

10. Population Health Management and Care Coordination

We have implemented a population health-management program in 25 Medicaid programs we serve nationwide, and we bring to Kentucky best practices learned through that work. For instance, in June 2018 we implemented our Hotspotting Tool, which provides timely identification of subpopulations of children with complex social, behavioral or medical needs and high costs within defined regions at the state, regional and local level. We have customized the tool to meet the needs of foster care enrollees, by separating their claims from the whole population for analysis and comparison to ensure our specialized model is meeting their needs.

We recognize the importance of population health management in identifying and addressing the social, behavioral, medical and functional needs of all the children and youth served through the SKY program to improve their health outcomes, reduce health disparities and confirm each child or youth receives services and supports most appropriate to meeting their needs and helping them achieve their goals and desired outcomes.

Children in foster care are more likely to be prescribed psychotropic medications compared to their peers, and are more likely to have been experienced an adverse childhood experience which can have a detrimental effect on their health. Additionally, we know these children face unique challenges, such as food insecurity, unsafe and unstable housing, lack of transportation and financial instability. Our population health

management strategy takes into account these social determinants of health that often prevent children or youth from receiving care. Our strategy aligns with the five components of NCQA's population health-management model. It informs and guides our managed care program, helping us identify the services, supports and programs children and youth in foster care across Kentucky need and the providers and community-based organizations qualified to deliver them.

Component 1: Our Population Health Management Strategy

Our evidence-based population health management program helps us understand the social, behavioral and medical needs, circumstances, health risk and level of intensity of care management services of every child in the SKY program. Based upon our understanding, we engage children or youth and their foster families across the care continuum, delivering a customized array of services, supports and programs that confirm **every** child receives an intensity of care management services appropriate to their needs and delivery to each child the right care or support, at the right time, in the most appropriate setting, in the most efficient way. The overarching goal of our identification process is to maximize their health by providing children or youth with preventive services and tools that promote wellness and provides more intensive supports to at-risk children and those with complex conditions to help them better manage their conditions, leading to improved health outcomes.

We have outreached to community providers in Kentucky and built a robust network and stakeholder group. For example, we 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 five communities to talk about the specific challenges to providing families and children services before removal by DCBS.

Our population health management program:

- **Promotes the development of robust partnerships** with DCBS, DJJ, providers and community partners through our local team-based approach to collaboration. We will integrate local care coordinators in the region who will interact with the teams supporting

children and youth in the SKY program to confirm support of the foster care child or youth, DCBS, sister agencies and our providers. Care coordinators will help DCBS and foster parents access the right care at the right time in the right place for children and youth in foster care. Our coordinators and specialists are part of our overall SKY provider relations team and have a direct link to the SKY provider relations liaison. Our SKY provider relations manager will work with providers to provide educational opportunities and support that helps them meet the unique needs of children and youth in the SKY program.

- **Supports innovation** by addressing key concerns that affect the coordinated delivery of integrated services to children and youth in foster care, such as a lack of data about their interactions with the health care system. We overcome this barrier to delivering coordinated care through our Data Sharing Technology Suite, which includes tools, such as *CommunityCare*, our care management platform. It houses each child's electronic health record and our integrated health record (IHR), which gives providers a 360-degree view of the child's medical history for the past 3 years. We presented our Data Sharing Technology Suite in our response to Section 10. Population Health Management and Care Coordination, subsection h.
- **Promotes high quality and health and wellness** in a variety of ways. For example, we have established baseline measures, such as HEDIS and NCQA Quality Compass Benchmarks, and key performance indicators specific to foster children that allow us to confirm children and youth have received recommended preventive care, track the effectiveness of our clinical solutions and identify opportunities for improvement and develop specific interventions to address them. Our robust EPSDT program uses relevant metrics and advanced data analytics to help us know which providers have significant numbers of children or youth with gaps in care and which children and youth have care gaps so we can implement interventions to close them.

We will use *CommunityCare* to house each child or youth's medical passport. By housing the medical passport in each child or youth's electronic health record, it can be updated and shared among the UnitedHealthcare care team and the providers serving the child or youth. So long as they are enrolled with UnitedHealthcare, their updated medical passport will be available to UnitedHealthcare care teams and the child or youth's MCT.

Component 2: Population Stratification and Resource Integration

Our evidence-based identification process integrates findings from the initial health risk assessment (HRA) and the results of the analyses provided by our suite of data analytics tools to understand every children's or youth's social, behavioral and medical needs, circumstances, health risk and their level of intensity of care management services. Using a suite of data analytics tools, we continually analyze a robust data set to provide the right care to children or youth, at the right time and the right setting. We describe our suite of data analytics tools and our approach to stratify children and youth in the SKY program into tiers for Care Management services in our response to Section 10. Population Health Management and Care Coordination, subsection c. We also analyze publicly available data from sources, such as America's Health Rankings, the U.S. Census, Robert Wood Johnson Foundation, the CDC Diabetes Interactive Atlas, the Behavioral Risk Factor Surveillance System, CDC WONDER Mortality Data and data from the National Center for Health Statistics.

Component 3: Targeted, Person-Centered Interventions

Based upon their health risk, we will employ unique interventions for children or youth in foster care at high-risk levels. For example, for children in the complex care-coordination level of care,

we will use targeted interventions, such as in-home wraparound services, to keep the child in the family home with supports instead of moving them to a Psychiatric Residential Treatment Facility (PRTF). For children in the intensive care coordination risk level, we will use focused pharmacy reviews for any child with a psychotropic medication with outreach to the prescribing physician if the medication is not indicated for the child's diagnosis or is being used off label, such as a 5-year-old being prescribed Trazadone.

Component 4: Delivery System Support and Alignment

We recognize our providers influence outcomes, utilization and quality as they deliver care. Our role is to confirm providers have access to data, tools and incentives that help them engage children and youth with the most urgent needs and highest risk and provide evidence-based services and supports that will lead to improved outcomes. For example, we know maintaining each child's or youth's medical records is critical to coordinating and maintaining the continuity of their care across varied delivery systems, care settings and placement changes. *CommunityCare* maintains each child or youth's electronic health record, such as utilization, assessment findings, IEPs and their care plan. It provides the mechanism for his multidisciplinary care team (MCT) to collaborate to deliver each child's or youth's care, develop a care plan that meets their needs and helps them achieve their goals, monitor the child's or youth's progress toward achieving their goals; and identify acute events so their MCT can coordinate relevant and timely interventions to meet their needs. We discuss our technologies to maintain each child or youth's medical records in our response to Section 10. Population Health Management and Care Coordination, subsection h., later in this section.

Component 5: Measurement

We compare the health outcome measures of our population against state and national rates and identify areas of opportunity to engage specific subpopulations using factors, such as:

- Risk level, geographic area and access to care
- Common demographic factors, such as race/ethnicity, age and gender
- Children or youth with specific circumstances, such as pregnant women and their infant children
- Social factors, such as food insecurity, unstable housing, employment and educational attainment

Baseline measures. We have established baseline measures, such as HEDIS and NCQA Quality Compass Benchmarks. We monitor utilization rates and HEDIS-reported rates, which allows us to identify areas of improvement in our SKY population against HEDIS measures, NCQA averages and percentiles and our own performance targets. We monitor traditional core health measures, such as tobacco use, pediatric obesity and diabetes prevalence rates, and identify social and environmental measures to add context to the health and well-being of a local community. We build on these measures by identifying key areas of concern in Kentucky, such as the use of psychotropic medications.

We are working with the Children's Alliance Foster Care IPA to implement its In-home Services to Prevent Institutionalization or Removal (INSPIRE) Kentucky program. INSPIRE provide strengths-based, short-term, intensive, person-centered, family-based services to children and youth between the ages of 5 and 18 who are at imminent risk of being institutionalized or removed from their home due to the child's mental health or high-risk behaviors. INSPIRE Kentucky services are provided in-home, community or an office-based setting with the goal of stabilizing the child or youth in their community.

Key performance indicators. We have established key performance indicators specific to foster children, which allow us to track performance and identify opportunities for improvement and develop specific interventions, such as:

- Access to primary care, such as the percentage of foster care children who have had well-child checks and received preventive vaccines
- Reducing behavioral health expenditures through a reduction in high cost services and a reduction of inpatient stays and length of stay in inpatient facilities
- Reducing the number of children under the age of 6 receiving a psychotropic medication
- The percentage of UnitedHealthcare clinical staff trained on Trauma-informed care

a. Describe plan for identifying and coordinating care for those Kentucky SKY Enrollees with the most immediate service needs leading up to and immediately following implementation of the Kentucky SKY program.

