

13. Use Cases for Kentucky SKY

Submit a response to the following use cases. The Department encourages the Vendor to provide a thorough response and suggest innovative ways to fulfill the requirements of this Contract.

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

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

Keeping with our approach of putting children and youth first, in developing of our use cases, we worked to give a voice to the portrayed foster child by telling their journey in the form of a story. We have tailored our answers to be in alignment with our approach to meeting the child and youth's needs. For use case 1, you will find the corresponding letter we are addressing at the beginning of the section. For use cases 2 through 8, we provide an introduction, an ecomap depicting the child's circle of support, a table with touchpoints addressing each question's subcomponents and describe how we will interact with the child, youth and their circle of support to meet their immediate and ongoing needs, including an example plan of care.

Use Case 1

Based on feedback from experienced DCBS Social Service Workers, certain providers in the Eastern Mountain Service Region have limited knowledge of trauma-informed evidence based practices. The DCBS caseworkers have documented numerous examples where Emergency Department (ED) staff and physicians/office staff neglected to conduct and document trauma assessments on children and youth, exacerbated trauma when physical assessments were performed on pre-teen girls, and failed to seek medical records before ordering duplicate testing/services.

Describe how the Vendor would address and ensure the delivery of trauma informed care by the contracted provider network for the Kentucky SKY membership. In particular, address how it assesses providers' knowledge of trauma informed care, the approach for targeted provider education at regional and state levels, as needed, and plans for collaborating with DCBS staff. At minimum, address the following in its response:

- a. Evidenced based practices and trauma-informed care for the Kentucky SKY membership;
- b. Unique needs of children and youth in Foster Care;
- c. Access to and sharing of medical records
- d. Provider contracting;
- e. Provider education and ongoing support;
- f. Performance monitoring;
- g. Cultural competency; and
- h. Community engagement.

(b) Addressing Trauma-Informed Care in East Mountain Region

Children in foster care require specialized health care that is high quality, continuous, well-coordinated and culturally informed. A coordinated systems approach is necessary to facilitate successful health care delivery that **meets the unique needs of these children and youth**. From our experience, we know children and youth in foster care have experienced trauma before their foster care placement, at the time of removal and within the foster care experience due to frequent placement moves, changes in community, and disruption of family and community ties. We must establish a robust trauma-informed system of providers who help SKY enrollees heal from their trauma using evidence based treatment practices.

To provide a robust trauma-informed system, we must help health care professionals understand how to deliver services using a trauma-informed approach **to meet the unique needs of children** in the SKY program, such as the need for customized trauma screens and assessments, enhanced communication between system partners and trauma focused interventions. Our model of care for children and youth in foster care is rooted in Trauma-informed Care principles, including enabling transparency, accessible and regular communication, empowering children, youth and young adults, building capacity for the care network, building skills for foster parents and providing local and culturally competent engagement teams.

We will partner with our provider network, already firmly established in the East Mountain Region, and partner stakeholders to improve the system by implementing a consistent model of care. We are prepared to help children in the SKY program realize improved outcomes by applying these principles.

(h) Community Engagement

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 that will meet their needs. Based on community partner feedback, our interaction and experience with Kentucky communities and foster children nationally, we have developed community engagement strategies including:

- Our experience training foster parents, foster care coordinators, DBCS social service workers and providers to understand how the system works and how they can seamlessly work together deliver care to children and families in foster care. Group training helps participants from various agencies work through real child and family scenarios, helping them to understand how each participant sees the situation. We will bring stakeholders together for in-person **training with the National Foster Parent Association** throughout the Commonwealth, including the East Mountain Region.
- Our SKY medical director will connect with the directors of the EDs in the East Mountain Region to establish relationships and offer to provide free lectures on Trauma-informed Care by subject matter experts. To accommodate varying schedules, we will make trainings available through UHCprovider.com. Since emergency physicians work on shifts, offering flexibility in training options and meeting them where they are is the best opportunity to engage them. We will offer free continuing medical education (CME) credits for attending these lectures to increase likelihood of attendance. We will offer to provide lectures delivered by

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

our medical director at scheduled meetings of the nurses and other ED staff, empowering them to use evidence-based assessment tools to identify trauma before the physician exam. We will target Appalachian Regional Healthcare Hospital in Hazard, and Pikeville Medical Center for outreach and training in the first 90 days of contract go live.

- We will ask leaders from the East Mountain Region communities to invite us to conferences, meetings, and town halls to present and train on trauma-informed care. We will provide information for our Foster Care Corner, which will house free screening and assessment tools to be administered to determine trauma for children and youth served in the SKY program. We know many entities already provide training and we want to be included in these forums to provide initial and ongoing training to our entire provider community.

(g) Cultural Competency

Because we have been working in the Commonwealth to build working relationships with local organizations, we know part of our **cultural competency strategy** includes understanding the role disproportionality plays in achieving desired outcomes for children in foster care. It is hard for children and families in the foster care system to trust caseworkers, providers and care coordinators who do not have first-hand experience in this field. Based on our time spent in communities like Hazard and Pikeville, we understand cultural norms, traditions, and customs are different from those in other parts of Kentucky. We know, based upon our interactions with community leaders, there continues to be a stigma around behavioral health and substance abuse treatment. Hiring a regional care coordinator from within an East Mountain Region community is one way we will address the stigma.

Our care coordinator, SKY provider liaison and SKY behavioral health specialist will engage community partners to be a support to the children, youth and families we serve. This includes faith-based community leaders, educators, law enforcement and nonprofit agencies. Treating those in need takes a community approach and we expect to bring this approach to all of Kentucky. Peer support is also a critical component of our model to provide resources that are culturally appropriate. We will contract with providers who can provide peer support services, recruiting peer support contractors from their communities. These peer supports must have lived experience in the region of the Commonwealth they are serving.

(e) Provider Support through Team Based Approach

We know children and youth served in the SKY program will have a team of families, professionals, and community members to support them. Part of the team will include network providers and staff who are not familiar with the needs and issues children in the SKY program face because of their trauma. We know the Eastern Mountain Region is rural and has limited **access to a robust provider education for network providers**. We will change

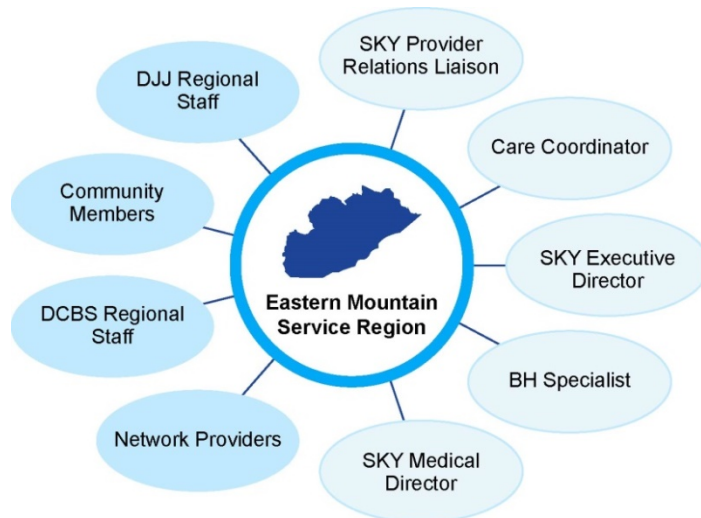


Figure 20. Creating a supportive provider experience, focusing on service, simplifying and reducing administrative burden is our goal. Our SKY provider relations team, including a network provider liaison, regional care coordinators and clinical staff — in addition to our Medicaid provider advocates — will work with our network providers to ensure timely access and quality care are provided to children and youth in the SKY program.

that with our unique approach to training, education and care management that includes a team approach as presented in the figure.

We will integrate a regional care coordinator who will interact with the MCT teams supporting SKY members, including providers, to confirm support of the foster care child or youth, DCBS and sister agencies. Care coordinators will help DCBS access trauma-informed providers. **Our SKY provider relations liaison will support providers by offering educational opportunities** including in-person, web-based and one-on-one trainings related to trauma-informed care, and support that helps them meet the needs of SKY children and youth.

(d) Provider Engagement and Contracting

For 18 months, we have developed a solid understanding of the specific needs of SKY children

In the Eastern Mountain Region, we already have contracts with 20 behavioral health providers in 75 locations in the region who say they provide trauma-informed care.

in all the Kentucky regions. We have developed relationships and entered into **contracts and letters of Intent for contracting with network providers and community-based organizations** that support them. We have built relationships with key providers through face-to-face meetings, such as Pikeville Medical Center. By attending meetings with community partners

such as Kentucky Primary Care Association, and community organizations, such as Kentucky Youth Advocates we have gained an understanding of the health priorities and social determinants in Kentucky.

We have conducted Consumer Need Studies, researched Kentucky demographics, culture, geography, health disparities, health needs and the concerns of current Medicaid enrollees across the Commonwealth. We credential providers every 90 days. Part of the credentialing process includes confirming providers are qualified to deliver Trauma-informed care. In addition to our credentialing process, our provider engagement to support trauma-informed care includes using staff dedicated to the SKY program to provide outreach, education and training to hospitals, practice groups and individual providers as presented in the table.

UnitedHealthcare SKY Support Resource and Role	
SKY Chief Medical Officer (Statewide Position)	
Will visit providers routinely to provide information, including provider profiles and solicit feedback on the quality initiative. The CMO will have expertise in Trauma-informed Care and will provide ongoing training and case consultation to providers.	
SKY Provider Relations Liaison (Statewide Position)	
Will provide education on our provider portal and its many capabilities to reduce administrative burden, HEDIS specifications (billing/documentation requirements), our quality incentive program and other key topics during their visits, including discussing how they engage SKY children and youth. Will provide in-person training on trauma-informed care and provide additional training resources including: Optum Health Education courses, National Child Trauma Stress Network courses, and the Foster Care Corner through LINK.	
SKY Executive Director (Statewide Position)	
Will be experienced in the field of working with providers and stakeholders across the foster care system to achieve optimal outcomes for children and youth in the SKY program. Will meet with providers and associations about the importance of the network being trained in trauma-informed care. Will review data related to how many providers are trained in trauma-informed care.	
Regional Care Coordinator (Local Position)	
Will help coordinate care for children in the SKY program. This will include outreach and coordination with the provider network teams to ensure care is being delivered in a trauma-informed manner.	



As part of our Kentucky provider strategy, our goal is to create a **supportive provider experience**, focusing on service, simplicity and reduction of administrative burden. Our teams of clinical and nonclinical staff across the Commonwealth will regularly meet face to face with network providers related to children in the SKY program. Our clinical practice consultants, practice care managers, behavioral health consultants and local provider advocates will

engage providers to share clinical data and performance metrics to align joint initiatives. Care coordinators will engage providers to coordinate needed care, which builds trust and strong relationships. Our SKY provider relations liaison will be a key member of the team providing support to the providers in the East Mountain Region.

We offer **free training** to providers through our OptumHealth Education platform, which is accredited by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education and the American Nurse Credentialing Center. Our platform provides education for providers through live and on-demand education. Providers can earn continuing education credits for participation, which we believe to be a benefit to the provider community. It offers training on a variety of subjects related to children and adolescents in foster care, including **education about delivering Trauma-informed Care for foster care children and youth** as presented in the table.

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 training 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 ▪ 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 series provides training for providers and clinicians to:</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 pediatric clinical outcomes ▪ Understand the available tools and resources to for referral, treatment and intervention services ▪ 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

(a) (c) (f) Provider Access to Evidence-based Practice Information, Medical Records and Performance Monitoring

We are committed to using **evidence-based approaches**, criteria and guidelines to confirm children and youth receive appropriate services and care is delivered in a manner appropriate to

the enrollee’s needs. We know these services are only effective if they are delivered in accordance with DCBS requirements, adhered to evidence-based practices and are provided by appropriately credentialed clinicians. We will educate providers about our evidence-based approaches, criteria and guidelines during initial and ongoing provider training. We also provide online training through **Optum Health Education** and **UHCprovider.com**, our source for live recordings and on-demand television video broadcast trainings created specifically for UnitedHealthcare network providers. We document our evidence-based approaches, criteria and guidelines for providers in our *Care Provider Manual*, on our secure *Link* provider portal and in our provider newsletter, *Practice Matters*. The table presents evidence-based practices for delivering Trauma-informed Care that we expect our network providers to use.

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 Youth and Family Peer Support
Provides intentional peer family (and youth) support with unrelenting focus on the parent/primary caregiver of the child. It is based upon strategic self-disclosure related to family experiences, and encourages 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. A practical, empathetic and short-term process takes into consideration how difficult it is to make life changes.
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 children in foster care with new skills to manage painful emotions and decrease conflict in relationships. DBT specifically focuses on providing therapeutic skills in four key areas. First, <i>mindfulness</i> focuses on improving a young person’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. Children in foster care often bring significant histories of abuse, neglect, and trauma while also experiencing separation from family and other support structures. The four therapeutic skills DBT targets speak meaningfully to key needs experienced by children in foster care.
Multisystemic Therapy (MST)
MST is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues designed to decrease 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.

Evidence-based Practices for Delivering Trauma-informed Care**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.

Sharing and reviewing medical records. *CommunityCare*, our care management platform, maintains each child or youth's **electronic health record** that includes information needed to coordinate their care, such as their care plan. It provides the mechanism for the MCT to collaborate to deliver care, develop the child or youth's care plan, monitor their progress toward achieving their goals; and identify acute events so the MCT can coordinate timely interventions to meet their needs. *CommunityCare* houses **the medical passport**. Each child, youth, foster family, and the MCT can update the passport and it can be shared among the UnitedHealthcare care team and MCT. Our **integrated health record (IHR)** gives providers a 360-degree view of a child or youth's medical history for the past 3 years. It helps providers prepare for visits with children, youth, and their foster parents to coordinate their care. Providers can access these resources through our secure *Link* provider portal.

Performance monitoring of the SKY program. Our comprehensive quality program begins with our Quality Improvement Committee, which oversees the Quality Assessment and Performance Improvement Program (QAPI) and is accountable for the implementation, coordination and integration of all QAPI activities. Our SKY quality manager reviews a quarterly dashboard that monitors activities pertinent to assessing our success managing care for SKY enrollees. One of the key performance indicators we will measure is how many of our providers have taken our training related to trauma-informed care on the Optum Health Education platform. For providers who have not taken the training, our provider relations liaison will contact providers and work to manage any barriers to taking the training.

In addition to monitoring providers who have taken the training, we will send an annual survey to our providers asking them to confirm they have been trained on trauma-informed systems, as a baseline to determine the training and education needs for the East Mountain Region. This will be conducted annually, and one-on-one training provided to any contractor who is serving SKY children who has not completed and certified they have been trained.

Use Case 2

Kimberly, 15 years old, has been in foster care for two years with placements in three different Service Regions during that period. She was placed in foster care following a report from her school that she came to school exhausted and hungry. Kimberly's teacher, who had been concerned about her outbursts at school, was able to get Kimberly to describe violence at home between her mother, Linda, and Linda's boyfriend. Kimberly would care for her two younger siblings, ages five and two, when the adults in the house fought and used drugs. Twice a week, Kimberly asked neighbors for food for her siblings, and occasionally stole money from Linda's boyfriend to buy food at a nearby gas station/food mart.

Upon investigation, the Social Service Worker found a filthy house without food in the refrigerator or kitchen cabinets. Kimberly's siblings were dirty and hungry. Kimberly told the Social Service Worker that Linda and her boyfriend would fight and use drugs "all of the time." Kimberly's siblings were placed in separate foster homes but have since been reunited with their mother. Linda now lives in eastern Kentucky, approximately 200 miles from Kimberly's current foster home.

After coming into foster care, Kimberly has been suspended from school four times for behavior issues. She has a pattern of absences, and is currently failing most of her classes. Kimberly has a 17 year old boyfriend and is sexually active. Attempts at reunification with her mother have failed after Linda expressed concerns over Kimberly's anger and hostility.

During a recent appointment for birth control, the PCP noted multiple cuts on Kimberly's arms and legs as well as healed scars. She told her physician that she was depressed, couldn't focus on school, and wanted to run away from home. The PCP prescribed an antidepressant and referred her to a behavioral health specialist. Kimberly was reluctant to visit a specialist and scheduling appointments was challenging for her foster parents given the lack of providers within 45 miles of their home. Kimberly's foster parents contacted the Social Service Worker about their concerns over Kimberly's behavioral health issues and the availability of providers.

To her classmates and on social media, Kimberly began describing her suicidal thoughts. Over the weekend, Kimberly's foster parents found her unconscious with a suicide note on the bedside table. Kimberly had overdosed on pain medication she found in her foster parents' medicine cabinet.

Kimberly had to stay in the ED for three days pending availability of a bed. Her foster parents discussed care options with the Social Service Worker and described their fears once Kimberly returns home. The Social Service Worker was unable to find a residential facility with an available bed and the hospital initiated plans to discharge Kimberly.

Describe how the Vendor would address Kimberly's situation and coordination with the DCBS Social Service Worker, the ED, residential facilities, behavioral health providers, foster parents, and mother. At a minimum, address the following programs and services:

- a. Care management, including coordination with the foster parents;
- b. Discharging planning between levels of care;
- c. Network adequacy and availability of services;
- d. Availability and utilization of telehealth for behavioral health services;
- e. Applicable evidence based practices; including psychotherapeutic interventions;
- f. Prescribing psychotropic medications and documentation in medical records (e.g., rationale, follow-up assessments and monitoring, etc.);
- g. Coordination of transportation, if needed;
- h. Provider contracting;
- i. Provider education and support;
- j. Access to and sharing of medical records; and
- k. Maintenance of the care plan.

Kimberly has experienced various traumas witnessing violence and drug abuse in her family home. She has also suffered separation from her family, particularly her siblings, who have been placed far from her. She has been removed from her community, school, neighbors and friends, leaving her isolated. Kimberly’s mother now lives over 200 miles from her, and she has expressed concern over Kimberly’s behaviors. It is likely Kimberly is feeling hopeless and that she cannot trust anyone, including her foster parents. Kimberly does not know how to manage her feelings, which has led to her acting out against herself physically.

Of immediate concern is engaging Kimberly, her family, her foster family and her DCBS social service worker to participate in planning for Kimberly’s discharge from the ED. This includes helping find a suitable residential facility to meet Kimberly’s needs or identifying services, supports and the providers that will deliver i-home services to help Kimberly and her foster parents transition her back to her foster home. Longer-term, we will work with Kimberly and her foster parents to assess her ongoing needs, identify plans for Kimberly to live independently or obtain permanency through reunification with her mother, Linda, (if that is what they desire) since we know most children in transition reconnect with their families after leaving the foster care system.

As presented in the figure, Kimberly’s care coordinator will collaborate with Kimberly, her DCBS social service worker, Linda (if appropriate), her foster parents, ED discharge planner and ED treating physician to identify her circles of support – the people and organizations that will support Kimberly through her discharge from the ED and during her recovery after discharge.

