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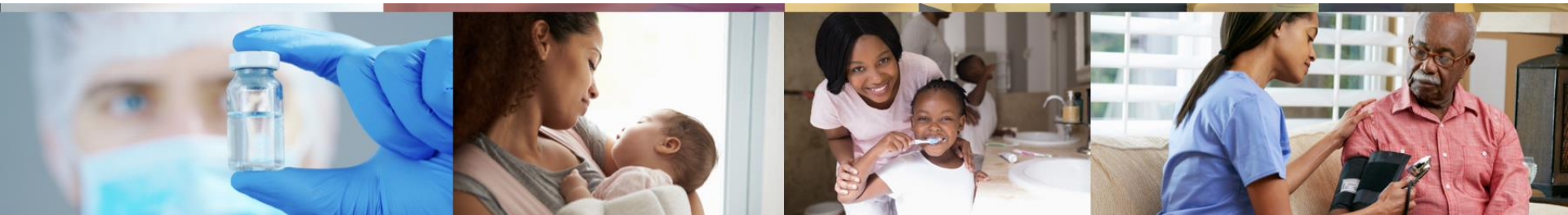
# Maternal Opioid Misuse Model Quarter 3 Design Collaborative

**Medicaid Office of Innovation, Research and Development**

September 14, 2020



*Laura Goodman*

# Agenda and Housekeeping

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# Agenda

- Welcome and Opening Remarks
- Maternal Opioid Misuse (MOM) Implementation Review and Update
- MOM Model Staffing Models and Case Management Workflow
- *Perspectives from the Field:* Panelist Discussion
- Wrap-up and Next Steps



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# Housekeeping

- Please be sure to enter your audio PIN to allow your participation during discussion portions of the agenda.
- We will keep lines muted during the meeting.
- Please send any questions you have through the webinar's question function.
- If we do not directly answer your question during the meeting, we will be keeping a list of 'parking lot' items for follow-up.



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*Tricia Roddy*

# Welcome

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*Laura Goodman*

# MOM Model Implementation Review and Update

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# Section Overview

- Recap: 2020 MOM model activities to-date
- MOM model implementation updates
- Q2 Design Collaborative results
  - Informed consent
  - Round-robin participant engagement strategies
  - Staffing models and workflow
- Summer stakeholder engagement activities
  - Social determinants of Health (SDOH) screening tool feedback and updates
  - Local Health Departments (LHDs), peer support specialists and others
- Next Steps



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# Recap: 2020 MOM Model To-Date

- Two MCO Design Collaboratives
  - SDOH screening tool
  - Core elements for a care plan
  - Participant engagement strategies
  - Data-sharing elements
  - Informed consent
- Major deliverables under development
  - SDOH screening tool and informed consent
  - Care Coordination Module
  - Coverage and payment strategy
  - Provider Incentive Plan



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# MOM Implementation Updates

- MOM model implementation contractor (Mathematica) released the initial data dictionary
- Hosted joint data-sharing meeting with subawardees Hilltop and CRISP to work on MOM data elements mapping process
- Engaged with subawardee Maryland Addiction Consultation Service (MACS) to prepare for Y2 MOM model services
- Updated SDOH screening tool and submitted to Center for Medicare and Medicaid Innovation (CMMI) for preliminary review
- Amended and fully executed all nine MCO CY 2020 contracts, sent finalized invoice templates to release Y1 monies
- Hired MOM Model Coordinator



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# Q2 Design Collaborative 'Homework': Participant Engagement

***Comparability:***

- Strategies presented during Q2 Design Collaborative highly comparable to strategies already in place by MCOs

***Feasibility:***

- Most strategies identified for participant engagement could be implemented with relative ease
- Potential barriers:
  - In-person service delivery and
  - Paraprofessional access to their Electronic Health Records (EHRs)



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# Q2 Design Collaborative 'Homework': Participant Engagement

***Successful Retention/Outreach Strategies:***

- Outreach call/comprehensive onboarding to new members
- Contact through multiple methods (phone, text, email, face-to-face, etc.)
- Establishment of trust/rapport building
- Coordination of care between case managers, providers and LHDs, including Administrative Care Coordination Units (ACCUs)
- Use of incentives
- Deploying community health workers (CHWs)
- Application of shared-decision making
- Dedicated outreach teams/vendors for hard-to-reach members



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# Q2 Design Collaborative Results: Participant Engagement

***Use of Paraprofessionals:***

- Five MCOs currently use CHWs and peers for their members, two additional MCOs interested in using paraprofessionals for the MOM model
- Of the MCOs who currently use CHWs, most reported positive experiences when needing to engage their members and all reported using CHWs in tandem with case managers assigned to their members.

