Health Care Oversight and Coordination Plan
2020 – 2024 Child and Family Services Plan

Administered by
State of Mississippi
Mississippi Department of Child Protection Services
Prevention Unit
Jess H. Dickinson, Commissioner
P. O. Box 346
Jackson, MS 39205

Health Care Oversight and Coordination Plan

The Mississippi Department of Child Protection Services, in collaboration with Magnolia Health Plan and the Mississippi Department of Mental Health, has prepared *The Health Care Oversight and Coordination Plan* to strengthen activities to improve the health care and oversight of children and youth in foster care for the next five years. The requirements listed below are requirements agreed upon in the 2nd Modified Settlement Agreement to help ensure the wellbeing of each child upon entering, and while in, the foster care system. When a child is placed in the custody of the Mississippi Department of Child Protection Services, MDCPS must provide access for the child to the physical, dental, and mental health care services requirements included below.

The goal is to increase services available to foster children throughout the state.

2nd MSA Requirements:

8.1 **Physical and Mental Health Care**

8.1.a. Children entering foster care shall receive an initial medical screening within 72 hours of entering foster care.

8.1.a.1. By July 1, 2018, 70% of children shall have an initial medical screening within 7 days of the child's entry into foster care.

8.1.a.2. By July 1, 2019, 80% of children shall have an initial medical screening within 7 days of the child's entry into foster care.

8.1.a.3. By July 1, 2020, 90% of children shall have an initial medical screening within 72 hours of the child's entry into foster care.

8.1.b. Children entering foster care shall receive an EPSDT or other comprehensive medical exam within 30 days of entering foster care. If a child has received an EPSDT or other comprehensive medical exam within 72 hours of entering foster care, it will count for both the screening and comprehensive medical examination.

8.1.b.1. By July 1, 2018, 70% of children shall have an initial EPDST or other

comprehensive medical examination within 60 days of the child's

entry into foster care.

8.1.b.2. By July 1, 2019, 80% of children shall have an initial EPDST or other

comprehensive medical examination within 60 days of the child's

entry into foster care.

8.1.b.3. By July 1, 2020, 90% of children shall have an initial EPDST or other

comprehensive medical examination within 30 days of the child's

entry into foster care.

8.1.c. Following an initial EPSDT or other comprehensive medical examination, children shall receive periodic and on-going medical examinations according to the periodicity schedule set forth by the EPSDT program.

8.1.c.1. By July 1, 2018, the Monitors in collaboration with MDCPS will establish the performance baseline for periodic and ongoing medical examinations;

8.1.c.2. By July 31, 2018, the Monitor will establish performance standards for MDCPS to meet by July 1, 2019.

8.1.c.3. By July 1, 2020, 90% of children shall be provided with periodic and on-going medical examinations.

8.1.d. Practitioner recommended follow-up treatment will be provided to children throughout the time they are in foster care.

8.1.d.1. By October 31, 2017, the performance baseline for practitioner recommended follow-up treatment will be established by Public Catalyst as required in the STRO.

8.1.d.2. By July 1, 2018, MDCPS shall meet the initial performance standard established by Public Catalyst in the STRO.

8.1.d.3. By July 1, 2019, 90% of children shall be provided with practitioner recommended follow up treatment.

8.1.e. Children in foster care shall receive a dental examination within 90 calendar days of foster care placement unless the child has had an examination within six months of placement, and every six months thereafter if they are age four or older. Foster children who reach the age of four while in foster care shall receive a dental examination within 90 calendar days of his/her fourth birthday, and every six months thereafter. Every foster child shall receive all medically necessary dental services.

8.1.e.1. By July 1, 2018, 60% of children shall have a dental examination within 90 days of the child's entry into foster care.

8.1.e.2. By July 1, 2019, 80% of children shall have a dental examination within 90 days of the child's entry into foster care.

8.1.e.3. By July 1, 2020, 90% of children shall have a dental examination within 90 days of the child's entry into foster care.

8.1.f. Within 15 days of placement, MDCPS shall provide the foster parents or facility staff with the completed foster child information form or other electronic record containing available medical, dental, educational and psychological information about the child.

8.1.f.1. By July 1, 2018, 75% of children shall have information provided to foster parents or facility staff within 15 days of placement.

8.1.f.2. By July 1, 2019, 90% of children shall have information provided to foster parents or facility staff within 15 days of placement.

8.1.g. By July 1, 2018, 85% of children shall have their Medicaid information provided to foster parents or facility staff at the time of placement.

Strategies for Increasing the Array of Services to Foster Children:

In striving to attain our objectives as stated above the following ten (10) items are the foundational information needed for children entering foster care to receive appropriate services. Each step includes guidelines to obtain information pertinent for the child to better determine what type of services are needed to serve the child's wellbeing.

1. **Obtain Medical Information on foster children.**

   Immediately upon placement into custody -

   - Social worker shall obtain a medical history on the foster child from the birth parents as part of the Comprehensive Family Assessment process.

   - Review all available data and medical history on the child.

   - Identify any developmental/mental health/health conditions requiring immediate attention.

   - Collect all medications the child is currently taking and assure they are provided to the current caretaker.

   - The role of the worker is to consult with the medical provider about current medications to make sure they are all appropriate and are being administered as prescribed. Birth, resource parents and age-appropriate youth should be part of this discussion whenever possible.

   - Key medical information obtained from the screenings/assessments should be shared with the birth parent and resource parent and age appropriate youth and documented in the case file.

   - Assure that as part of the youth's participation in independent living services he/she obtains information on health insurance, Medicaid and medical care services.

2. **Initial Health Screening.**

   Within 72 hours of placement -

   - Every child shall receive a health screening evaluation from a qualified medical practitioner within 72 hours of placement to identify health conditions that should be considered in making placement decision.

   - The purpose of this screen is to identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases, signs of abuse or neglect, signs of infection or communicable diseases, hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances.

   - Birth parents/resource parents should be involved in all assessments/screenings. Participation in these appointments provides a good opportunity for shared parenting allowing the birth parent to remain involved in the regular care of their child assuming there are not safety concerns.

3. **Comprehensive Health Assessment.**

   Within 30 days of placement -

   - Every child entering foster care shall receive a comprehensive health assessment within 30 days of placement and yearly thereafter.

   - The assessment must be done by a qualified pediatrician, nurse practitioner or other qualified health professional.

   - The purpose of this assessment is to review all available medical data and medical history about the child/adolescent; to identify medical conditions, to identify developmental and mental health conditions requiring immediate attention and to develop an individual treatment plan.

   - ***The initial health screening evaluation and the comprehensive health assessment could be conducted in one clinical visit. However, in such instances, this combined visit must be conducted within 72 hours of placement. This includes the EPSDT examination. EPSDT practitioners can complete comprehensive health assessments but EPSDT examinations must be conducted by approved EPSDT providers.***

4. **Initial Mental Health Intake Assessment.**

   Within 30 days of placement -

   - Every child 4 years old and older shall receive a mental health assessment by a qualified professional with expertise in the developmental, educational and mental health conditions of children and adolescents within 30 calendar days of foster care placement. Every foster child who reaches age 4 in care shall receive a mental health assessment within 30 calendar days of his/her 4th birthday. Every foster child shall receive any mental health services that are recommended/referred in the assessment including, but not limited to, individual counseling, family counseling,

group counseling, and medical treatment. Mississippi Department of Child Protection services is continually working to identify additional mental health providers that provide treatment to children under five years of age so that every foster child shall receive services recommended at the time of assessment.

- Psychological assessments are not indicated initially unless ordered by the court and do not replace the 30-day mental health intake assessment for children 4 years or older.

5. **Initial Dental Assessment.**

Within 90 days of placement -

- Every child four years old and older shall receive a dental examination within 90 calendar days of foster care placement. Every foster child who reaches the age of four in care shall be provided with a dental examination within 90 calendar days of his/her fourth birthday.

- Children shall receive follow up dental services every six months after the initial dental examination as well as all medically necessary dental services.

6. **Periodic Ongoing Medical Examinations.**

- More frequent preventive pediatric visits are recommended for the child/youth in foster care because of the multiple environmental and social issues that can adversely impact their health and development.

- All children shall receive periodic medical examinations and all medically necessary follow up services and treatment throughout the time they are in state custody. Preventive pediatric visits are recommended for the child and adolescent in foster care because of the multiple environmental and social issues that can adversely impact their health and development.

- The purpose of these examinations is to promote overall wellness by fostering healthy growth and development, to identify significant medical, behavioral, emotional, developmental and school problems through periodic history, physical examination and screenings, to regularly assess for success of foster care placement, to regularly monitor for signs or symptoms of abuse or neglect and to provide age-appropriate anticipatory guidance on a regular basis to children and adolescents in foster care and birth and resource parents.

7. **Therapeutic Services.**

As needed -

- Necessary therapeutic and rehabilitative services because of a diagnosis of significant medical, developmental, emotional or behavioral problems shall be provided to children in foster care.

- These service needs should be identified as part of the comprehensive family assessment process, incorporated into the Family Service Plan and monitored as part of the case planning process.