We understand the critical need to maintain continuity of care for each child and adolescent in the Kentucky SKY program. Children or youth who have care plans in place rely on the services identified in their care plan. They and their foster parents want to know we will protect them by confirming the benefits they are receiving today will continue without disruption. We have substantial experience onboarding and delivering care management services to enrollees – often in short time frames after contract award. Our overarching plan for identifying and coordinating care for Kentucky SKY Enrollees with immediate service needs just preceding and during their transition to our health plan entails:

- **Working with the Department to gather information about each enrollee’s health care history and needs.** In other states, we have introduced a scope-of-need document and engaged program stakeholders in gathering this important information for each person transitioning to our plan. The scope of need documents allows us to:
 - Develop a priority list that identifies the top 10 high-risk groups, so that we can triage each group most effectively
 - Find out if the Department can share additional data with us about the incoming enrollee’s journey, including any prior authorization, complex/chronic care, out-of-state and out-of-network scenarios that we need to address as part of the enrollee’s transition plan
 - Agree upon a meeting schedule for the duration of the transition
 - Share key contact names and numbers
 - Agree upon who is on point at the Department and our team for certain tasks
- **Coordinating transitions with the other MCOs.** Where possible, we will enter into data-sharing agreements with the other MCOs. These agreements set the stage for effective two-way sharing of clinical data to support care coordination with enrollees, providers, our clinical care team, and the other MCO’s care coordination staff. Also, we need our health services managers and our medical directors to work together and frequently communicate during the transition.

Identifying Children and Youth with the Most Immediate Service Needs

We place special emphasis on providing continuity of care for children who are in residential care, children who are medically complex, children with pre-authorized services, children who are pregnant or become pregnant, and children in an inpatient setting who require an immediate discharge plan. Before go-live, our SKY executive director will work with the SKY Medical Director, DCBS and other MCOs to set up processes and identify data requirements to support the identification of children with immediate service needs. For example, we:

- Can identify these children more readily using our advanced data analytics tools to identify their health risk using historical claims and encounter data. We will work with DCBS to identify what data it can share with us to conduct this analysis.
- Know DCBS social service workers have insights into those children who have immediate service needs. We will work with DCBS to establish mechanisms to obtain this information from DCBS so we can prioritize our outreach to these children.
- Understand a certain number of children may exit enrollments and new children will enter enrollment between the time we are provided the initial data and the go live date. We will work with DCBS to establish mechanisms to identify and prioritize these children.
- Will locate care coordinators in each DCBS service region location to establish relationships with DCBS staff. By co-locating our staff with DCBS staff, we expect to develop working relationships that will help us prioritize children and youth for immediate engagement, and locate and engage foster parents and caregivers to conduct an HRA and begin providing care management services.
- Will work with DCBS and Kentucky MCOs managing SKY children and youth to establish mechanisms to prioritize children for engagement and exchange data that will improve our ability to quickly coordinate their care, such as the child's or youth's most recent assessments and care plans.
- Will submit a detailed implementation plan to DMS and, in coordination with DCBS and DJJ, discuss how our care coordinators will be made aware of any children or youth at high risk during the transition.

At go-live, we will analyze any data supplied by DCBS using our data analytics suite described in the following section. This analysis will help us identify a variety of information needed to prioritize children and youth for immediate outreach so we can begin coordinating their care. For example, the analysis will help identify each child's health risk and provide inputs into their care management level, such as the services each child is receiving, the providers delivering those services, each child's social, medical and behavioral needs, and children and youth who may be experiencing a care setting transition.

Coordinating Care for Children and Youth with the Most Immediate Service Needs

To promote continuity of care for services already being delivered to children, we will continue to authorize those services requiring prior authorization for a period of up to 90 days or until the child's care plan has been updated. For children and youth identified with immediate service needs, we will **immediately** assign a care coordinator to engage the child or youth and begin coordinating their care. To reduce complexity for children and those supporting them, our care coordinator serves as the **primary point of contact to coordinate care** and help them navigate the health care system. We maintain the relationship between each child and their care coordinator, regardless of placement changes to provide stability for the child and allow the child and their care coordinator to establish a trusted relationship. Establishing trust is the first step in helping each child or youth and their foster families participate in their care and navigate the health care system.

Throughout the implementation, our care coordinators and SKY behavioral health specialist will continue to engage DCBS staff in each service region to identify children and youth with immediate needs. Additionally, DCBS and DJJ can reach a care coordinator through our line dedicated to SKY to identify children and youth with immediate service needs, 24 hours a day, seven days a week.

b. Describe how the Vendor would identify and monitor new Kentucky SKY Enrollees with high physical or behavioral health needs to ensure continuity of care.

We recognize the critical importance of identifying those children and youth who are the most vulnerable during this significant transition in their lives. We know children and youth with high physical and behavioral health needs require increased coordination to confirm their needs continue to be met without disruption throughout the implementation. We will use the methods discussed in the following section, such as our predictive modeling analysis, to identify children with high physical or behavioral health needs. Throughout the implementation, our care coordinators and SKY behavioral health specialist will engage DCBS staff in each service region to identify children or youth with high physical or behavioral health needs. Some characteristics of children or youth who have high physical or behavioral health needs include children designated as:

- Medically complex
- Who have preauthorized services
- who are pregnant
- in residential care
- In a PRTF or inpatient placement
- Under the age of 3 and taking antipsychotic medication
- On four or more psychotropic medications
- Suicidal or homicidal ideation requiring inpatient hospital in last 30 days
- Medically fragile, blind, deaf
- Who have multiple fractures as a result of child abuse in the last 6 months
- technology dependent
- A serious ongoing illness or complex/chronic condition
- A disability that has lasted or is anticipated to last at least 12 months
- An illness, condition, disability that significantly limits ADLs or social roles in comparison with accepted pediatric age milestones in general
- Traumatic brain injury

Once identified, we will assign a care coordinator or nurse case manager depending on the intensity of the child or youth's care management tier to engage with and begin coordinating their care. Initial coordination will include meeting with the DCBS worker to gather documents, outreach to providers as needed, and to complete assessments. The care coordinator will continually monitor the child or youth's care plan to verify they are achieving their goals and for indications their health status, needs or living situation have changed. When the care coordinator sees these indications, they will reach out to the child or youth's foster parents to implement interventions that will address the child or youth's concerns.

Our clinical team will monitor these children and youth using the methods described in the following section, including our predictive modeling analysis of all children or youth to identify each child or youth's tier of care management. Children or youth with specific physical or behavioral health needs, our Hotspotting tool, which provides the timely identification and engagement enrollees groups who have inappropriate utilization patterns, complex social, behavioral or medical needs and high costs within a defined region of Kentucky.

c. Describe how the Vendor will stratify Kentucky SKY Enrollees into tiers for Care Management services.

We recognize the importance of identifying and addressing the social, behavioral, medical and functional needs of all the children and youth in the SKY program and delivering care management interventions that align with their health risk and tier of care management. Core to our approach to identifying every child’s or youth’s social, behavioral, medical and functional needs and their care management services tier is having the right data inputs, innovative tools to synthesize and interpret data, and the clinical expertise and local relationships to provide a 360 degree view of each child’s or youth’s circumstances. Our tools identify key drivers common to children or youth who require intensive clinical intervention, such as special health care needs, high-risk pregnancy, unmanaged complex medical or behavioral conditions or acute social determinants, such as homelessness. As presented in the figure, our identification process integrates findings from the initial health risk assessment (HRA), the results of our **monthly predictive modeling analyses** and our **Hotspotting Tool** to understand each child’s or youth’s social, behavioral and medical needs, circumstances, health risk and their level of intensity of care management services. Our risk stratification aligns with the tiers of care management services in Attachment C – Draft Medicaid Managed Care Contract, 42.10.2 Care Coordination Teams.