***Use of Incentives:***

- The majority of MCOs specifically mentioned incentives as being an effective strategy for engagement.
- Five MCOs reported planning on using incentives for MOM model participants with preliminary discussions underway around the possibility of tying incentives to enrollment, achievement of program milestones and/or goals
- Two MCOs reported being undecided about incentives, with two opting to utilize their existing incentive programs for the pregnant and postpartum population



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# Q2 Design Collaborative 'Homework': Consent

- Strategies for informed consent discussion:
  - Using clear, easy to understand language
  - Focusing on the positive benefits of participation
  - Rapport-building and answering any questions that arise
  - Educating participants on their rights including the right to opt-out
- Latest draft submitted to CMMI and MCO Consumer Advisory Boards (CABs) for review by their members



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# Q2 Design Collaborative Results: Staffing Models and Workflow

***Staffing Models—LHD Contracting:***

- Five (of seven responses) MCOs interested in either partnering or contracting with LHDs
- Two MCOs preferred using their own case managers and staff.
- This information was shared with LHDs during the Department's summer engagement activities.

# Q2 Design Collaborative Results: Staffing Models and Workflow

***Workflow—Part 2 Release of Information (ROI):***

- MCOs reported a range of responses for when they check for Part 2 ROI including:
  - When the MCO needs additional treatment information
  - Once it is determined a member has a co-occurring behavioral health issue
  - Once an MCO case manager engages with the behavioral health administrative services organization (ASO) for member case management services
  - To verify behavioral health treatment compliance once a member is referred for services



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# Summer Engagement Activities: SDOH Screening Tool Review

The Department reached out to interested MCOs to solicit feedback on the draft SDOH screening tool:

- Presentation at three MCO CAB meetings
- Written feedback from another three MCOs

***Feedback:***

- Redundancy of questions related to disability
- Issues with the question order and length of the screening tool
- Sensitivity around intimate partner violence (IPV) and household substance use

# Summer Engagement Activities: SDOH Screening Tool Review

- Updates
  - Eliminated IPV and neighborhood safety questions and restored to the original community safety questions asked in the Accountable Health Communities (AHC) tool
  - Removed family substance use question and restored tobacco use question
  - Removed the disability questions domain to reduce redundancy
  - Restored family and community support domain and created new maternal and child health (MCH) domain with questions related to pregnancy support and childcare
- The Department submitted an updated SDOH tool to CMMI for review and will work on finalizing shortly.



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# Summer Engagement Activities: Stakeholder Engagement

- Had a follow-up meeting with Mosaic to learn more about their hospital-based program servicing pregnant individuals with OUD
- Continued to engage with MD MOM to leverage opportunities for alignment and prevent service duplication
- Ongoing engagement with other state agencies, including the Opioid Operational Command Center (OOCC), Public Health Services and OD2A
- Ongoing engagement with other MOM awardee states: Tennessee and Indiana



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# Summer Engagement Activities: Stakeholder Engagement

***LHD Engagement***

- Hosted webinar discussing MOM model with LHDs in July with representatives from 13 jurisdictions present
- Sent out a follow-up survey to gauge LHDs interest in engaging with the MOM model
- Engaged with members from Harford, Calvert, St. Mary's and Baltimore Counties individually, in additional to Maryland Area Health Education Center (AHEC) West



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# Next Steps

- Solicit informed consent feedback from MCO CABs prior to IRB submission
- Provide MCOs with an updated SDOH tool once finalized
- Continue to support CRISP in the Care Coordination Module build-out; engage with MCOs on roll-out
- Continue to engage with stakeholders to leverage alignment
- Maintain a list of programs similar to MOM and share with MCOs
- Engage in dialogue around staffing models and approaches



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*Marcia Crandall*

# MOM Model Staffing Model and Case Management Workflow

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# Staffing Model: Overview

**Considerations:** Case management provider types, staffing ratios and models

**Case management literature review:** Models of integrated behavioral health

**Looking forward**: Additional guidance, including a best practices write-up



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# Case Management Ratio Examples

## Improving Mood: Providing Access to Collaborative Treatment (IMPACT)

- Typical caseload: 100-120 participants
- Case managers provider types: Clinical social workers, master's-level counselors/therapists, nurses and psychologists