- Therapeutic Placement Unit reviews psychological reports and documentation submitted with residential applications when support is needed to locate an appropriate therapeutic placement. If concerns are noted in the reports the Therapeutic Placement, nursing unit and other MDCPS staff conducts a review of the information using a Multidisciplinary approach and contacts other state agencies and community providers as needed for consultation

- Therapeutic Placement unit assist caseworkers in gaining documentation from acute and residential treatment facilities prior to discharge when available to assist with appropriate discharge planning and identifying appropriate placement to ensure that children are not placed in settings that are not foster family homes because of inappropriate diagnosis.

8. **Information gathered from specialized screenings/Assessment.**

Prior to developing case and when assessments and case plans are updated -

- Use information from medical, dental, and mental health screenings, assessment, and case file information to identify need for more in-depth evaluations.

- Assess individual health, dental, developmental, and mental health needs of children and families.

- Discuss needs for specialized screenings/evaluations with parents and relevant family members; determine provider/locations that can best serve them.

- Make prompt referrals for additional evaluations and needed services as soon as the need is identified. Involve family in decisions about where to obtain the services.

- Clarify with providers the precise needs for screening/evaluation or services and ensure provider has the information needed to proceed.

- Identify and provide assistance the family may need in participating in evaluations.

- Obtain copies from service providers of the results of the evaluations, file in the case record, and include in the child's medical passport.

- Discuss assessment findings and recommendation with the family and seek their views and perspectives about the information and any conclusions that are drawn.

- Provide copies of medical, dental, and mental health information on children in care to their resource parents/caretakers and birth parents as appropriate.

9. **Update assessments on a regular basis.**

As needed -

- In visits with family members, ask about changes in strength/needs regarding medical, dental and mental health issues of the child/youth and identify any related emerging issues that need assessing including emotional trauma associated with child's removal from the home.

- Track and make referrals for ongoing periodic screenings and assessments, e.g. EPSDT, and follow up assessment activities for other screenings/evaluation, e.g., re-evaluation of mental health issues. Magnolia Health Plan provides reports to MDCPS to assist with tracking and making referrals for ongoing screenings and assessments.

- Make prompt and clearly defined referrals for additional or updated specialized evaluations needed as circumstances change or new needs emerge.

- Obtain copies of new/updated screenings/evaluations and use in revising plans, file in the child's medical passport, and provide to foster care providers.

- Make direct contact with providers of assessments/evaluations (with family's consent) to evaluate progress, identify needs, etc.

- Discuss progress needs with relevant family members and resource parents/caretakers.

10. Ongoing medical care.

Exit from custody -

- Review child's health conditions with birth parents and/or whoever is assuming responsibility for the child as identified during the child's stay in foster care.

- Be certain to include the older youth in all discussions regarding their medical/dental/mental health care.

- Identify ongoing conditions that will require intervention.

- Convey summary of child's health history to appropriate caregivers and primary physicians.

- Obtain needed supports and make referrals for services that can ensure any medical/dental/mental health issues the child/youth may have are addressed when the case is closed.

- Provide documents to the age appropriate youth and/or caregiver.

- The worker shall provide each youth transitioning to independence with at least six months of notice of cessation of any health benefits.

- The worker shall inform all youth transitioning to independence that he/she is eligible for Medicaid through age twenty-one. It shall be the workers responsibility to assist the youth with completing the necessary documents to

continue Medicaid services and to ensure he/she has received his/her Medicaid care prior to transitioning out of care.

In addition to the foundational information above the MDCPS nursing unit has added an additional strategy to ensure children in foster care are all receiving required physical, dental and mental health services. The MDCPS nursing unit is now tracking and monitoring medical screenings and assessments for children entering care. The MDCPS nursing unit is responsible for daily review of the custody child snapshot and providing reminders to caseworkers of Well-Being Assessment due dates. A Smartsheet tool has been developed for this tracking process that is monitored by various MDCPS staff. A report is generated each month on the 5th day of the following month from Smartsheet that shows children entering custody for the month who still need exams. This information is disseminated monthly by the Nursing Unit and shared with the Deputy Commissioner of Child Safety. As of June 1, 2019, the nursing unit will be setting alerts in the Smartsheet tool to follow up on ongoing and periodic medicals of children that remain in foster care for a year or more.

Oversight of Prescription Medications and Psychotropic Medications

The MDCPS Nursing unit is available to all MDCPS caseworkers for consultation related to information on prescription medications such as status of FDA approval, recommended dosage for children based on age and weight and most common side effects. Magnolia Health Plan assists MDCPS with the oversight of psychotropic medications by providing reports identifying children currently prescribed psychotropic medications that is generated from claims for filled medications.

It is the policy of MDCPS that if a child in foster care is prescribed a psychotropic medication by a qualified mental health professional or licensed medical professional with expertise in children's mental health, the case worker will obtain the following in writing:

- The prescribed medication;
- The prescribed dosage;
- The dosage recommended by the manufacturer or the United States Food and Drug Administration;
- The reason for the medication;
- The efficacy of the medication;
- The side effects of the medication;
- Whether the medication has been approved by the FDA for use by children.

Case workers are required to staff this information with their supervisor before giving approval and consult with MDCPS nursing unit as needed before giving approval. Approval shall be documented in the case file and consent signed by caseworker and supervisor. The child's parents/guardians are notified if possible unless parental rights have been terminated.

Increasing and Improving the Service Array Through Collaboration with Magnolia Health Plan

Mississippi Department of Human Services/Division of Family and Children Services (MDHS/DFCS) began a partnership with Magnolia Health (Magnolia) Plan on January 1, 2013, to

provide services for the foster children of Mississippi. The Mississippi Division of Medicaid contracted with Magnolia to provide services for foster children age birth to 19 years of age. Children over 19 will receive Medicaid direct services. Children aging out of the foster care system will have a copy of their electronic health record that has captured their physical, dental and mental health history. The Mississippi Department of Child Protection Services was created as the state's lead child welfare agency by the 2016 Mississippi Legislature, separating it from the Mississippi Department of Human Services.

Magnolia is a subsidiary of Centene Corporation. While Centene is a national company with corporate offices in St. Louis, Missouri, its local approach to managing health plans enables it to provide accessible, high quality, culturally sensitive healthcare services to its members. This local approach allows Medicaid recipients, providers and state regulators direct access to the local health plan where its officers and staff are available and accountable. For optimum organization and efficiency, Centene combines its local approach with centralized finance, information systems, claims processing and medical management support functions. Currently Centene provides foster care services for the states of Arizona, California, Florida, Georgia, Illinois, Indiana, Kansas, Missouri, New Hampshire, Ohio, Texas, Washington, Louisiana, Nebraska, Oregon, and Mississippi.

Centene is a multi-line health care enterprise operating primarily in two segments: Medicaid managed care and specialty services. The government services Medicaid managed care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP) and Supplemental Security Income (SSI).

The U.S. Children's Bureau estimates around 800,000 children are served in the foster care system each year. The Urban Institute found that States disburse approximately $10 billion annually in federal and state funds to meet the needs of children placed in foster care. Much of the foster care population has special behavioral and medical needs.

One study by the Urban Institute suggests that as many as 80 percent of children involved with child welfare agencies have conditions which require mental health services. Coordinating services and health information for this population has unique challenges. Keeping track of medical history including medical conditions, doctor visits, immunization, and prescription drug history is complicated by the temporary nature of care situations. Many states are turning to Medicaid managed care solutions to help coordinate the unique medical, behavioral and social services for these children.

On April 1, 2008, Centene began providing statewide managed care services to foster care children in the state of Texas under its subsidiary, Superior Health Plan. With commencement of operations, Centene became the first organization in the country to serve as a state's exclusive managed care company for the foster care population.

Magnolia Health Plan is a managed care organization providing services to MDCPS foster children under Mississippi Coordinated (MSCAN). Magnolia assists our case workers in locating medical, dental and mental health services. Magnolia has approximately 15,000 providers in Mississippi and the surrounding states that are available to provide physical, mental health and dental services. Magnolia has providers in all 84 counties in Mississippi. This is a vast improvement in services

for our foster care children. Gaps that were previously identified in the northern part of the state have been closed.

Being a part of the Magnolia Health Plan has greatly enhanced our service array for foster children. They are afforded the continuity of having a medical home. Partnering with Magnolia also provides opportunities for more specialized services, case management services and access to follow up care. Because of the number of Magnolia providers our children will be able to be serviced within their communities. The foster children will have access to specialized services not only in Mississippi but out of state to provide the best services possible to meet their particular needs. Medical providers for Magnolia Health Plan are supplied with the American Academy of Pediatrics Healthy Foster Care America form which includes a brief medical history as well as the initial health screening (within 72 hours of placement) and the comprehensive admission health assessment (within 30 days of placement). A Provider Reference Card is provided for the MDCPS caseworkers, foster parents, parents or other caregivers and the public listing most used services and how they can be accessed. Magnolia Health Plan has a dedicated Foster Care Case Management phone number (1-888-869-7747) for the convenience of MDCPS workers and foster parents and/or other caregivers for foster children to answer questions and to assist in scheduling appointments or any other related needs.

Magnolia Health Plan provides a CentAccount Card for foster children that meet certain healthy behaviors. The card is given to the foster parent for the child. The CentAccount rewards program lets you earn money onto your own CentAccount card simply by doing things that help you stay healthy. The card is accepted at most local pharmacies and stores. It can be used at stores and pharmacies that accept credit cards for health related items only. The card can also be used to help pay for utilities such as gas and electricity. There is a chart that explains the amount that will be put into the account for each behavior you complete. This form is currently being updated by Magnolia Health Plan and will be changing effective 6/1/19. MDCPS also benefits from collaborations and open communication with Magnolia Health Plan. Representatives from MDCPS participates in a bi-monthly meeting with Magnolia to discuss health care needs of foster children, current data and other relative information.