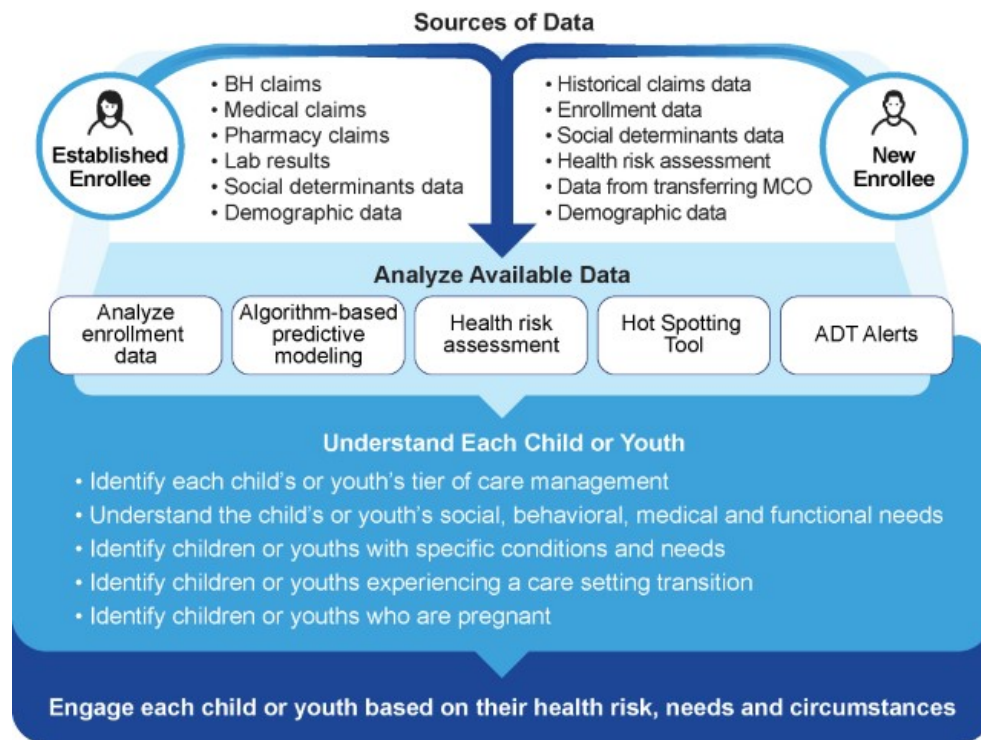


Figure 12. Understanding each child or youth. Our process incorporates an HNA for new enrollees and a monthly analysis of all enrollees using data from a variety of sources and a suite of advanced analytics tools. It delivers a risk score for each child or youth, identifies their tier of care management and children or youth with special health care needs, specific conditions or who are experiencing a care setting transition.

Defined Tiers of Care Management

Using the methods described in the following sections, we will identify each child or youth’s level of care management. By using claims data, diagnosis codes, results from assessments and pharmacy data to stratify each child month over month in alignment with Attachment C – Draft Medicaid Managed Care Contract, 42.10.2 Care Coordination Teams. Our stratification algorithm is tailored to the SKY population and we use this stratification across our markets

nationally. We believe all children from the lowest risk to the highest risk require intervention and our unique foster care clinical model provides interventions aligned with their tier of care management. We know, based upon our experience, running our stratification month over month produces information showing approximately 3% of the population will move up in risk level, and about 3% of children and youth will stabilize in that same month. This tool provides us with an advantage in ensuring care management is targeted to those children who have moved up in the risk stratification first each month to help stabilize them. The table describes the criteria for identification in a care management tier.

Care Management Tiers and Enrollee Criteria for Each Tier
Care Management Services
Enrollees with one well-managed or no chronic conditions and is stable and well-managed.
Intensive Care Coordination
<ul style="list-style-type: none"> ▪ Enrollees receiving two or more psychotropic medications prescribed at the same time OR receiving duplicate antidepressants ▪ Infants/toddlers with risk for developmental delays ▪ Former foster care youth who have transitioned to adult system (up to age 26) with behavioral health condition or physical health condition that is uncontrolled ▪ PRTF stay in the last 12 months ▪ Enrollee receiving three or more psychotropic medications prescribed at the same time. Non-compliance with medication management ▪ Serious emotional disturbance (SED) ▪ Diagnoses of Bipolar Disorder, psychotic disorders, major depressive and anxiety disorders ▪ Substance abuse ▪ Enrollee has had more than two ED visits in the most recent 12 months ▪ Enrollee has established developmental delays ▪ Former foster care youth who have behavioral health condition or physical health condition that is uncontrolled
Complex Care Coordination
<ul style="list-style-type: none"> ▪ Currently in PRTF or residential placement ▪ Under the age of 3 and taking antipsychotic medication ▪ Any child on four or more psychotropic medications ▪ Suicidal or homicidal ideation requiring inpatient hospital in last 30 days ▪ Has a serious ongoing illness or complex/chronic condition or a disability that has lasted, or is anticipated to last at least 12 months. ▪ Has an illness, condition, disability that significantly limits ADLs or social roles in comparison with accepted pediatric age milestones in general ▪ Medically fragile ▪ Traumatic brain injury ▪ Blind or deaf ▪ Multiple fractures as a result of child abuse in the last 6 months ▪ Technology dependent
Enrollees Designated as a Medically Complex Child
Children designated as Medically Complex by DCBS Medical Support Section staff

Identifying Children and Youth– Initial HRA

Our evidence-based pediatric and adult HRAs evaluate each child’s or youth’s health and wellness and identify critical information, such as social, behavioral, medical and functional needs, PCP and provider relationships, active treatment plans, current services, including

overutilization and underutilization of services, barriers to accessing care and chronic physical or behavioral health conditions. HRA findings lead to immediate engagement of resources to meet the child or youth's needs.

Children in foster care experience high rates of trauma; our pediatric HRA asks about any trauma the child has experienced so we are able to address the trauma to improve their health and well-being.

For instance, we refer children and youth with high risk scores or special health care needs for a comprehensive assessment and engagement in Intensive or Complex Care Coordination and connect children or youth who are pregnant to a maternal support team to help them actively access perinatal care and programs, such as Healthy First Steps (HFS) and HFS Rewards. If the HRA identifies a child or youth's behavioral health condition, we use assessments to understand their needs. For example, our adult HRA includes validated behavioral health screening tools, such as the Alcohol Use Disorders Identification Test (AUDIT)-C to screen for risky drinking and the Patient Health Questionnaire (PHQ)-2 to screen for depression. Our pediatric HRA assesses trauma, using the Child Stress Disorders Checklist-Screening Form, and depression using the PHQ-9.

Identifying Children and Youth- Referrals

We accept referrals from children, youth, families, relatives, foster families providers, state agencies, DCBS social service workers, and UnitedHealthcare departments, such as our *Advocate4Me* enrollee services center or our utilization management program. We rely on our care coordinators and strong relationships with providers, such as behavioral health therapists, PCPs and specialists, to identify children for intensive case management. Our provider advocates and clinical practice consultants work with physician practices to identify children who are in the hospital, have visited the ED, have gaps in care, and may require Intensive or Complex Care Coordination or who have specialized needs, such as pregnant enrollees.

Data Analytics Suite

We continually integrate and analyze data using our suite of data analytics tools to understand every child or youth's social, behavioral and medical needs, circumstances, health risk and their appropriate intensity of care management services. These tools help us:

- Stratify SKY children and youth in alignment with the tiers of care management in Attachment C – Draft Medicaid Managed Care Contract, 42.10.2 Care Coordination Teams
- Identify drivers common to children and youth who require intensive clinical intervention, such as high psychotropic use, unmanaged complex medical or behavioral conditions or acute social determinants
- Identify sub-populations within the larger population and provide interventions accordingly. We identify subpopulations within our population based upon a variety of factors, such as risk level, region, geographic area, ability to access care, health disparities, demographics, utilization and children and youth with specific needs
- Measure population health status using baseline measures and key performance indicators discussed previously

We know children in foster care can move from a low risk level to a high risk level quickly due to factors such as placement changes, missed visitation with a parent or the disruption of a close relationship. To be able to respond effectively to these changes, we run our predictive modeling analysis each month for established enrollees and use our Hotspotting Tool to identify children with specific characteristics.

Identifying Children and Youth – Predictive Modeling



INNOVATE

Each month, we use Impact Pro™, our predictive modeling tool, to analyze all of our enrollees and identify each child or youth's appropriate tier of care management. The analysis applies more than 300 clinical rules to identify children with gaps in care, condition-specific triggering events, high utilization, risk markers, substance use concerns and the impact of social determinants to their overall risk. **Our predictive modeling algorithms have positive predictive validity of nearly 80%.** Our algorithms integrate and analyze a variety of data sources, including medical, behavioral and pharmacy claims; lab results; prior year total cost of care; utilization, such as acute inpatient admissions, ED visits and pharmacy; social determinants-related data; and demographics. **Our algorithms analyze factors more prevalent for children in foster care such as increased use of psychotropic medications and the presence of trauma.**

Identifying Children and Youth — Our Hotspotting Tool

Hotspotting is a data-driven process to map geographical areas with the highest concentration of children and youth who have high needs and costs and who use a disproportionately large quantity of medical resources and limited assets. Launched in June 2018, our Hotspotting tool provides timely identification and engagement of cohorts of children who have inappropriate utilization patterns, complex social, behavioral or medical needs and high costs within a defined region of Kentucky. Its dashboard provides filters to segment enrollees in a variety of ways, such as demographics, region, social determinants, utilization patterns, cost, diagnosis and risk factors. The tool provides heat maps that identify utilization across Kentucky. An individual child view provides front-line staff with a 12-month look back of utilization, cost and summary health care statistics. An individual child summary, presented in the figure, offers an enhanced view of the child.