## Mental Health Integration Program (MHIP)

- Typical caseload: 50-75 participants
- Case manager provider types: Social workers and nurses
- Larger caseloads managed with support from CHWs

## Collaborative Care Model (CoCM)

- Typical caseload: Varies, based on the target population characteristics (One full-time case manager could have a lower caseload of 60-80 participants if they were Medicaid enrollees diagnosed with behavioral health conditions and had limited social supports)
- Case manager provider types: Nurses, social workers, psychologists and licensed counselors

# Case Management Approach Example

The Substance Abuse and Mental Health Services Administration (SAMHSA) notes that effective case management consists of the following set of functions: assessment, planning, linkage, monitoring, and advocacy.

Case manager has been *defined* as an individual responsible for executing case management activities, including assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, and case closure.

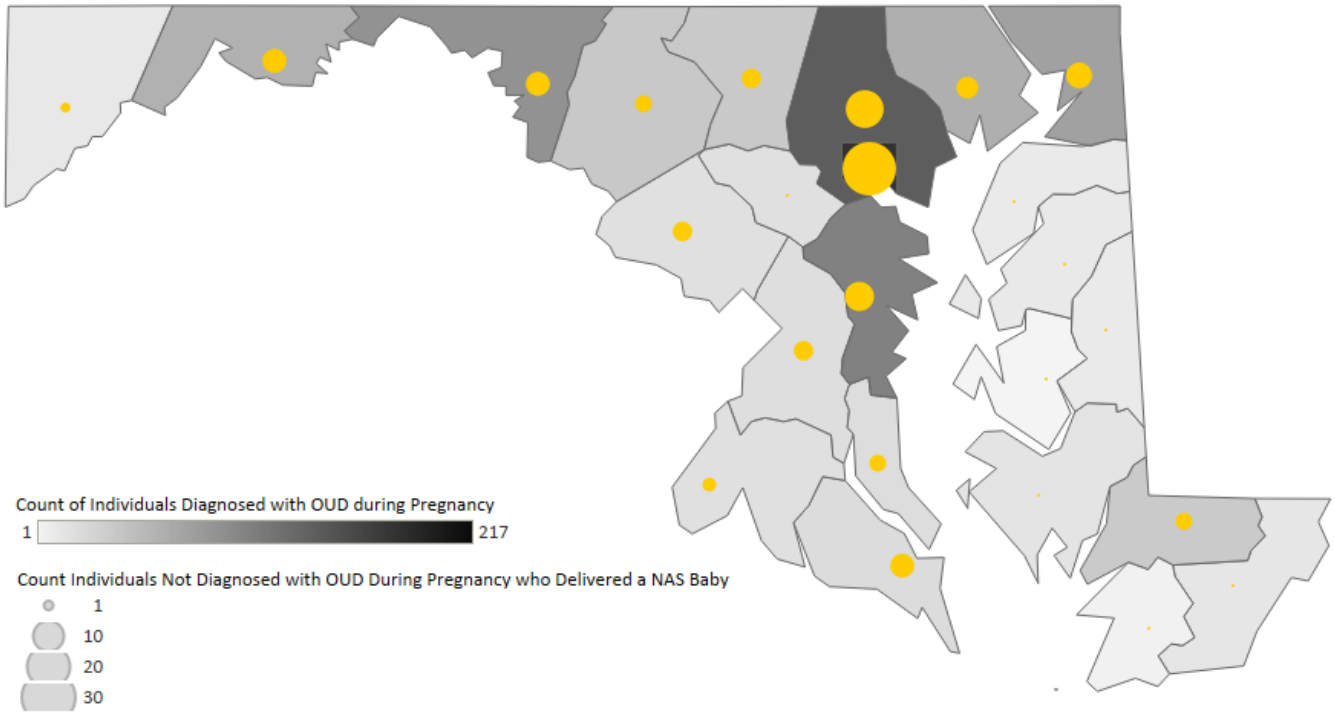
# MOM Model Participant Ratios

The Maryland MOM model proposes having a ratio of **one dedicated full-time MCO case manager per 30 MOM model participants (1:30)** to conduct the required case management activities, which are different from those already offered to pregnant and postpartum MCO beneficiaries.

The number of case managers per MCO needed to implement the MOM model depends largely on:

- The number of eligible participants within each MCO; and
- The geographic location and distribution of potential participants.