The following information will explain the Case Management Program that Magnolia provides. Magnolia has a specialized team of 6 Foster Care Case Managers and 4 additional staff for backup. These staff include registered nurses and social workers.

The purpose of the Case Management Program is to define the goals and objectives of the program, the target Case Management population, and the methods and processes of identifying and assessing members, managing member care, and measuring the impact of interventions. Magnolia provides foster children under their Foster Care Case Management Program specific plans of care that focus on organizing, securing, integrating, and modifying the resources necessary to maximize and support the wellness and autonomy of each child.

Centene and Magnolia Health Plan (Magnolia) adhere to the Case Management Society of America's (CMSA) definition of case management: "a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a foster child's health needs through communication and available resources to promote quality cost-effective outcomes". Centene and Magnolia provide both episodic and complex case management, based on member needs and the intensity of service required. Magnolia refers to its case management program as

Case Management. Magnolia Case Management Program coordinates and monitors the care for members with special needs. Magnolia Case Management Program is designed to ensure the intensity of interventions provided corresponds to the member's level of need.

Levels of Case Management include:

- All members of Magnolia Health Plan receive Care Coordination including evaluation of risk factors, identification of special needs, identification of barriers, and coordination of referrals, residential support services, and other assistance with accessing health care services.

  - Low - Stable – appropriate for members with primarily psychosocial issues such as housing, financial, etc. with need for referrals to community resources or assistance with accessing health care services. Low Level Care Management typically involves non-clinical activities performed by non-clinical staff; clinical staff may provide assistance if minor medical or behavioral health concerns arise.

  - Moderate – Complex but Stable – appropriate for members needing a higher level of service, with clinical needs. Members with moderate risk level may have a complex condition or multiple co-morbidities that are generally well managed. Members typically have adequate family or other care giver support and are in need of moderate to minimal assistance from a Care Manager. In addition, this level of care may include members who have diseases that may not be impactable from a financial perspective but still require significant intervention such as those members that are frail, elderly, or at the end of life, or who have chronic diseases such as cancer or end stage renal disease.

  - High - Complex Care Management – a high level of Care Management services for members with complex needs, including members classified as children or adults with special health care needs; those with catastrophic, high-cost, high-risk, or co-morbid conditions; those who have been non-adherent in less intensive programs. Complex Care Management/high risk is performed by Magnolia Care Management staff for members who have experienced a critical event or have a complex diagnosis requiring oversight and coordination to ensure the member receives appropriate services and care. Services included in complex case management include frequent outreach to the member, identification of member agreed upon care plan goals and assessment of progress towards meeting the goals. Members are generally categorized into Complex Care Management/high risk based on Magnolia ability to have the greatest impact on health outcomes and cost.

  - High – Transitional Care – a high level of Care Management services for members with a recent episode of illness or injury resulting in hospitalization. Transitional Care Management is performed by Magnolia Care Management staff for members with needs for discharge planning and outpatient coordination of services to prevent unnecessary readmission.

  - Rising Risk- Identification of a member with a new catastrophic or chronic condition. A member that has just been brought into foster care (with unknown medical history), premature infants and pregnant members under the age of 21. Rising Risk is established to monitor members who have disease or condition processes that could

rise to high risk levels without appropriate care coordination and care management. Stratification to a Rising Risk is a marker for all Care Management Staff to be vigilant in monitor, support and management of that member.

The goals of Magnolia Case Management Program are to:

- Assist members in achieving optimum health outcomes, functional capability, and quality of life through improved management of their disease or condition.

- Assist members in determining and accessing available benefits and resources.

- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals and improving their ability to self-manage their disease or condition.

- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.

- Maximize benefits and resources through oversight and cost-effective utilization management.

Case Management functions include:

- Early identification of members who have special needs.

- Assessment of member's risk factors. Stratification and PHM category for best Care Management services.

- Development of an individualized care treatment plan in collaboration with the member and/or member's family, Primary Care Provider (PCP), and managing providers.

- Identification of barriers to meeting goals included in the care treatment plan.

- Referrals and assistance to ensure timely access to providers.

- Active coordination of care linking members to providers, medical services, residential, social and other support services where needed. Social Determinants of Health Management.

- Ongoing monitoring and revision of the care treatment plan as required by the member's changing condition.

- Continuity and coordination of care.

- Ongoing monitoring, follow up, and documentation of all Care Management activities.

- Addressing the member's right to decline participation in the Care Management program or disenroll at any time.

- Accommodating the specific cultural and linguistic needs of all members.

- Conducting all Care Management procedures in compliance with HIPAA and state law.

Medication Reconciliation evaluation and support through Care Management in collaborative integration with the Pharmacy Department is ongoing with all members in Complex Care Management.

Care Management Criteria

Centene has defined a set of criteria for complex case management. This creates efficiencies such as a consistent Case Management Program Description and a consistent measurement process of case management program effectiveness.

Care Management Criteria:

- Three or more inpatient admission within the last 6 months for same or similar diagnosis

- Three or more Emergency Room visits in the last 3 months

- Complex cases/multiple co-morbidities, including but not limited to:

    o Chronic or on-healing wounds

    o Cancer

    o HIV/AIDS

    o Requires life sustaining device- ventilator, tracheostomy, oxygen

    o Total Parenteral Nutrition (TPN) or continuous tube feedings

    o Recent functional decline

    o Private Duty Nursing

    o Skilled Nursing Visits greater than 3 per week

    o Multiple co-morbidities that require 4 or more specialist

    o Diabetes with Hgb A1c greater than 7

    o High Risk Pregnancy including members on 17-P (and under 21 years old)

    o Post-transplant within 6 months

    o Neonatal Intensive Care admissions

    o Catastrophic illness or injury

    o End Stage Renal Disease

    o Dual Diagnosis – members with serious chronic behavioral health and physical health diagnosis

    o Sickle Cell Disease not well managed

- o Autism

- o Depression

- o Substance Use Disorder

- o Post-Partum Depression

INFRASTRUCTURE AND TOOLS

Organizational Structure/Care Management Team

The organizational structure of Magnolia Heath plan includes professionals with diverse backgrounds in both physical and mental health. Access to this diverse teams of professionals is beneficial to MDCPS as the agency continues to serve children and families with changing needs and diverse backgrounds. MDCPS has access to the following personnel for the purpose of collaborating to improve care coordination and medical outcomes for children in foster care:

Chief Medical Director

The Vice President of Medical Management (VPMM), and/or any designee as assigned by Magnolia President and CEO are the senior executives responsible for implementing the Care Management Program in collaboration with the Chief Medical Director (CMD), including quality improvement, cost containment, medical review activities, outcomes tracking, and reporting relevant to Care Management. The Chief Medical Director is involved in the implementation, monitoring, and directing of behavioral health aspects of the Care Management Program. A pharmacist oversees the implementation, monitoring, and directing of pharmacy-related services.

The CMD's responsibilities include, but are not limited to, collaboration with the VPMM on the following activities:

- Assists in the development and revision of Care Management policies and procedures as necessary to meet state statutes and regulations.

- Monitors compliance with the Care Management Program.

- Provides clinical support to the Care Management staff in the performance of their Care Management responsibilities.

- Provides a point of contact for practitioners with questions about the Care Management process.

- Communicates with practitioners as necessary to discuss Care Management issues.

- Assures there is appropriate integration of physical and behavioral health services for all members in Care Management as needed.

- Educates practitioners regarding Care Management issues, activities, reports, requirements, etc.

- Reports Care Management activities to the Quality Improvement Committee and other relevant committees.

Vice President of Medical Management (VPMM)

The VPMM is a Registered Nurse with experience in Utilization Management and Care Management. The VPMM is responsible for overseeing the day-to-day operational activities of the Magnolia Care Management Program. The VPMM reports to the Magnolia President and CEO. The VPMM, in collaboration with the CMD, assists with the development of the Care Management Program strategic vision in alignment with state, corporate, and Magnolia objectives, policies, and procedures.

Senior Director of Medical Management

The Director of Medical Management is a registered nurse or other appropriately licensed healthcare professional with care management experience. The Director of Medical Management directs the care management program including utilization management, complex case management, and quality improvement activities. The Director of Medical Management reports to the VPMM. The Director of Medical Management develops department objectives and organizes activities to meet goals, coordinates with other departments on research and implementation of best practices, is responsible for the statistical analysis of program data, and implements changes to medical service functions and performance in relation to state, corporate, and Magnolia objectives and policies.

Director of Behavioral Health, Care Management

The Director of Behavioral Health Care Management is an appropriately licensed health care professional with Behavioral Health care management experience. The Director of BHCM works through integration with the Medical Management Department in directing the BH Care Management Program including utilization management, BH Complex Case Management and quality improvement activities. The Director of Behavioral Health reports to the Senior Director of Medical Management and works collaboratively in developing department objectives and goals, coordinating with other departments on research and implementation of best practices, is responsible for the statistical analysis of program data and implements changes to behavioral health service functions and performance in relation to state, corporate and Magnolia objectives and policies.