The Hotspotting tool allows our care coordinators to isolate the foster care population to determine places where there are a large numbers of children in foster care, provides real time data on current medications and medical information that is valuable to the caseworkers and foster parents when developing case plans and discharge plans.

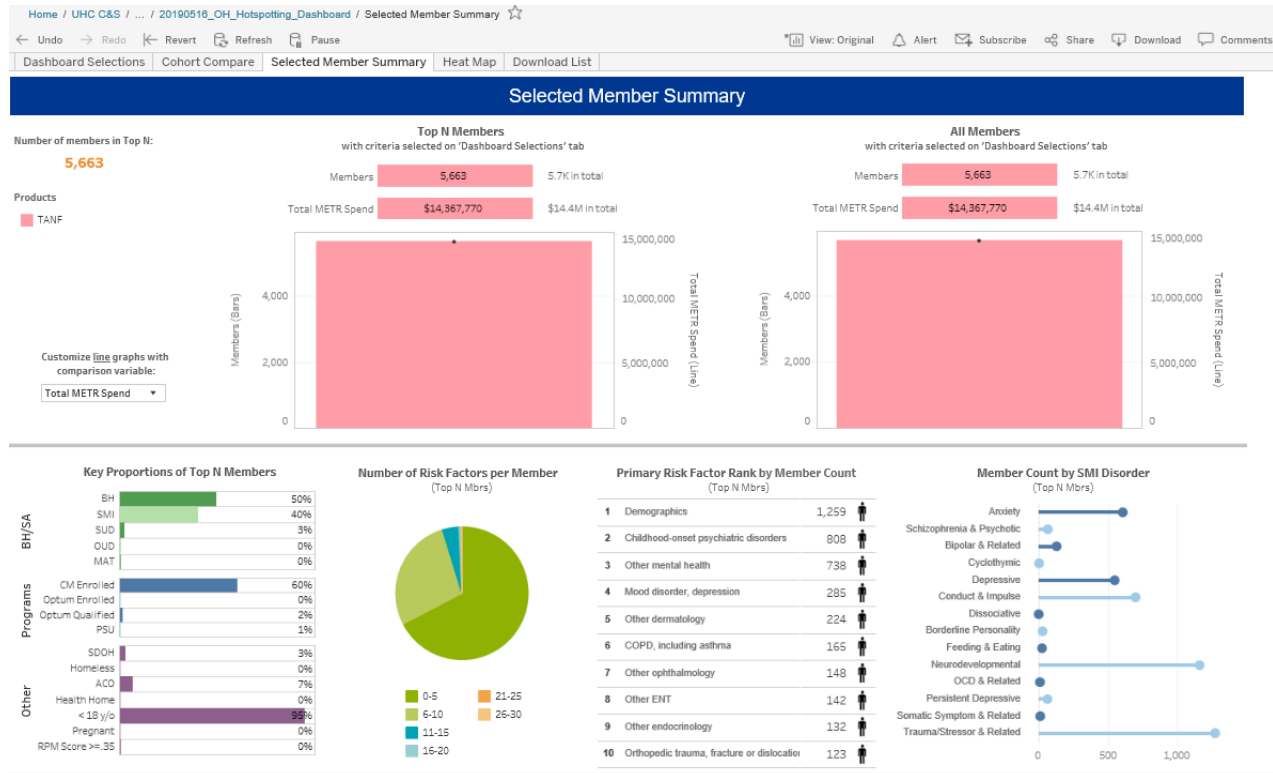


Figure 13. Enrollee summary. This view summarizes statistics for cohorts of enrollees using filter criteria determined by the user. The view provides information such as the top 10 risk factors, social determinants and serious mental illness (SMI) diagnoses and identifies care management utilization statistics within the cohort, such as the percentage of enrollees with an opioid prescription and average inpatient admissions.

d. Provide a description of the Vendor’s targeted evidence based approaches applicable to the Kentucky SKY populations. Provide details on the Vendor’s approach for ensuring Network Providers’ compliance with evidence based approaches mandated by the Vendor for Kentucky SKY Enrollees.

Our care management program is evidence-based, supporting the delivery of high-value care and service excellence. For instance, we confirm the care delivered to children and youth aligns with MCG criteria for physical health care services and behavioral health guidelines based upon published references from the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the most recent version of the Diagnostic and Statistical Manual of Mental Disorders and the American Society of Addiction Medicine.

Evidence-based Practices for Delivering Trauma-informed Care	
Functional Family Therapy (FFT)	
Functional Family Therapy through Child Welfare (FFT-CW®) is an adaptation of Functional Family Therapy (FFT) that was designed to provide services to youth (0-18 years old) and families in child welfare settings.	
Foster Care Family & Youth & Peer Support	
<ul style="list-style-type: none"> Provides intentional peer family (and youth) support with unrelenting focus on the parent/primary caregiver of the child; Based upon strategic self-disclosure related to family experiences Encourage and supports parents to achieve their own identified outcomes 	
Motivational Interviewing	
Motivational interviewing is a counseling method that helps people resolve ambivalent feelings and insecurities to find the internal motivation they need to change their behavior. It is a practical, empathetic and short-term process that takes into consideration how difficult it is to make life changes.	

Evidence-based Practices for Delivering Trauma-informed Care
Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Cognitive-behavioral intervention used primarily to treat traumatized children ages 3 to 17. TF-CBT consists of several core treatment components including psychoeducation about trauma; strategies for managing distressing feelings, thoughts and behavior; exposure to and processing of trauma-related memories through development of a trauma narrative; and enhancing parenting skills and child safety.
Dialectical Behavior Therapy (DBT) DBT provides clients with new skills to manage painful emotions and decrease conflict in relationships. DBT specifically focuses on providing therapeutic skills in four key areas. First, mindfulness focuses on improving an individual's ability to accept and be present in the current moment. Second, distress tolerance is geared toward increasing a person's tolerance of negative emotion, rather than trying to escape from it. Third, emotion regulation covers strategies to manage and change intense emotions that are causing problems in a person's life. Fourth, interpersonal effectiveness consists of techniques that allow a person to communicate with others in a way that is assertive , maintains self-respect and strengthens relationships.
Multisystemic Therapy (MST) MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of <i>MST</i> are to decrease youth criminal behavior and out-of-home placements.
National Alliance on Mental Illness (NAMI) Family-to-Family NAMI Family-to-Family is a free, 12-session, evidence-based educational program for family, significant others and friends of people living with mental illness. Research shows the program significantly improves the coping and problem-solving abilities of the people closest to an individual living with a mental health condition. Programs include evidence-based parenting education and skills training, education to increase understanding of parenting and child development, support from program staff and peer-to-peer support among parents, linkages to services and resources to help improve overall family functioning and efforts to build parents' leadership and advocacy skills. Four of the 19 local chapters in the Commonwealth offer this program at no cost periodically throughout the year, including the chapters in Lexington, Louisville and Northern Kentucky and Winchester.
Eye Movement Desensitization and Reprocessing (EMDR) EMDR is a psychotherapy that enables people to heal from the symptoms and emotional distress that are the result of disturbing life experiences.

Approach for Ensuring Network Providers' Compliance with Evidence-based Approaches Mandated by the Vendor

We are committed to using evidence-based approaches, criteria and guidelines to ensure children and youth receive appropriate services and care is delivered in a manner appropriate to the child's or youth's needs. We know these services are only effective if they are delivered in accordance with DCBS requirements, adhere to evidence-based practices and are provided by appropriately credentialed clinicians. To confirm provider compliance and fidelity with evidence-based approaches, criteria and guidelines, we:

- Educate providers about evidence-based approaches, and the criteria and guidelines by which to use them during initial and ongoing provider training. Ongoing training occurs when criteria and guidelines change and when we identify providers who need assistance and during provider performance data-sharing visits.
- Document our evidence-based approaches, criteria and guidelines to providers in our *Care Provider Manual*, on our secure *Link* provider portal and in our provider newsletter, *Practice Matters*.

