12. Aging Out Services

Provide the Vendor’s recommendations for enhancing the services and outcomes for FC Enrollees, Former Foster Care Enrollees, and JJ Enrollees aging out of Care and the Kentucky SKY program. Provide examples of services or tools the Vendor has used for other similar programs and detail how these tools have contributed to the Vendor achieving program goals.

In accordance with Attachment C – Draft Medicaid Managed Care Contract and Appendices, section 42, we have a transition process in place that includes all elements involved.

Helping people live healthier lives is not just our mission statement – we are committed to ensuring children and youth in foster care are engaged and empowered to be successful as they age out of foster care. Children in foster care experience multiple unpredictable transitions, which can include transitions among families and agencies; among treating providers; of medication regimens; and in and out of foster care. These transitions require a commitment to planning and delivering services that meets and responds to them where they are in their experience. Our recommendations for enhancing the services and outcomes for children and youth in foster care, former foster care and juvenile justice (JJ) aging out of care and the SKY program are to provide innovative solutions to help mitigate any issues that arise from this transition. These include: conducting a Pediatric to Adult Transition Assessment, providing a family/youth peer support specialist (FYPSS) and offering a tool that incorporates the special circumstances and needs of this population, UnitedHealthcare On My Way™.

Enhancing Services and Outcomes for Children in Foster Care

Youth who transition from the foster care system to adulthood without a permanent home and intact family need enhanced support. We help these young people, a small but highly vulnerable population, successfully transition to adulthood by providing intensive, individualized and holistically focused transition planning and care management to meet their needs. This approach includes working with the Department of Community Based Services (DCBS) to ensure we have access to vital assessments they have already conducted to further inform our care assessment and planning such as the Ansel Casey Lifeskills Assessment. By accessing assessments youth have already completed, we can streamline our planning process. This strategy is aligned with our intention to find ways to create an easier path for youth in foster care. Building a trusting relationship with these youth is critical to effective planning and preparation for adulthood. Key areas of focus include how to:

- Navigate the health care systems for continuity of care
- Remain in foster care between the ages of 18 and 21 and retain Medicaid eligibility to age 26
- Keep youth in school and prepare them for college or other post-high school training
- Plan for safe, stable and affordable housing
- Manage money, access community resources or compile a job application
- Maintain connections to supportive peers and adults
- Access legal documents related to their personal, medical and educational records

Cross over youth, who are engaged with both DCBS and the Department of Juvenile Justice (DJJ) systems need additional transition planning services to reduce the likelihood of continued involvement in the justice system. Our care coordinator will bring together a youth’s circle of support, including their DCBS social service worker and DJJ worker, to ensure their plan
includes the services and supports to meet their ongoing medical and behavioral health needs as they transition into adulthood.

**Care Coordinator**
The care coordinator has a relationship with the youth in foster care to support transition activities and keep them engaged in the process, staying with the youth through all levels and types of transitions. Through the Pediatric to Adult Transition Assessment, care coordinators work with the youth transitioning out of foster care and provide person-centered clinical and transitional services. Collaborating with the DCBS caseworker, our care coordinators will initiate transitional care management activities including assessments, interventions, coaching, resource coordination and transition planning. Throughout this process, the care coordinator will consider the youth’s needs, interests and barriers when determining services; and how often to reassess a youth. The young adult is reassessed at least annually before transition to the adult system of care, beginning at the age of 14. Referrals may be made to community organizations to assist young adults in achieving a seamless transition into adulthood.

**Family/Youth Peer Support Specialist**
The FYPSS will provide direct support to transition age youth as they move into adulthood. As these youth transition out of foster care, the FYPSS will provide direct support via many ways. They help young adults sign up for On My Way, as a tool to help them be successful during the transition, help them understand how to set up appointments for medical and behavioral health needs, and how to navigate the health care system and give them resources to meet social determinants of health.