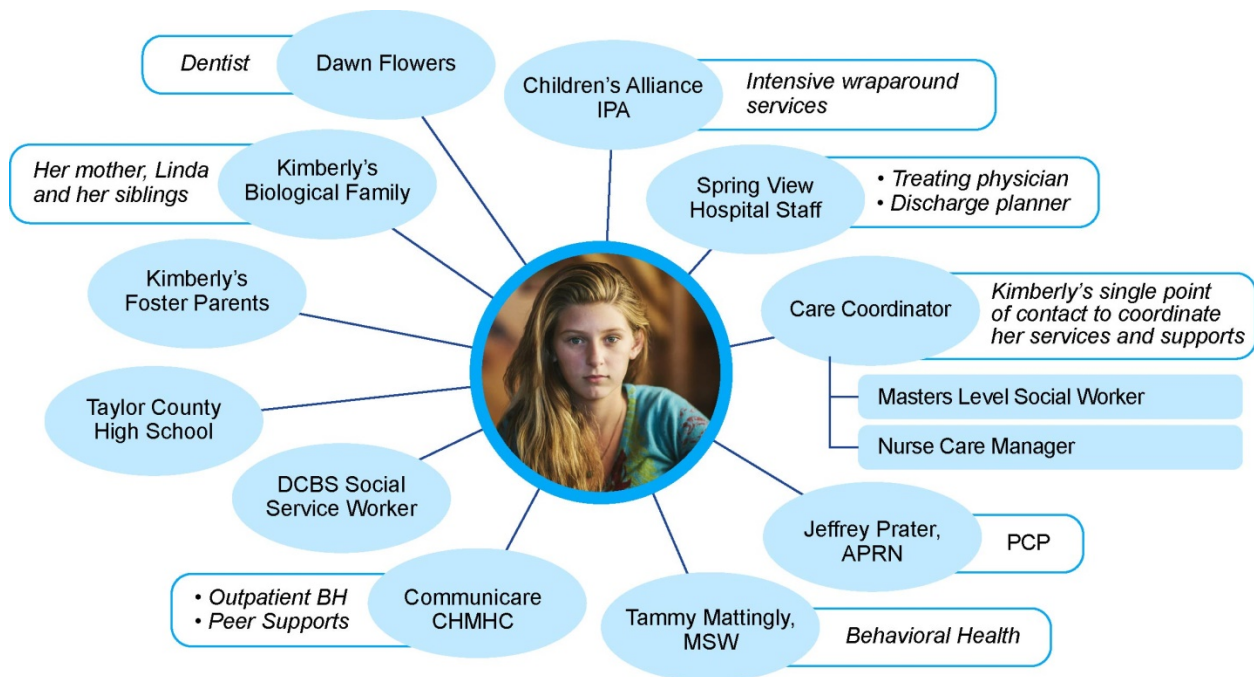


Figure 21. Kimberly’s circles of support. Kimberly’s care coordinator will help identify and coordinate with the people and organizations that will support her through her discharge from the ED and recovery post-discharge.

For this use case, we have assumed Kimberly and her foster family live near Mannsville, Kentucky, which is 200 miles away from her mother who is living in Eastern Kentucky. We have placed her at Spring View Hospital in Lebanon, Kentucky, where she is ready for discharge. The table presents an overview of our approach to address Kimberly’s needs in alignment with the requirements presented in her use case. Following the table, we describe how we will work with Kimberly and her support team to develop a care plan to meet her ongoing needs.

Programs and Services	Addressing Kimberly's Needs
a. Care management, including coordination with the foster parents	<ul style="list-style-type: none"> ▪ Assign a care coordinator. Kimberly's care coordinator is her primary contact to coordinate her care, meeting with her and her foster parents to offer support and coordinate her discharge. During business hours, the DCBS social service worker or foster parent can contact the care coordinator directly; after-hours they can call our number, 24 hours a day, seven days a week to be connected to a care coordinator who can assist in planning. ▪ Develop a holistic, individualized care plan for the full continuum of care ▪ MCT/Team and Circle of Support ▪ Frequency of Contacts based upon stratification ▪ Brokering social support services in the community
b. Discharging planning between levels of care	<p>Our care coordinator collaborates with the hospital discharge planner to convene a planning meeting with her care team, and members of her circle of support, to develop Kimberly's discharge plan, to ensure her safety and well-being is maintained as part of her transition between levels of care.</p>
c. Network adequacy and availability of services	<p>We have identified network services and providers to meet Kimberly's needs, including outpatient behavioral health therapy, peer support, PCP, hospital staff, Children's Alliance and our care coordinator. We have selected specific providers with expertise in trauma and anger/grief and in working with adolescents to provide care for Kimberly.</p>
d. Availability and utilization of telehealth for behavioral health services	<p>In rural areas, we will use telehealth services to provide additional provider options that can deliver care in their home. Behavioral health virtual visits will be available through our enrollee portal, <i>myUHC.com</i>, and via our mobile application. Kimberly and her foster parents can choose a provider, and schedule virtual visits. As part of her plan of care, we suggest Kimberly be seen for tele-behavioral health services, and telepsychiatry services for medication management as part of her ongoing care plan. Our virtual visits platform enables DCBS, foster parents and Kimberly to, schedule and share documents/resources through smartphones, tablets and computers. We can allow caregivers to join a session and conduct group therapy sessions through virtual visits.</p>
e. Applicable evidence-based practices; including psychotherapeutic interventions	<p>We will refer Kimberly to providers who deliver the following evidence-based practices and interventions: Foster youth and family peer support model, motivational interviewing, trauma focused cognitive behavioral therapy and wraparound INSPIRE Kentucky program.</p>
f. Prescribing psychotropic medications and documentation in medical records (e.g., rationale, follow-up assessments and monitoring)	<p>We train providers on best practices and clinical practice guidelines for prescribing psychotropic medication, especially for foster youth, and adopt evidence-based guidelines endorsed by SAMHSA. We identify inappropriate prescribing practices through prospective and retrospective utilization review. Kimberly's medications will be documented in <i>CommunityCare</i> and our utilization management system. We conduct medical record reviews to verify providers are documenting the rationale, follow-up schedule and plan to taper the medication (when appropriate).</p>
g. Coordination of transportation, if needed	<p>Through MCT meetings, the care coordinator and team will identify Kimberly's transportation needs (e.g., visits with her siblings). The care coordinator will discuss with the DCBS worker available transportation resources including: transportation provided by the foster parent, non-emergency medical transportation as described in the foster care handbook, DCBS transportation resources, coordinating with the county transportation broker, and identifying transportation through informal relationships, such as kin or fictive kin to Kimberly who live in the area.</p>

Programs and Services	Addressing Kimberly's Needs
h. Provider contracting	The providers described in this use case are in our contracted network. We contract with providers who deliver evidence-based care and share our vision of using a team based approach, which is critical to delivering integrated supports that meet the needs of Kimberly and her family.
i. Provider education and support	This includes OptumHealth Education platform, connecting providers to online resources, such as The National Child Traumatic Stress Network, the Foster Care Corner, and our field-based provider advocates.
j. Access to and medical records	<i>CommunityCare</i> maintains Kimberly's electronic health record, such as assessment findings, court records and her care plan. Our individual health record (IHR), available to providers through <i>Link</i> , gives them a 360-degree view of Kimberly's medical history for the past 3 years.
k. Maintenance of the care plan	Kimberly's care coordinator and multidisciplinary care team (MCT) continually monitor for indications her health status, needs or living situation have changed and verify she is achieving her goals. With any changes, they reassess her needs and update the care plan with her input, monitoring compliance via <i>CommunityCare</i> and our Clinical Adherence Program.

Initiating Contact with Kimberly and her Foster Parents

To reduce complexity for Kimberly and those supporting her, her care coordinator is Kimberly's **primary point of contact to coordinate her care** and help her navigate the health care system. She also will be supported by other SKY team members through our interdisciplinary care team clinical rounds including: our nurse care manager, master level licensed behavioral health clinician, licensed child psychiatrist as needed, and the transition aged youth specialist. Regardless of placement changes, Kimberly's care coordinator remains the same, to provide stability and allows the team to establish and maintain trusted relationships.

As part of the team process, **Kimberly's care coordinator** would be alerted to Kimberly's escalating acuity, including her cutting behavior through her PCP, **foster parents** or DCBS social service worker. With regard to the current situation, our care coordinator would be made aware of Kimberly's ED admission through a variety of alerts. The alerts can include admission, discharge and transfer alerts; alerts from DCBS staff; **a call from her foster parents**; or an alert from our utilization management (UM) team when the ED submits an authorization request for an inpatient bed during Kimberly's ED visit.

Once the care coordinator is alerted, an immediate connection will be made with the DCBS social service worker to start discharge planning activities as indicated herein.

Meeting Kimberly's foster parents. Kimberly's care coordinator will collaborate with her mother (if appropriate) her foster family and her DCBS social worker to participate in planning for Kimberly's discharge from the ED, including helping to find a suitable residential facility, if appropriate or identifying services, supports and providers that will help Kimberly transition her back to her foster home. Kimberly's care coordinator obtains permission from the DCBS social service worker to reach out to the foster parents to understand Kimberly's needs and obtain additional information required to prepare for her discharge. Her care coordinator makes every effort to meet them in the ED.

Meeting Kimberly. The care coordinator initiates outreach to Kimberly, with permission of the DCBS social service worker, explaining their role and using active listening and motivational interviewing to build rapport with Kimberly by asking her about herself, her experiences, the circumstances that led to her ED visit, her needs and goals and other issues, such as reuniting

with her mother, Linda. Her care coordinator may also become aware of other relevant issues, including that she is sexually active.

Kimberly's care coordinator chooses from a variety of assessments, including our **evidence-based Pediatric Core Comprehensive Assessment**, Access to Care assessment, and Pediatric to Adult Transition Core Assessment. The assessment process provides valuable information in coordinating Kimberly's care and tell us about her trauma, behavioral or physical health issues, **current medications**, social determinants concerns and being sexually active. The care coordinator will use assessments and information obtained through other providers to fill gaps in knowledge to avoid asking Kimberly the same questions multiple times, which can trigger a trauma response.

Identifying Kimberly's care management level. Given her care coordinator's initial review of Kimberly, the results of the assessment and her ED admission, her care coordinator identifies Kimberly for engagement in the Complex Care Coordination tier of care management services. As part of our ongoing process, children in the SKY program will be stratified on a monthly basis using our algorithm-based stratification, to confirm children with the highest needs are getting the most intensive care management services.

Coordinating in Crisis – Developing Kimberly's Discharge Plan and Securing her Safe and Appropriate Care

Assembling Kimberly's Care Team. In the few hours following Kimberly being admitted to the ED, Kimberly's care coordinator collaborates with the hospital discharge planner to hold a meeting with Kimberly, her DCBS social service worker, her mother, foster parents, ED discharge planner and ED treating physician. The purpose is to identify her circles of support, which will include providers who have existing relationships with Kimberly, and the addition of new providers to support her treatment. The team also will discuss placement options for Kimberly as part of her discharge plan. The planning meeting is part of an ongoing process that includes meetings with Kimberly and her circles of support; and activities, such as peer-to-peer discussions between her providers and our medical directors, interdisciplinary case conferences and MCT meetings to discuss services and supports that may be beneficial to her.

Discussing Kimberly's placement options upon discharge. Kimberly's planning team discusses appropriate placement options for Kimberly to keep her safe, and meet her needs identified through assessments conducted by the hospital, her treating professionals, the DCBS caseworker and Kimberly's care coordinator. The planning team discusses a number of options, including a residential bed, a psychiatric inpatient facility and crisis respite placement. The team asks Kimberly to sign a safety plan related to self-harming behavior and suicidal ideations. After the assessments, and the meeting, Kimberly and her planning team determine her best option is to return to her foster home supported with the following supports:

- Intensive wraparound services in the foster home through the INSPIRE program with the Children's Alliance. Services will be delivered in the foster home and include home-based family therapy, home-based individual therapy, collateral consultation, community supports identification, psychosocial education and mobile crisis intervention (in-person or on call).
- Peer support services provided through the CMHC.
- Telepsychiatry services to monitor her psychotropic medications.
- School-based services with a school counselor.

If residential treatment had been most appropriate, Kimberly’s care coordinator and inpatient case manager from our utilization management team would have coordinated with the provider to manage Kimberly’s transfer. If no beds were available in Kentucky, our inpatient case manager would look to adjacent states for facilities near to her foster parents’ residence. They would also consider Spring View Hospital’s inpatient facility for people with suicidal ideations.

Developing her care plan. Following the discharge meeting, which included decisions related to placement and wraparound services, the care coordinator will develop a care plan to meet Kimberly’s ongoing needs, and make referrals to services. Kimberly’s plan of care is included here.

Kimberly’s Potential Goal	Stated	“I don’t want to feel sad and continue to cut myself.”
	Measurable	Kimberly will not show signs of continual self-harm or active suicidal ideation in the next 90 days.
Opportunity	Kimberly obtains treatment to cope with her trauma and will not need to be transported to the ED or to a physician office due to new acts of self-harm.	
Interventions	<ul style="list-style-type: none"> ▪ Refer Kimberly to the INSPIRE wraparound program in the short term for in-home behavioral health and crisis supports. Through this program, Kimberly’s foster parents will learn de-escalation techniques to help manage Kimberly’s behaviors. ▪ Refer Kimberly to a behavioral health therapist in the Lebanon area for long-term treatment, with expertise in depression, self-harm, trauma and school issues. ▪ Referral to CMHCs transition peer supports and peer support specialist with foster care lived experience, to empower her to make her own decisions about her care. ▪ Refer to school-based counseling, engaging school-based therapist to provide crisis intervention when needed for Kimberly. ▪ Telepsychiatry to review depression medications prescribed by PCP. ▪ PCP follow-up visits with prescribed medication access and adherence plan. ▪ Develop plan with foster parents to lock up medications securely in the home so Kimberly cannot access them. 	
Kimberly’s Potential Goal	Stated	“I want to stay with my foster parents, so I don’t have to keep moving.”
	Measurable	Kimberly will safely stay with her foster parents until she reaches her permanency goal.
Opportunity	Kimberly will not disrupt her placement due to behavior.	
Interventions	<ul style="list-style-type: none"> ▪ Refer to NAMI Family to Family to provide Kimberly’s foster parents support. ▪ Develop a crisis plan so Kimberly’s foster parents know who to call if a crisis occurs, including the use of de-escalation techniques. ▪ Set up a meeting with DCBS to develop a plan to work on reunification activities, at the very least contact between Kimberly and her siblings. Team meetings with circle of support partners with Kimberly and her foster parents to have a cohesive plan for addressing safety, permanency and well-being. ▪ Set up a MCT meeting to discuss the use of telemedicine, BH, and psychiatry services to alleviate transportation burdens. 	
Kimberly’s Potential Goal	Stated	“I want to be able to stay in my school with my friends.”
	Measurable	Kimberly will not have an outburst in school requiring suspension.
Opportunity	Kimberly will be able to stay in school to finish the school year with her peers.	
Interventions	<ul style="list-style-type: none"> ▪ Upload Behavioral Plan through Individual Education Plan (if appropriate) to provider portal, so the team understands the safety plan to implement when there is an outburst in school using a team based approach. ▪ Referral to school based counseling to provide education related to her being sexually active. ▪ Referral to youth peer specialist to begin to plan for the future. 	

Ongoing Care Management

Care management post-discharge. Recognizing Kimberly returning to her foster home post-discharge could be stressful and filled with apprehension, Kimberly's care coordinator visits her and her foster parents in-person within 48 hours of Kimberly's discharge to confirm receipt of services and supports in the discharge plan. In the 30 days post-discharge, Kimberly's care coordinator will meet with the DCBS social service worker and discuss any barriers to continuing the plan of care. They will confirm the discharge plan is meeting Kimberly's needs and that Kimberly and her foster parents understand her conditions and document her progress. Her care coordinator will verify Kimberly has follow-up appointments scheduled with her providers and that she attends these appointments.

Given the distance from many of her providers, providing Kimberly and her foster parents with access to qualified behavioral health professionals via telehealth solutions and in her school is essential to her recovery. Kimberly's care coordinator will benefit from our tele-behavioral health and telepsychiatry technologies as a virtual resource, enabling Kimberly and her foster parents to choose a behavioral health provider and psychiatrist and schedule virtual visits.

Additionally, Kimberly's care coordinator will coordinate with her DCBS social service worker to provide transportation resources to Kimberly and her foster parents, to confirm Kimberly can access peer supports through the CMHC as per her discharge plan. Since Kimberly is sexually active, our care coordinator will provide a referral to her PCP to discuss her health and wellness including family planning.

Supporting Kimberly's Continued Growth

With the right supports and compassionate care in place for Kimberly, we envision a future where she feels safe and secure and she has built meaningful relationships with her peers and the adults in her life, enabling her to thrive into young adulthood. Longer-term, we will work with Kimberly and her foster parents to assess her ongoing needs, identify plans for her to live independently and to pursue permanency through reunification with Kimberly's mother (if that is what they both desire) since we know most children in transition reconnect with their families after leaving the foster care system.

Maintaining and sharing Kimberly's medical records is critical to coordinating and maintaining the continuity of her care across varied delivery systems, care settings and placement changes. To ensure Kimberly continues to meet her goals, her care coordinator updates her **care plan in CommunityCare** at least annually and in accordance with Attachment C – Draft Medicaid Managed Care Contract, Sections 34.4 Care Planning, 42.10.1 Care Plans and 42.10.2 Care Coordination Teams. Her care coordinator and her multidisciplinary care team (MCT) continually monitor Kimberly and her Individual Health Record (IHR), through our stratification process, to verify she is achieving her goals. As her stratification is reassessed, her risk level will be adjusted to a lower level for care management.

As a 15-year-old, Kimberly and her team need to begin planning for her transition to adulthood. Her care coordinator will connect her with our youth peer support specialist who will provide her with education and tools, such as **UnitedHealthcare On My Way**. Its *Vault* allows Kimberly to have a repository of her most important documents (e.g., birth certificates, individual education plans, insurance cards, health records) in a secure, easily accessible location.

Use Case 3

Shakira, 16 years, entered foster care two months ago after her primary caregiver, her grandmother, Mrs. Miller, passed away. Shakira was nine years old when she went to live with her grandmother in Lexington after her mother was incarcerated twice for shoplifting and drug possession with intent to sell.

Before the death of her grandmother, Shakira was an excellent student, a member of the swim team, played the clarinet in the school band, and hoped to go to the University of Kentucky (UK) to fulfill her dream of becoming a veterinarian. She had a boyfriend, Mike, who was the star player on the school's baseball team. Mrs. Miller had a full-time job with a modest income and was supportive of her granddaughter's studies and extracurricular activities.

Shakira and her grandmother had discussed UK scholarship opportunities with the high school counselor.

Three months ago, Shakira's PCP confirmed that she was pregnant in her first trimester. Shakira and her grandmother discussed options: keep the baby, adoption, and abortion. Eventually, they decided to keep the baby to raise in their home. Mike and his parents strongly recommended adoption and refused to be involved in the baby's support or upbringing. Within a week of the final discussion with Mike, Mrs. Miller died from a myocardial infarction. She was found in her home by Shakira when she came home from band practice.

Shakira stayed with school friends for two weeks but the school counselor contacted DCBS and Shakira was placed in foster care. After two weeks in a Lexington group home, Shakira was placed in a private foster home in Bowling Green. Shakira began seeing an OB/GYN and made plans to keep her baby. She was also diagnosed with depression resulting from the death of her grandmother and transition to a foster home in Bowling Green. Shakira stopped talking about her dream to become a veterinarian.

Shakira's foster parents wanted both Shakira and her baby to stay with them as a teen mother and baby in foster care. The foster parents expressed concerns to the DCBS Social Service Worker, however, about Shakira's depression, poor school performance, and development of her skills to care for a baby.

Describe how the Vendor would address Shakira's situation and coordination with the DCBS Social Service Worker, the foster family, physical and behavioral health providers, transition from the family to the community, and community resources. At a minimum, address the following programs and services:

- a. Care management;
- b. Access to and coordination between physical health providers (e.g., OB/GYN, pediatrician) and behavioral health providers;
- c. Access to network providers;
- d. Discharge planning for all levels of care;
- e. Coordination of school based services and an Individualized Education Plan
- f. Community services for parenting skills;
- g. Applicable evidence based practices;
- h. Coordination of transportation, if needed;
- i. Options for aging out of foster care and risk management;
- j. Social determinants of health;
- k. Provider education and support;
- l. Access to and sharing of medical records; and
- m. Maintenance of the Care Plan.

Shakira’s demonstrated ability for resiliency at a young age is being tested by a series of profoundly traumatic events. The decision to continue a teen pregnancy would overwhelm any child, but this situation occurring in the midst of her grandmother’s death, removal from a friend’s home, incarceration of her mother, the absence of her boyfriend’s support and a series of radical changes in her living environment would lead anyone to feel overwhelmed, depressed and despair. This represents a critical juncture in Shakira’s life. We recognize the simultaneous need to respond with urgency and with a deep sense of sensitivity backed by trauma-informed practices.

By directly supporting Shakira and her foster parents and connecting them to appropriate clinical, behavioral and community resources, we will help stabilize Shakira and her unborn child, and help her realize a pathway to future success. Achieving this outcome requires activating a circle of support, as presented in the figure.