- Conduct onsite provider quality improvement reviews to analyze and review quality outcomes, educate providers on clinical guidelines and conduct medical record reviews to verify compliance.
- Review complaints, grievances and appeals to determine if there is an issue with provider adherence to clinical guidelines causing unnecessary denials of care.
- Conduct medical record reviews as a key method for assessing the quality of care rendered by our participating providers, to complete a focused study, and/or to ascertain adherence to evidence-based guidelines.
- Give providers tools that help them understand our evidence-based approaches, criteria and guidelines; and how to use them in various situations. For example, our *Behavioral Health Toolkit for Medical Providers* connects PCPs to free screening tools and information about the treatment of common behavioral health conditions. It helps PCPs link children or youth to treatment, includes clinical practice guidelines for behavioral health disorders and promotes the use of behavioral health screening tools, such as the PHQ-9 and the DAST-10 drug screener.

Verifying Compliance by Tracking Key Performance Indicators

Using a suite of advanced data analytics tools, our clinical leadership team continually analyzes data at the population, provider and facility level and compares our performance to nationally recognized standards (e.g., HEDIS) and key performance indicators. We use these analyses to evaluate the ongoing effectiveness of our clinical programs, monitor utilization patterns and identify trends, and recognize opportunities for improvement so we verify we are delivering positive outcomes in terms of quality of care, enrollee experience, outcomes and quality of life and the cost of care. The table presents key performance indicators related to the use of psychotropic medications.

Key Performance Indicators Related to Psychotropic Medications		
Outcomes	Measured Metric	Source
Reduce the number of children under the age of 6 receiving a psychotropic medication	Number of children under the age of 6 receiving a psychotropic medication (codes in appendix)	Claims Data
Reduce the number of children receiving more than one antipsychotic	Number of children under the age of 18 receiving more than one antidepressant at the same time	Claims Data/HEDIS
Reduce the number of children under the age of 3 receiving an antipsychotic	Number of children under the age of 3 receiving an antipsychotic medication	Claims Data
Reduce the number of children receiving more than four psychotropic medications in 1 month	Number of children under the age of 18 receiving more than four psychotropic medications in one month	Claims Data

e. Provide a description of the Vendor’s approach for ensuring Network Providers are providing Trauma-informed Care to Kentucky SKY Enrollees.

Trauma-informed services can help change a child or youth’s view of the world from one of fear and distrust to safety and trust. Outside of interactions with our staff, we recognize that providers furnish the greatest link to children and youth in foster care. Beyond the expectation that they provide the highest quality care to children and youth in SKY, they serve as our eyes and ears in protecting our children and youth. The complex needs of children and youth in foster care require training providers to integrate a trauma-informed practice that demonstrates understanding, compassion and sensitivity in providing all services and in all interactions related to doing so. As part of their contractual obligations, network providers must be knowledgeable about program requirements to serve this special population effectively. We also will work with

DCBS to choose a trauma screen to be administered across the provider community to ensure we can watch results over time. We have experience with several trauma tools for children in foster care, through our partnership, we will choose amongst this list. We will train the provider community on administering this tool for each child in the SKY program. The tools we have experience with and recommend for consideration include:

1. Adverse Childhood Effects (ACEs)
2. Assessment of Complex Trauma for Children (from National Child Trauma Stress Network [NCTSN])
3. Brief Trauma Questionnaire (National Center for PTSD)
4. Child and Adolescent Needs Assessment – Trauma

Coordinating Services for the Right Service at the Right Time

Our care coordinator met an 8-year old child who was not responding to behavioral health treatment and was desperate for a family. Her care coordinator realized she needed a new assessment for a clear diagnosis. The care coordinator set up further assessment with a provider with deep understanding of and expertise in Trauma-informed Care and suggested her PCP check the child's glucose level. It was determined the child's glucose level was high. After controlling her sugar intake, the child's behavioral health outbursts reduced. It took a trauma-informed approach to meet this child's needs by not only discontinuing treatment that was not working, but also by having the right resources to recognize the need for reassessment and bringing the most person-centered approach to bear to meet the child's needs.

To confirm network providers are providing trauma-informed care to children and youth served in the SKY program:

- We deliver training to providers using various modalities that allow them to access education on their schedule. As we discuss later, two training options we offer to providers include **in-person** and online education delivered by **OptumHealth Education**.
- We will track key performance indicators and review claims data using our data analytics tools to confirm children and youth are getting better because of the intervention.
- Our care coordinators will participate in each child or youth's care as part of the DCBS social service team to discuss case plans and goal progress for children and youth in the SKY program.
- We will analyze UM data, such as inpatient admissions, to determine if the services provided before the emergency incident were delivered in a trauma-informed manner.
- Our inquiry coordinator will take any calls from children, youth, or their caregivers if they believe they are not receiving Trauma-informed Care. The coordinator will then notify the provider relations liaison for follow up.

Feedback from Optum Health Education Trainings

- 24% of participants said they would use alternative communication methodologies with patients and families because of the trauma-informed services training.
- 15% of participants said they would use alternative communication methodologies with patients and families because of the psychotropic medication training.
- 17% of participants said they would use alternative communication methodologies with patients and families because of the child-welfare practitioner community training.

Educating providers about Trauma-informed care through UHCProvider.com.

UHCProvider.com is our source for live recordings and on-demand television video broadcast

trainings created specifically for UnitedHealthcare network providers and our field-based care teams. Our flexible, dynamic UHCProvider.com is a webcasting solution that simplifies how providers learn about the key topics and programs needed to meet their administrative and clinical needs.

Providers can access content via our secure *Link* portal and through mobile devices. We organize content by channels and customize it for each state in which we work. For example, a channel for Kentucky will focus on content related to foster youth, childhood immunizations, trauma-informed care, LTSS or behavioral health services, all of which can be updated quickly. UHCProvider.com is available 24 hours a day, seven days a week. The system currently hosts over 300 different presentations that have been viewed by 5,000 unique providers.

Educating providers about trauma-informed care through online education. OptumHealth Education, accredited by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education and the American Nurse Credentialing Center, provides education for providers through live and on-demand education. Providers can earn continuing education credits for participation. Providers can participate in training on various subjects related to children and youth in foster care, including education about implementing a trauma-informed approach. For instance, OptumHealth Education offers delivering Trauma-informed Care courses for foster care children and youth as presented in the table.

Optum Health Education Courses Related to Implementing a Trauma-informed Approach
Building Trauma-Informed Services and Supports for Children, Families and Foster Caregivers Involved with the Child Welfare System
<p>This program identifies the core elements of a trauma-informed child welfare system, and discusses best practices for building services and supports that strengthen children’s relationships with caregiving adults and foster resilience and well-being. It helps providers and clinicians:</p> <ul style="list-style-type: none"> ▪ Define the core elements of a trauma-informed child welfare system ▪ Describe protective factors contributing to the well-being and resilience of children who have experienced abuse, neglect and other trauma ▪ Explain the developmental needs and trauma-related responses of children in the foster care system ▪ Identify best practices for delivering trauma-informed services and supports for children in foster care ▪ Discuss strategies for how child welfare and allied health practitioners can be responsive to the needs and trauma-related responses of children in their care
Adverse Childhood Experiences
<p>This two-part program helps providers and clinicians:</p> <ul style="list-style-type: none"> ▪ Understand the science of adverse childhood experiences (ACEs) and toxic stress ▪ Understand importance of and rationale behind ACE screening ▪ Identify the rationale for early detection and ACE screening along with the associated barriers ▪ Interpret the relationship between early life adversity and toxic stress to clinical outcomes in pediatric primary care ▪ Understand the available tools and resources to use appropriate referral, treatment and intervention services for individuals ▪ Compare and contrast protocols and practices for ACE screening ▪ Identify opportunities for expanding ACE screening in the pediatric setting and identify the steps to integrate ACE screening into medical practice ▪ Apply and use appropriate ACE referrals, services and treatment and intervention strategies ▪ Understand the supports and opportunities offered by the National Pediatric Practice Community to facilitate integration of ACE screening into practice

f. Describe how the Vendor will use telemedicine and telehealth to improve quality or access to physical and Behavioral Health services.

Given the distance some of our foster families live from many of their providers, especially in more rural areas of the Commonwealth, providing children or youth and their foster parents with easy access to qualified behavioral health professionals is essential to overall health and well-being, suicide prevention and recovery from issues such as substance use and trauma. We understand that by making it easier for children or youth and their foster families to access the care they need, we are helping them improve their health outcomes and the quality of their lives. We are implementing a telehealth suite that improves access to care by providing PCPs with access to specialty services via telemental health and providing children or youth and their family's access to behavioral health services in their homes.