The FYPSS will attend meetings with DCBS, DJJ, providers and other stakeholders to discuss any unique challenges with the transition population and identify opportunities for improving aging out services and encouraging youth to remain in foster care. The FYPSS also will work with community-based organizations to validate the system is wrapping around these young adults so they can be successful adults.

**Examples of Services and Tools Supporting Successful Transitions**
Providing support for teens transitioning from foster care is important. Studies have shown youth who leave foster care are more likely to drop out of high school, be unemployed and depend on public assistance. In addition, social determinants of health, such as home-life and work environment, are connected to peoples’ physical health and well-being. The following assessment and tool can provide valuable information to transition age youth:

**Pediatric to Adult Transition Assessment:** The care coordinator, supported by the care team, leads care management for children in foster care. They will complete the transition assessment with the youth and anyone the youth wants present to assess needs and barriers that may affect their ability to achieve a seamless transition to adult services. The information gathered supports the development of a comprehensive, person-centered transition care plan and suggests in-depth interventions the care coordinators should take based upon whether the child or youth answers: “Yes, I have this,” “Yes, I have part of this,” “No, but I want to have this,” or “Someone will have to do this for me.” Some of the questions on the assessment include, but are not limited to:

- I currently have a family doctor or clinic that I feel comfortable to go to when I am sick or in need of a checkup and know the kinds of health care providers to see as an adult
- I have an individualized continuity of care plan for transitioning from my current children’s health plan to an adult Medicaid option
I understand the risks and dangers of smoking, drinking and using drugs including how they affect my condition or interact with the medications I take.

I know where I want to live as an adult and know what supports I need to live independently (e.g., meal preparation, cleaning, laundry, getting to stores).

I have a reliable transportation plan in place to get around in the community and to any appointments I have scheduled.

I am able to manage my own money and budget household expenses.

I am responsible for scheduling my own doctor appointments and ordering my own medical supplies.

I know what I want to do after high school and have a plan in place to achieve my goals.

I am currently receiving Social Security Income or another type of public assistance and know how much I receive each month.

**UnitedHealthcare On My Way (OMW™):** OMW is an online tool designed by the UnitedHealthcare Innovation Center of Excellence to help young adults transition to adulthood and independence. Individuals in foster care often do not have access to the same kind of support and guidance other teens their age have; they are struggling for independence while trying to make smart life decisions. OMW takes the overwhelming transition process and breaks it down into bite-size, manageable steps and connects foster youth with the support/guidance they need. The tool includes:

- **The Vault:** Many children in foster care have fragmented documentation, including medical records, due to the lack of having one safe repository to keep it all during ongoing life transitions. This area of the tool allows youth to have a repository of their most important documents – birth certificates, driver’s license, individual education plans, insurance cards, health records – in a secure, easily accessible place. Youth can upload documents in many ways, including scanning and/or taking a picture of the document and uploading it in a process similar to uploading pictures on their phone.

- **Secure Website:** Users register to create an account via a secure server.

- **Gamified Experience:** Users earn as they learn. UnitedHealthcare OMW™ rewards users with virtual points, badges, and messages of encouragement as they progress through each life track.

- **Key Life Tracks:** The program uses an interactive website to help teens learn about six key areas that have historically prevented them from achieving stable, independent lives. This tool was developed with young adults providing valuable feedback to areas they struggled with when transitioning to adulthood. Youth will find important, relevant information that is easy to understand and step-by-step guidance for actions to take. Focus is placed on transitional areas that historically have prevented youth in care from achieving stable, independent living. The areas of focus and curriculum include:
Engagement of Social Worker: OMW™ incorporates content from the Independent Living Plan (ILP) and engages users in setting personal goals. As a result, youth in care can share the progress they make with their social worker — and together they can apply it to their ILP. DCBS social workers can receive reporting on how many tracks have been completed to verify the youth are making progress in their journey.

We received positive feedback about the OMW tool in consumer research focus groups:

- 65% of respondents in Virginia stated they would “definitely” or “probably” use this site
- 62% stated they would be more likely to choose an MCO that offered this service

Helping Foster Care Youth in Ohio using OMW

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

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

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