# Potential MOM Participants by Jurisdiction



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# MOM Model Case Management Best Practices

- Developing and revisiting MOM care plans during face-to-face meetings
- Jointly developing measurable goals and activities—taking into consideration factors such as available resources, support networks, an individual's cognitive and physical abilities and motivation
- Offering a copy of the MOM care plan to the participant
- Documenting changes or updates to the MOM care plan as well as goal outcomes to track MOM model participant progress
- Engaging family members and the participant's support network to assist participant's with carrying out care plan identified goals and activities



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# MOM Model Staffing Plans

- MCOs must include one or more Medicaid-approved qualified provider type as the designated MOM model case manager(s) in their proposed staffing model.
- MCOs may enlist lay health workers, such as CHWs and CPRSs, to support engagement and outreach activities.
- MCOs also have the option to outsource case management to LHDs or other entities.
- The Department issued a guided staffing plan document to MCOs and has reviewed draft staffing plans submitted to ensure staffing models properly address the requirements of the MOM model.
- MCOs will submit their finalized staffing plans to the Department in December 2020.



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# Case Management Workflow: Overview

The Department reviewed the MOM Model Program Terms and Conditions, data dictionary and original proposal to provide MCOs with required tasks and case management activities that must be completed throughout a participant's participation in the MOM model.

Receipt of MOM model per member, per month (PMPM) payments is contingent upon the completion and proper documentation of highlighted case management activities and associated tasks.

Subsequent to the Design Collaborative, additional guidance will be published on the MOM model website.



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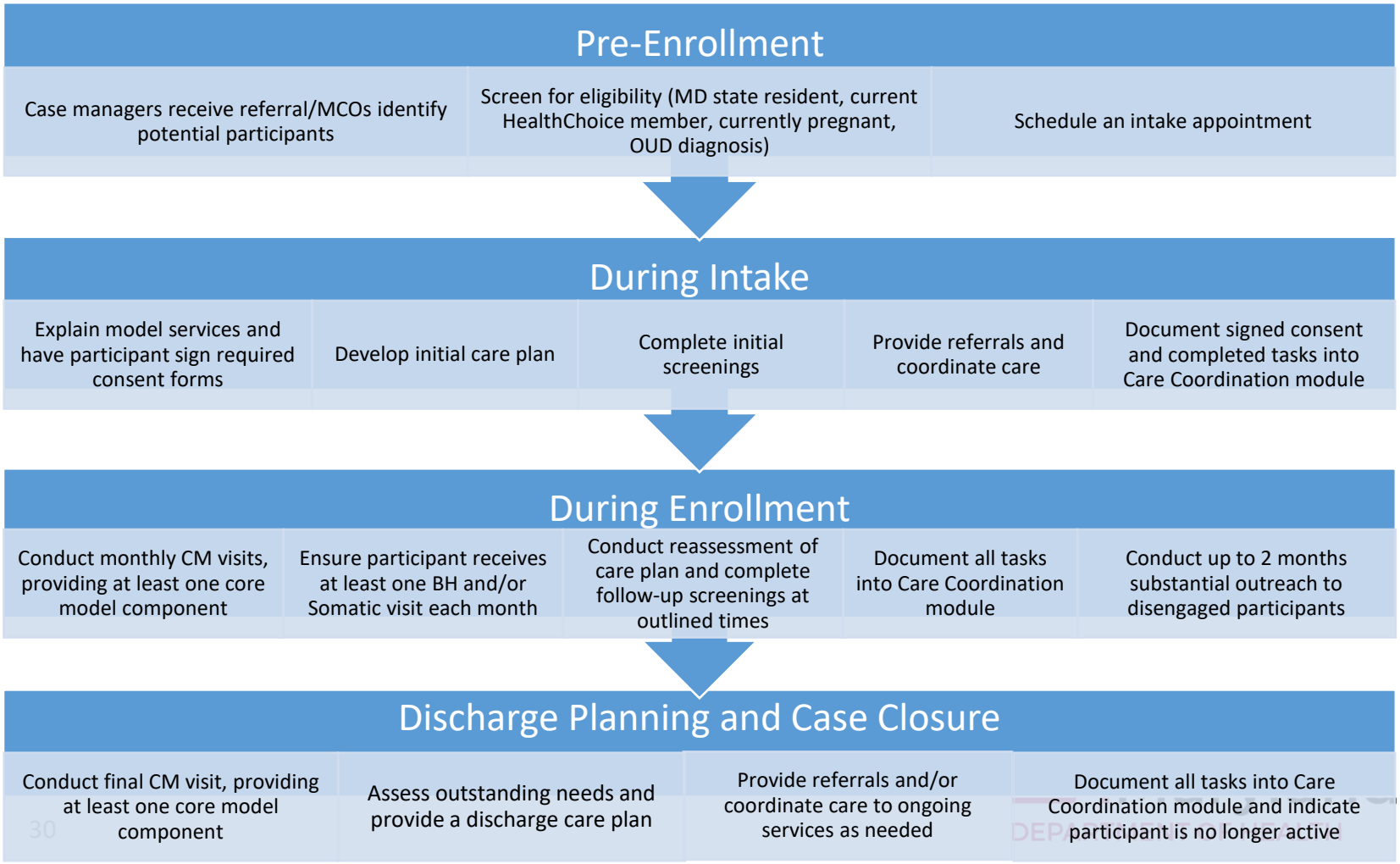
# Case Management Workflow