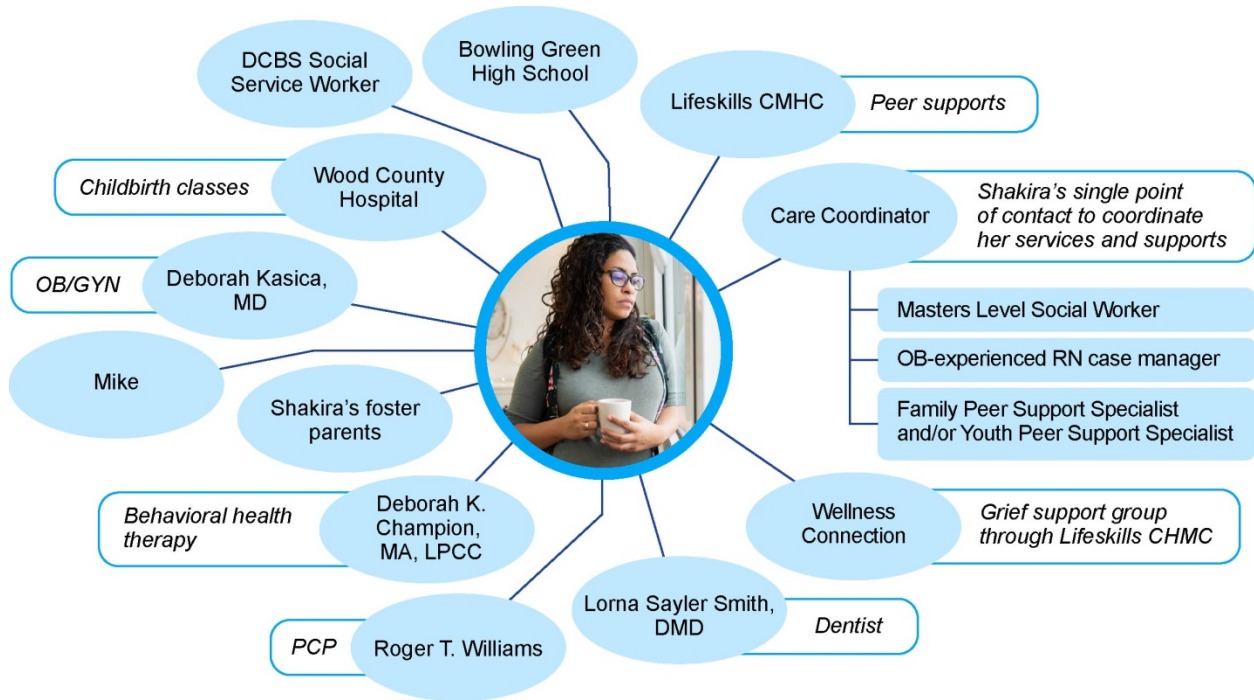


Figure 22. Shakira’s circles of support. Shakira’s care coordinator will help identify and coordinate with the people and organizations that will support her through care planning and her pregnancy.

We will engage and support Shakira in her current situation through her ultimate transition from foster care to independence. This journey will involve collaboration and deep partnership with Shakira and the many support systems around her — including her foster family, DCBS, her providers, school, friends and community resources.

The table presents an overview of our approach to address Shakira’s needs in alignment with the requirements presented in her use case. Following the table, we describe how we will work with Shakira and her support team to develop a care plan to meet her ongoing needs.

Programs and Services	Addressing Shakira’s Needs
a. Care management	Shakira’s transition to foster care would trigger a call from the DCBS social service worker to our regional care coordinator. After understanding Shakira’s needs, our team would assign a master level social worker and care coordinator for care management. Several factors would identify Shakira for our complex care management team, including her teen pregnancy, indication of depression and

Programs and Services	Addressing Shakira's Needs
	school disruptions/issues.
b. Access to and coordination between physical health providers and behavioral health providers	With our network adequacy in Bowling Green, Shakira would have access to the physical and behavioral providers she needs. The care coordinator promotes coordination among the members of her multidisciplinary care team (MCT) through one-on-one discussions, convening MCT meetings to discuss Shakira's care, and connecting her providers to our clinical team for peer-to-peer discussions.
c. Access to network providers	Shakira will have access to her providers within the community she resides, as indicated earlier. If she had coverage with another MCO before becoming enrolled in the Kentucky SKY program and had an OB/GYN inside our network, we would reach out and discuss care coordination. If she was seeing an OB/GYN outside of our network, we would call the provider and ask them to become a network provider to ensure Shakira's continuity of care.
d. Discharge planning for all levels of care	The care coordinator will assemble Shakira's team and identify any necessary post-discharge services and supports after Shakira delivers and for any unplanned admission. The planning process anticipates post-discharge issues and identifies interventions to mitigate them.
e. Coordination of school based services and an Individualized Education Plan	As Shakira's depression is prevalent and affecting her school performance, the care coordinator reaches out to the school to ask them to be a part of MCT meetings. In coordination with the DCBS social service worker, the care coordinator asks about whether an IEP is appropriate given Shakira's needs. If Shakira has not had an IEP developed, her care coordinator will participate in the IEP process if invited by her school and her DCBS social service worker.
f. Community services for parenting skills	Her care coordinator will work with Shakira's DCBS social service worker to identify parenting classes offered by DCBS. Her care coordinator will help identify and connect her to local community-based services, such as Kentucky's Health Access Nurturing Development Services (HANDS) program.
g. Applicable evidence based practices	Our engagement and referral to community-based providers will involve a range of evidence-based practices including motivational interviewing, Dialectical Behavior Therapy and Family Functional Therapy with her foster parents.
h. Coordination of transportation, if needed	Shakira's care coordinator will coordinate with her DCBS social service worker to discuss the transportation resources available to her and her foster parents. This could include transportation provided by DCBS, coordinating with the county transportation broker and options through informal relationships.
i. Options for aging out of foster care and risk management	In collaboration with the DCBS social service worker and Shakira, her care coordinator will initiate transitional care management activities including our pediatric to adult transition assessment, coaching, resource coordination and transition planning. Shakira is reassessed at least annually, but we recognize as part of our ongoing stratification process she may be assessed more often depending on her changing status and needs. Shakira's care coordinator will engage our youth peer support specialist to serve as a conduit for Shakira to get the services and support she needs as she moves into adulthood. Our specialist will demonstrate and help Shakira sign up to use UnitedHealthcare On My Way.
j. Social determinants of health	Shakira's care coordinator identifies resources that address her social determinants needs based upon her HRA and pediatric core assessment. Her care coordinator uses <i>Healthify</i> , our resource library, to connect Shakira to relevant and available social resources such as food, legal resources and child care.
k. Provider education and support	We help educate and support providers in a variety of ways, including: OptumHealth Education platform, connecting providers to online resources, such as The National Child Traumatic Stress Network, the Foster Care Corner, and our field-based provider advocates.

Programs and Services	Addressing Shakira's Needs
l. Access to and sharing of medical records	<i>CommunityCare</i> maintains Shakira's electronic health record, such as assessment findings, court records and her care plan. Shakira also will have access to her <i>Individual Health Record</i> available on her <i>myuhc.com</i> member portal. This aggregates all of Shakira's health records from the past 3 years. Shakira will learn to use these tools through the transition youth liaison.
m. Maintenance of the Care Plan	Shakira's care coordinator updates her care plan using the planning process through her MCT. Her care coordinator and MCT continually monitor Shakira's progress toward her goals and look for indications that her health status, needs or living situation have changed. When they see these indications, they reassess Shakira's needs and work with her to update her care plan, monitoring compliance to these requirements through <i>CommunityCare</i> and our Clinical Adherence Program.

Supporting Shakira and Her Foster Parents through Care Management

We recognize the complexity of Shakira's situation, and in response to the concern her foster parent's raised to her DCBS social services worker, we will support them through our evidence-based care management program, which includes team-based decision-making, algorithm-based stratification, and development of person-centered plans of care. This program will support Shakira and her foster family by connecting them with a care coordinator who serves as a **primary point of contact to coordinate** her care and help her and her foster family navigate the health care system.

To begin building a relationship, Shakira's care coordinator, and our masters level social worker (MLSW) will obtain permission from the DCBS social service worker to reach out to Shakira and her foster parents for a face-to-face visit. In advance of the meeting, Shakira's care coordinator will review any information we have about Shakira that will inform the assessment process and the development of her care plan in *CommunityCare*, our care management platform. If Shakira previously received coverage through another MCO before becoming a SKY enrollee, her care coordinator could also review Shakira's Individual Health Record (IHR), which pulls and translates a 360-degree view of Shakira's medical history for the past 3 years into a single, digestible format. Preparing for the initial visit by reviewing critical information will better position the care coordinator to understand and meet Shakira's needs.

We recognize that Shakira's recent life circumstances may make establishing a new and trusting relationship challenging. To build a trusting relationship with Shakira, her foster parents and her DCBS social service worker, our care managers employ evidence-based practices like motivational interviewing and Trauma-informed care practices. To provide continuity and demonstrate our commitment to supporting Shakira, this relationship will remain intact, regardless if Shakira experiences a placement change in the future.

Shakira's care coordinator will refer her to our Healthy First Steps (HFS) maternity management program. HFS provides support for pregnant enrollees and babies at every stage of the reproductive health cycle and at all risk levels, including:

- **HFS case management:** Specialized case management for high-risk pregnant enrollees and babies with an OB-experienced RN case manager, with case consults provided by a MLSW for enrollees with behavioral concerns.
- **HFS Rewards:** Provides education through a mobile-enabled website, clinical texting to remind pregnant enrollees and new moms about important prenatal, postpartum and well-child visits, and incentives for achieving important milestones throughout and 15 months after pregnancy. Nationally, those enrolled in HFS Rewards have a **15% higher physician visit rate**.

Coordinating the Care Shakira needs for Stability, Health and Wellness. As a pregnant teen who has experienced multiple and profound traumas, Shakira requires comprehensive care from a range of specialists including a pediatrician for routine EPSDT visits, a behavioral health clinician to help Shakira through her recent trauma and exhibited depression and an OB/GYN for prenatal care. To facilitate this process, and in doing so, eliminate any barriers that could inhibit Shakira from routinely accessing necessary care, Shakira’s care coordinator coordinates among the providers and community-organizations delivering services and supports to Shakira and with her DCBS social service worker and foster parents.

Shakira’s care coordinator begins this process by assembling our internal care management team, including an MLSW who provides behavioral expertise to address Shakira’s depression, and school performance and an HFS RN case manager to provide specialized case management during Shakira’s pregnancy. As part of our clinical rounding process, Shakira’s team would discuss the following needs her care coordinator will address, including:

- **Pediatric primary care.** Even as Shakira requires specialized care, her need for ongoing primary care and EPSDT services remains. Her care coordinator reviews Shakira’s IHR to determine her needs related to EPSDT and helps to schedule appointments, if necessary.
- **Maternity care.** If Shakira was engaged in prenatal care with an OB/GYN before coming into the SKY program, her care manager would alert and engage our Provider Advocates to try to contract with the provider to ensure Shakira’s continuity of care. Shakira’s HFS case manager would provide maternity-specific education, support, and incentives to help ensure Shakira receives appropriate prenatal and postpartum care. Due to Shakira’s current placement in foster care in Bowling Green, the care coordinator would refer Shakira to an OB/GYN in the area. For this use case we selected Deborah Kasica, which is in direct alignment with Shakira’s needs and care plan.
- **Behavioral health care.** After Shakira’s indicated depression through the PHQ-9 and with consultation with the MLSW, her care coordinator connects her with a local behavioral health clinician Deborah Champion, who provides behavioral health treatment for depression, grief and loss. Her care coordinator will connect her to resources available through *myuhc.com*, such as our Whole Health Tracker to help her develop a crisis plan, 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.
- **School-based care.** Hearing concerns about Shakira’s declined school performance, the care coordinator outreaches to the school for a referral. In coordination with the DCBS social service worker, the care coordinator asks about whether an IEP is appropriate. If Shakira has not had an IEP developed, her care coordinator will participate in the IEP development process if invited by her school and her DCBS social service worker. If Shakira has an IEP, her care coordinator will obtain a copy and upload into Shakira’s *CommunityCare* electronic health record. This, together with ongoing coordination, will avoid duplication of services.

To help Shakira refocus on school, her care coordinator will connect her to the *High School Center* on *myuhc.com*, our secure member portal. The Center has content to help Shakira 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.”

Collaborating to Develop Shakira’s care plan. Once Shakira’s care coordinator establishes a trusting relationship, they will explain to Shakira and her foster parents the process for assembling the MCT to develop her care plan. Shakira’s care coordinator works with her and her foster parents to identify the people they would like to include in the planning process, including members of her MCT. If Mike were to decide to re-engage and support Shakira’s pregnancy, for example, she may invite him and his family to participate. The coordinator relays the importance of the plan and its role in verifying Shakira gets the care she needs to achieve the goals she sets for herself. This person-centered approach seeks to empower Shakira to identify goals and the supports available to help her achieve them.

We understand the process to develop Shakira’s care plan is not completed in one planning session. To gain the best insight into the services and supports that will address her needs, the planning process will include MCT meetings, peer-to-peer discussions with MCT participants and our medical directors and promoting Shakira’s case for review during interdisciplinary case conferences. The table presents two goals Shakira and her foster family may articulate to address her concerns and help Shakira achieve her goals. For each goal, we have described the measure to determine if the goal has been achieved, the outcomes we would expect to see for Shakira if she achieves the goal and the interventions needed to achieve each goal.

Shakira’s Potential Goal	Stated	I want to deliver a healthy baby.
	Measurable	Shakira will carry her baby to term, and have a healthy delivery.
Opportunity	Shakira will routinely engage in prenatal care according to evidence-based guidelines	
Interventions	<ul style="list-style-type: none"> ▪ Enroll Shakira in HFS case management and rewards programs. ▪ Refer to OB/GYN Dr. Deborah Kasica to monitor her medical needs related to pregnancy, postpartum care and future contraceptive care. ▪ Refer to Roger T. Williams PCP to ensure EPSTD visits occur. ▪ Refer to and help coordinate with the HANDS program. ▪ Refer Shakira to WIC, and get her signed up for benefits. ▪ Connect Shakira with child birth classes at Woods County Hospital. 	
Shakira’s Potential Goal	Stated	I want to stay in school to pursue my dream of becoming a veterinarian.
	Measurable	Shakira will attend school and improve her grades — work with the school to support her so she can complete her school year regardless of when the delivery occurs.
Opportunity	Shakira receives behavioral health services to treat depression and supports to re-engage in school.	
Interventions	<ul style="list-style-type: none"> ▪ Refer to behavioral health clinician to address grief, transition and depression, including preparation for potential postpartum depression. ▪ Refer to the school counselor at Bowling Green High School to address challenges of school performance. ▪ Upload relevant school documents to <i>CommunityCare</i> to provide care team access to the plan, facilitating work toward the stated goal while avoiding duplication of services. 	

Discharge planning. Shakira’s care coordinator will conduct discharge planning for Shakira if it becomes necessary. For example, if Shakira experiences an inpatient admission, her care coordinator collaborates with an inpatient care manager from our UM team and Shakira, facility staff, DMS, DCBS case manager, the foster family and anyone Shakira and her family chooses to participate to develop a discharge plan. The plan identifies the services and supports to sustain the progress Shakira has made during the inpatient stay. The discharge plan builds on the Shakira’s strengths and identifies the services and supports that meet her needs and help her achieve her goals. The planning process improves Shakira’s outcomes by anticipating post-discharge issues and identifying interventions to mitigate them.

Connecting Shakira to necessary community and social supports. As a child in transition and mom-to-be, ensuring that Shakira and her foster family have the necessary resources and social supports plays a critical role in Shakira's ability to regain stability and wellness. During the care planning process, Shakira's care coordinator gleans information on Shakira's needs using information from the HRA and pediatric core assessment which respectively include two and 33 questions related to **social determinants**. To connect Shakira and her foster family to the necessary community resources and social supports to meet these needs, her care coordinator uses *Healthify*, a web-based catalogue of 5,000 Kentucky-based resources that deliver services, such as food, legal resources, employment assistance, support groups and child care.

Developing Shakira's parenting skills. Shakira's care coordinator will work with her DCBS social service worker to identify parenting skills courses offered by DCBS. Her care coordinator may also identify and connect Shakira to additional state and community-based services. For instance, Wood County Hospital provides behavioral health therapy, peer support and child birthing classes. If her DCBS social service worker did not already enroll Shakira in Kentucky's Health Access Nurturing Development Services (HANDS) home visiting program for pregnant moms-to-be and new parents, her care manager would ensure Shakira was connected.

Helping Shakira Transition to Adulthood. In

collaboration with the DCBS social service worker and Shakira, her care coordinator will initiate transitional care management activities including our pediatric to adult transition assessment, coaching, resource coordination and transition planning. Shakira is reassessed at least annually, but more often due to her individual circumstances, to ensure a well-coordinated transition to adulthood. Because Shakira has indicated she wants to attend college, the care coordinator will provide information related to the Kentucky tuition program for foster and adopted children. Kentucky Revised Statute 164.2847 waives tuition and mandatory fees for Kentucky foster or adopted children at any public Kentucky university, technical or community college. The tuition waiver is a last-resort resource applied if federal financial assistance, Kentucky Educational Excellence Scholarship, College Access Program and/or other private scholarships do not cover all expenses.

Our Pediatric to Adult Transition Assessment (ages 14 to 18 years) assesses Shakira's needs and barriers that may affect her ability to achieve a seamless transition to adult services.

Shakira's care coordinator will engage our **transition aged youth liaison** to serve as a conduit for Shakira to get the services and support she needs as she moves into adulthood. The liaison will demonstrate and help Shakira sign up to use **UnitedHealthcare On My Way**, including the *Vault* that allows Shakira to have a repository of her most important documents in a secure, easily accessible location. Shakira would continue to have access to her electronic health record available on *CommunityCare* or through her IHR.

Use Case 4

Kirk is a 3 year old with cerebral palsy (CP), hydrocephalus with a ventriculoperitoneal (VP) shunt, and seizures. He was placed in foster care when he was two months old after his parents terminated parental rights. Kirk has been in six different foster homes in four different Service Regions. He is on multiple medications for his CP symptoms, including anticonvulsant medication. His infant VP shunt was replaced when Kirk turned 2 years old but two foster homes have reported problems with the shunt and repeated follow-up visits with the pediatrician and pediatric neurosurgeon. Access to a pediatric neurosurgeon and the availability of Kirk's medical records as his placements change have been a significant problem. In addition, medication management and pharmacy records are problematic for the DCBS Social Service Worker and foster parents.

Kirk's current foster family lives in a rural community in Webster County. They have discussed adoption with the Social Service Worker but expressed concerns with access to the care that he needs in the long-term. The family has attempted to access care at the nearest children's hospital but availability of appointments was problematic. The family now must travel to Cincinnati Children's Hospital, which is more than a nine hour roundtrip commute. The travel and time off from work are hardships for the foster family but their primary concern is for Kirk's health. The foster family is concerned about availability of primary care and dental providers, clinical specialists (e.g., pediatric neurosurgeons), specialists to support his cognition, behavior, communication and developmental needs, medications to treat his CP symptoms and associated conditions, physical therapy, durable medical equipment, planned family respite care, etc.

Describe how the Vendor would address Kirk's situation and coordination with the Social Service Worker, the foster family, in-state and out-of-state providers, and community resources. At a minimum, address the following programs and services:

- a. Care management, including coordination to address fragmented care and timeliness of care;
- b. Availability of services and network access, including out-of-state providers;
- c. Availability of services, such as skilled nursing services;
- d. Access to school based services;
- e. Applicable evidence based practices;
- f. Coordination of transportation, as needed;
- g. Community resources;
- h. Social determinants of health;
- i. Planned respite care;
- j. Provider education and support;
- k. Access to and sharing of medical records; and
- l. Maintenance of the care plan.

After entering the foster system and experiencing multiple placements during a critical period of development, Kirk has found supportive foster parents committed to providing him a stable home. However, his highly complex medical and functional needs and intensive, specialty care requirements significantly challenge his foster family’s ability to provide Kirk with long-term support and care. We recognize the critical importance of stability for children like Kirk, especially related to the issues of his shunt. To help Kirk’s foster parents continue to meet his needs with confidence and minimal barriers, we commit to identifying and coordinating the necessary services and supports that will enable them to continue providing Kirk with a stable family life, which will hopefully lead to his adoption.

Due to his complex needs, Kirk requires a multifaceted care team. As presented in the figure, we will assign a nurse care manager (NCM) to lead Kirk’s care team. The NCM will collaborate with Kirk’s foster parents and DCBS social service worker to identify his circles of support — the people and organizations that will support Kirk and his foster family through the assessment and care planning process.