Virtual Visits through Partnership with Genoa Healthcare

Genoa's personalized and outcomes driven care produces more than 90% medication adherence rates and reduces hospitalizations by 40% and ED visits by 18%.

We have an established partnership with Genoa Healthcare, the largest behavioral health care pharmacy network and outpatient telepsychiatry operator in the United States. Genoa specializes in serving the needs of enrollees with behavioral health, addiction and complex, chronic health issues. Genoa is a full service pharmacy. They operate in eight locations in Kentucky, including Bowling Green, Lexington, Louisville (three locations with Centerstone of Kentucky), Mayfield, Paducah and

Richmond, and are available to provide telepsychiatry throughout the Commonwealth.

Genoa offers pharmacy and outpatient telepsychiatry services to Community Mental Health Centers (CMHCs), primary care offices and behavioral health practices. Genoa contracts directly with LifeSkills, Inc. (Bowling Green), *Bluegrass.org* (Lexington), Centerstone of Kentucky (Louisville), Four Rivers Behavioral Health, Inc. (Mayfield and Paducah) and Bluegrass Regional Mental Health (Richmond), allowing the CMHCs to offer psychiatric services to enrollees. In addition, Genoa provides Consumer Medication Coordinators (i.e., Pharmacy Technicians) to the North Key CMHC in Covington. We are actively working with Genoa to complete in-network credentialing and continue identifying high-volume practices and providers serving specialty populations, such as children with depression and individuals with SUD, where we can increase access to virtual visits and educate them about services available.

Telemental Health in The Enrollee's Home

In 2018 in Kentucky, UnitedHealthcare provided 82,261 outpatient virtual visits, 45,199 medication virtual visits and 1,709 virtual visits to UnitedHealthcare employees through our employee assistance program. The highest volume behavioral condition addressed through virtual visits in Kentucky was depressive disorder, followed by anxiety disorders.

Available through our enrollee portal, *myuhc.com*, and via our mobile application, enrollees can access behavioral health virtual visits. Enrollees can identify behavioral health providers and schedule virtual visits for diagnosis, medication management and integration of behavioral health into primary care. Our virtual visits solution allows children or youth to have direct access for provider search, scheduling and document/resource sharing through smartphones, tablets and computers. We are working on additional functionality that will

allow caregivers to join a session and conduct group therapy sessions through virtual visits.

We continue to explore opportunities for special/unique needs populations, such as children or youth with SUD, eating disorders and autism. A recent initiative focused on extending the Family Coaching aspect of Applied Behavioral Analysis through virtual visits for our commercial population. We have seen great momentum through this work and we look forward to bringing it

to additional populations in 2020. We anticipate that the upcoming changes to the Kentucky regulations for telemedicine with the Medicaid population will continue encouraging providers to offer virtual visits and continue eliminating barriers for children or youth to access virtual visits. Given that we require providers to use two-way audio video technology in conducting virtual visits, we look forward to offering seamless telemental health services to our enrollees.

Telepsychiatry Initiatives

Our telepsychiatry programs allow us to distribute psychiatric access across the Commonwealth, to any location that has access to high-speed internet. Historically, we have been able to use these programs to enable community clinics, FQHCs, CMHCs, primary care offices and community hospitals to have access to dedicated psychiatric care (MDs, DOs and NPs), thereby expanding access and maintaining network adequacy across underserved communities, such as communities in the East Mountain Region.

Partnering with the Boys & Girls Club to deliver telemental health services. 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 use telehealth to improve access to care for children and adolescents in 33 North Carolina schools.

g. Describe how the Vendor will capture data related to Social Determinants of Health and incorporate this information into its Care Management approach.

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 these resources to understand their mission, strategy, capabilities and expertise, build relationships and determine the extent of future partnerships with community resources.

children or youth and their foster families find ways to meet their basic/social needs, we improve their ability to focus on their health and overall well-being. Key components of our approach to address the social determinants include robust mechanisms to identify enrollees with social determinants needs, care planning processes that incorporate social determinants needs into the care plan and developing community partnerships to address the social needs of children, youth and foster families.

Capturing Data Related to Social Determinants of Health

Our population health management program identifies social and economic barriers that stand

Research demonstrates that the cause of intense utilization of services is often not due to the severity of medical illness, but rather is due to social barriers to accessing care. Social determinants, such as housing, food, financial resources or caregiver support, are a significant driver of an individual's health. By helping

One of the key barriers to expanding access to nonmedical care for social needs is a lack of coding standardization. We have partnered with the NCQA and the National Association of Community Health Centers to implement diagnostic codes for services that target the social determinants of health.

Adding new code options confirms social services are tracked effectively and our enrollees actually receive them, while avoiding additional administrative work for providers. We are actively working with CMS and the CDC to adopt these codes.

We have developed a social determinants of health quick reference guide to help providers understand the social determinants ICD-10 codes, and how to use them appropriately during claims submission.

in the way of children or youth and their foster families achieving their health care goals. We incorporate social determinants into our care management approach as follows:

- **ICD-10 codes.** Implementing ICD-10 codes that help us identify the impact of social determinants on our enrollees’ ability to access care and track the delivery of services to address social determinants, while avoiding additional administrative work for providers.
- **Screenings.** Using data from enrollee screenings to identify barriers that may negatively affect their ability to meet their goals. Our health risk assessment includes two questions related to social determinants. Our adult and pediatric core assessments each include 33 questions related to social determinants.
- **Data analytics.** Impact Pro™ analyzes a variety of data sources to identify the impact of social determinants on each child or youth’s overall risk. We use our Hotspotting tool to identify cohorts of enrollees with specific needs, including social determinants, so that we can connect those enrollees to resources that address their social needs.

Incorporating Social Determinants of Health Information into Our Care Management Approach

During the care planning process, the care coordinator identifies resources that address the enrollee’s social determinants identified using the methods discussed previously.

The care coordinator uses *Healthify*, a web-based tool accessible by mobile phone or tablet that helps care coordinators connect foster families to relevant and available social resources that deliver services, such as food, housing, legal resources, employment assistance, energy, support groups and child care. The *Healthify* database includes 5,000 Kentucky-based resources, including social support, financial support, food and housing. Once identified, the care coordinator will document these resources in the enrollee’s care plan in

CommunityCare and work with the enrollee and the community-based organization to connect the enrollee to the resource and coordinate the delivery of these services with the rest of the services in the enrollee’s care plan.

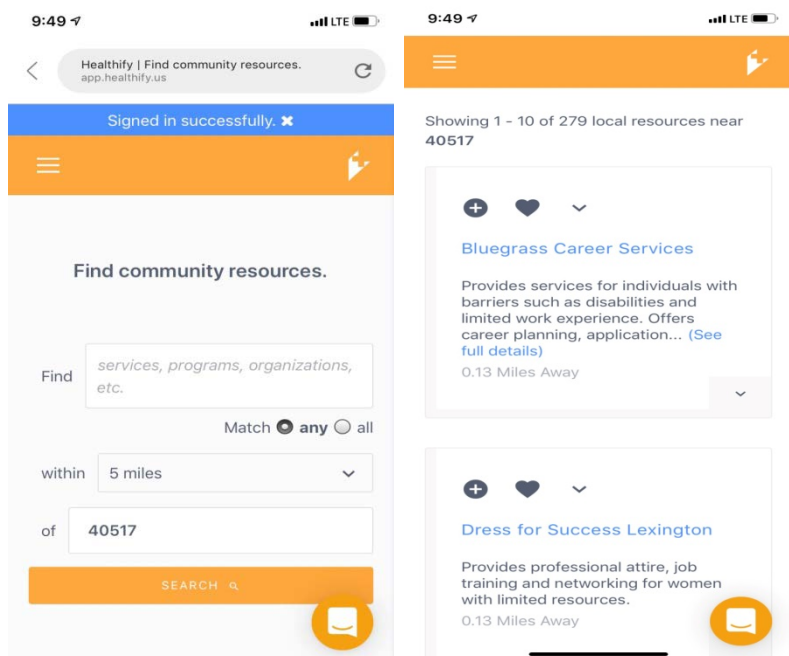


Figure 14. *Healthify* allows care coordinators to help children, youth and foster families access local community-based resources. This figure shows the *Healthify* mobile app search screen on the left and the results screen on the right, which has identified 279 local resources within 5 miles of the 40517 ZIP code (Lexington, Kentucky).

h. Describe how the Vendor will coordinate with the Department, DCBS, DJJ, and physical and Behavioral Health Providers to ensure each Provider has access to the most up-to-date medical records for Kentucky SKY Enrollees.

