Jefferson Health Plans

JEFFERSON 200

Care Coordination Support for You and Your Patients

Clinical Programs - Medicaid and CHIP

June 5, 2024

Agenda

Today's presentation will provide a comprehensive look at our clinical programs and resources, including:

- **Clinical Connections**, which conducts appropriate patient follow-up following a health risk assessment and after a hospital discharge to ensure a patient's safe transition to their home.
- **Baby Partners**, which offers coordination of care for pregnant members throughout pregnancy and 84 days after delivery.
- **Pediatric Care Coordination** for children up to age 21, which provides reminders for parents and guardians to ensure patients receive appropriate screenings with guidance from the **EPSDT/Bright Future** requirements, including help for children with high lead levels, high risk asthma, developmental delays, NICU graduates and children with complex needs.
- **Adult Care Coordination** for patients (age 21 and older) with a disability or chronic condition.

Clinical Programs

Designed to address needs of members across the life continuum

Staffed by licensed and non-licensed staff
Supervised by managers with CCM certification-licensed staff obtain CCM certification within 2 years of hire

Program Objectives:

- Support provider's treatment plan and health care goals
- Reduce or eliminate barriers to care, such as social, behavioral health needs

Clinical Programs (continued)

- Critical components for all programs:
  - Collaboration with member, family/caregiver, health care providers, community agencies, and other government program (as appropriate)
  - Member-centric/whole-person focus
  - Voluntary, with the ability to opt out at any time by calling Jefferson Health Plans Member Relations or discussing with the Jefferson Health Plans Care Coordinator
  - Telephonic, face to face, email
  - Follow CM process:
    - Assess Needs
    - Identify Goals
    - Develop Plan to Reach Goals
    - Implement Interventions
    - Evaluate Plan – Goal Achievement or Readjust as needed
  - Use of **Find Help** to identify resources to address social issues that can adversely impact health (SDOH) outcomes

Examples of Services Provided

- Complete needs assessment of physical, behavioral and social needs as well as SOGI, health literacy and ethnic/cultural preferences
- Assist member to prioritize goals and develop plan to address goals
- Referrals to food resources including medically tailored meals and dietary counseling
- Coordination with community resources and programs to address social determinates of health such as childcare, legal assistance, transportation, access to care, utility, financial, and employment/education
- Assistance with appointment scheduling
- Assistance with arranging transportation through Pennsylvania Medical Assistance Transportation Program (MAPT)
- Link to Disease education
- Medication adherence tips
- Behavioral health and substance abuse referrals, as needed
- Collaborative care plan goals and interventions with behavioral health MCO
- Transitioning pediatric members to adult benefits and care
- Additional services needed for members with physical or intellectual disability – may qualify for a PA waiver and requires coordination with DHS agencies and programs such as early intervention

Clinical Programs: Medicaid and CHIP

Clinical Programs activities focus on both long- and short-term goals for members who may require assistance coordinating their care.

Consider any of these programs for your patients:

- Clinical Connections
- Baby Partners Program
- Pediatric Care Management
- Adult Care Coordination

Support Services

- New Member Health Survey
- Member Incentives
- MANNA Medically Tailored Meals

Clinical Connections

- Oversee the member and provider clinical program (special needs) hotlines
  - Triage member and assist with urgent issues
  - Determine if follow up indicated and transition to appropriate care coordination program

- Outreach post inpatient discharge to assist members in adhering with discharge instructions
  - Check in that member following discharge instructions
  - Received any applicable medications, equipment, and home care services
  - Verify, or help schedule, follow up appointment with PCP/specialist
  - Offer medically tailored meals for select diagnoses

- Follow up on select responses within Member Health Survey
  - Question responses scored for stratification of potential risk- members with Medium and High-risk scores referred for additional outreach
  - Select responses trigger referral for member outreach such as missing medications, behavioral health concerns, pregnancy, and multiple conditions

Perinatal Care Coordination- Baby Partners

Care coordination for prenatal and postpartum members	•Various sources to identify members who are pregnant •Referrals for doulas as needed •If not already connected, assist member in connecting with OB practice and encourage attendance at all visits
Postpartum Home Visit	•Outreach within 7 days post delivery to ensure postpartum visit is schedule or assist with scheduling •If member unable to attend office appointment, member will be offered telehealth or home postpartum visit •Care Coordinator stays connected with mother and child through 12 weeks postpartum
Maternal Home Visiting Referrals	•Home visiting community programs that can start during pregnancy or after birth •Provide education on child development and parental
Breast Pump	•Updated distribution guidelines on ordering Breast Pump- can now order and receive in third trimester
Blood Pressure Cuffs	•Updated guidelines and order form for Blood Pressure cuff

Maternal/Child Home Visiting Programs

Non-clinical home visit

Program Eligibility

- Pregnant women
- Children – birth to at least 18 months (some programs can extend to 3-5 years old children)