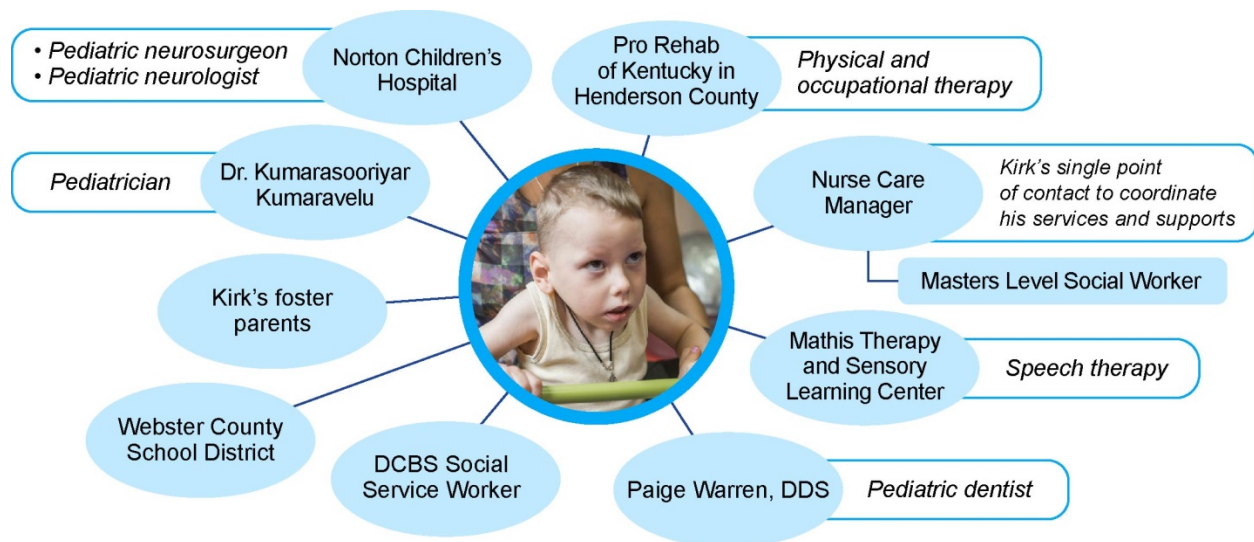


Figure 23. Kirk’s circles of support. Kirk’s NCM will help identify and coordinate with the people and organizations that will support him through the assessment and care planning process

We will begin to describe our care management approach for Kirk assuming we have completed his initial health risk assessment and identified him for engagement in Complex Care Coordination. Due to his complex needs, his NCM will make a referral to the DCBS Medical Support Section staff to determine if Kirk meets the criteria for designation as a Medically Complex Child. The table presents an overview of our approach to address Kirk’s needs in alignment with the requirements presented in his use case. Following the table, we describe how we will work with Kirk and his support team to develop a care plan to meet his needs.

Programs and Services	Addressing Kirk’s Needs
a. Care management, including coordination to address fragmented care and timeliness of care	Given Kirk’s complex needs, we will engage him in high-touch, evidence-based case management, led by his NCM. Our case management program is evidence-based, supporting the delivery of high-value care and service excellence. Our program uses person-centered planning, evidence-based assessments and motivational interviewing to provide quality coordination for children who have complex needs, like Kirk.
b. Availability of services and network access,	Kirk’s NCM will identify opportunities to connect Kirk to services closer to his foster home through our provider relations liaison. For Kirk, our network team

Programs and Services	Addressing Kirk's Needs
including out-of-state providers	reaches agreement with Norton's Children's Hospital to deliver care for Kirk. If Kirk requires services from an out-of-state provider, his NCM will coordinate access to this service. This will include discussing this option with his foster parents, identifying providers that can meet his needs, confirming the provider has a Kentucky Medicaid ID for billing purposes and developing a plan for Kirk and his foster parents to attend follow-up visits.
c. Availability of services, such as skilled nursing services	During the assessment and planning process, Kirk's NCM will collaborate with his MCT team to identify the need and availability of a range services, including for example in-home skilled nursing.
d. Access to school based services	Kirk's NCM will contact the Webster County School to discuss Kirk's receipt of an individual education plan (IEP), and early childhood services for children with disabilities. During the meeting, the team will identify Kirk's health issues and services needed to address them, ultimately documenting these in his care plan to avoid duplication of services.
e Applicable evidence based practices	We include evidence-based practices in each of our engagements with enrollees. Examples specifically applicable to Kirk may include physical therapy, speech therapy and medication reconciliation.
f. Coordination of transportation, as needed	Kirk's NCM will coordinate with his DCBS social service worker to discuss the transportation resources available to his foster parents, as indicated in the foster parent handbook that might alleviate the burdens for accessing Kirk's medical treatment. This may include using non-emergency transportation services available through DMS.
g. Community resources	Kirk's NCM will identify and coordinate community resources that will support Kirk's foster parents in providing Kirk appropriate care. These might include assisting the DCBS social service worker in in completing Kirks application for Social Security benefits, working with the Commission for Children with Special Health Care Needs, and referring to the special education department at the Webster County School District.
h. Social determinants of health	Kirk's NCM identifies resources that address his foster family's social determinants needs using data from the HRA and pediatric core assessment, which could include transportation resources. His NCM uses <i>Healthify</i> , a mobile tool that helps his NCM connect Kirk's family to relevant and locally available resources, such as parenting classes, transportation and child care.
i. Planned respite care	Kirk's NCM will work with his DCBS social service worker to coordinate the respite care available to Kirk's foster parents to provide relief in meeting the extraordinary demands of care for him, consistent with the respite care eligibility among all foster parents. Kirk's NCM also will help provide his foster parents other options for respite through family support.
j. Provider education and support	We help educate and support Kirk's providers in a variety of ways, including through on demand trainings about management of complex children, and participating in interdisciplinary care coordination teams. Our education also includes robust training related to technological support that seamlessly provides a holistic view of the services Kirk receives.
k. Access to and sharing of medical records	We commit to continuity of medical records by using IT systems that make accessing records seamless for Kirk's foster parents, care manager, and multiple providers in his multidisciplinary care team (MCT) through our <i>CommunityCare</i> platform and through Kirk's <i>Individual Health Record</i> .
l. Maintenance of the care plan	His NCM and MCT continually monitor Kirk's care (e.g., confirming he receives EPSDT screenings and PCP visits), and develop emergency management plans and encourage planned respite for the foster parents to help him avoid unnecessary ED visits and hospitalizations, and verify that he is achieving his goals. If his NCM identifies any issues, the NCM will reassess Kirk's needs and

Programs and Services	Addressing Kirk's Needs
	update his care plan.

Supporting Kirk and his foster parents through care management. Kirk's foster family has demonstrated an immense commitment to helping him receive the care he needs, even in the face of logistical challenges. To help them overcome these challenges, Kirk's NCM serves as his foster parents' primary point of contact to help them navigate the complex system of care Kirk requires. We maintain the relationship between his NCM, Kirk and his caregivers, regardless of placement changes, to provide stability for Kirk, and allow his foster parents and care team to maintain a trusted relationship.

Identifying Kirk's services and supports. We understand the process to develop Kirk's care plan is not completed in one planning session. To gain the best insight into the services and supports that will address his needs, the planning process will include MCT meetings, peer-to-peer discussions with MCT participants and our medical directors as part of the interdisciplinary case conference review. Kirk's NCM, supported by his MCT, empowers Kirk's foster parents to actively participate in all aspects of care planning and to make decisions about Kirk's care and services in meaningful ways. Kirk's care plan builds upon his strengths that can serve as a foundation for achieving positive outcomes based upon Kirk's unique situation and needs. The table presents the services and supports in Kirk's care plan.

Kirk's Potential Goal	
Stated	Kirk's shunt will work properly.
Measurable	Kirk does not require any emergency interventions related to his shunt for the next 90 days.
Opportunity	Kirk's NCM collaborates with his MCT to ensure that he has regular visits with his physicians and that his foster family receives education for proper at home care for Kirk's shunt.
Interventions	
<ul style="list-style-type: none"> ▪ The NCM assists the foster parent in scheduling appointment and confirms Kirk attends regularly scheduled visits with his physicians (pediatric neurologist, neurosurgeon and any other subspecialist). ▪ The NCM verifies that Kirk and his family have transportation to attend all appointments. ▪ NCM gathers documents including instructions from the pediatric neurosurgeon related to the shunt and any complications or side effects that could occur. ▪ NCM collaborates with the MCT to write a protocol that details symptoms to watch for, follow-up steps and emergency procedures should his shunt malfunction and address any questions Kirk's foster family has. ▪ NCM educates Kirk's foster parents that when these signs and symptoms are present they must have him seen at Norton Children's Hospital, another acute care hospital with neurological services including imagery and surgery or his pediatrician. 	
Kirk's Potential Goal	
Stated	Accessing Kirk's care becomes more manageable.
Measurable	The foster family and Kirk's circle of support live within a manageable distance from the same health system.
Opportunity	Kirk's care will be transferred to Norton Children's Hospital.
Interventions	
<ul style="list-style-type: none"> ▪ NCM meets with Norton Children's Hospital social worker and identifies available providers to meet Kirk's immediate and long-term needs. ▪ NCM will set up an appointment, if needed, with Kirk's pediatrician. ▪ The CMO verifies the quality of Norton's services, is comparable to the services in Cincinnati, and now that Kirk is stable his transfer is appropriate to remove the barrier of transportation for the foster parent. ▪ After receiving approval from Kirk's foster parents and DCBS social service worker, his NCM will work with Norton, to transfer Kirk's care. ▪ Kirk's NCM will arrange appointments at Norton Children's Hospital, medical record transfer, and transfer of all clinical services to maintain his continuity of care. 	

<ul style="list-style-type: none"> His NCM will provide social supports for Kirk's foster parents to facilitate stability in the foster home, which could lead to adoption (e.g., activities for children with disabilities). 	
Kirk's Potential Goal	
Stated	Kirk does not have ongoing seizures.
Measurable	Kirk receives appropriate treatment to control seizures, and does not experience one in the next 90 days.
Opportunity	Kirk's treatment plan is reviewed, appropriate treatment confirmed.
Interventions	
<ul style="list-style-type: none"> NCM will initiate review of pharmacy management plan, including treatment for seizure control and a review of the medications prescribed in relation to the formulary, outreach to the providers in the event prior authorization assistance is needed, and discuss minimizing side effects of polypharmacy use. To help Kirk's foster parents adhere to his medication schedule, Kirk's NCM will work with a pharmacist to offer mail order prescriptions, if available, and collaboratively and regularly review Kirk's medication profile to confirm Kirk's foster parents understand his medication administration and schedule. Alternatively, his NCM may refer Kirk's foster parents to a pharmacy that includes compounding for pediatric specialty medication, such as liquid formulations. His NCM will schedule pediatric neurology appointments as appropriate. His NCM will collaborate with the MCT to educate Kirk's foster parents on managing seizure episodes, including airway management and what increases his seizure threshold. His NCM will connect Kirk's foster parents with CPR training. 	
Kirk's Potential Goal	
Stated	Despite limitations due to Cerebral Palsy, Kirk can function to his maximum capacity.
Measurable	Kirk will be able to meet developmental milestones on schedule.
Opportunity	Kirk receives therapeutic interventions to successfully reach physical, mental, and social developmental milestones as closely aligned with Bright Futures schedule as possible.
Interventions	
<ul style="list-style-type: none"> NCM refers to and schedules, if necessary, appropriate therapy services in the home including PT, OT and ST to prevent complications that would result in future loss of function. NCM will review physician's orders to meet identified DME needs and make necessary referrals. Kirk's NCM schedules pediatric neurology follow up visits, in collaboration with his foster parents. Referral and evaluation by developmental pediatrician at Norton hospital. His NCM will meet with the physical therapist and occupational therapist about their plan to teach the foster parents how to assist Kirk in meeting developmental milestones (e.g., range of motion exercises). 	
Kirk's Potential Goal	
Stated	Kirk receives routine, core services.
Measurable	Kirk remains up to date on routine dental and primary care, and EPSDT screening services.
Opportunity	Kirk visits a local dentist and pediatrician equipped to provide care to a child with his functional needs.
Interventions	
<ul style="list-style-type: none"> His NCM will schedule a visit with a dentist Paige Warren, DDS in Providence, Kentucky, who treats children with ID/D. His NCM will make a referral for developmental evaluation by a pediatrician. Kirk will continue to see his pediatrician for routine care (e.g., immunizations, well-child checks). 	
Kirk's Potential Goal	
Stated	Kirk will have an opportunity to interact with children his age.
Measurable	Kirk will be referred to a child care program or pre-school program for children with special needs, including a referral for an early education assessment for the development of an individual education plan.
Opportunity	Kirk will be enrolled in a program related to his educational needs to determine the level of service he needs to be successful.

Interventions	
<ul style="list-style-type: none"> ▪ The NCM will refer Kirk for an early education assessment to develop an individual education plan. ▪ The NCM will provide information to Kirk’s foster parent about the Special Education Cooperative Network to help them advocate for Kirk’s education needs. ▪ The NCM will include a school representative on Kirk’s MCT. 	
Kirk’s Potential Goal	
Stated	Kirk’s foster parent will have respite care.
Measurable	Kirk’s foster parent will have routine respite care for the next 90 days.
Opportunity	Kirk’s foster parents will be able to trust caregivers to care for Kirk.
Interventions	
<ul style="list-style-type: none"> ▪ The NCM will meet with the DCBS social service worker to discuss the foster parent respite program through DCBS. ▪ The NCM will help identify potential respite providers for Kirk through community organizations such as the Cerebral Palsy Commission. ▪ The NCM will help train Kirk’s foster parents family members who provide respite care for him to ensure they understand signs of distress and implementation of his emergency medical plan. 	

Connecting Kirk to accessible providers. As outlined in Kirk’s care plan, Kirk’s NCM supports this need by identifying local providers in network, such as Norton Children’s Hospital, while also identifying opportunities to increase access to care through innovations such as telehealth. For example, in addition to connecting Kirk to a local dentist that treats children with DID, we are piloting a teledentistry program that promotes collaboration with pediatric and family medicine clinicians. In partnership with the Kentucky Primary Care Association, we are committed to providing a teledentistry program in Kentucky to increase access to oral health care for rural enrollees like Kirk. If coverage for asynchronous telehealth is restored following the expiration of emergency regulation 907 KAR 3:170E, we will develop a teledentistry program in Kentucky, with KPCA’s integrated sites targeted for potential implementation.

Coordinating with out-of-state providers/transportation needs. In the event Kirk requires services from an out-of-state provider, the NCM will coordinate access to the service. This will include discussing options with his foster parents, identifying providers that can meet his needs, and confirming the provider has a Kentucky Medicaid ID for billing purposes. Kirk’s NCM also will identify any transportation needs and coordinate with his DCBS social service worker to discuss the transportation resources available to Kirk’s foster parents. The NCM will help explain the transportation benefit provided to foster parents as outlined in the foster parent handbook. The NCM can also assist Kirk’s foster parents in contacting the county transportation broker to arrange non-emergency medical transportation, and identifying transportation options through informal relationships, such as kin or fictive kin to Kirk who live in the area of his foster home.

Coordinating additional services. Kirk’s NCM will collaborate with his MCT to identify his need for any additional services, such as speech therapy including relevant EPSDT special services such as in-home skilled nursing. We understand that in-home skilled nursing services must be medically reasonable and necessary for the treatment of Kirk’s conditions. If Kirk requires skilled nursing, his NCM will identify resources and ensure Kirk’s foster parents have the information they need to access them, which may involve our Private Duty Nursing care manager for tailored support.

Coordinating with Kirk’s school. Kirk is at the age where a referral needs to be made to the education system. His NCM will work with DCBS to refer Kirk to the early education program through the Webster County school district. His NCM will work with entities to support Kirk and his foster parents, including the Commission for Children with Special Health Care Needs and

the special education department at the Webster County School District. Kirk's NCM will attend the initial meeting with the team to discuss Kirk's individual education plan. Once completed, Kirk's care manager will upload a copy into Kirk's *CommunityCare* electronic health record where it can be accessed by his MCT to avoid any duplication of services.

Supporting Kirk's providers through technology. We recognize a consolidated, sharable, and up-to-date medical record can have immense benefits for children in foster care whose changing placements and multiple treating physicians often contribute to fragmented records. *CommunityCare* maintains Kirk's comprehensive electronic health record, including any assessment findings, his care plan, any IEP, care manager notes, and information on services and treatments received. It provides the mechanism for Kirk's MCT to collaborate and deliver coordinated care aligned with Kirk's goals. In addition to *CommunityCare*, our integrated health record (IHR) gives providers a 360-degree view of Kirk's medical history for the past 3 years, regardless of coverage. It helps his providers, who may not have a full view of his medical history, prepare for visits with Kirk and his foster parents.

Connections to Community and Social Support Services

We recognize health care services alone cannot meet the needs of children like Kirk and his caregivers. Kirk's NCM helps his foster parents to identify and connect to the services and resources they need to provide a healthy and safe environment for Kirk, which may include services, such as childcare, transportation and supports for health-related social needs such as energy assistance. Though expressing these needs may be challenging initially, Kirk's NCM will create a trusting relationship with Kirk's foster family. Other services the NCM could refer Kirk's foster parents to for ongoing support include mentoring programs, comprising Parent to Parent, local Tools for Life organizations, and the local cerebral palsy organization. To address any needs they express to the NCM, Kirk's NCM also will leverage *Healthify*, which includes over 5,000 Kentucky-based resources.

Though Kirk's family has not expressly identified any resource needs other than more accessible care, an important opportunity exists for the NCM to assist the DCBS worker in completing the application for Social Security benefits to help determine services Kirk is eligible for through Social Security due to his complex medical needs and disabilities. While coordinating health care services for Kirk is the primary focus of his nurse care manager, we recognize that Kirk's well-being and permanency relate directly to the supports his foster parents receive. His NCM will work with Kirk's DCBS social service worker to coordinate once per month respite to provide relief in meeting the extraordinary demands of care for him. To further support Kirk's foster family, Kirk's NCM will assess his foster parents for caregiver stress using the Caregiver Self-Assessment Questionnaire, developed by the American Medical Association. Using this information, his NCM will connect the foster parents to resources available through our secure enrollee portal, *myuhc.com*, which provides caregiver supports and the Community Resource Database, which helps his foster parents locate services and supports near them, including additional respite services beyond DCBS's coverage.

Use Case 5

Enrico, age 16, has a history of violence, aggression, and destructive behavior. Both parents live in the home and Enrico has five siblings, ages two – nine years. Spanish is the primary language spoken by his parent and Enrico often had to interpret for his parents when talking with health care professionals, school officials, and law enforcement. He has a history of harming his parents, siblings, and a family pet. When in middle school he started fires at school and physically bullied younger students. Once in high school, Enrico began experimenting with drugs and alcohol, and was suspended twice for bullying students and destruction of school property. After physically attacking a high school teacher, Enrico was arrested and placed in a DJJ regional juvenile detention center. The charges against Enrico were later dropped so that he could receive treatment.

Enrico's parents refused his request to return home and DJJ and DCBS coordinated his placement in foster care. His behavioral issues in a private foster home (e.g., aggression and destructive behavior) caused him to be relocated to a group home. Despite repeated requests from Enrico, there has been no contact between Enrico and his family since he entered foster care.

Enrico has been prescribed two psychotropic medications at the higher end of the dosage range but hasn't been evaluated by his PCP or behavioral health provider in over a year. In addition to his ongoing behavioral issues, Enrico has moderate persistent asthma and has a history of several ED visits and one hospitalization related to his asthma over the past 2 years. His BMI is 25.

With his Social Service Worker, Enrico discussed his loneliness, desire to return home, and regrets over hurting his family, especially his parents. Enrico especially misses his siblings and is anxious to see them or to talk with them over the phone. He expressed his frustration over not being able to talk with his family to discuss how they "can be a family again." He shared his confusion over who could help him with talking or meeting with his family.

Enrico is ambivalent about remaining in foster care once he reaches his 18th birthday. Sometimes he expresses a desire to leave foster care and, at other times, he states his understanding of the support needed to transition into the community and possibly reconcile with his family. Enrico's poor performance in school has intensified his feelings of failure and caused him to question whether staying in foster care will be of any value to him.