Care Management (CM) Manager and/or Supervisor

The CM Manager is a registered nurse or other appropriately licensed healthcare professional with Care Management experience. The CM Manager directs and coordinates the activities of the department including supervision of Case Managers, Social Services Specialist, Program Coordinators, and Connections Representatives. The CM Manager reports to the Director of Medical Management. The CM Supervisor works in conjunction with the CM Directors/Managers and Utilization Management staff to execute the strategic vision in conjunction with Centene Corporate and Magnolia objectives and attendant policies and procedures and state contractual responsibilities. The CM Manager/Supervisor is responsible for ensuring that the CM staff is operating within their scope of practice.

Integrated Care Team (ICT) Staffing Model

Care Management Teams are generally comprised of multidisciplinary clinical and non-clinical staff. This integrated approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. The teams utilize a common clinical documentation system to maintain centralized health information for each member that includes medical, behavioral health, discharge planning and all other services the member receives. The clinical staff consults with and/or seeks advice from the Medical Director as indicated. Based on severity and complexity of the member needs, a Care Manager's average case load would be 80-120 cases. ICT roles include:

Medical Director

- Physician who holds an unrestricted license to practice medicine in Mississippi and is Board Certified with experience in direct patient care.

- Serves as a clinical resource for Case Managers and members' treating providers.

- Facilitates multi-disciplinary rounds on a regular basis to discuss, educate, and provide guidance on cases.

- Provides a point of contact for providers with questions about the Care Management process.

- Communicates with practitioners as necessary to discuss Care Management issues.

- Can provide face to face member interaction as necessary based on member's specific needs.

Care Manager

- Licensed Nurse (CCM credential preferred)

- Accountable point of contact for all members in complex care management/high risk Care Management. Responsible for oversight of non-clinical members of the integrated team. Ensures staff is operating within their scope of practice.

- Responsible for working with the member and their provider to identify needs and create a care treatment plan to help the members achieve their goals.

- CM (BH) Coordinates with the ICT team, BH and Physical health providers and pharmacy as a fully integrated Care Management Team.

- Communicates and coordinates with the member and their caregivers, providers, behavioral health providers, Disease Management health coaches, and other members of the Care Management multi-disciplinary team to ensure that member's needs are addressed.

- Provides face to face member interaction at point of service as determined by member's specific needs and goals of care treatment plan.

Social Services Specialists (SSS)

- SSS are licensed social workers or college graduates with a background in social services or other applicable health related field who may or may not be licensed.

- Works under direction of the Care Manager (PH and BH), performing member outreach and care coordination.

- Licensed program specialists can provide face to face member interaction as directed by the Care Manager.

- SSS provides socioeconomic support and assistance through resources and community support driven by the Resource Data Base. Resources given are followed up on for utilization by member via outreach, communication, coordination and a self-management plan.

Program Coordinator (PC)

- Non-clinical staff person

- Provides administrative support to Care Management team.

- Collects data for Health Risk Screening.

- Provides educational promotion, member follow up, arranges PCP visits, and performs care coordination under direction of the Care Manager.

- Find a Provider and Provider options for all members.

Community Connections Representative (CCR)

- Community Connections Representatives are workers typically hired from within the communities served to ensure that outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area.

- Works both in the office and in the community with face to face member interaction at point of service.

- Performs member outreach, education, and home safety evaluations.

- Assists with community outreach events such as: Health Check Days, Healthy Lifestyle events, Baby Showers, Diaper Days, Library/Reading Events, etc.

- Assists with Connections Plus cell phone and Safelink programs, texting programs, etc.

Other licensed/certified staff that may be included in the Integrated Care Teams

- Quality Coordinators and Clinic based Health Check Coordinators

- Pharmacists, etc.

- Any licensed/certified staff utilized for face to face member interaction, will be fulfilling care treatment plan goals or actions within their respective scope of practice, and will do so at the direction of the Care Manager.

Information Systems

Assessments, care plans, and all Care Management activities are documented in a central clinical documentation system which facilitates automatic documentation of the individual user's name, along with date and time notations for all entries. The clinical documentation system also allows the Care Management team to generate reminder/task prompts for follow-up according to the timelines established in the Care Management care plan. Reminders/tasks can be sent to any team member, e.g. allowing Care Managers to request that non-clinical staff arrange for referrals to community resources.

The clinical documentation system contains additional clinical information, e.g. inpatient admissions, outpatient referral authorizations, reviews by Medical Directors, etc. related to the member. It also houses documentation of other activities regarding the member, such as letters sent, quality of care issues, etc. In addition, the clinical documentation system enables the Care Manager to add all providers and facilities associated with the member's care to a list which allows the information to be readily available without having to review authorization and referral data. These features permit the Care Management team to easily access all clinical information associated to a member's care in one central location.

The clinical documentation system is maintained and accessible twenty-four (24) hours per day seven (7) days per week by members of the Care Management Team as needed.

The clinical documentation system has a biometric data reporting feature that can be utilized to manage members on a daily and ongoing basis. It contains modules that allow graphing of measures such as blood pressure, lab values, daily weights, etc. which can be used to track progress and measure effectiveness of Care Management interventions.

Member Access to Required Services

Members will have available the following services as part of Magnolia Health Plan:

- Assignment to a Care Manager as a point of contact for members stratified to High or Medium risk categories

- Access to Member Services call center

- Assistance with care coordination for Primary Care, Inpatient Services, Behavioral Health/Substance Use Disorder Services, Preventative and Specialty care services as needed

- Coordination of discharge planning and follow up to care post inpatient discharge

- Coordination of discharge planning and follow up care post discharge from a PRTF

- Coordination with other Health and Social programs such as SMDH's PHRM/ISS program, Individuals with Disabilities Education Act (IDEA), WIC, Head Start, school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, the Department of Human Services, Community based services and free care initiatives and support groups.

- Respond to member inquiries regarding clinical care decisions that promote Member self-direction and involvement

- When requested by members, identifying participating providers, facilitating access and assisting with appointment scheduling when necessary

- Provide information about the availability of services and access to those services

- Working with Members, Providers, and other Contractors to ensure continuity of care and population health management.

- Following up with Members and Providers which may include regular mailings, newsletters, or face to face meetings as appropriate.

MEMBER IDENTIFICATION AND ACCESS TO CARE MANAGEMENT

A key objective of Magnolia Care Management Program is early identification of members who have the greatest need for Care Management services. This includes, but is not limited to, those classified as children or adults with special health care needs; with catastrophic, high-cost, high-risk or co-morbid conditions; who have been non-compliant in less intensive programs; or are frail, elderly, disabled, or at the end of life.

Data sources

Members are identified as potential candidates for Care Management through several data sources, including, but not limited to:

- Predictive modeling software (Impact Pro™)

- Administrative data: claims or encounters

- Direct referral

- Hospital discharge data

- Pharmacy data

- UM data - e.g. hospital admission data, NICU reports, inpatient census, precertification/prior authorization data

- ED Utilization reports

- Laboratory data

- Readmission reports

- State/CMS Enrollment Process and other State/CMS supplied data

- State defined groups such as Children with Special Health Care Needs and Aged, Blind, and Disabled (ABD)

- Information provided by members or their care givers, such as data gathered from Health Risk Screenings

- Information provided by practitioners, such as Notification of Pregnancy (NOP) and Provider Referral Forms for CM and or DM services.

Reports identifying members for Care Management are reviewed by management staff at least on a monthly basis and forwarded to the Care Management team for outreach and further review for Care Management.

Referral sources

Additionally, direct referrals for Care Management may come from sources such as:

- Community/social service agencies – community agency staff are informed of the Care Management Program during interactions with the Magnolia Care Management team in the course of gathering information about available services, coordinating services, etc., and are encouraged to communicate potential Care Management needs to Magnolia staff.

- Delegated entity staff (e.g., vision, dental, DME/home health, etc.) – all delegates have policies and procedures in place addressing coordination of care and referring appropriate members for Care Management. Magnolia CM staff also regularly communicates with delegates through oversight meetings, Care Management rounds, coordination of care programs, etc., and makes referrals to the delegated entities as needed.

- Disease Management (DM) Health Coaches – Envolve People Care-Disease Management, the DM vendor for Magnolia, works closely with the Magnolia Medical

Management department and Care Management staff to refer members who could benefit from more intensive services. Policies and procedures are in place regarding coordination of care, and regularly scheduled meetings, such as Care Management rounds, are held between the Care Management team and DM staff.

- Division of Medicaid (DOM) – written, electronic, or telephonic requests for assistance, including Care Management evaluation, may be made to the Plan by DOM.

- Health care providers – physicians, other practitioners, and ancillary providers. Providers are educated about the Care Management Program and referral process through the Provider Handbook, the Magnolia website, Provider Newsletters, and by Provider Services staff.

- Magnolia Staff -

  o UM staff work closely with Care Management staff on a daily basis and can initiate a referral for Care Management verbally or through a reminder/task in the clinical documentation system when a member is identified through the UM processes, including prior authorization and discharge planning.

  o Magnolia Community Connections Program- Community Connections Representatives (CCRs) are trained on all departments within Magnolia and have a full understanding of all staff functions. CCR's work as an important part of the Care Management team, maintaining care coordination cases or referring members who may benefit from more complex Care Management services.

  o Magnolia Member Services - Member Services staff is also trained on all departments within Magnolia and have a full understanding of all staff functions, including the role and function of the Care Management team.

  o Other intradepartmental referrals e.g., Provider Specialists, EPSDT Coordinators, Pharmacy staff, and QI Department.

