the case planning process, the DCBS social service worker will develop safety plans for children and youth in foster care. In the instance of a disrupted safety plan, such as a child running away from a placement, foster parents often get overwhelmed and ask for immediate removal, which may result in an ED visit.
- Lack of discharge planning with transitional care: if there is lack of discharge planning for children leaving residential facilities, the appropriate services may not be in place to stabilize them in a lower level of care. Because of this, they may have symptoms that cause foster parents to take them to the hospital because they were unprepared for the child's behaviors or needs.

## Accounting for the Role of Non-medical Factors in our Delivery Approach



We have several ways to account for the role in these factors in our clinical care model framework. First, we want to be sure we are part of the case planning process for children in the highest risk categories to ensure safety planning, crisis management planning, and discharge planning have occurred in a way to support the parents, kin, and foster parents to keep the child or youth stable in a family setting.

Another way we will work on controlling for inappropriate utilization is tracking through our Hotspotting Tool and key performance indicator (KPI) dashboard to find outliers. If we find an outlier, we will immediately engage the team that is wrapped around the child including and, if appropriate, DCBS, DJJ and other sister agencies, foster parents, biological parents, and other community-based organizations including providers to plan for any crisis situations to control the use of ED and inpatient services.

Since our care coordinators will be integrated in the DCBS offices in the regions, we will partner with them as part of the planning processes. In addition, if DCBS indicates a child has escalating medical or behavioral health issues, or if we notice they are moving up the risk stratification to higher levels of risk, we will be able to respond and help coordinate care before it becomes an emergency.

## Identifying, Leveraging and Assisting Non-Medicaid Community-based Resources

We have developed diverse community relationships with agencies and community organizations that provide community services to our members in the Medicaid programs we serve across the county. We recognize the importance of identifying and engaging local resources who know their communities and the children and youth living in them and who can deliver services to these children, youth and foster families that will be most effective in connecting them to the services and supports they need. Our SKY behavioral health specialist will use their knowledge of the community, our national experience and relationships, research conducted by our provider network team, information from the Commonwealth and input from key stakeholders to learn about community-based capabilities and expertise. They will work with community-based organizations to bring their capabilities and experience to children and youth in the SKY program.

Our SKY behavioral health specialist will work throughout the Commonwealth to learn about the community-based resources available to SKY enrollees. They will meet with non-profits, faith-based organizations and other community members to understand their mission, strategy, capabilities and expertise, build relationships and determine the extent of future partnerships with community resources.

We have already begun outreaching to community providers in Kentucky to build a robust network of community-based organizations. For example, UnitedHealthcare representatives Keith Mason, Director of Community Engagement, and Sara Goscha, Interim Executive Director of SKY, toured the Commonwealth with Kentucky Youth Advocates (KYA) to discuss data and help communities develop local strategies to reduce the number of children going into the Commonwealth's child welfare system. Over a 5-day period, we met with approximately 175 stakeholders across Louisville, Paducah, Glasgow and Manchester to talk about the challenges facing each community related to providing families and children services before removal by DCBS.

Stakeholders included the governor's office, state representatives, the DCBS commissioner and staff, city mayors, judges, providers, nonprofit agencies, educators, administrators, foster parents, and other private citizens all wanting to work toward a common goal. In each meeting, local Kids Count data was presented, community stakeholders shared the barriers they saw with the current system, and then provided solutions on how to better the prevention service system.

"Our partnership with UnitedHealthcare has enriched our ability to connect local leaders to important data on children in their communities and foster collaborations that will help us toward our vision of Kentucky, the best place in America to be young. We are grateful for the UnitedHealthcare team's commitment to build relationships with local community leaders and find innovative ways to address the social determinants that will ultimately improve the health of Kentucky's children."

— *Terry Brooks, Ed.D.*  
*Executive Director of KYA*



**COLLABORATE**

The groups developed a list of activities they could implement over the next 12 to 18 months.

UnitedHealthcare donated \$10,000 to each community (provided they could find a dollar-for-dollar match on the donation) to operationalize one of the solutions they identified. During meetings in Louisville, Paducah, Glasgow and Manchester, donors provided the match within the 3-hour live meeting. As one person remarked at the meeting in Glasgow, "We have to come together as a community, because we are the only ones who can do it for our children."

Our vision for the Commonwealth is to develop relationships like this throughout Kentucky using our SKY behavioral health specialist and regional care coordinators so we can provide these resources to the DCBS caseworker and foster parent. In our experience, using our analytics tools, we can identify children who need engagement timely, and our staff operates as part of the team that can assist in ensuring the child and youth's needs are met. We will re-engage the community-based organizations and providers, by having in-person meetings within the first 30 days, and give the updates at 60 days and 90 days to confirm we have a robust network of partners, not just Medicaid providers, who will work with us to streamline services and supports for the highest risk children we serve. Using these meetings as a springboard, if awarded the contract, we will quickly re-engage the 175 stakeholders we have met with, along with our partners at Kentucky Youth Advocates, to discuss how we can assist the community-based partners with programs and services to improve the health of the children we serve under SKY.

Some additional **examples of community organizations** we anticipate involving to provide services to support Kentucky SKY Enrollees' needs and goals, include:

- **Boys and Girls Clubs:** We know children and youth in foster care often want to feel like they are part of the larger community, and children and youth who participate in pro-social activities have better health outcomes. In July, we will launch a telemental health program with the Boys & Girls Club of Glasgow-Barron County. Via computers donated by UnitedHealthcare, all children will have access to mental health services delivered virtually by local providers, regardless of payer. To ensure success, we have retained Dr. Steve North and Amanda Martin to support us as consultants. Dr. North and Ms. Martin are the Medical Director and Executive Director, respectively, of the North Carolina Health-e-Schools program. Health-e-Schools uses telehealth to improve access to care for children and adolescents in 33 North Carolina schools.
- **Kentucky Foster Parent Association (KFPA):** We partner with the KFPA to train foster parents, providers, internal staff and other stakeholders about the unique needs of children in foster care. The goals of the training are to help participants gain:
  - Increased awareness and understanding of and empathy for the unique needs of children and youth living with foster, kinship, adoptive parents or in residential care
  - Enhanced understanding of roles in combination with other team members to support children and youth in foster care
  - Specific skills to address the needs of children and youth in out-of-home care and the families and staff who care for them
  - Enhanced enrollee advocacy by our staff and other team members
  - Increased teamwork and advocacy by UnitedHealthcare staff and foster, kinship, adoptive parents and residential care staff on behalf of the children they serve
  - Collaboration in developing multidisciplinary dissemination strategies that inform the larger health care and child welfare community on behalf of this vulnerable population, including educating about grief, trauma and loss

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