Describe how it would address Enrico's situation and coordination with the DCBS Social Service Worker, group home, physical and behavioral health providers, and his family. At minimum address the following programs and services:

- a. Care Management, including coordinated management of his physical and behavioral health conditions
- b. Discharge planning for all levels of care;
- c. Language accessibility;
- d. Psychotropic medications and documentation in medical records (e.g., rationale, follow up assessments and monitoring);
- e. Evidence based psychotherapeutic interventions;
- f. Social determinants of health;
- g. Community resources;
- h. Aging out of foster care;
- i. Access to and sharing of medical records; and
- j. Maintenance of the care plan.

Enrico stands at a critical juncture in his life. Similar to many youth in foster care, Enrico experiences feelings of remorse over his inability to control his actions and a sense of abandonment from his family. He dually faces hope for reconciliation alongside a sense of hopelessness for his future. Our experience indicates that Enrico desperately needs the support of adults who care for him, regardless of his behaviors, to instill a sense of connection and fulfillment. With this validation, Enrico will have greater capacity and willingness to engage in the actions he needs to successfully transition to adulthood.

Though Enrico's parents have chosen to remain absent, Enrico's has a circle of support, and each person provides of support and care, as illustrated in the figure herein. In addition to Enrico's emotional state, his prolonged disengagement from physical and behavioral health care providers causes concern. Most pressingly, Enrico must reconnect with providers to evaluate the continued appropriateness of his medications. He should also be assessed for a history of trauma, have a comprehensive psychological assessment, including history and evaluation of substance abuse and history. Part of the ongoing assessment and planning process should include considerations of Enrico's strong desire to reunite with his family, and how to support their involvement in a way that is respectful of and supportive to all. Additionally, we need to work with Enrico to develop a care plan to address his persistent and uncontrolled asthma and instill behaviors that will support a healthy lifestyle and weight. With sustained time, we also will support Enrico's personal growth, helping him envision and prepare for a future after foster care.

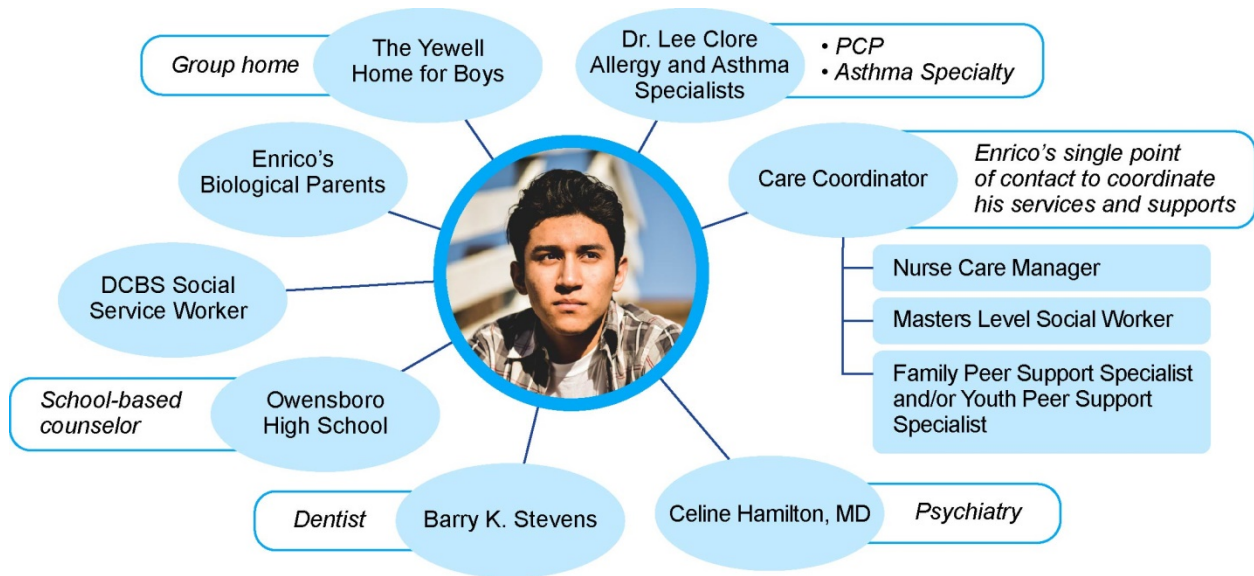


Figure 24. Enrico's circles of support. Enrico's care coordinator will help identify and coordinate with the people and organizations that will support him through care planning, his transition from the group home and his transition from foster care.

We have placed Enrico at The Yewell Home for Boys in Owensboro, Kentucky. The table presents an overview of our approach to address Enrico's needs in alignment with the requirements presented in his use case. Following the table, we describe how we will work with Enrico and his support team to develop a care plan to meet his ongoing needs.

Programs and Services	Addressing Enrico's Needs
a. Care Management, including coordinated management of his physical and behavioral health conditions	Enrico's multiple behavioral and physical health conditions and ED utilization identify him for complex care management and associated care coordinator. Enrico's care coordinator will help to identify appropriate providers and schedule all necessary physical, behavioral and social support services, including a comprehensive diagnostic evaluation.

Programs and Services	Addressing Enrico's Needs
b. Discharge planning for all levels of care	Any admission to a new level of care would alert Enrico's care coordinator to begin the discharge planning process, as appropriate based upon the level and duration of care. The process will involve multiple members from Enrico's circle of support to discuss and plan the services and supports he needs upon transitioning levels of care.
c. Language accessibility	If Enrico chooses to include his parents in the care planning process, his care coordinator will work with DCBS to ensure involvement is appropriate, and will arrange for interpretive services. Additionally, Enrico's care coordinator has the option to connect his family to a Spanish-speaking provider — Online Care Network II PC — that addresses relevant services in Spanish, including family therapy.
d. Psychotropic medications and documentation in medical records	Enrico's care coordinator will work with his psychiatrist to assess his needs and determine if Enrico's medications are appropriate for his symptoms. Any diagnosis, findings or filled prescription will be available through <i>CommunityCare</i> along with Enrico's care plan, assessment, and care coordinator or provider notes.
e. Evidence based psychotherapeutic interventions	Working through Enrico's feelings of loneliness and sentiments of guilt or regret will be important to his success. Relevant evidence-based practices include: family functioning therapy, Foster Care Youth & Family Peer Support, trauma screening and Dialectical Behavior Therapy.
f. Social determinants of health	During the care planning process, Enrico's care coordinator identifies resources that address his social determinants needs identified by the HRA and the Pediatric to Adult Transition Core assessment. His care coordinator uses <i>Healthify</i> , a web-based tool with information relevant and available social resources that deliver services, such as food, housing, legal resources and employment assistance.
g. Community resources	His care coordinator will contact community-based organizations where Enrico will be able to learn relevant skills outside of a controlled environment like a group home. As part of the pediatric to adult transition core assessment, the care coordinator will ask Enrico what activities he likes to do, and then provide options within the community, such as activities at the local Boys & Girls club.
h. Aging out of foster care	In collaboration with the DCBS social service worker and Enrico, his care coordinator will initiate transitional care management activities including our pediatric to adult transition assessment, at least annually before transition to the adult system of care. Enrico's care coordinator also will refer Enrico to our youth peer support specialist to serve as a conduit for Enrico to get the services and support he needs as he moves into adulthood, including making the decision when to leave foster care.
i. Access to and sharing of medical records	To provide Enrico and his care team with updated, information on his medical history, his care team will use <i>CommunityCare</i> , which maintains Enrico's full electronic health record. Enrico and his care team are also equipped with his <i>Individual Health Record</i> , which translates and then consolidates his past 3 years of medical records into clear, practical information. For example, in identifying a PCP to meet Enrico's needs, the care coordinator would look at his health records. The care coordinator would notice that he has not been seen in over a year, and new providers need to be identified and Enrico connected with them to meet his needs.
j. Maintenance of the care plan	To support and empower Enrico, his care coordinator, together with Enrico's multidisciplinary care team including his DCBS social service worker, helps him to develop a plan of care based upon new assessments and his identified needs. Due to the lack of consistent medical care, Enrico will likely need unique supports to ensure his success.

Supporting Enrico through Care Management

Like many teens in foster care, Enrico desperately wants to be reunited with his family, but he will have to learn how to cope better to make that happen. At the same time, he needs the support to navigate the challenges and opportunities ahead. In collaboration with his DCBS worker and staff at his group home, Enrico's care coordinator helps to fill this role with respect to the supports he needs to regain control over his physical and mental health, and his overall wellness. Enrico's care coordinator will do so by first working to establish a trusting relationship, helping Enrico to understand the ways in which care management and his coordinator can support him. His care coordinator will serve as a single point of contact to coordinate Enrico's care and to assist him in navigating the health care system. Regardless of any future placement changes, the relationship between Enrico and his care coordinator will remain intact.

The care coordinator meets with the DCBS social service worker to discuss Enrico and obtain documents, such as his case plan, court report, independent living plan and IEP. Upon learning about Enrico's physical and behavioral health needs, his care coordinator will put Enrico on the list for a clinical round with the SKY clinical team including: a masters-level social worker, clinical consultant who provides expertise to address Enrico's behavioral concerns and an RN care manager who provides expertise to address his medical concerns. Given Enrico's symptoms of depression, regret and anxiety of not seeing his parents, the care coordinator may begin to locate options for additional behavioral health therapy for Enrico either in the group home setting, or in the community. Since Enrico is 16 years of age, we would provide alternative opportunities for Enrico to begin to have choice about his health care providers, including both physical and behavioral health providers. The care coordinator will ensure that Enrico feels comfortable with the providers caring for him, and will connect him to alternative providers, if it becomes necessary.

To understand Enrico's needs and goals, his care coordinator uses evidence-based practices, such as motivational interviewing, our Pediatric Core Comprehensive Assessment and assessments specific to Enrico's conditions, such as the PHQ-2/9 to assess his depression. The care coordinator also will refer Enrico for a full psychological evaluation to assess Enrico's needs related to harming others, substance abuse issues, and the complexity of his family situation. Once the comprehensive assessment process has been completed, the care coordinator explains to Enrico, his DCBS social worker and the group home staff the next steps of the process. This includes assembling his circle of support to review the outcomes of the comprehensive assessment and begin to develop his care plan that will help identify appropriate resources and support to meet his goals.

If Enrico wants to include his parents in the care planning process, his care coordinator will arrange for interpretive services to ensure their full engagement and remove any burden from Enrico to translate, allowing him to instead focus on envisioning and articulating goals. If Enrico's parents choose to not respond to his request, the care coordinator will discuss the planning process with Enrico's parents, in an effort to continue to engage them. The team will work with Enrico to accept his parents' response, using a Trauma-informed approach to discussing the situation with him.

Collaborating to Plan Enrico's Care

Enrico, his care coordinator, and his circle of support will meet to develop his plan of care. Enrico's care coordinator assists and empowers Enrico to identify goals and outlines the concrete steps to achieve them. This exercise will not only help to ensure Enrico receives person-centered care aligned with his goals and preferences, but it will help Enrico recognize that, with appropriate goal setting, planning and support, he can take control of his future. Based

upon our experience, it is important for children who are contemplating transition to adulthood to have connections to caring adults who can assist them. The care planning team can begin to serve as these connections for Enrico.

The table outlines Enrico's care plan goals and the ways our care management team coordinates his physical, behavioral and social services and supports.

Enrico's Potential Goal	Stated	"I don't want to have asthma attacks."
	Measurable	Enrico will not be in the ED due to asthma attacks.
Opportunity	Enrico will re-engage in EPSDT scheduled visits with his PCP, and additional routine visits to monitor his asthma per his treating physician.	
Interventions	<ul style="list-style-type: none"> ▪ Referral to and set up an appointment with Dr. Lee Clore, a board certified pediatrician and specializes in asthma for initial and regular follow-up care. ▪ Identify pharmacies near the group home for medication fill and refills. ▪ Discuss importance of regular PCP visits, medication adherence and of emotional and environmental triggers to reduce asthmatic events with group home staff. ▪ Provide resources to Enrico about his asthma condition, triggers for asthma exacerbations and work with him to establish an asthma action plan. ▪ Establish regular follow-up care with the PCP to provide routine preventive services including addressing current BMI of 25 and comprehensive integrated medication review. 	
Enrico's Potential Goal	Stated	"I am lonely without my family."
	Measurable	Enrico will have an assessment to determine his treatment needs related to anger, violence and substance misuse.
Outcome	Enrico will be assessed to determine the appropriate treatment regimine related to his underlying behavioral health symptoms to prevent further violent acts against his family.	
Interventions	<ul style="list-style-type: none"> ▪ Refer Enrico to Dr. Celine Hamilton, a psychiatrist, for an assessment and review of his psychotropic medications. ▪ Upload Dr. Hamilton's assessment to <i>CommunityCare</i>. ▪ Coordinate with Dr. Hamilton and The Yewell Home for Boys to address his behavioral health concerns related to loss, grief, feelings of failure and frustration. If the group home does not provide outpatient therapy, the care coordinator will set up a therapist with expertise in grief and loss, history of aggression, and understanding of transition aged youth. ▪ Educate Enrico's parents about his diagnosis and potential for treatment, along with how important it is to mitigate potential trauma responses by working to get the family engaged in family therapy. ▪ Identify pharmacies near the group home for medication fill and refill. ▪ Discuss importance of follow up visits with the psychiatrist with group home staff. ▪ Provide resources to Enrico about the effects of the medications he is prescribed. ▪ Connect Enrico to telemental health and telepsychiatry options to deliver behavioral health interventions in his home. 	
Enrico's Potential Goal	Stated	"I want to graduate from high school."
	Measurable	Enrico and circle of support, including school officials, create a plan to enable him to stay in school and improve school performance.
Opportunity	Enrico will graduate from high school, or GED program.	
Interventions	<ul style="list-style-type: none"> ▪ Care coordinator will work with DCBS social service worker to explore whether an IEP is needed since he has poor school performance. ▪ Care coordinator will discuss a plan for tutoring with his circle of support, and assist DCBS and group home in arranging the service. ▪ Care coordinator will work with the circle of support to make a referral to the school based counselor to discuss Enrico's future with him related to plans for post high school education. 	

Enrico's Potential Goal	Stated	"I want to be independent when I turn 18."
	Measurable	Enrico creates a plan that enables him to support himself by 18.
Opportunity	Enrico will enroll in and complete the "On My Way" program for youth in transition and will connect with a member services advocate (MSA) on specialized employment opportunities.	
Interventions	<ul style="list-style-type: none"> ▪ Assist Enrico in finding the online On My Way program and provide an overview. ▪ Discuss with Enrico the benefits of the On My Way program including the modules, the vault and the plan of care features. ▪ Gather the independent living plan from DCBS and upload to the provider portal. ▪ Discuss the tuition assistance program with Enrico, should he remain in foster care until he is 18 or 21 years of age. 	

To empower Enrico to follow his plan of care, his care coordinator and MCT continually monitor and support Enrico in pursuit of his goals and look for indications of any changes in his health status, needs or living situation, which would trigger reassessment and care plan updates.

In addition to planning Enrico's self-identified goals, Enrico's care coordinator will be prepared to assist Enrico and team with discharge planning. A strong individualized discharge plan will be necessary when Enrico is discharged from the Yewell Home for Boys to a lower level of care (as appropriate). As part of his ongoing MCT meetings, his care coordinator will begin to discuss services and processes Enrico and the team need to develop to ensure the transition is coordinated, occurs smoothly, and that Enrico has immediate and seamless access to the supports he needs as identified through assessments and appointments with his PCP, psychiatrist and behavioral health therapist, and community supports.

During these, any other care transitions, or as Enrico ages out of foster care, we recognize the important role maintaining Enrico's **medical records** plays in maintaining the appropriateness and continuity of care he receives across varied delivery systems, care settings and placement changes. Thus, we created *CommunityCare* as a single platform to contain Enrico's electronic health record — including utilization, prescription assessment findings, IEPs — and his care plan and any notes and additional information inputted by any individual on his MCT. This consolidated resource allows his MCT to identify acute events so they can coordinate relevant and timely interventions to meet Enrico's needs. Providers can access *CommunityCare* through *Link*, which gives providers single sign on access to a variety of applications, including Enrico's Individual Health Record (IHR).

Managing Enrico's Psychotropic Medications

Our approach to psychotropic medication management for children and youth in the SKY program begins with comprehensive provider training and education, including care consultation with our behavioral health medical director and medical director, on best practices and clinical practice guidelines for psychotropic medication prescribing and the use of therapeutic interventions before and in conjunction with medication. We also provide an online training about psychotropic medications for children in foster care, and alternatives to prescribing them.

To ensure Enrico is receiving appropriate treatment, his care coordinator, in collaboration with our clinical pharmacist, will discuss his medication regimen with his psychiatrist to determine clinical appropriateness of Enrico's medications based upon his conditions and symptoms. These discussions could result in Enrico continuing his medication, Enrico's psychiatrist working to taper medications, or trying an alternative treatment. This encounter and any resulting changes would be updated in *CommunityCare*. We document the use of psychotropic medications in Enrico's *CommunityCare* electronic health record and our utilization management system. We use this system to verify providers are documenting the rationale, follow-up schedule and plan to taper the medication, when appropriate, for whom they have

prescribed psychotropics. We also use this information when we conduct psychotropic medications reviews through our clinical pharmacy team.

Supporting Enrico's Transition to Adulthood

In addition to supporting Enrico's physical and behavioral health needs, Enrico's care coordinator supports his connection to the community and social supports Enrico needs to successfully achieve his goals and feel empowered to plan and pursue a future. For example, Enrico may want to obtain employment; in this case, his care coordinator could use *Healthify*, a web-based tool accessible by mobile phone or tablet, to connect Enrico to relevant and available resources. His care coordinator also will work to set Enrico up with pro-social activities to assist him in building healthy relationships with peers and adults outside a group home setting. This could be through the school, or through community-based organizations, such as Boys & Girls Clubs throughout Kentucky.

Many youth transition from the foster care system to adulthood without a permanent home and intact family. They often do not have access to the same kind of support and guidance other teens their age have and they are struggling for independence while trying to make smart life decisions. We support helping young people make a successful transition to adulthood by providing intensive, individualized and holistically focused transition planning and care management.

In collaboration with the DCBS social service worker and Enrico, his care coordinator will initiate transitional care management activities including our pediatric to adult transition assessment, coaching, resource coordination and transition planning. The care coordinator will consider Enrico's needs, interests and barriers when determining needed services, and how often to reassess him. Enrico is reassessed at least annually before transition to the adult system of care.

Enrico's care coordinator will engage our youth peer support specialist to support him as he moves toward adulthood. The specialist will help Enrico sign up to use **UnitedHealthcare On My Way**, an interactive website that helps young adults transition to adulthood and independence by helping him learn about six key areas that have historically prevented transition age youth around Enrico's age from achieving stable independent lives, including money, housing, work, education, health and transportation. The **On My Way's Vault** allows Enrico to have a repository of his most important documents (e.g., birth certificate, driver's license, individual education plan, insurance card, health record) in a secure, easily accessible location, which is critical since he is not having contact with his family.

Use Case 6

Mary is a five year old who was placed in foster care in Louisville when her mom left her in the car for 6 hours while visiting and drinking with friends. This is Mary's second placement in foster care within the past year.

Based on the initial assessment by her PCP, it was determined that Mary is deaf, has numerous dental caries, and is malnourished. She has almost no language (minimal speech) and has not been taught sign language. Her affect is flat, and she has almost no expression. After a more detailed assessment, Mary was diagnosed as being cognitively delayed.

The DCBS Social Service Worker was unable to locate medical, dental or pharmacy records, or evidence that Mary had been prescribed hearing aids. Mary's mother provided vague information about visits to a pediatrician, immunization history, and dental care.

Describe how the Vendor would address Mary's situation and coordinate with the DCBS Social Service Worker, parent, and providers. At minimum, address the following programs and services:

- a. Care Management including coordination of multispecialty developmental evaluations and care;
- b. Discharge planning for all levels of care;
- c. Applicable evidence based practices;
- d. School based services;
- e. Social determinants of health;
- f. Community resources;
- g. Access to and sharing of medical records; and
- h. Maintenance of the care plan.