- Hospital staff, e.g. hospital discharge planning, Emergency Department staff - facility staff such as PRTF (Psychiatric Residential Treatment Facilities) and IP Behavioral Health Hospitals are notified of the Magnolia Care Management Program during interactions with Utilization Management (UM) staff throughout the utilization review process or by the Care Management staff when coordinating discharge needs. Hospital staff is encouraged to inform Magnolia Utilization Management or Care Management staff if they feel a member may benefit from Care Management services.

- Envolve People Care Nurse Advice Line staff, the nurse advice/medical triage phone service for Magnolia, has policies and procedures in place for referring members to Magnolia for Care Management screening. This may be accomplished via a "triage summary report" that is sent to Magnolia electronically on the next business day after member contact has occurred, or by direct communication with the designated contact person at Magnolia.

- Members and/or their families or caregivers, including parent, foster parent, guardian or medical consenter - members are educated about Care Management services in the Member Handbook, received upon enrollment and available on the Magnolia website, and through contact with Member Services and/or other Magnolia staff.

The specific means, by which a member was identified as a potential candidate for Care Management, whether a data source or other referral source as noted above, is documented in the clinical documentation system for each referral to Care Management. Multiple referral avenues help to minimize the time between need for and initiation of Care Management services. Summary results of the number of members referred by each source are analyzed on at least an annual basis, to assure referrals are being received from a variety of sources.

SCREENING AND ASSESSMENT

As soon as a child enters foster care MDCPS frontline caseworkers call Magnolia to alert them and to provide information on the child so that the care management process can begin.

Member outreach is initiated telephonically at the earliest possible opportunity, but in all cases within 30 days of identification as potential candidates for Complex Case Management. Care Management team staff obtain consent to complete the Care Management screening and/or initial assessment for Complex Case Management once member contact is made. Care Management staff also explains the Care Manager role and explains the function, value and benefits of the Care Management Program to the member and/or their authorized representative or guardian.

General standardized assessments have been developed internally to address the specific issues of Magnolia unique populations. Standardized assessments allow for consistency in application of criteria and objective appraisal of appropriateness of members for Care Management. All assessments are documented in the central clinical documentation system which date/time stamps each activity, including documentation of the staff member completing the activity. An additional, condition-specific assessment may also be completed, to obtain even more detailed information about a member's conditions (s). These condition-specific assessments, such as Sickle Cell, Diabetes and Asthma assessment are derived from evidence-based clinical guidelines.

Members and/or their authorized representative or guardian are always asked if they are willing to participate in the Care Management Program, and are informed they are entitled to decline participation in, or dis-enroll (opt out) from Care Management at any time.. The member/guardian is notified of the potential need for the Care Management team to contact outside sources (providers, significant others, community organizations, etc.) to gather additional information and is informed that member consent is always obtained prior to any contact. Documentation of verbal member consent to participate in Complex Case Management is included in the assessment questions and/or is documented in the clinical documentation system. If a member declines participation, it is also documented.

Members unable to be contacted via telephone are mailed a letter requesting that the member call the Care Management team. CCR may also be utilized when necessary, to assist in outreach for members who are difficult to contact. The CCR may go the member's physical address and attempt to initiate contact. They may also outreach to local community agencies and provider offices in an effort to locate a member. If a CCR is successful in locating the member, they may perform a general screening in person, including observation of the member in their home

surroundings, and identify any potential needs such as safety issues, mobility assistance, living conditions, etc. If necessary, a Health Risk Assessment (HRA) may be completed at the same time. The CCR will get the Care Manager on the phone while at the member's residence to complete the HRA.

Based on application of the criteria in the screening evaluation, the Care Manager sorts the referrals by risk level and contacts the member based on the following:

- High risk – Care Manager Initiates contact to the member as quickly as the member's health condition requires, but no later than thirty days of referral, and completes further comprehensive Health Risk Assessment (HRA) to determine care management needs.

    o Member is unstable and/or has a multiple complex illnesses.

    o Member is currently hospitalized.

    o Member is symptomatic and at risk for immediate emergency room visit, hospital admission, or hospital readmission.

- Moderate risk – Care manager contacts the member and assessment is completed as quickly as required, but no later than thirty days of referral.

    o Member is stable but has complex health needs.

    o Member currently needs routine ongoing physical or behavioral services, which may include but are not limited to PCP visits, specialist visits, home care provider, lab work, medications, or referral and intervention by community organizations.

- Low risk – Care Manager contacts the member and completes the assessment no later than thirty days from referral.

    o Member is stable but the screening indicates a possible risk for a potential problem or complication.

    o Member has a history of illness or injury but currently requires little or no medical, behavioral, or social support services; or, if they do, the family is managing the care well.

    o Rising Risk-while a member will be stratified into one of the above three categories. A member with new or catastrophic diagnoses and Foster Care and Under 21 pregnant will be set and tracked as Rising Risk as per contract with the Division of Medicaid. This will trigger CM ICT to monitor and support a rising risk member for a better outcome.

The Care Manager reviews all available information, including pertinent past and present medical history gathered from the screening assessment, referral source, and/or reports. Care Managers also access pharmacy and claims data if available that provide information regarding pharmacy utilization and treatment adherence. This review allows the Care Manager to identify specific areas of focus for the member based on their diagnosis and/or medical treatment history. The risk level will determine the intensity of interventions and follow-up care that is required for each

member.   One care contact based upon prevailing diagnosis/condition with integrated team wrapping around other necessary services.

During the in-depth Case Management assessment, the Care Manager evaluates the member's situation holistically, including:

- The member's health status, including condition–specific issues and likely co-morbidities.

- Documentation of the member's clinical history, including disease onset, key events such as acute phases and inpatient stays, treatment history, current and past medications, and compliance with current and past therapies and monitoring.

- Identification of the severity of the Member's conditions/disease state

- Assessment of activities and instrumental activities of daily living.

- Assessment of barriers to meeting goals, for example social barriers to treatment adherence such as transportation, childcare needs, etc.

- Assessment of mental health status (e.g. presence of depression and/or anxiety) and cognitive functioning.

- Assessment of psychosocial issues such as alcohol or drug dependency, smoking, significant life stressors, etc.

- Assessment of visual or hearing impairments.

- Assessment of life planning activities such as living wills, advance directives, etc.

- Evaluation of ethnic, cultural and linguistic needs, preferences or limitations.

- Evaluation of caregiver resources and level of caregiver involvement in care plan implementation.

- Assessment of personal resources and limitations.

- Evaluation of available benefits and other financial resources; referrals to community resources.

- Assessment of educational and vocational factors.

- Demographic information including living situation/housing, legal status, and employment status

Care Managers also frequently reach out to the referral source, the member's PCP, other providers, hospital case managers, and any others involved in the member's care, to gather additional information that can assist in building a complete picture of the member's abilities and needs. The role and function of the Care Manager is also explained to the member's family, providers, etc. Member consent as required is always obtained prior to any contact with outside sources and is documented in the clinical documentation system. Placement into Care Coordination, Low Level Care Management, Moderate Level Care Management, Complex Care Management, or High

Level Transitional Care Management occurs following this review and may be revised upon even further assessment.

Members assigned to the medium risk level will receive all services included in the low risk level and the following services at minimum;

- Facilitate relapse prevention plans for Members with substance use disorder, depression, and other high-risk behavioral health conditions and their PCPs/Community Mental Health Centers/Private Mental Health Centers

- Partner with Provider practices having higher medication adherence rates to identify best practices and leverage tools and education to support practices with lower rates of adherence

- Educate Provider office staff about symptoms of exacerbations and how to communicate with the patient

- Develop speaking points and triggers for making emergency appointments

- Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors or unmet needs

Members assigned to the high risk level receive all services included in the low risk and medium risk levels and the following services, at minimum:

- Inter-disciplinary treatment teams to assist with development and implementation if individual medical treatment plans

- List of community resources (for referral) including Medicaid PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.

- Identify providers with special accommodations (e.g., sedation dentistry)

- Educate staff about barriers Members experience in making and keeping appointments

- Facilitate group visits to encourage self-management of various physical, substance use disorder, and behavioral health conditions/diagnoses such as pregnancy, diabetes and tobacco use

- Communicate on a patient-by-patient basis on gaps/needs to assure patient has baseline and periodic medical evaluations from the PCP

The Care Manager reviews the gathered information and begins to build a care treatment plan if the member is placed into Moderate Level, Complex Care, or Transitional Care Management. The health risk assessment (HRA) is completed no later than 30 days after a member is identified as appropriate, but in most cases is completed earlier. Care Treatment Plan is completed within 30 days of completion of the HRA, but in most cases earlier. Care Management teams may include Care Managers, Program Coordinators, Social Services Specialists, Behavioral Health Specialists, and Member Connection Representatives. Each contributes different skills and functions to the management of the member's care. Each must work within their scope of practice and are

monitored by the Care Manager and human resources department to ensure that this occurs. Other key participants in the development of the care plan may include:

- Member

- Member authorized representative or guardian

- PCP and specialty providers

- Magnolia Medical Directors

- Hospital discharge planners

- Ancillary providers (e.g.. home health, physical therapy, occupational therapy)

- Behavioral health providers

- Representatives from community social service, civic, and religious based organizations (e.g. United Way, Cerebral Palsy, food banks, WIC programs, local church groups that may provide food, transportation; companionship, etc.)