Maintaining and sharing the medical records of children and youth is critical to coordinating and maintaining the continuity of their care across varied delivery systems, care settings and placement changes. We will coordinate with DMS, DCBS, DJJ, and physical and behavioral health providers to share the most up-to-date medical records for SKY enrollees in a variety of

ways, including **developing working relationships with DCBS staff and sharing data through our data sharing technology suite.**

Developing working relationships with DCBS staff. We are staffing care coordinators in each of the nine DCBS service regions. This will allow our care coordinators to develop working relationships with DCBS staff so that we more readily meet the needs of enrollees, particularly those children and adolescents with urgent needs or who are in crisis. These working relationships also will allow care coordinators to share information about enrollees with DCBS as staff as needed. We are also staffing SKY behavioral health specialists who will work with DCBS staff to understand changes to the foster care system, resolve issues and confirm our care coordinators and SKY team understand how changes that may affect their daily work. They will work with DCBS staff to understand data sharing needs and coordinate data sharing with our care coordinators.

Data Sharing Technology Suite

An interdisciplinary care management approach is central to our clinical model and meeting the needs of children or youth and their foster families. As presented in the figure, we enable collaboration among the child's or youth's care coordinator, their MCT (including physical and Behavioral Providers) and DMS, DCBS, DJJ and using our secure, cloud-based data sharing technology suite. Our suite includes technologies to **share data, promote collaboration** with children or youth, their foster parents and their MCT and train **providers** specific to Trauma-informed Care and **connect them to assessments and evidence-based practices** applicable to children and youth in the SKY program. The *CommunityCare* enrollee portal, discussed later in this section, provides a variety of tools to communicate with their UnitedHealthcare team and MCT, track the completion of goals in their care plan, keep track of appointments in their calendar and complete assessments.

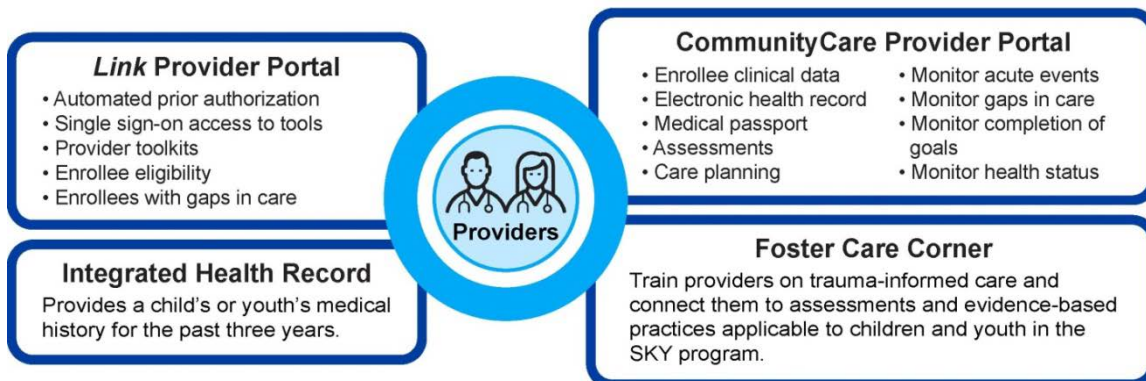


Figure 15. Data sharing technology suite. Our suite provides a timely flow of information about children or youth and care management tools that enable the care coordinator and MCT to work together to coordinate and monitor each child's or youth's care. Through our *Link* provider portal, the MCT has single sign-on access to a variety of tools, including the *CommunityCare* provider portal, the integrated health record and the Foster Care Corner.

CommunityCare

CommunityCare provides the mechanism for the child's or youth's MCT to collaborate to develop a care plan that meets their needs, goals and desired outcomes; monitor the enrollee's progress toward achieving their goals; and identify acute events (e.g., hospitalization) so the MCT can coordinate relevant and timely enrollee interventions. *CommunityCare* facilitates the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems. It supports the ongoing management of the enrollee's care and they achieve their goals or experience changes in health status or changes in care settings.

Electronic Health Record and Medical Passport

CommunityCare maintains all information about the child's or youth's care and services in their electronic health record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. The *CommunityCare* electronic health record includes information, such as:

- The enrollee's care plan, including the enrollee's care preferences, prioritized goals and interventions need to achieve them
- Assessment results, including the enrollee's goals and desired outcomes, and social, behavioral, medical and functional needs, and circumstances
- The enrollee's utilization of health care services
- The names and contact information of the members of the child's or youth's MCT
- The enrollee's care preferences, prioritized health concerns, issues, intervention strategies and self-sufficiency goals and how well the enrollee understands and is adhering to the goals
- The enrollee's claims data, pharmacy claims, condition list, medications, service dates, history, provider visits, diagnoses, issues, case conference notes and lab results
- The child's or youth's medical passport

CommunityCare Provider Portal

Available through our secure *Link* provider portal, which gives providers single sign on access to a variety of applications, the *CommunityCare* Provider Portal, *CommunityCare* gives providers a variety of capabilities to manage enrollee care, including:

- **Data sharing.** Securely shares the information in the enrollee's electronic health record with authorized members of the child's or youth's MCT
- **Assessment.** Allows providers to review, acknowledge, sign and contribute to enrollee assessment using *CommunityCare's* assessment suite
- **Care planning.** Allows providers to review, acknowledge, sign and contribute to an enrollee's care plan in *CommunityCare*
- **Communication.** Provides a mechanism for providers to securely communicating with care team enrollees and email external users with direct email addresses
- **Monitoring enrollee care.** Integrates data from our monthly algorithm-based predictive modeling analysis and provides this information to the MCT in a useful way. For instance, *CommunityCare* helps the MCT:
 - Monitor the enrollee's progress toward achieving the goals in their care plan
 - Monitor the enrollee's adherence to their care plan
 - Respond to data regarding changes in the enrollee's health status
 - Respond to admission, discharge and transfer (ADT) alerts from the Kentucky Health Information Exchange (KHIE), such as a child who has visited the ED
- **Managing care setting transitions.** *CommunityCare* provides workflows that help manage care setting transitions, such as prompting for follow-up PCP appointments, performing patient reminders and tracking the completion of a post-hospital assessment
- **Identifying enrollees with gaps in care using** a customizable Quality Measure Dashboard, which allows providers to view their enrollees with care gaps using HEDIS quality measure data, refreshed twice monthly

- **Identifying each enrollee's risk level**, allowing providers to engage their enrollees with the highest risk

The figure presents the provider portal Population Dashboard. The dashboard is the screen providers see when they log in to the provider portal.

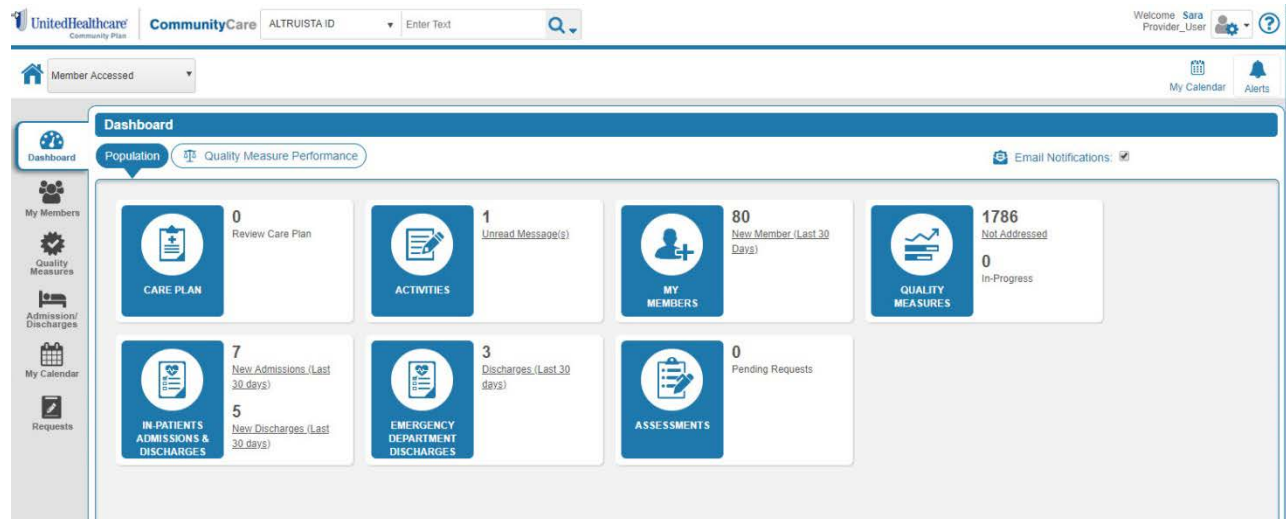


Figure 16. Population Dashboard. This dashboard is the screen providers see when they log in to the provider portal. It provides quick application access to tools, such as the care planning tool, and provides tiles with summary statistics of the UnitedHealthcare enrollees in the provider's panel.