As a young child, Mary has faced long-standing neglect by her mother, which has kept her from accessing basic needs, such as food, and developing fundamental skills to express her emotions. When paired with the instability of multiple placements in a short time, this scenario would place immense stress on any child. We recognize the importance of immediate intervention to identify Mary's needs, helping her move toward meeting developmental milestones, and mitigate the trauma and isolation she is likely experiencing.

Our priority is to connect Mary with specialized resources in and around the Louisville area to obtain a comprehensive multispecialty developmental evaluation and address her needs in spite of the dearth of prior medical records. This evaluation will enable us to identify her nutritional and developmental needs and testing by an audiologist to fully understand her needs related to communication and language. This will most likely include helping her learn American Sign Language, but may also be assisted communication devices, or cochlear implants. Mary requires a strong circle of support to meet her array of health, social and educational needs, as presented in the figure.

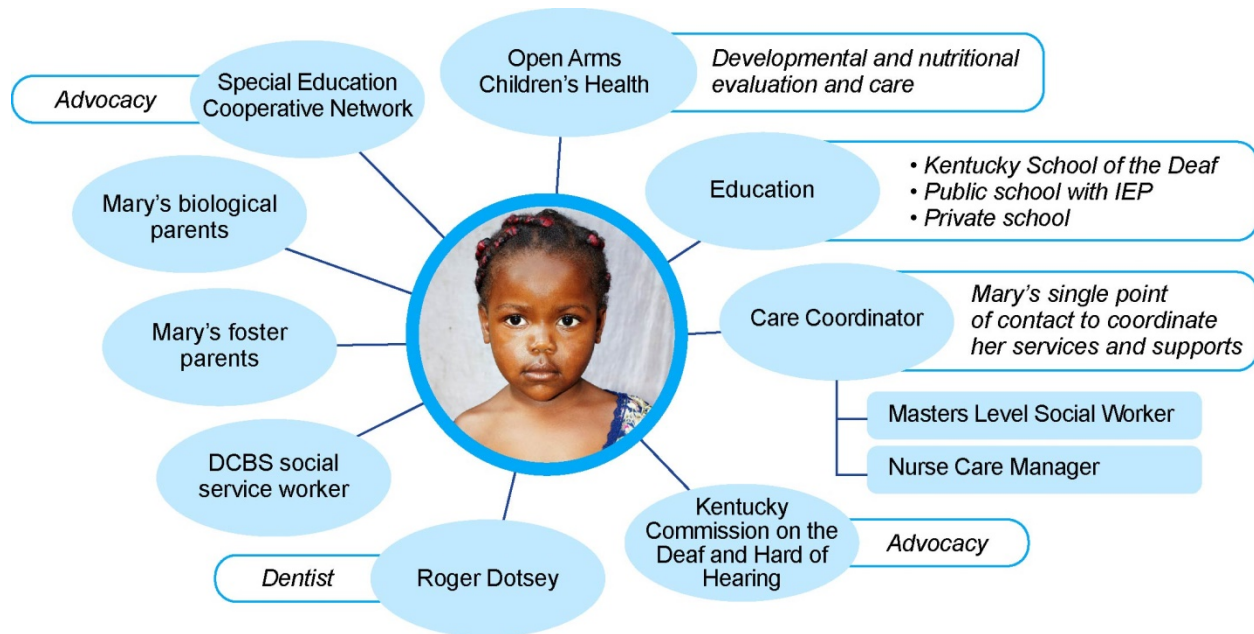


Figure 25. Mary's circles of support. Mary's care coordinator will help identify and coordinate with the people and organizations that will support her through the assessment and care planning process.

The table presents an overview of our approach to address Mary's needs in alignment with the requirements presented in her use case. Following the table, we describe how we will work with Mary and her support team to develop a care plan to meet her ongoing needs.

Programs and Services	Addressing Mary's Needs
a. Care Management including coordination of multispecialty developmental evaluations and care	Mary's care coordinator refers her to Open Arms Children's Health in Louisville. The care coordinator will work with Dr. Matt Kinney, the medical director, to be a part of Mary's planning team, and coordinate her multispecialty developmental evaluation at the facility. Dr. Kinney is highly regarded in Kentucky as a specialist for children in foster care. The evaluation should include evaluations by specialty physicians including: developmental milestones, hearing, nutrition and language.
b. Discharge planning for all levels of care	If Mary transitions to another foster home, our care coordinator would gather the team of professionals working with her to make a plan for transition. The care coordinator would update the plan of care and upload it to our portal so the new providers have access to it.
c. Applicable evidence based practices	Using evidence-based approaches, criteria and guidelines, we confirm Mary receives appropriate health care services in a trauma-informed manner. These services are only effective if they are delivered in accordance with DCBS requirements, adhere to evidence-based practices and provide the outcomes expected. For Mary this will include: speech therapy, nutrition services and occupational therapy when determined. We also will use motivational interviewing with the foster parents to ensure we understand their needs in caring for Mary.
d. School based services	Mary's care coordinator will work with the DCBS social service worker, Mary's mother (if appropriate), and Mary's foster parent about a referral to educational services. This could be through the Kentucky School for the Deaf, a private school, or public school with an individual education plan for meeting her communication needs.
e. Social determinants of health	Our HRA and pediatric core assessment contain two and 33 questions, respectively, related to social determinants. Examples of questions include: Do

Programs and Services	Addressing Mary's Needs
	you have barriers to transportation for appointments? Do you have informal supports to help you cope with life stressors? Mary's care coordinator uses <i>Healthify</i> to connect her foster family to relevant social resources.
f. Community resources	Mary's care coordinator refers her to the Special Education Cooperative Network to help provide Mary with advocates to support her educational needs and cognitive delays. We also will connect Mary's foster parents to organizations like the Kentucky Commission for the Deaf and Hard of Hearing to provide resources related to Mary's communication barriers.
g. Access to and sharing of medical records	<i>CommunityCare</i> maintains Mary's electronic health record. It enables Mary's multidisciplinary care team (MCT) to collaborate to deliver care, develop a care plan that meets Mary's needs and monitor her progress. The plan of care will be monitored through clinical rounds with the SKY Medical Director, NCM, and masters-level social worker along with the care coordinator, when appropriate.
h. Maintenance of the care plan	Mary's care coordinator updates her care plan at least annually, however, understanding Mary's current needs will require dynamic care planning process, especially in the first year. Her care coordinator and MCT will meet regularly to verify she is achieving her goals, to ensure there are no barriers to her receiving services and check for indications that her health status/needs have changed. As needed, they reassess Mary's needs and work with her foster parents to update her care plan. We monitor compliance to these requirements through <i>CommunityCare</i> and our Clinical Adherence Program.

Understanding Mary's Complex Care Needs

Outreach upon Mary's enrollment. Within 30 days, at a minimum of Mary's enrollment, an *Advocate4Me* member services advocate (MSA) will reach out to Mary's foster parents to complete the new enrollee welcome call and initial health risk assessment (HRA), which are critical to identifying Mary's care management needs and connecting her to resources as soon as possible. In Mary's case, we would expect at the time of removal to be alerted by DCBS through our regional care coordinator that immediate care management is required. We recognize Mary's foster parents may be feeling overwhelmed by the challenges they face in caring for and communicating with Mary, so we train our MSAs on enrollee-centered engagement strategies that build trust and confidence. If an MSA is not able to reach the foster parents, they will alert the regional care coordinator to engage with the DCBS worker to obtain up to date contact information for the foster parents.

The MSA uses our evidence-based pediatric HRA to evaluate Mary's health and wellness and identify critical information, such as her social, behavioral, medical and functional needs, PCP and provider relationships, active treatment plans, current services, barriers to accessing care and chronic physical or behavioral health conditions. The HRA also includes questions about social determinants of health to identify the family's social determinant needs. The MSA documents the HRA's findings in *CommunityCare*, our care management platform, so it can be shared with Mary's care coordinator and everyone in her circles of support.

Care coordinator initiates coordination. Our care coordinator is the primary contact for coordinating Mary's care and will work with Mary regardless of placement to ensure continuity of care coordination. Mary's care management team, who will conduct clinical rounds internally with the care coordinator also includes the chief medical officer, and a NCM who provide expertise on her developmental and medical needs.

Before the MSA welcome call, through our relationship with the DCBS social service workers, Mary's care coordinator is aware that Mary needs immediate intervention and that she has

recently been placed in a new foster home in Louisville. Mary's care coordinator works with her DCBS social service worker to obtain any information DCBS has about her, including the initial assessment by her PCP. Mary's care coordinator will review in *CommunityCare* any information we have that will inform the assessment process and care plan development. We also will ask DCBS for any assessments they have completed, and upload them to *CommunityCare*. Due primarily to complex Mary's developmental delays, including deafness and her current inability to express herself; extensive dental caries; and history of systemic neglect and chronic malnutrition, Mary is identified for engagement in Complex Care Coordination to stabilize her health. The care coordinator also will reach out to Mary's mother (if approved by the DCBS social service worker) to understand her desires and goals for Mary.

Meeting Mary and her foster parents. Mary's care coordinator contacts her DCBS social service worker and her foster parents to arrange a face-to-face visit to understand their goals for Mary and begin to develop a comprehensive plan of care. Mary's care coordinator uses motivational interviewing to engage her foster parents and provides insight into how our services can support Mary. During the meeting, the foster parents share their concerns and priorities, such as being able to communicate with her and helping restore her health after tooth decay and malnourishment. To understand Mary's needs and goals, her care coordinator uses shared decision-making, evidence-based practices, such as motivational interviewing, and our evidence-based Pediatric Core Comprehensive Assessment to form her care plan goals.

Supporting Mary's Care through Care Management and Coordination

Developing Mary's Care Plan. Mary's care coordinator collaborates with Mary's foster parents and her DCBS social service worker to identify her circles of support — the people and organizations that will support Mary after the comprehensive assessment and through the care planning process. The care coordinator then gleans Mary's DCBS social service worker and her foster parents' preferences for where and when the planning meeting should occur. At the completion of the comprehensive assessment, and assessment and consultation with our internal care management team, the MCT will come together to develop her plan of care.

Coordinating a Comprehensive Developmental Evaluation. Based upon the initial PCP assessment and discussions with Mary's planning team, her care coordinator makes a referral to Open Arms Children's Health for a comprehensive multispecialty developmental evaluation of Mary. Open Arms Children's Health has a team of developmental/behavioral pediatricians, psychologists, occupational therapists, speech/language therapists, social workers, child psychiatrists, ear, nose and throat specialist, audiologist and registered dieticians and nutritionists who bring unique skills and experience to comprehensively evaluate and address Mary's developmental and nutritional needs. Mary will receive genetic testing, and cognitive and nutritional assessments, among other services. Once Mary's needs are identified, providers at Open Arms Children's Health will recommend specific intervention programs, either provided at the Center or in the community.

Discussing Next Steps. Once the comprehensive assessment process has been completed, Mary's care coordinator will ensure referrals are made to all the appropriate services, either through Open Arms Children's Health, or other community providers. Mary's care manager also will make referrals to the following community resources:

1. The Special Education Cooperative Network to help provide advocacy on behalf of Mary for her educational needs related to her cognitive delays, and deafness; including the development of an individual education plan.

2. The Kentucky Commission on the Deaf and Hard of Hearing so those working with Mary have resources related to interpreter services, equipment for communication access, and advocacy on Mary’s behalf.

Coordinating Mary’s School-based Services. When the comprehensive assessment through Open Arms Children’s Health is complete, Mary’s care coordinator will work with her planning team to engage the appropriate education system. The system could include: Kentucky School of the Deaf; a private school, or public school, depending on the preference of the MCT to assess Mary and get her enrolled so she can begin to learn communication, as appropriate to meet her needs. The goal is to develop an individual education plan to support Mary. The care coordinator will contact the Special Education Cooperative Network as they can assist in advocacy for her educational needs. Helping Mary enroll in an educational setting, and learn to communicate will help to address her social isolation.

- **Coordinating Mary’s Dental Needs.** Mary is unable to communicate any pain she may be feeling because of her numerous dental cavities, which could be contributing to her malnutrition and inability to eat. The care coordinator will provide a referral and connect Mary’s foster parents with Roger Dotsey, a dentist at Kids Dentistree, a pediatric dental practice in Louisville with robust experience working with children with special health care needs.
- **Coordinating Social Determinants Needs.** During the care planning process, Mary’s care coordinator identifies resources that address her social determinants needs using data from the HRA and pediatric core assessment. Mary’s care coordinator uses *Healthify*, a web-based tool with 5,000 Kentucky-based resources to connect Mary’s foster parents to relevant and available social resources, such as interpreter services, age-appropriate activities for Mary, and transportation resources. Her care coordinator documents social determinants needs and resources in Mary’s care plan in *CommunityCare* and works with Mary’s foster parents and the appropriate CBOs to coordinate the delivery of these services with the rest of the services in Mary’s care plan. We know the tremendous commitment it takes to care for children with complex needs, therefore, our care coordinator will provide resources such as the *myuhc.com* platform to assist in organizing appointments and tracking plan of care outcomes.

This table presents Mary’s goals and the services, supports and providers who will deliver them:

Mary Potential Goal	Stated	Mary needs to learn how to communicate.
	Measurable	Mary will be supported in learning how to communicate through a variety of methods, depending on her comprehensive evaluation.
Opportunity	Mary will receive a comprehensive evaluation and the family will be offered multiple options for communication/language.	
Interventions	<ul style="list-style-type: none"> ■ Refer Mary to Open Arms Children’s Health for a comprehensive evaluation to include an ENT and audiologist who can perform an assessment to determine her level of hearing loss and cognitive delays. ■ Based upon these assessments, the care coordinator will ensure that Mary and her foster family are offered all appropriate options to improve her communication. ■ If Mary’s foster family, in collaboration with DCBS and her mother, desires a specialized learning environment, the care coordinator will refer Mary to the Kentucky School for the Deaf (KSD). ■ If Mary’s foster family in collaboration with DCBS and her mother, desire the care coordinator will make a referral to the Kentucky School for the Deaf. ■ If Mary’s foster family, in collaboration with DCBS and her mother, desire a mainstream learning environment, the care coordinator will work with a school in the community to 	

	ensure that Mary has an IEP with intensive supports. <ul style="list-style-type: none"> ▪ The care coordinator will refer Mary to the Kentucky Commission on the Deaf and Hard of Hearing. ▪ The care coordinator will refer Mary to Special Education Cooperative Network. ▪ If Mary's foster family desires, or her mother desires, the care coordinator will refer them to peer support services, and for ASL classes. 	
Mary Potential Goal	Stated	Mary will be able to do activities like other children her age.
	Measurable	Mary will receive a cognitive assessment within 30 days.
Opportunity	Mary will have an assessment and a plan developed to address her cognitive delays, which may be a result of her inability to hear.	
Interventions	<ul style="list-style-type: none"> ▪ Referral to Open Arms Children's Health for cognitive assessment, genetic testing and to see a nutritionist. ▪ Confirm Mary's care needs are discussed internally during complex member rounds within the health plan's interdisciplinary team. 	
Mary Potential Goal	Stated	Mary will no longer be malnourished and will receive dental care.
	Measurable	Mary will have appropriate nutrition and her dental caries will be fixed.
Opportunity	Mary's foster parents will observe improved eating habits in Mary.	
Interventions	<ul style="list-style-type: none"> ▪ Referral to PCP, GI/nutritionist, and dental evaluation to determine the degree of her malnutrition and if there is underlying medical conditions that needs to be addressed. ▪ Referral to pediatric dentist so Mary receives appropriate dental care. The team should note Mary may be malnourished due to the oral pain and inability to eat. 	
Mary Potential Goal	Stated	Mary's records will be accessible and appointment information shared.
	Measurable	The care team can access records about Mary to better coordinate and deliver care.
Opportunity	All providers working with Mary will be able to have access to up-to-date information.	
Interventions	<ul style="list-style-type: none"> ▪ The care coordinator will contact other MCOs, the immunization registry, and work with the DCBS social service worker to get Mary's assessments and information, all of which will be uploaded to the provider portal. ▪ Care coordinator will contact the PCP who conducted the initial assessment and upload those records into the provider portal. ▪ Care coordinator will upload the plan of care to the provider portal. This is an ever-changing document based upon assessments. The updates will give providers needed information to best care for Mary. 	

Access to and sharing of Mary's medical records. Maintaining and sharing Mary's medical records is critical to coordinating and maintaining the continuity of her care across varied delivery systems, care settings and placement changes. *CommunityCare* maintains Mary's electronic health record, such as utilization, assessment findings, court records and her care plan. It provides the mechanism for Mary's multidisciplinary care team (MCT) to collaborate to deliver her care, develop a care plan that meets Mary's needs and helps her achieve her foster parents' goals for her, monitor Mary's progress toward achieving those goals; and identify acute events (e.g., hospitalization) so the MCT can coordinate relevant and timely interventions to meet Mary's needs. Providers can access *CommunityCare* through *Link*, which gives providers single-sign-on access to a variety of applications, including our IHR.

Supporting Mary's Ongoing Development

With the complexity of Mary's care plan and the numerous supports she requires, we recognize Mary's foster parents may feel overwhelmed or confused. Within 30 days after all referrals are made, and her specialty assessment is completed, the care coordinator will meet with the DCBS social service worker and confirm services are being delivered in accordance with the plan of

care. They will confirm Mary's foster parents understand her conditions and needs, and they have the supports they need to carry out the plan of care. The care coordinator will verify Mary has follow-up appointments scheduled with the dentist, nutritionist (if needed), PCP, relevant CBOs, and the Kentucky School of the Deaf, or other school program and that she attends those appointments.

Our goal is for Mary to address her medical and nonmedical needs so she can thrive in her surroundings and develop meaningful relationships with the people in her life. If Mary were to transition to another foster home, or be reunified with her mother, it would be an important part of her discharging process for our care coordinator to gather the team of professionals working with Mary, including the DCBS social service worker, educational staff, her therapists and physicians, to make a plan for transition to a team that can support Mary. The care coordinator would be able to then provide resources related to the physical health and behavioral health issues Mary needs addressed. The care coordinator would update the plan of care reflecting her current needs, treatment protocols and upload to our online portal so the new providers have access to it.

As Mary is evaluated and stabilized, it will be important to consider whether Mary desires, and the team agrees she be assessed for cochlear implants, which could allow her to hear, depending on the extent of her deafness. A choice to have the implants is very personal, and it will be important to engage Mary's entire support team, including her mother, in making this decision. The Kentucky Commission for the Deaf and Hard of Hearing can provide valuable resources and advocacy in this area. It also will be important to ensure Mary is physically and developmentally stable before the team moves to have an evaluation completed and decision made about this.

As Mary continues in care and her DCBS social service worker continues to work on her permanency plan, it will be important that, if Mary is to return home to her mother, her mother is re-engaged in services with Mary. The care coordinator will work with the DCBS social service worker to include Mary's mother in the care planning process, and provide resources to verify reunification goes smoothly and Mary has the services she needs to continue to be healthy.

Use Case 7

Julie is a 17-year-old who has been in the foster care system for ten years. She has minimal contact with her family. Julie has been placed in residential care. She has been diagnosed with an intellectual disability and low IQ and has a long history of mental health treatment in outpatient and inpatient settings. She has highly variable emotional states, typically brief in duration and reactive to circumstances.

At the time of admission to residential care Julie's medication regimen included chlorpromazine, fluoxetine, lurasidone, lamotrigine, trazodone, and oxcarbazepine. There is limited information about the chronology of medication treatment and no records of psychotherapy services. Julie is not able to provide much information about her response to the medication regimen, and there are no other sources of information. She continues to demonstrate frequent shifts in emotions and aggressive behaviors. On one occasion, she became physically aggressive, which led to assault charges and a 72-hour incarceration.

The Social Service Worker and behavioral health providers are evaluating treatment in a setting that is a lower level than acute care but more structured than a PRTF.