- Other non-health care entities (e.g. Meals on Wheels, home construction companies, etc.)

The Care Management team will utilize predictive modeling software which incorporates pharmacy data to identify and evaluate the Member's risk level initially and ongoing while the member remains in Care Management. The Plan will obtain Division approval for other analysis used to identify Member's risk level prior to use.

Continuity and Coordination of Care between Medical and Behavioral Health Care

When Magnolia staff identifies a member with coexisting medical and behavioral health disorders, the identifying staff will notify a Care Manager.

The Care Manager reviews the member's clinical information, makes sure the member has been referred to the integrated ICM team and that the CM lead is established based on member priority of more severe physical or behavioral health issues.. The Care Manager will consult with the behavioral health Care Manager (or vice versa) to ensure that the member's behavioral health and physical health concerns are addressed in creating the plan of care in full integration between PH and BH whenever necessary.

When appropriate (including but not limited to when the Care Manager is revising the care treatment plan or evaluating a member for discharge from Care Management), the Care Manager and BH Care Manager collaborate with each other to ensure that the necessary expertise is available to monitor and guide member's care. The Magnolia Care Manager includes appropriate behavioral health follow-up or physical health follow up in Care Management discharge planning.

Outreach may also occur to treating providers and individual practitioners when appropriate. The Care Manager assures proper member consent, specific to information pertaining to behavioral health treatment, is obtained prior to any communication regarding the member.

ONGOING MANAGEMENT

Care Treatment Plan Development

The HRA serves as the foundation for the member's care treatment plan for high- and moderate-risk members. The Care Management team identifies issues and needs, and utilizing input from team participants, develops a proposed care treatment plan. The care treatment plan is developed in conjunction with the member; the member's authorized representative or guardian, authorized family members, and the managing physician and other members of the health care team. Behavioral health care coordination is incorporated in the care treatment plan as needed. Prioritized short-term and long-term goals are established and barriers to meeting goals or complying with the care treatment plan are identified, as well as possible solutions to the barriers. The proposed care treatment plan is based on medical necessity, appropriateness of the discharge plan as applicable, support systems to assist the patient in the home setting, community resources/services availability, and the potential for member adherence to the prescribed care treatment plan.

The proposed care treatment plan is discussed with the member and/or member authorized representative or guardian, the PCP/SCP, and the health care team. The member's role is discussed and member/caretaker and provider input is obtained and used to modify the goals according to member's ability and willingness to participate. The Care Manager assures all parties are in agreement with the care treatment plan to ensure successful implementation.

The care treatment plan for members in high risk, complex Case Management includes, at a minimum:

- Prioritized goals and actions with timeframes for completion and member's documented progress towards achieving the goals. Goals are specific, realistic and measurable. Goals are designed to be achievable and to help the member make changes towards the most optimal recovery possible. There should be at least one short-term and one long-term goal prioritized and individualized to meet member needs.

- Identification of barriers to meeting the goals and recommended solutions for each barrier.

- Resources to be utilized, including the appropriate level of care.

- Interventions to reach those goals, including development of member self-management plans. The Care Manager assures the member has a full understanding of their responsibilities regarding the self-management plan and is in agreement with it. The Care Manager ensures follow-up on the self-management plan at every subsequent contact.

- Planning for continuity of care and effective and comprehensive transitions of care between settings.

- Collaboration with and involvement of family and significant others, health care providers, etc.

- Documentation in the notes of a schedule for on-going communication with the member and other involved parties, based on individual needs and member preference including anticipated frequency of contacts

- Communication plan with PCP/SCP to ascertain the needs the provider has identified and prioritized including a process to ensure the provider's treatment plan is reflected in the treatment plan developed by Magnolia.

- Identification of providers responsible for delivering services

- Identification of referrals made to specialists or providers and confirmation that the member received these services and follow up care as indicated

- Referrals to community/social/recovery support agencies including assisting members in contacting the agency and validating member received needed service.

- Continuous review and revision of the care treatment plan.

- Provision to report feedback to provider on member compliance with care treatment plan.

- Time limits – providing points in time for which successful outcomes can be determined, and agreement with the member/guardian on how progress will be demonstrated.

- Maintain treatment plans and referral services when the member changes PCP

- Documentation of all Urgent Care, emergency encounters and any medically indicated follow ups.

The care plan is derived from evidence-based goals and interventions outlined in condition-specific clinical guidelines, such as for diabetes and asthma management, and nursing-based guidelines for issues such as skin integrity, mobility, safety, etc.

Transition of Care

Care managers will assist member's transition their care when any of the following situations occur:

- Provider is no longer available through the participating network

- Members who dis-enroll from Magnolia Health

- Receive new members who transition from another contractor

When a provider leaves the network and remains in good standing, members will be allowed to continue an ongoing course of treatment or access services from Out-of-network Providers for sixty (60) days.

When members dis-enroll from the Plan, the Plan is responsible for transferring to the Division, the Member's Care Management history, six (6) months of claims history, and pertinent information related to any special needs of the transitioning member.

When the Plan receives a transitioning Member with special needs, the Care Manager will coordinate care with the former plan so that services are not interrupted, and will provide the new Member with service information, emergency numbers, and instructions on how to obtain services.

Magnolia Health Plan Process for Monitoring and Evaluation

Once the care treatment plan is agreed to, agreement is documented in the clinical documentation system and timelines are put into place to evaluate and monitor the effectiveness of the plan. Care plan appropriateness is monitored at least monthly, and revisions to the care treatment plan are made when necessary, e.g. when the member's condition progresses or regresses, when goals are

reached, etc. Significant revisions to the care treatment plan are also shared with the PCP or specialist as appropriate. A schedule for continuous review and revision which includes follow-up and monitoring of the member's progress is developed, using as a minimum the intervals defined according to priority level and current needs. The Care Manager may assign tasks to other members of the Care Management team, such as a Social Services Specialist to manage or assist with psychosocial issues or a Program Coordinator to assist with coordination of non-clinical functions such as verifying appointments, obtaining lab results, etc.

The clinical documentation system allows for automatic reminders/tasks to be created for each case, alerting the Care Management team when follow-up contacts are needed. Follow-up reminders can be set for daily, weekly, monthly, etc. Intervals for follow-up are based on the goals and time lines in the Care Management care plan.

The Care Manager is responsible for oversight to ensure all information is documented by the appropriate team member and is updated after each contact with the member, providers, or other involved parties. The information documented in the clinical documentation system includes, but is not limited to:

- Member or caretaker agreement to participate in the Care Management Program (agreement may be oral or written; if oral, the Case Manager documents the discussion with the member/caretaker).

- Notes, including a summary of team conferences and all communications with the member/family, health care providers and any other parties pertaining to the member's care.

- Provider treatment plan developed by the PCP in collaboration with the member/caretaker outlining the course of treatment and/or regular care monitoring, if available.

- The Care Management care treatment plan, including:

    o Prioritized goals, barriers to meeting the goals and/or adhering to the care plan, identification of gaps between recommended care and the care that is received by the member and interventions for meeting the member's goals and overcoming barriers.

    o Provision for input to the care treatment plan by the member

    o Provision to share the care treatment plan when requested by the provider

    o Schedule for continuous review and follow-up and communication with the member, member's family, providers, etc.

    o The member's self-management plan.

    o Progress toward meeting the goals outlined in the care plan, changes to the care plan, goals attained, etc. as described below.

The Care Manager regularly evaluates the member's progress considering the following factors:

- Change in the member's medical or behavioral status.

- Change in the member's social stability.

- Change in the member's functional capability and mobility.

- Progress made in reaching the defined goals.

- The member's adherence to the established care treatment plan, including adherence to the self-management plan such as monitoring of weight, activity level, glucose levels, etc.

- Changes in the member or family's satisfaction with the Care Management Program and other services addressed in the care plan.

- The member's quality of life.

- Benefit limits and financial liability.

The Care Manager completes a re-assessment and updates the risk level, at any time the member has a significant change of condition. The plan of care is also updated at these times and shared with the PCP or specialist, as appropriate.

The Care Manager implements necessary changes to the care treatment plan and modifies the goals based on the findings of on-going evaluation. The Care Manager contacts the PCP, or other members of the multi-disciplinary health care team, as needed to discuss modifications and obtain an updated medical treatment plan. The Care Management team considers alternatives in health care delivery settings and available funding options during the process and communicates the alternatives to the providers and the member/family. Any changes in status, goals, or outcomes are documented in the clinical documentation system. As with the initial development of the care treatment plan, the Care Manager assures all involved are in agreement with changes to the care treatment plan to ensure ongoing success. The Care Management team also monitors the care on an ongoing basis for quality indicators and, if present, makes the appropriate referral to the Quality Improvement department.

Discharge from Care Management

The Care Manager will evaluate case information on the member to determine if the member is appropriate for discharge from the Care Management program. The Care Manager may receive input from the PCP, member/family/guardian/caretaker, and other health care providers involved in the member's care treatment plan to determine the appropriateness for closing the case. With the exceptions of member refusal, member expiration, and inability to maintain contact with member, discharge from high- or moderate-level care management will include a transitional period to a lower level of care (disease management or care coordination) to ensure stability and adherence to established treatment plans. The following criteria are used on an ongoing basis to determine when discharge from Care Management should occur:

- Member terminates with Magnolia.