Integrated Health Record

In addition to *CommunityCare*, our integrated health record (IHR) gives providers a 360-degree view of the child or youth's medical history for the past 3 years. It helps providers, who may not have a full view of a child's or youth's medical history, prepare for visits with the foster family and improve their ability to coordinate the delivery of integrated services and supports that meet the child's or youth's needs and help them achieve their goals.

Foster Care Corner

Foster Care Corner, accessible through *Link*, gives providers access to training specific to Trauma-informed Care. It connects them to assessments and evidence based practices most applicable to the SKY population, such as screening tools that determine the severity of the trauma to which a child or youth has been exposed.

Enrollee Technology Suite

We connect children, youth and foster families to a variety of tools that help them:

- Access services using telehealth technologies
- Locate services and supports near the family
- Support youth experiencing common issues in high school
- Connect families to resources to help address conditions, such as depression
- Provide supports to young adults transitioning to adulthood and independence
- Help children, youth and foster parents communicate with their UnitedHealthcare team and MCT
- Track the completion of goals in their care plan
- Keep track of appointments in their calendar and complete assessments

Providing Access to Resources through myuhc.com

We provide children, youth and families with access to these resources through our secure enrollee portal, *myuhc.com*. Using *myuhc.com*, via website or mobile app, children, youth and families can:

- Search for providers that can help address the child's or youth's needs
- Access behavioral health virtual visits by identifying behavioral health providers and scheduling virtual visits for diagnosis, medication management and integration of behavioral health into primary care
- Access caregiver supports, including guides and articles, such as *Respite Care* and *Self-Care for Caregivers* and the *Community Resource Database*, which helps her foster parents locate services and supports near them, such as respite care
- Use Whole Health Tracker, an evidence-based self-management tool that addresses healthy eating, managing stress and physical activity, to help children and youth reach whole health and resiliency goals through effective self-care. It allows children and youth to develop a crisis plan and set and actively work on goals in 10 domains of wellness
- Access the *High School Center*, which includes content to help children or youth address common issues in high school, such as managing stress, bullying and teen relationships. It has resources for her foster parents, such as the "Managing the Teen Years" and "Talking to Young People about Tough Issues"
- Complete online assessments using the PHQ-9 and access resources, such as online CBT for depression and videos, articles and guides, such as "Building Resilience," "Helping Yourself Through Grief" and access to resources from The Dougy Center – The National Center for Grieving Children & Families
- UnitedHealthcare On My Way, which helps young adults transition to adulthood and independence. It helps them learn about six key areas that have historically prevented transition age youth from achieving stable, independent lives
- Engage in their health care by providing tools to communicate with their UnitedHealthcare team and MCT, track the completion of goals in their care plan, keep track of appointments in their calendar and complete assessments.

On My Way (OMW) and the On My Way Vault



On My Way is an interactive website that helps young adults transition to adulthood and independence. It helps them learn about six key areas that have historically prevented transition age youth from achieving stable, independent lives, including money, housing, work, education, health and transportation. Recognizing many young adults in foster care have fragmented documentation, **OMW's Vault** allows young adults to have a repository of their most important documents (e.g., birth certificate, driver's license, individual education plan, insurance card, health record) in a secure, easily accessible location. Youth can upload documents in many ways, including scanning and/or taking a picture of the document and uploading it in a process similar to uploading pictures on their phone.

Helping Foster Care Youth in Ohio using OMW

"It has been a pleasurable experience partnering with United HealthCare Services, Inc. (UHS) an affiliate of UnitedHealthcare Community Plan of Ohio, Inc. (UHCCP) namely the OMW Program for the past year. The half-day seminar presented by UHCCP to the youth we mentor and disciple at Kingdom Life Church INC. as well as the youth we mentor through NYAP National Youth Advocacy Program was essential in opening their minds to the importance of financial planning. They were

enlightened as the realities of creating a budget, money saving strategies and tools made available to them through the OMW website were presented to them.

Our youth and mentees are now committed to doing better with their finances and some of have opened savings accounts are maintaining a prepaid Visa accounts, thanks to the OWM seminar. This is huge; the 10 youth that attended the seminar were ages 15-21 and are from low income single parent homes, were in foster care at the time and aged out foster care young adults. They are most appreciative of the information you shared with them and the free Kindle Fire Tablet donated to them. We have continued to educate them in this area. Through their training they continue to pursue attaining and maintain gainful employment, personal skills and competencies for self-sufficiency and healthy independence.”

— Mary Ellen Crutcher, Senior Pastor of Kingdom of Life Church

CommunityCare Enrollee Portal

The *CommunityCare* enrollee portal engages children or youth and their foster parents in their health care by providing a variety of tools to communicate with their UnitedHealthcare team and MCT, track the completion of goals in their care plan, keep track of appointments in their calendar and complete assessments. The portal is available in English and Spanish. The figure herein presents the Enrollee Dashboard, which is the screen the child or youth and their foster parents see when they log in to the enrollee portal.

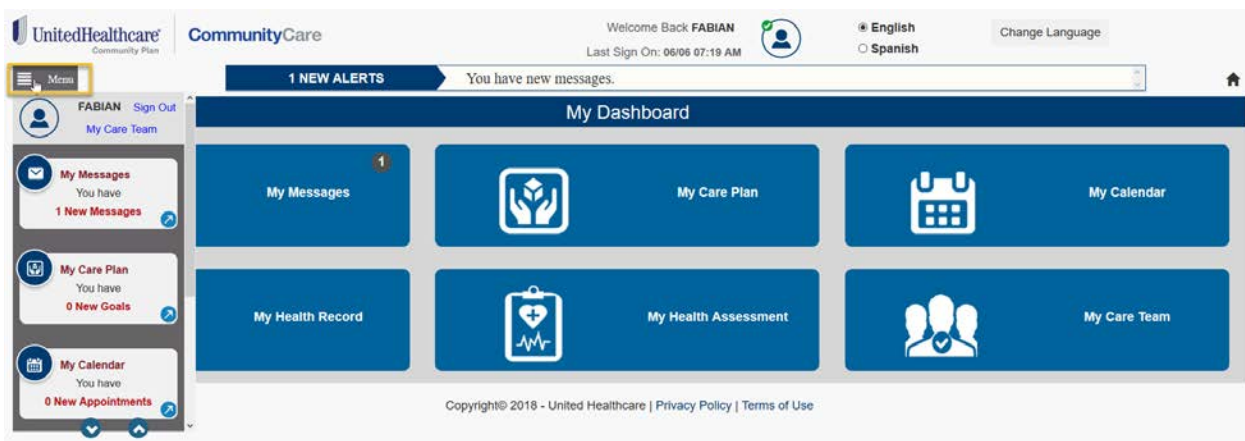


Figure 17. Enrollee Dashboard. This dashboard is the screen children, youth and families see when they log in to the enrollee portal. It provides quick application access to tools, such as My Messages, and invites action from the child or youth and their foster parents by showing counts for newly added information, such as new care plan goals or appointments.

The enrollee dashboard provides access to the following tools:

- **My Messages** enables the youth or child to send and receive messages from their providers and their care coordinator. It also displays the sent, received and archived messages
- **My Care Plan** allows the child or youth to see their goals and the action plan to achieve them, which they can accept and track progress
- **My Calendar** displays the events scheduled by child or youth or their care coordinator
- **My Health Record.** The child or youth can view their health summary, including medical information, diagnoses, most recent visits and medications
- **My Health Assessment:**
 - The child’s or youth’s care coordinator can schedule a self-assessment activity for the child to complete

- The child or youth can complete the assessment in the portal's workflow mode
- The child or youth can stop the assessment at any point and complete it later
- The care coordinator is notified when the child or youth completes the assessment
- The child or youth can print the completed assessment
- **My Care Team** displays the child's or youth's care team and providers and enables the child or youth to send secure messages. The child or youth can also request their care coordinator to add their designated caregiver