Describe how the Vendor would address Julie's situation and coordination with the DCBS Social Service Worker, and physical and behavioral health providers. At minimum address the following programs and services:

- a. Care Management;
- b. Discharging planning for all levels of care;
- c. Prescribing psychotropic meds and documentation in medical records (e.g., rationale);
- d. Evidence based psychotherapeutic interventions;
- e. Viability of aging out of foster care;
- f. Option for transitioning to an applicable waiver;
- g. Access to and sharing of medical records; and
- h. Maintenance of the care plan

Julie is at a crossroads as she has been in foster care for many years, and is still in a residential placement. At the time of her most recent residential placement, she has been prescribed a medication regimen of anti-psychotics, an anti-epileptic, anticonvulsant and an antidepressant, all with an unknown chronology of prescribing and no available supporting medical documentation. Julie's behavioral symptoms may, in fact, be triggered by the side effects of these numerous medications. Her intellectual disability, intelligence quotient (IQ), and long history of mental health treatment without apparent improved outcomes may also position her for a poorer prognosis as she ages out of foster care.

For this example, we have placed Julie at Sunrise Children's Services, which is in Elizabethtown, Kentucky. They provide therapeutic care and individual support for girls ages 12 through 18. Most of these girls arrive with a history of abuse or neglect which has led to behavioral and emotional problems.

We know Julie is struggling at Sunrise Children's Services, and is in need of a highly coordinated, thoughtful plan to ensure her comprehensive care needs are met and that she has a successful transition to adulthood. Julie will be at the center of her multidisciplinary care team (MCT) as represented in her circle of support herein. While Julie has minimal contact with her family, the DCBS social service worker, the care coordinator and the MLSW, working together, will be instrumental in determining if Julie's parents are involved in her transition plans.

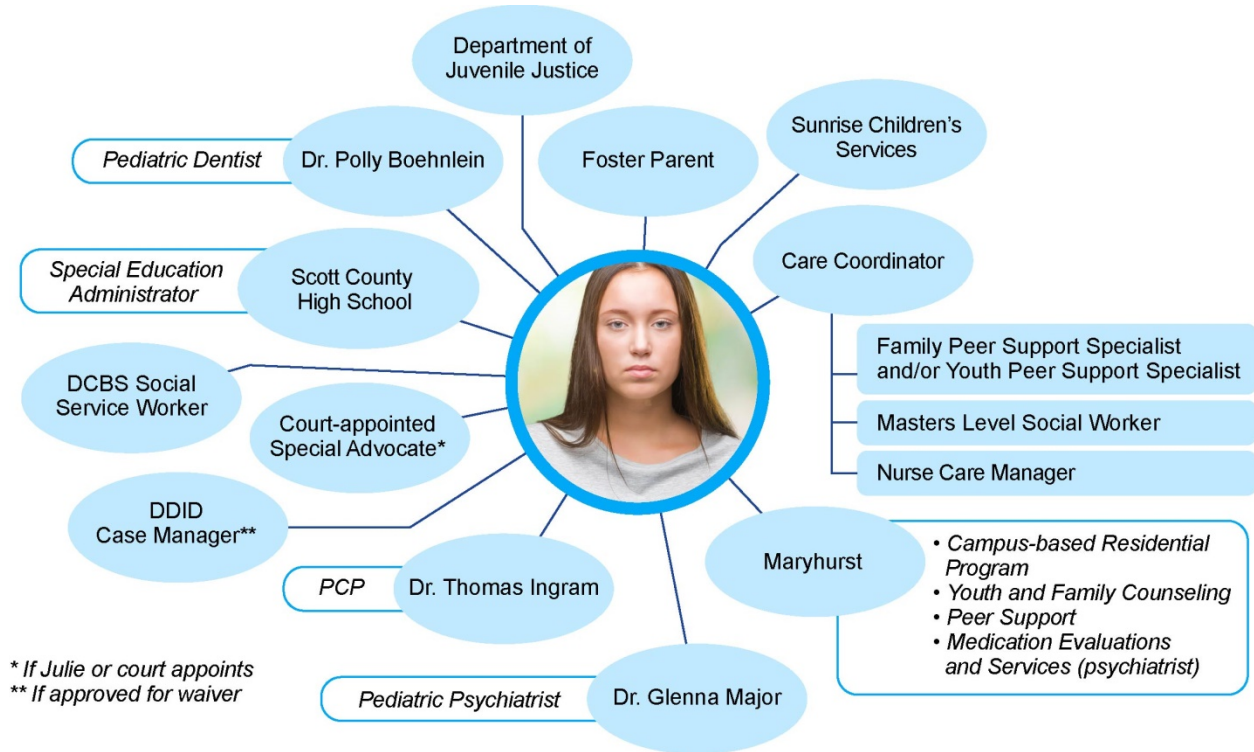


Figure 26. Julie’s circles of support. Julie’s care coordinator will help identify and coordinate with the people and organizations that will support her through assessment and care planning.

The table presents an overview of our approach to address Julie’s needs in alignment with the requirements presented in her use case. Following the table, we describe how we will work with Julie and her support team to develop a care plan to meet her ongoing needs.

Programs and Services	Addressing Julie’s Needs
a. Care Management	Our care coordinator is Julie’s primary contact to coordinate her care, and will facilitate a meeting with her, her MLSW, her community-based providers and supporting entities (e.g., DCBS, court advocate), Sunrise, and Maryhurst to offer support and coordinate her care during and after the transition in care placements.
b. Discharging planning for all levels of care	Julie’s discharge planning is a comprehensive person-centered planning process that will span all of her services and supports. Since Julie is in need of specialized services, we will conduct the Pediatric Core Comprehensive Assessment to match her with the appropriate care and community services to meet her needs. Due to her age, we also will use the Pediatric to Adult Core assessment to determine her needs related to transitioning to adult services. The care coordinator conducts the assessment and arranges all the necessary services for Julie’s transition from Sunrise to Maryhurst with community supports and services needed outside of Maryhurst (e.g., dental care).
c. Prescribing psychotropic meds and documentation in medical records (e.g., rationale)	We train providers on best practices and clinical practice guidelines for prescribing psychotropic medication, especially for Julie’s mediations, all of which would be documented in our <i>CommunityCare</i> and utilization management (UM) systems, and would meet the need for a review by our behavioral health medical director as she is on more than three psychotropic medications. Our clinical pharmacist conducts medical record reviews to verify providers are documenting the rationale, follow-up schedule and any plans to taper the medication.

Programs and Services	Addressing Julie's Needs
d. Evidence based psychotherapeutic interventions	For Julie, some of the evidence-based interventions will include: holistic assessments, trauma screens, trauma based cognitive behavioral therapy, medication management, motivational interviewing, dialectical behavioral therapy and peer support services.
e. Viability of aging out of foster care	Julie, our FYPSS, care coordinator, DCBS Social Services Worker and other participants in Julie's multidisciplinary team who Julie chooses to include will discuss the viability of her aging out of foster care. To help Julie understand the implications, we will use a person-centered planning process to complete her Pediatric to Adult Transition assessment to guide her through the process. Since Julie has an intellectual disability, we also will apply LifeCourse™ principles to support her in defining her life's trajectory to leading a good life and support her self-advocacy goals for her transition to adulthood.
f. Option for transitioning to an applicable waiver	Julie's DCBS social service worker, and care coordinator will help Julie complete the Medicaid Waiver Management Application. This application and in-person screening will determine whether Julie is eligible for services and whether she will need to be on the waitlist for services, or can be moved to a priority enrollment status due to the urgency of her transition.
g. Access to and sharing of medical records	<i>CommunityCare</i> maintains Julie's electronic health record, such as assessment findings, court records and her care plan. Our individual health record (IHR), available to providers through <i>Link</i> , gives them a 360-degree view of Julie's medical history for the past 3 years. We will work with the DCBS social service worker to review Julie's medical passport, and upload information into <i>CommunityCare</i> .
h. Maintenance of the care plan	Julie's care coordinator and multidisciplinary team continually monitor for indications of her health status; to determine if her needs or living situation have changed; and, to verify she is achieving her goals. With any changes, they reassess her needs and update the care plan with her input, monitoring adherence to her care plan via <i>CommunityCare</i> and our Clinical Adherence Program.

Initiating Contact with Julie and Care Team

Julie's **care coordinator will be her primary point of contact to coordinate her care**. Initially, it is imperative to gain an understanding of Julie's goals **by asking her what she wants**. We must also assess her physical, behavioral, functional, social needs and current cognitive functioning so that we can better support her. Before conducting the initial assessments, the care coordinator will gather documents from the DCBS social service worker and residential staff including Julie's case plan, court report from her brief incarceration, independent living plan and any other documents including her Individual Education Plan (IEP), if available.

Her care coordinator will then conduct assessments including our Pediatric Core and the Pediatric to Adult Transition assessment. These integrated assessments capture Julie's medical, behavioral health and social determinants of health needs. Given Julie's intellectual disability, extensive behavioral health history and prescribed psychotropic medications, our care coordinator would also administer the Anxiety, Depression and Mood Scale (ADAMS) and PSYRATS psychosis screener, both tools created specifically for assessing individuals with DID, for a more in-depth assessment of Julie's mental health symptoms to inform care planning and interventions. To conduct the assessments, Julie meets with her care coordinator, and anyone else that Julie chooses including, but not limited to, the DCBS social service worker and residential staff, to gather unfettered input. The care coordinator is trained in LifeCourse person-centered principles, and begins to build a trusting relationship with Julie. It is important that the

care coordinator understand and support Julie's life goals, which will support her in her self-determination, social capital and community inclusion goals and her transition to adulthood.

Our care coordinator enters the completed assessments into *CommunityCare*, our community-based portal, which the MCT accesses to review and use during clinical rounds. The care coordinator will present Julie's information during our internal clinical rounds, to the MLSW and RN care manager for input on treatment options and goals. Based upon the input and records, a plan of care will be developed and shared on *CommunityCare*. If there was an adjustment to her medication regime, the MCT will revisit that care plan after 30 days to evaluate if there was an improvement in her triggering behaviors. The care coordinator will engage the DCBS worker to assure the appropriate members of the MCT have access to Julie's information on the portal.

Coordinating DDID Evaluations: It is important to understand Julie's current cognitive functioning to determine to what degree she can engage in and make decisions about for her care plan. We will coordinate an evaluation through Julie's DCBS social service worker and the Division of Developmental and Intellectual Disabilities (DDID). This evaluation will determine Julie's eligibility for a waiver, and will assess her needs using the Health Risk Screening Tool (HRST) and the Supports Intensity Scale (SIS), a standardized assessment tool to measure the intensity of supports required by a person aged 16 years or older with a developmental or intellectual disability. If Julie has recent evaluations through her school, we will request those through her DCBS social service worker and capture in our portal.

Julie's Plan of Care Considerations and Development

Julie's Well-Being: Julie and her multidisciplinary team, through comprehensive assessments, will work to determine an appropriate placement in the least restrictive setting that works for her. A goal for Julie is to complete her Medicaid Waiver Management Application (MWMA), if not already complete, so that she can be considered for emergent services under the Supported Community Living waiver. Julie's well-being can be improved through complex care coordination and support planning that meets her immediate needs, while also understanding and addressing Julie's longer-term transition to the community once she ages out of foster care, or enrolls on the Supports for Community Living (SCL) 1915(c) HCBS waiver. Her brief encounters with juvenile justice and incarceration must be addressed to determine if they have lasting implications (e.g., probation), or were traumatizing. Longer-term, Julie's life outcomes go beyond her health and safety and must be considered in her care planning. The care coordinators role is to support Julie in meeting her goals as she defines them includes building self-advocacy skills, attaining educational and employment goals, her future housing goals, and her relationship and community inclusion goals.

Determining placement and developing her care plan: Due to Julie's current behaviors and needs, the care coordinator will arrange for a comprehensive assessment to obtain recommendations related to her treatment needs, placement considerations and a medication review. Following a comprehensive assessment by a psychiatrist, with attention to her medication regimen, we will meet the DCBS social service worker, Julie, and her circle of support to discuss placement and treatment services from a provider with a specialization treating adolescents with similar needs. Key Assets in Lexington and Maryhurst in Louisville are two providers with this specialization.

Maryhurst serves children and adolescent girls from all over the Commonwealth, and offers residential services for females, youth counseling, transitional living and other services that may assist Julie as she moves into adulthood. **Ninety percent of children who complete a program with Maryhurst move on the less-restrictive settings.** Maryhurst's campus program can provide stability and services to meet Julie's specialized needs. Our care

coordinator will work with the DCBS social service worker to have Mary’s care transitioned from Sunrise to Maryhurst through our thorough discharge planning process which includes: MCT meeting, referrals being completed for ongoing treatment services, completion of the plan of care, and uploading records into *CommunityCare*. We will capture documents such as her transition assessments, the results of any screens, results of her comprehensive assessment, her IEP and Person Centered Service Plan, if available.

The table presents four goals Julie may articulate to address her concerns and help Julie achieve her goals. For each goal, we have described the measure to determine if the goal has been achieved, the opportunities we would expect to see for Julie if she achieves the goal and the interventions needed to achieve each goal.

Julie’s Potential Goal	Stated	“I don’t want to take so many pills.”
	Measurable	Improved medication management, possible reduction in the number of prescriptions, and monitoring to reduce medication side effects that Julie is experiencing due to polypharmacy, and reduce the variability in her emotional state.
Outcome	Julie will see improvements in her emotional well-being, and demonstrate fewer reactive outbursts, and less physical aggression.	
Interventions	<ul style="list-style-type: none"> ▪ Referral to a pediatric psychiatrist with expertise in intellectual disabilities to complete a holistic assessment with Julie to determine diagnosis, treatment plan and appropriate medications. ▪ Provide continuing care management including medication monitoring and management to assure Julie is receiving the right medications and the right dosage once a diagnosis is established. ▪ Referral to therapist and placement facility that can provide positive behavior support to help Julie manage her emotions. 	
Julie’s Potential Goal	Stated	“I want people to like me.”
	Measurable	Increased time spent in social interactions, reduced number of emotional outbursts and acts of aggression.
Outcome	Julie can establish and sustain friendships.	
Interventions	<ul style="list-style-type: none"> ▪ Julie is referred by her care coordinator to a residential treatment facility with expertise in working with individuals with intellectual disabilities to improve social skills. ▪ Referral to a therapy who can work with Julie to express herself when she is upset. ▪ Engage a foster care youth peer support specialist (FYPS) to assist Julie in her behavioral self-regulation through self-management techniques. 	
Julie’s Potential Goal	Stated	“I want to live independently when I am 21 years old.”
	Measurable	Provide care coordination and peer support services to Julie, including transition services to Maryhurst to help her learn skills to be independent.
Outcome	Julie finds a good place to live for an extended period without disruption.	
Interventions	<ul style="list-style-type: none"> ▪ Using person-centered planning and discovery processes, Julie shares her life goals and desires to have a good life with the care coordinator. Through this process, the care coordinator will understand what Julie likes and does not like about living in a residential setting and helps Julie begin to understand her future living environment options. ▪ Support Julie in her transition to a community-based provider that services individuals with wants and needs similar to Julie’s. ▪ Maximize her school services that help her live independently in the community. 	
Julie’s Potential Goal	Stated	“I want to use DDID services available to me to support my life goals”
	Measurable	Following agreement from her provider, the DCBS social service worker and together with Julie, complete and submit her MWMA application.

Outcome	Julie is eligible for community-based services as early as possible.
Interventions	<ul style="list-style-type: none"> ■ With input from the DCBS social service worker, assist Julie in completing applications for the applicable Medicaid waivers and Supplemental Security Income, if she is not already receiving. ■ Coordinate submission of the MWMA application with DDID so that there is a seamless flow of communication regarding Julie’s emergent status.

Discharge Planning from Sunrise to Maryhurst

Julie is at a critical point in her life, and it will be important for her to have a smooth transition between Sunrise and Maryhurst. Our care coordinator will ensure a discharge plan is developed and shared with the MCT based upon Julie’s desires and needs. As part of the discharge planning effort, the care coordinator will make referrals to ancillary support services such as a PCP, dentist, and other key medical providers in the Louisville area, who will support Julie while she is at Maryhurst. In addition to this, it will be important for the team to identify supports within the community to help Julie acclimate to the community. The care coordinator will document Julie’s discharge plan in *CommunityCare* so the MCT can access it to help streamline her care.

Preparing and Supporting Julie’s Transition to Adulthood

Transition Planning: As Julie approaches adulthood, the team will meet with Julie to determine whether she ages out of foster care at age 18 or 21 years of age. Our staff (FYPSS, care coordinator, and other members of her MCT) will support DCBS in:

- Using person-centered thinking and trauma-informed planning (if she has experienced trauma) with Julie, so she has choice in how she proceeds in life.
- Completing an application for the applicable Kentucky Home and Community Based Waiver to potentially transition Julie from foster care to DDID. Our care coordinator, the DCBS social service worker and our FYPSS – will help coordinate Julie’s Medicaid Waiver Management Application (MWMA). DDID’s Clinical Services Branch, which completes eligibility screening and maintains the waiting list for services, will determine if Julie is eligible for emergent services.
- Completing a Supplemental Security Income (SSI) application (if Julie is not already receiving SSI) which will help her attain Medicaid eligibility. Julie, her DCBS social service worker, and the Social Security Administration will identify a representative payee if Julie is unable to manage her money. As part of the transition planning process, we will work with DCBS to assess other supports for Julie, such as a foster parent.
- Maximizing her school based services since she will age out of those services at age 22. This may include the addition of job training, educational training, therapies and other services, which can be included in her educational transition plan.
- Asking the FYPSS to work with Julie and her residential treatment staff to introduce Julie to the “On My Way” website to help prepare Julie, to the extent possible, with developing a plan for transition. This will include helping Julie set up an account where she can store important records she may need in the future.

Adult Housing Options: With the supportive activities listed previously, also understanding where Julie will live after she ages out of foster care will be important. Because Julie is currently in a residential placement, with a planned transition another residential placement with more intensive services, the care coordinator will work with DCBS and Julie to discuss transition plans for Julie to either live in a supportive living arrangement or independently.

Maryhurst has transitional living assistance and community living supports that can aid Julie as she transitions from residential to less restrictive housing. Decisions related to housing will be

critical to developing and supporting Julie through her transition. There will be many options for Julie, depending on eligibility for waiver services. It also will be important for Julie to be connected to adults who can assist her in the transitions since she has had limited connection with her family. The care coordinator will consult with DCBS and Julie about adults in her life who are supportive and could include: teachers, mentors, extended family or former foster parents. Enlisting these individuals to join the care team will be a top priority of the care coordinator. As part of Julie's support team, our care coordinator will work diligently to close any gaps in Julie's life to set her up for a successful transition to adulthood.

Use Case 8

Amanda, 10 years old, was born with multiple heart defects that affected blood flow between her heart and lungs. Amanda was placed into foster care when she was five (5) after her mother, a substance abuser, was incarcerated for neglect of a dependent. She has had multiple open heart surgeries, bouts of pneumonia, and frequent ED visits. Amanda's initial placement was with her aunt who could no longer care for her due to the stress of managing Amanda's level of care. Amanda's second foster home placement is with a family located in eastern Kentucky with two (2) additional foster children, ages 6 and 8, in the home. The family has one car and transportation is an issue when it is needed to transport Amanda to appointments with her PCP, pediatric cardiologist, behavioral health therapist, dentist, and other specialists. Amanda's foster father works full-time as an assistant bank manager and her foster mother does not work outside of the home.

Amanda is on thirteen (13) medications and is oxygen dependent. She frequently exhibits behaviors such as defiance, impulsivity, and disruptiveness. She has been diagnosed with depression and has extended crying spells that trigger tachycardia and cyanotic episodes. Amanda has growing fatigue and is refusing to eat anything other than yogurt, fruit, and breakfast cereal. Amanda has multiple caregivers who assist with activities of daily living, medication management, and monitoring oxygen levels. Amanda participates in home bound school services provided by the public school system, as her health permits.

Over the past six months, Amanda has been to the emergency room nine (9) times for respiratory/cardiac distress. She had three inpatient admissions for pneumonia and evaluation of her cardiac status. During her last visit with the pediatric cardiologist, the family was advised that Amanda's oxygen levels were worsening with significant changes in cardiac function. The pediatric cardiologist recommended another open heart surgical procedure, but advised the family that a heart transplant may be the only viable long-term solution. The foster family met with the cardiologist's Nurse Practitioner to develop a plan for building Amanda's strength prior to surgery or placement on a transplant list. The foster family is struggling to figure out how to keep up Amanda's spirits up and improve her appetite.

Amanda meets the designation of a Medically Complex Child pursuant to 922 KAR 1:350, The Kentucky SKY Contractor is responsible for providing Care Management and nursing consultative services to enrollees who are determined by the Medical Support Section staff to be Medically Complex.