- Member requests to dis-enroll (opt out) from the Care Management Program.

- The member/family refuses to participate in Care Management despite efforts to explain how it can benefit the member.

- The member reaches maximum medical improvement or meets established goals regarding improvement or medical stability (which may include preventing further decline in condition when improvement is not medically possible) and is directed to community resources.

- Member expires.

If the above criteria indicate a case should be closed, the Care Manager, as appropriate:

- Discusses the impending discharge from Care Management with the member/family.

- Explains to a member who wishes to decline further care management how it can be of help to them and encourages the use of care management services. Community resources may also be presented as an option.

- If high risk, complex Case Management has been refused by the member/family, the Care Manager provides the member with contact information for future reference and documents the refusal in the clinical documentation system.

- Coordinates care with the new medical entity and community resources as required, allowing for a smooth transition for the member if the member is transitioning to another plan.

- Contacts the PCP and other providers, when appropriate, regarding impending discharge from Care Management.

A letter noting the member is discharged from Care Management is generated and sent to the PCP and the member. The letter includes, if the member has not terminated with Magnolia, a reminder to contact the Care Management team in the future should medical concerns arise. The case is closed in the clinical documentation system and the circumstances and discharge activities are thoroughly documented.

PROGRAM ASSESSMENT AND IMPACT MEASUREMENT

Population Health Management Assessment

At least annually, Magnolia CMD and VPMM and designees will assess the entire member population and any relevant subpopulations to determine if the Care Management Program meets the needs of all members eligible for Care Management. Data utilized for assessment of the entire member population includes information provided by CMS and/or the state agency and includes information such as age, gender, ethnicity, race, and/or primary language, and benefit category. The population assessment will specifically address the needs of children and adolescents, individuals with disabilities, and members with serious and persistent mental illness.

Results of the population assessment are analyzed and subsequent enhancements made to the Care Management Program if opportunities for improvement or gaps in Care Management services are identified. Potential revisions to the Care Management Program may include:

- Changes related to number of staff or staffing ratios, reduction in caseloads, etc.

- Revisions to types of Care Management activities assigned to specific members of the Care Management team (e.g. clinical versus non-clinical staff responsibilities).

- Implementation of targeted training, e.g. related to cultural competency, specific medical or behavioral health conditions, cross-training for medical and behavioral health staff.

- Improvement in identification of appropriate community resources provided to members and process for assisting members in accessing resources.

The annual population assessment is reported by document/report form to NCQA and included as part of an annual Utilization Management Program Evaluation and will be presented to the Magnolia Medical Management Sub-Committee, the Magnolia Quality Improvement Committee, and Magnolia Board of Directors for review and feedback.

Satisfaction

Member satisfaction with the Care Management Program is assessed no less than annually. Member satisfaction surveys, specific to Care Management services, are completed at least annually for members enrolled in Care Management. Surveys are completed via mail, or telephonically for members who have been enrolled in Care Management. The results of the surveys are aggregated and evaluated annually both quantitatively and qualitatively and are included in the overall evaluation of the Care Management Program, which is a part of the Utilization Management Program Evaluation as described below.

Member complaints and grievances regarding the Care Management Program are also monitored no less than quarterly. Results of the analysis of member satisfaction surveys and the monitoring of complaints/grievances are used to identify opportunities for improvement, set priorities and determine which opportunities to pursue regarding changes to the Care Management Program, as needed.

Outcomes

Care Management Program outcomes are evaluated at an aggregate level looking at the following key areas:

- Reduction in medical costs.

- Improved clinical outcomes.

- Member/provider satisfaction.

- Plan specific state requirements/expectations.

- Reduction in hospital readmissions.

- Reduction in Length of stay for NICU infants.

Magnolia measures effectiveness of complex Case Management no less than annually using at least three measures that identify a relevant process or outcome and are based on valid methods that provide quantitative results. Measures of effectiveness may include indicators such as:

- Readmission rate for members in complex Case Management with specific diagnoses such as CHF or asthma.

- Repeat ED visits for members in complex Case Management.

- Rate of members in complex Case Management who received the annual flu vaccine

- Rate of members at risk of pre-term birth receiving 17-P/Makena for members in complex Case Management

Plan will set a performance goal for each measure, clearly identify measure specifications, analyze results, identify opportunities for improvement, and develop a plan for intervention and re-measurement. Measurement and analysis of the Care Management program is documented as part of the annual Utilization Management Program Evaluation. The Care Management Program is evaluated at least annually and modifications to the program are made as necessary. Magnolia evaluates the impact of the Care Management Program by using:

- Results of the population assessment.

- The results of member satisfaction surveys (i.e. members in Care Management).

- Member complaint, grievance, and inquiry data regarding the Care Management Program.

- Practitioner complaints and practitioner satisfaction surveys regarding the Care Management Program.

- Other relevant data as described above.

The evaluation covers all aspects of the Care Management Program. Problems and/or concerns are identified, recommendations for removing barriers to improvement are provided, and opportunities to improve satisfaction are identified. The evaluation and recommendations are submitted to the Utilization Management Committee for review, action and follow-up. The final document is then submitted to the Board of Directors through the Quality Improvement Committee for approval.

Condition Specific CM and DM Programs

Members in condition specific care/disease management programs are identified, screened, and managed as documented in the individual programs' policies and procedures. The Care Management policies provide the instructions for identification, referrals, screening and assessment, plan of care development, implementation, monitoring and evaluation, coordination with behavioral health, and discharge from Care Management when not specifically addressed in the program. Disease Management has been delegated to Magnolia Disease Management vendor (EPC Disease Management) and Magnolia Care Managers coordinate care and member interaction to prevent duplication of contacts and services.

Magnolia Condition Specific Care Management Programs may include, but are not limited to:

- Emergency Department Diversion Program

- Sickle Cell

- HIV/AIDS

- High Risk Pregnancy

- Transplant

- Children and Adults with Special Health Care Needs

- Discharge Planning/ Transitional Inpatient Care Needs

- Substance Abuse Disorders

- Depression

- Autism

Magnolia Disease Management Programs may include, but are not limited to:

- Asthma

- Diabetes

- Heart Failure

- Weight Loss & Obesity Program

- Hypertension/ Hyperlipidemia

- Smoking Cessation

- Puff Free Pregnancy

MDCPS Continuous Quality Improvement (CQI)

The Case Review Unit) is responsible for conducting regular reviews of child welfare activities in MDCPS regions of the state. The Case Review Unit) evaluates work for consistency with applicable laws and regulations and principles of family-centered practice. The Foster Care Review Unit (FCR) fulfills a federal requirement to conduct an administrative review for all children in foster care every six months. Among other areas, the FCR evaluates the timeliness and appropriateness of services to children and plans for achieving permanency and stability in their lives. The FCR will capture information related to physical, dental and mental health services. Continuous Quality Improvement (CQI) reviews will also capture information related to the physical requirements of the Modified Settlement Agreement. The data reports are used to monitor MDCPS performance and to make decisions about how MDCPS can best serve children and families. Monitoring by both groups will be used to gage what areas of the state need assistance in accessing and utilizing services required for foster children.

As Mississippi moves to implement the provisions of the *Olivia Y.* Settlement Agreement, the Council on Accreditation (COA) standards, and practices within the Child and Family Services Reviews (CFSR), the vision for Continuous Quality Improvement is that the effort is thoroughly integrated into MDCPS' ongoing work and serves primarily as a means of reinforcing the practices which are being implemented in the state. CQI is a means of keeping the mission and vision in clear focus for MDCPS staff in the field and as a primary means of sustaining the improvements

achieved in practice and outcomes over time. For it to serve that function, CQI must actually monitor for the practices put into place and provide sufficient feedback to staff to inform practice, decision making and resource allocation.

Quality Data Collection Sources

The data used to manage the child welfare services in Mississippi and for the effective use by the CQI unit is collected from multiple sources. The primary sources of the data used are monthly MACWIS reports, Foster Care Reviews and Periodic Administrative Reviews (PAD), AFCARS files, and the Evaluation and Monitoring Unit's case reviews.

MDCPS has developed CQI instruments and processes coordinated with and integrated into The Mississippi Child Welfare Practice Model. As the Practice Model learning cycles are completed, MDCPS will develop specific outcome measures and instruments that include the components of the Practice Model. As MDCPS continues to develop CQI instruments and procedures for obtaining information, CQI will make sure that these practices are routinely monitored as a part of the Practice Model, so there is a basis for determining conformity to practice requirements, but also to use the CQI process to reinforce these practices on an ongoing basis at the local level. Similarly, the Settlement Agreement and the CFSR include requirements that are less oriented toward direct practice and more oriented toward the agency's capacity to support good practice in the field.

In developing strategies for implementing the many requirements of the *Olivia Y.* Settlement Agreement, MDCPS understands that these requirements must be presented in ways that caseworkers and supervisors in the field can understand them in relation to their work with children and families and in relation to the mission and values. MDCPS intends for these many requirements to lead to measurable improvements in the outcomes of the work with children and families, rather than simply being put into place as a compliance process. MDCPS' CQI process is designed in accordance with the Mississippi Child Welfare Practice Model (Practice Model), and thereby supports its implementation and sustainability.