Examples of programs include:

- Nurse-Family Partnership
- Parents as Teachers
- Early Head Start
- Healthy Families America

Programs focus on:

- Parental education of early childhood development and positive parenting practices
- Assist in detection of developmental delays and connection to additional services
- Promote parent, child and family health and wellness
- Strengthen community connectedness
- Address social issues impacting health and wellness of family

Program Referrals

- Families self-refer
- Baby Partners and Pediatric Care Coordinators educate members and refer pregnant women/families with children 18 months or younger
- Healthcare providers can make referral either directly or contact Baby Partners to make referrals

Pediatric Care Coordination

Healthy Kids

- For Medicaid and CHIP members under the age of 21
  - Reminders about important preventive services (such as lead screening and connection to services for developmental delay concerns) for members under the age of 21
  - Coordinate with OCYF as needed
  - Care Coordination and disease education for children with at risk and complex conditions such as
    - Elevated lead levels
    - Developmental Delay
    - Coordination with Behavioral Health MCO
    - Asthma
    - Diabetes
    - Identify and coordinate

Fragile Children

- Medical members 21 years and younger
- Often receiving shiftcare, medical daycare and/or reside in pediatric long term care facility
- Coordinate wit UM team as well as provider to help member select shift care staffing
- Coordinate with Office of Developmental Programs' Family Facilitator and school as needed as well as child's family and healthcare providers

Adult Care Coordination

- Physical and behavioral health care coordination, disease education, and connection to supplemental benefits and Jefferson Health Plans programs, community resources for adult members with multiple co-morbidities and/or special needs
- Multiple Referral Sources:
  - Predictive Modeling
  - Member/Provider Referrals
  - Government agency referrals
  - Health Survey trigger responses
  - Behavioral Health MCOs
  - Other internal Health Partners teams such as Medical Management and Pharmacy
- Conduct needs assessment with member to identify areas Care Coordinator can assist
- Develop plan of care to address goals and monitor intervention and progress

MANNA Medically Tailored Meal Program

Jefferson Health Plans has partnered with Metropolitan Area Neighborhood Nutrition Alliance (MANNA) to provide medically tailored meals to members with complex health care needs and high-risk pregnancy

This partnership has proved to be successful in helping members

- Understand their diet
- Lose weight
- Improve some important disease state measures like A1c levels
- Engage in their own health care

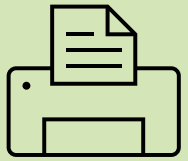
Program consists of 3 meals per day along with nutritional counseling for 12-weeks

At end of 12 weeks, may decide to extend program for additional 6 weeks based on member's progress and adherence with the meal plan

Member Rewards Programs

- Member incentives for completing select preventative and condition management activities annually
- Many of the activities are tied to current measures associated with measures that are part of the Quality Care Plus and the Maternity Quality Care Plus programs
- Members automatically enrolled in the programs
- Members reminded at points throughout the year about these programs- newsletters, phone messages, and social media campaigns
- Members notified when a reward is earned and reminded to claim the reward
- Incentives associated with either Visa gift cards or Uber gift cards depending on the measure

How Can you Refer?

	Call: Clinical Connections: **215-548-4797**
	**EMAIL:** ClinicalConnections@Jeffersonhealthplans.com *Email should include the Referral Form as an attachment*
	**FAX:** Fax the Clinical Programs Provider Referral Form (form on Jefferson Health Plans website HPPlans.com/forms) to 215-845-4181

Together we can improve health care!

Resources & Links

Clinical Program Provider Referral Form	• provider-referral-form.pdf (healthpartnersplans.com)
MANNA Program	• https://www.healthpartnersplans.com/providers/provider-news/2023/meals-as-medicine • https://www.healthpartnersplans.com/media/100897364/manna-physician-referral-form.pdf
Blood Pressure Cuff Order Form	• hdis-blood-pressure-monitor-referral-form-2024.pdf (healthpartnersplans.com)
Breast Pump Order Form	• hdis-breast-pump-referral-form-2023.pdf (healthpartnersplans.com)
Behavioral Health Managed Care Organization Information	• https://www.healthpartnersplans.com/members/health-partners/using-the-plan/drug-alcohol-and-mental-health-services
TIPS (Telephonic Psychiatric Consultation Services Program) – for children	•https://www.healthpartnersplans.com/providers/resources/tips-telephonic-psychiatric-consultation-service-program
Maternal/Child Home Visiting Program	• https://www.healthpartnersplans.com/providers/plan-info/baby-partners
Member Rewards Program	• https://www.healthpartnersplans.com/providers/plan-info/member-rewards-programs
County Assistance Office (CAO) Contact Information	• https://www.dhs.pa.gov/Services/Assistance/Pages/CAO-Contact.aspx
Medial Assistance Transportation Program	• https://www.healthpartnersplans.com/members/health-partners/benefits-overview/transportation

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