Describe how the Vendor would address Amanda's situation and coordination with the DCBS Social Service Worker, Medically Complex Liaison, foster family, all providers, and community resources. At minimum, address the following programs and services:

- a. Care management, including the assignment of the Nurse Case Manager;
- b. Involvement of Medically Complex service team;
- c. Discharge planning between levels of care;
- d. Individual Health Plan development and maintenance within specified timeframes;
- e. Availability of and access to providers;
- f. The Medical Passport;
- g. Training and support for caregivers;
- h. Coordination of transportation, as needed;
- i. Coordination of physical and behavioral health services;
- j. Community resources;
- k. Assistance with the Individualized Education Plan;
- l. Social Determinants of Health;
- m. Planned respite care;
- n. Applicable evidence-based practices;
- o. Sharing and review of medical records; and
- p. Maintenance of the care plan.

The severity and complexity of Amanda’s health condition are profoundly challenging, and are likely intensified by a fear of medical procedures and the emotional trauma she faces from being separated from her mother and aunt at a young age. Amanda’s heart defects may affect her length of life and her quality of life; she is not able to engage in activities children her age normally would be able to do such as playing with friends and going to public school.

Amanda’s foster parents are also struggling with the responsibility of managing her care, which requires intensive planning and time and limits their ability to attend to their other two foster children. On top of their care duties, her foster parents must support Amanda’s overall emotional health as she copes with overwhelming challenges that will likely increase her depression. This is an intensely difficult period in Amanda and her foster parents’ lives, and we recognize the need to respond with compassion and in a well-coordinated manner.

For this use case, we have placed Amanda and her foster family in Pikeville, Kentucky (Region 8). As presented in the figure, her nurse case manager (NCM) will activate her circle of support for Amanda, including the DCBS social service worker, her foster parents, her providers and specialists as she prepares for heart surgery or a possible transplant.

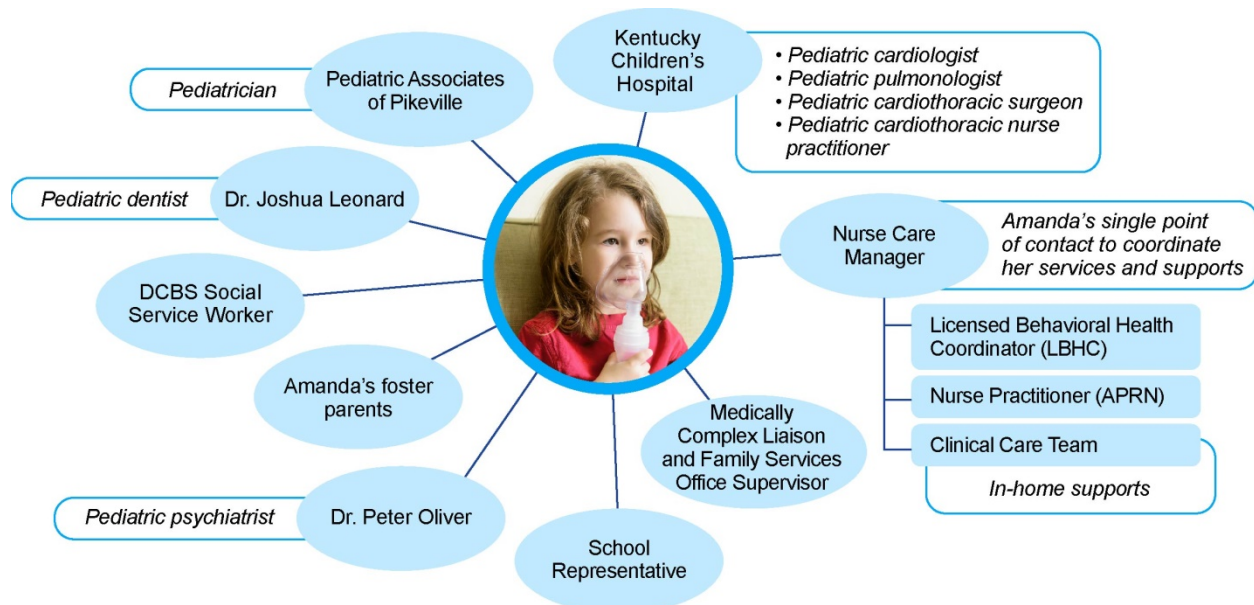


Figure 27. Amanda’s circles of support. Amanda’s NCM will help identify and coordinate with the people and organizations that will support her through care planning and help prepare her for another open heart surgery or heart transplant.

We will begin describing our care management approach for Amanda assuming we have completed her initial health risk assessment (HRA) and we are aware of her designation as a medically complex child as identified through the DCBS enrollment file. The table presents an overview of our approach to address Amanda’s needs in alignment with the requirements presented in her use case. Following the table, we describe how we will work with Amanda and her support team to develop a care plan to meet her ongoing needs.

Programs and Services	Addressing Amanda’s Needs
a. Care management, including the assignment of the Nurse Case Manager	Amanda’s NCM will convene and facilitate the development of Amanda’s IHP, completing it within 30 days of completion of her comprehensive assessment. Amanda’s NCM and her planning team, empower Amanda and her foster parents to actively participate in care planning.
b. Involvement of	Amanda’s NCM will involve her medically complex service team in accordance

Programs and Services	Addressing Amanda's Needs
Medically Complex service team	with <i>Appendix F, 42.20 Kentucky Enrollees with Medically Complex Needs</i> . We describe this engagement following the table.
c. Discharge planning between levels of care	Amanda's NCM collaborates with several stakeholders to develop the discharge plan: Amanda, facility staff, DMS, DCBS, her foster parents and an inpatient care manager. If Amanda receives a transplant, our transplant case manager arranges transplant, manages discharge planning and coordinates post-transplant services for 12 months post-transplant.
d. Individual Health Plan development and maintenance within specified timeframes	Amanda's NCM will schedule IHP meetings engaging the Clinical Care Team on in-home care every 3 months to reassess her needs, update her IHP and re-evaluate her continued medically complex determination <i>in accordance with Appendix F, 42.20 Kentucky Enrollees with Medically Complex Needs</i> .
e. Availability of and access to providers	Amanda's NCM will identify opportunities to connect her to in-home physical and behavioral health services, whenever possible. We also will engage our Clinical Care Team to deliver in-home services to Amanda, if there are gaps present.
f. The Medical Passport	Amanda's NCM will ask to review her medical passport document and upload the passport into <i>CommunityCare</i> .
g. Training and support for caregivers	Amanda's NCM assesses her foster parents for caregiver stress using the Caregiver Self-assessment Questionnaire and connects them to resources on <i>myuhc.com</i> and our Solutions for Caregivers program.
h. Coordination of transportation, as needed	Amanda's NCM and DCBS social service worker collaborate on transportation resources available to Amanda's foster parents including non-emergency transportation with the county transportation broker and other options through relationships with kin and fictive kin.
i. Coordination of physical and behavioral health services	Amanda's NCM, DCBS social service worker, foster parents and medical and behavioral providers meet regularly to coordinate. All clinical documentation will be uploaded into <i>CommunityCare</i> to make sure information is shared timely and provides accurate progress updates.
j. Community resources	Amanda's NCM will identify community resources to help her foster parents, such as a local faith-based community and peer support.
k. Assistance with the Individualized Education Plan	Amanda is receiving homebound educational services. She likely has an IEP due to her medical condition; if not, her NCM will collaborate with the DCBS case worker and the school to create one. Her NCM will upload a copy of her IEP into her electronic health record to be accessed by her MCT when appropriate.
l. Social Determinants of Health	Amanda's NCM identifies her family's social determinants needs using data from the HRA and pediatric core assessment. Her NCM uses <i>Healthify</i> to connect them to relevant, social resources.
m. Planned respite care	The NCM will work with DCBS and her foster parents to determine available resources for respite care regarding Amanda. Respite care is available to Amanda's foster parents for two additional respite days per month due to her medically complex designation.
n. Applicable evidence-based practices	We use evidence-based approaches, criteria and guidelines to confirm Amanda receives appropriate care in a manner appropriate to her needs, including motivational interviewing, family functioning therapy, and trauma-focused cognitive behavioral therapy. Evidence based practices also will include medical services based upon guidelines by the American Academy of Pediatrics.
o. Sharing and review of medical records	<i>CommunityCare</i> maintains Amanda's electronic health record, such as assessment findings and her IHP, enabling her MCT to collaborate to deliver care. Our integrated health record (IHR) gives providers a 360-degree view of

Programs and Services	Addressing Amanda's Needs
	Amanda's medical history for the past 3 years.
p. Maintenance of the care plan	Amanda's NCM updates the IHP in accordance with <i>Appendix F, 42.20 Kentucky SKY Enrollees with Medically Complex Needs</i> .

Identifying Amanda's Complex Care Needs through Care Management

Assignment of Amanda's NCM. Once we become aware of Amanda's designation by the DCBS Medical Support Section staff as a medically complex child, we assign an NCM to coordinate her care in accordance with *Appendix F, 42.20 Kentucky Enrollees with Medically Complex Needs*. Amanda's NCM reviews medical records provided upon her enrollment by DCBS, and our care management platform, *CommunityCare*, for information about Amanda to inform their initial outreach. If Amanda had been served by another MCO before her placement in foster care, our NCM would reach out to the other MCO to obtain her plan of care to facilitate treatment continuity.

To reduce complexity for Amanda and those supporting her, her NCM acts as the **primary point of contact to coordinate her care**. We maintain the relationship between Amanda and her NCM, regardless of placement changes, to provide Amanda stability. In the event of a transplant, we assign a transplant case manager to Amanda's care team. Her NCM assembles our internal Clinical Care Team, which includes a nurse practitioner and a masters-level social worker to address Amanda's medical and behavioral concerns.

Meeting Amanda and her foster parents. Amanda's NCM will coordinate with her DCBS social service worker in all care management activities, beginning with the initial home visit to meet Amanda and her foster parents and conduct the pediatric core assessment. Amanda's NCM contacts her foster parents to arrange a face-to-face visit to understand their goals for Amanda and to develop a comprehensive plan of care. To build trust with Amanda and her family, the NCM will actively listen to their story, and spend time in the foster family home to understand their daily routine. Her NCM will conduct this visit with the DCBS social service worker due to Amanda's medically complex child designation. Amanda and her foster parents share their priorities, such as building Amanda's strength before surgery or placement on a transplant list, keeping her spirits up and improving her appetite.

Assessing Amanda's needs, goals and next steps. To understand Amanda's needs, goals and preferences, her NCM uses evidence-based practices, such as motivational interviewing, our Pediatric Core Comprehensive Assessment and assessments specific to Amanda's conditions, such as depression and anxiety. Once the comprehensive assessment process has been completed, Amanda's NCM explains to Amanda and her foster parents the next steps of the process, including assembling MCT team to review the outcomes of the comprehensive assessment, coordinating with the DCBS Medically Complex Service Team and convening a meeting to develop Amanda's initial health plan (IHP).

Involvement of the Medically Complex service team in developing Amanda's IHP.

Amanda's NCM will integrate her medically complex service team, including the Medically Complex Liaison and the Family Services Office Supervisor (FSOS), into Amanda's planning team and the assessment and care planning processes. Her NCM will coordinate with her DCBS social service worker in all care management activities, beginning with the initial home visit to meet Amanda and her foster parents and conduct the pediatric core assessment. If Amanda has a transplant, we will assign a transplant case manager to Amanda's care team to manage her case from pre-transplant, transplant to 1 year post-transplant.

Identifying Amanda’s services and supports. Amanda’s NCM, supported by her planning team, empowers Amanda and her foster parents to actively participate in all aspects of care planning and to make decisions about Amanda’s care and services in meaningful ways. Amanda’s IHP builds upon her strengths that can serve as a foundation for achieving positive outcomes based upon Amanda’s unique situation and needs. The table presents four goals Amanda and her family may articulate to address her concerns and help Amanda achieve her goals. For each goal, we have described the measure to determine if the goal has been achieved, the opportunities we would expect to see for Amanda if she achieves the goal and the interventions needed to achieve each goal.

Amanda’s Potential Goal	
Stated	I want to be able to eat more.
Measurable	Amanda’s weight meets the baseline weight for open heart surgery or transplant.
Opportunity	Amanda will be healthy enough for open heart surgery or a transplant.
Interventions	
<ul style="list-style-type: none"> ▪ NCM will refer Amanda for a nutrition evaluation to determine daily goal caloric and fluid intake goals. ▪ NCM will evaluate and meet with her team of physicians to identify options if Amanda is unable to meet her nutritional needs orally, such as supplemental feeds via oral high caloric supplement intake or overnight nasal gastric tube or an outpatient feeding program. ▪ The NCM will help the foster parents develop a chart for Amanda to use to reach her daily goals related to nutrition. ▪ The NCM will work with the in home caregivers who attend to Amanda’s daily needs and ask them to list any barriers to getting Amanda to eat. The NCM will ask the caregivers to share those during MCT meetings to the team can work on solutions. 	
Amanda’s Potential Goal	
Stated	“I don’t want to be sad.”
Measurable	Amanda’s foster parents observe decreased defiant behavior.
Opportunity	Amanda will be able to express herself in healthy ways.
Interventions	
<ul style="list-style-type: none"> ▪ NCM will refer Amanda and her foster parents to behavioral health therapy. ▪ NCM will discuss the option of having Amanda’s mother, or other family members, involved in her care planning. ▪ NCM will provide the foster family online resources to help them feel connected to others facing the same issues. ▪ NCM will refer Amanda and her foster parents to foster care peer support services. ▪ NCM will receive reports from her caregivers assisting with daily living, medication management and oxygen levels to understand Amanda’s changing moods. 	
Amanda’s Potential Goal	
Stated	Tracking Amanda’s medications will be simplified.
Measurable	NCM will work with Amanda’s care team to simplify her medication schedule by providing resources to track and fill her medications in a streamlined manner.
Opportunity	Amanda’s medication regimen will be less burdensome on her foster parents.
Interventions	
<ul style="list-style-type: none"> ▪ NCM will collaborate with her medical providers to fill a 90-day supply of medications to help alleviate monthly medication refills. Work with providers to verify that Amanda is receiving 90-day supply of all her medications. ▪ NCM will provide Amanda’s foster family with a pill box and educate family about appropriate administration of the medications. ▪ If available, the NCM will refer the family to a Genoa pharmacy to have medications filled and sent in 	

bubble packs for ease of administration.	
Amanda's Potential Goal	
Stated	Amanda's cardiac function will be stable until she receives a transplant.
Measurable	The nurse care manager will work with the physicians to obtain an assessment of cardiac function: baseline ejection fraction and oxygen saturations and dependence.
Opportunity	Stabilize Amanda's cardiac function to sustain her until she can get a transplant.
Interventions	
<ul style="list-style-type: none"> ▪ NCM will work with Amanda's cardiac physicians to understand and anticipate the progression of her heart failure while awaiting transplant, such as mechanical circulatory support via ECMO or VAD as a bridge to support cardiac function until transplant. These interventions will require inpatient admission to pediatric intensive care for an extended period of time. ▪ The NCM will arrange for an extended stay at the hospital facilities for her foster parents if Amanda requires extended hospital stays. ▪ NCM will review documents from all physicians and daily caregivers to determine any cardiac readings that may be concerning, and alert the MCT regarding any alarming results. 	

Assisting Amanda with her Individualized Education Plan (IEP). Amanda participates in a homebound school program, as her health permits. Amanda likely has an individual education plan. Due to Amanda's feelings of isolation and being depressed, the NCM will invite the IEP coordinator to the MCT meetings to discuss how school activities could be completed online, or with peers via web technology, as Amanda's health permits, to help her feel more included in daily education activities.

Coordinating Amanda's Care through Integration

Coordination of physical and behavioral health services. With Amanda having numerous providers for her physical and behavioral health needs, regularly scheduled meetings between her NCM, the DCBS social service worker, foster parents and her medical and behavioral providers are critical. Additionally, it will be important for all medical documentation to be uploaded into *CommunityCare* for access by providers, the social service worker, foster parents and behavioral health therapist, and others to verify information is shared timely and provides accurate updates about Amanda's progress. The NCM will work on a crisis plan that will be shared amongst the providers, and be administered by the foster parents. The plan should address what must occur should Amanda go into crisis, either physically or emotionally.

Discharge planning between levels of care. Should Amanda experience an inpatient admission, such as for her open heart surgery, her NCM will immediately implement our discharge planning process. Her NCM collaborates with Amanda, facility staff, her foster parents and her circle of support to develop a discharge plan. The planning process anticipates post-discharge issues and identifies interventions to mitigate them. The discharge plan builds on Amanda's strengths and identifies the services and supports that help her achieve her goals and confirm the progress Amanda has made during the inpatient stay continues when she returns to her foster family. If Amanda receives a transplant, our transplant case manager will manage discharge planning and coordinate post-transplant services.

Care management and coordination in the event of a transplant. We provide Amanda and her family with specialized transplant case management provided by a transplant case manager who will manage Amanda's case from pre-transplant, to transplant and post-transplant. We have built a network of high-quality Centers of Excellence (COE) by evaluating organ programs twice a year according to The Scientific Registry of Transplant Recipients data releases and program volumes, outcomes, structure and processes annually. We have qualified Cincinnati Children's Hospital Medical Center as Medicaid pediatric heart transplant COE.

Availability of and access to providers. All providers described in this use case are contracted and in our provider network. Amanda's NCM understands the importance of permanency for children, so they will do everything possible to lessen the burden on her foster parents to maintain Amanda's placement. Given Amanda's significant need to access specialty services, her NCM will identify opportunities to connect Amanda to services using telehealth technologies and in-home provider care for physical and behavioral health, whenever possible. Since Amanda is homebound, and in need of dental services, an example of this may include a teledentistry program we are piloting with the Kentucky Primary Care Association that promotes collaboration with pediatric and family medicine clinicians to perform screenings for dental carriers, provides guidance to parents and provides a referral for a dental visit. If coverage for asynchronous telehealth is restored following the expiration of emergency regulation 907 KAR 3:170E, we will develop a teledentistry program in Kentucky, with KPCA's integrated sites targeted for potential implementation.

Amanda's NCM can engage our Clinical Care Team, which is a team of clinical experts including: physicians, nurse practitioners, RNs, behavioral health clinicians and social workers that provide direct, integrated medical and behavioral care to children in their home. Unique to the Clinical Care Team's model are providers who specialize exclusively in addressing the integrated needs of vulnerable children and youth who have complex social, behavioral and medical needs. Amanda's NCM will make a referral to the Clinical Care Team if Amanda needs in-home services, and the MCT is not able to identify providers who can deliver the needed in-home services such as medication management.

Training and Supporting Amanda's Foster Parents

The stress on Amanda's foster parents is likely overwhelming and family and caregiver supports are essential resources to enable them to continue caring for Amanda. Amanda's NCM will assess her foster parents for caregiver stress using the *Caregiver Self-Assessment Questionnaire*, developed by the American Medical Association. Her NCM will connect them to resources available through *myuhc.com*, which provides caregiver support, including guides, such as *Self-Care for Caregivers*, and the *Community Resource Database*, which helps her foster parents locate services and supports near them, such as respite care.

Coordination of transportation. When telehealth services are not available or not a suitable option, Amanda's NCM will coordinate with her DCBS social service worker to discuss available transportation resources with Amanda's foster parents. We will familiarize Amanda's foster parents with the DCBS transportation benefits as indicated in the foster parent handbook, this may include coordinating with the county transportation broker to arrange non-emergency transportation. We will work with Amanda's foster parent to identify transportation options through informal relationships, such as kin to Amanda who live in the area of her foster home.

Supporting Amanda's Ongoing Health and Well-being

Maintenance of Amanda's care plan. Amanda's NCM will collaborate to schedule IHP meetings, engaging the Clinical Care Team for input on the in-home care provided every 3 months to reassess her needs, update her IHP and re-evaluate her continued medically complex determination in accordance with *Appendix F, 42.20 Kentucky SKY Enrollees with Medically Complex Needs*. When they see indications that Amanda's health status, needs or living situation have changed, they work with her foster parents to reassess Amanda's needs and update her IHP, monitoring compliance to these requirements through *CommunityCare* and our Clinical Adherence Program.