Training

Magnolia Foster Care Case Managers have a team of 4 members (3 social workers and 1 registered nurses) with MDCPS nurse and 2 members from Division of Medicaid that train MDCPS front line workers about Magnolia Health Plan and the benefits/services that are available for the foster children in Mississippi under this program. This training is provided on a regional basis covering all MDCPS Regions each year. Trainings began in January 2013. and will continue to be ongoing to educate all staff concerning benefits/services available as well as how to access their services. The most recent trainings were held between May 7, 2019 and June 29, 2019. This training has been successful in helping frontline staff understand the health care needs of children and the benefits and services available to them. The training will continue to be ongoing to educate all staff concerning benefits/services available as well as how to access their services.

Increasing and Improving the Service Array Through Collaboration with Mississippi Department of Mental Health

As of May 2019, there are 51 providers of mental health services for children and youth in the state of Mississippi. MDCPS works closely with Mississippi Department of Mental Health

personnel to increase access to these services for children in foster care. Representatives from MDCPS participate in local Map team meetings. Two representatives from MDCPS participate in monthly State Level Case Review meetings in addition to county staff and other agency personnel as needed.

Mississippi's System of Care (SOC) is a partnership of child and family service agencies and organizations, who incidentally, usually find themselves serving the same children. By working together, they are able to build on each partner's strengths to provide care that is more comprehensive and effective. This coordination also helps reduce the stress on children, youth, and families because they do not have to meet the competing demands of agencies that would otherwise be working independently. MDCPS and DMH are service agencies within the SOC.

On the state level, the Specialized Planning, Options to Transition Team (SPOTT), was designed to help provide a person-centered, recovery-oriented system of care for all Mississippians in need of services. Specifically, it has been developed to support adults, youth, and children who have required mental health treatment in inpatient programs on multiple occasions, linking them with additional services in the community to help them remain successful in their recovery. Members of the SPOTT team meet twice a month and come from a variety of backgrounds and agencies, including private providers and state agencies such as the Division of Medicaid, Department of Human Services, Mississippi Department of Child Protection Services, Department of Mental Health, and the Department of Rehabilitation Services.

In addition, the Interagency State-Level Case Review Team meets monthly and serves children with serious emotional disturbances and complex needs that usually require the intervention of multiple state agencies. The majority of children and youth referred to the State Level Case Review Team are children involved with Child Protection Services. The DMH provides flexible funding to this state-level team and to local interagency Making A Plan (MAP) Teams that are designed to implement cross-agency planning to meet the needs of youth most at risk of inappropriate out-of-home placement. On the local level, Multidisciplinary Assessment and Planning (MAP) Teams serve the target population of children and youth (up to 21 years of age) with serious emotional/behavioral disorders or serious mental illness who are at risk for an inappropriate 24 hour institutional placement due to lack of access to, or availability of, needed services and supports in the home and community or who are returning to a primary caregiver in the community from an inpatient acute psychiatric hospital or psychiatric residential treatment facility. The State Level Case Review Team and the local MAP Teams facilitate the provision and coordination of services across agencies/entities for the target population, facilitate continuity of care for children/youth with serious emotional disorders/serious mental illness, and facilitate support for children/youth with serious emotional disorders/serious mental illness and their families. Membership for the Interagency State Level Case Review Team meets monthly and includes representation from each of the following:

- Mississippi Department of Education

- Mississippi Department of Child Protection Services

- Mississippi Division of Medicaid

- Mississippi Department of Mental Health

- Mississippi Department of Health

- Mississippi Department of Human Services, Division of Family and Youth Services

- Attorney General's Office

Local MAP Teams meet monthly and include representation from each of the following:

- Families
- Local Schools
- Community Mental Health Center
- County Child Protection Services
- Juvenile Justice
- Local Department of Rehabilitation Services
- Local Health Department
- Local Law Enforcement
- Ministers
- Youth Leaders
- Other representatives of children/youth and family service groups or organizations

Crossover X -Pand provides services to children and youth 3 to 21 years of age who are involved in the child welfare/ advocacy system and/or juvenile justice system, referred to as "crossover youth," and those at risk of becoming crossover youth and their families in Lauderdale, Forrest, Jones, and Marion Counties.

The Department of Mental Health will keep MDCPS staff informed of new providers through dissemination of our *Division of Children and Youth Services Directory* via printed copies and/or the DMH website. The directory is updated annually and includes information regarding new and existing mental health programs available for children and youth in Mississippi. All DMH certified and/or funded residential and non-residential programs for children and youth, including therapeutic group home and foster care providers, can be found in the directory. Programs that provide MYPAC services, Wraparound Facilitation, Acute Partial Hospitalization, transitional living services, substance use services, crisis services and respite care are listed in this resource directory. Contact information for Multidisciplinary Assessment and Planning (MAP) Teams serving all 82 counties as well as contact information for the fourteen (14) Community Mental Health Centers and DMH inpatient services is included. A listing of the Psychiatric Residential Treatment Facilities (PRTFs) serving the children and youth of Mississippi is also included in the directory. Finally, the directory highlights new and existing programs available to Mississippi's children and youth through grant funding, such as Mississippi BUDS, N-Fusion, CAN, HYPED 4 Change, and Crossover X-Pand.

Additional Efforts to Improve Service Array through Collaborations

MDCPS is collaborating with all of Mississippi children and youth state serving agencies, health and behavioral health providers, family-centered advocacy, and early childhood entities/organizations to improve physical and behavioral health services provided to children across the state. UMMC and Medicaid are the lead agencies in this exciting project called MS InCK. Since September 2018 the Mississippi partners has been meeting to identify the populations to include in the model, service delivery structure, service level assessments, information

technology infrastructure needs, and desired quality measures and outcomes. Centers for Medicare and Medicaid Services will be providing grant funding through their Integrated Care for Kids (InCK) model to support states with this project. The InCK model is a child-centered, local service delivery with the goal of reducing expenditures and improve the quality of care for children under 21 years of age covered by Medicaid and Children's Health Insurance Program (CHIP). The InCK model will provide through prevention, early identification, and treatment of behavioral and physical health needs ways to ensure children needs are being met. This model will empower states and local providers to better address these needs and the impact of opioid addiction through care integration across all types of healthcare providers. MS InCK goal will be to, improve performance on priority measures of child health, reduce avoidable inpatient hospitalizations and out of home placements, and create sustainable Alternative Payment Models (APM). The goal of the project is to improve early identification and treatment, integrated care coordination and case management services, coordination of child health services and intensive team-based case management.

MDCPS collaborates with MS Division of Medicaid on ways to improve physical and behavioral health services to children in CPS custody. Medicaid Mental Health Office and Coordinated Care Office work closely with CPS Therapeutic Placement Unit to support appropriate placement for children identified as having a Serious Emotional Disturbance and chronic or terminal medical conditions. Many of these placements are coordinated through State Level Case Review (SLCR) or Specialized Planning, Options to Transition Team SPOTT team meetings. CPS and Medicaid work to enroll children in waiver programs when the children meet the criteria for waiver services.

MDCPS currently has a representative that as a member of the Help Me Grow Mississippi Leadership Team. Help Me Grow is a system that builds collaborations across health care, early child care and education, and family support through community outreach and centralized information referral centers. A major focus of the program is support and linkage to appropriate resources for children ages 0 to 5 with special needs through a centralized access point. These resources are available to the public and can be accessed by MDCPS frontline workers, foster parents and biological parents as needed. MDCPS plans to continue being a part of this effort to increase agency knowledge of new resources becoming available to children ages 0 to 5 across the state.

MDCPS collaborates with Families First, Healthy Families MS, Department of Mental Health and the Health Department for referring caregivers and infants being identified as born affected by substances as required by the Comprehensive Addiction and Recovery Act (CARA). MDCPS plans to continue collaborations with these referral sources and will continue to work on identifying other agencies to engage in the referral processes for these infants and caregivers.

Lessons Learned from 2015-2019

Since the development of the prior plan MDCPS has learned more about the medical and mental health needs of the children we serve, available medical resources and gaps in services in some areas. MDCPS also learned since the development of the last plan that the agency would benefit from giving the Nursing Unit an active role in monitoring medical documentation. Based on the lessons learned since the development of the previous plan MDCPS recognized the need for greater communication and collaboration with the Division of Medicaid, MS Department of Mental Health, managed care organizations and other community providers. As a result, MDCPS participates in coordination meetings as often as possible with other organizations to gain

additional insight on ways to strengthen activities related to improving healthcare and oversight of children in foster care and is working to determine additional ways that data from managed care organizations and community providers can contribute to MDCPS data collection related to child wellbeing. Over the next five years, MDCPS plans to continue to worker with the Division of Medicaid, MS Department of Mental Health, Managed Care organizations and other mental health service providers to strengthen procedures and protocol for ensuring that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions or developmental disabilities and placed in settings that are not foster family homes as a result of inappropriate diagnosis. There have been significant efforts made in this area through agency representatives participating in State Level Case Review, SPOTT meetings and Plan of Services and Supports meetings for children identified as having Intellectual and Developmental Disability.

Review of the Plan

MDCPS will review, update and re-organize the Health Care Oversight and Coordination Plan as needed based on information learned and the changing needs of the children and families being served. MDCPS will update the plan based on opportunities for new collaborations and access to new health, mental health and dental services arise for children and families being served by MDCPS. The agency will continue to welcome feedback pertaining to Health Care Oversight and Coordination from community partners and medical professionals.