# Referral Pathways

MCOs identify potentially-eligible participants through the following avenues and forward referrals to case managers:

- *No wrong door referral from other agencies: LHDs, Local Behavioral Health Authorities (LBHAs), law enforcement, emergency departments, somatic and behavioral health providers, Department of Human Services*
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Maryland Prenatal Risk Assessment (MPRA)
- MCO data-mining and enrollment screening
- Referral from behavioral health ASO
- Referral from a community-services organization (CSO)
- See also: Participant Engagement Strategies Brief

# Clinical Eligibility and Intake

- Case managers receive referrals and contact identified potential participants to verify interest and confirm clinical eligibility
  - Current MD state resident
  - Current HealthChoice member
  - Currently pregnant (cannot enroll postpartum)
  - OUD Diagnosis - Must have a formal OUD diagnosis, at any point in participant's medical history, before the participant enrolls into the model. Additional guidance will be forthcoming
- Schedule an intake appointment (conducted in-person*)
  - Review approximate length of appointment and what to expect during session

**Subject to change due to COVID-19*



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# Intake

- Informed Consent
  - Case Manager explains program requirements and participant right to voluntarily participate and withdraw and answers any questions
  - Collect participant signature for informed consent and any other intake forms in addition to those required by the MOM model
- Initial Care Plan
  - Developed jointly during intake session
  - Confirm/collect participant contact information, denote preferred contact method and emergency/secondary contacts
  - Confirm/collect information on all providers participant is currently under the care of and their contact information
  - Identify 2-3 goals based on participant identified areas of need, to be reviewed during every monthly meeting and updated as needed

# Screenings

- Screenings that must be conducted within seven days of MOM model enrollment:
  - **Health Related Social Needs (HRSN)** – adapted Accountable Health Communities (AHC) SDOH tool
    - **Depression** – PHQ-2 is part of AHC tool, a follow-up plan must be created if a participant screens positive. Awaiting guidance from CMMI to determine if additional screening questions are needed
    - **Tobacco** – refer to tobacco cessation if participant screens positive
  - **Participant Activation Measure (PAM)** – enter into the Flourish tool administered by Insignia Health and document participant score in care plan

# Documentation

Case managers need to document all MOM-related tasks within the Care Coordination Module hosted by CRISP in addition to documentation that would normally occur within their EHR.

- Will determine MCO MOM model PMPM payments
- Will support required monitoring and reporting component of the model,
- MCO performance tied to the possibility of additional MOM milestone funding, which may translate to incentive payments for MCOs

# Monthly Requirement: Case Management Visits

The CM will need to fulfill at least one of the five core components on a monthly basis.

The CM will document which core component was completed in the Care Coordination Module under the 'Monthly Contact' tab by checking a box and inserting a date into the date field.

| Monthly Contact | Complete | Date Field |
|---|---|---|
| Comprehensive Case Management | ☐ | MM/DD/YY |
| Care Coordination | ☐ | MM/DD/YY |
| Health Promotion | ☐ | MM/DD/YY |
| Individual and Family Support | ☐ | MM/DD/YY |
| Linkages to Community and Support Services | ☐ | MM/DD/YY |

Insert Date

Check Box



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# Comprehensive Case Management

- Initial SDOH screening, PAM assessment and care plan development
- Development and periodic reassessment of MOM care plan and screenings
- Warm handoffs and referrals to entities that support SDOH, such as the welfare system and employment and housing agencies

# Care Coordination

- Serve as the established case manager across different providers, the behavioral health ASO and CSOs serving the MOM model participant
- Provide appropriate linkages to somatic and behavioral health providers as identified within care plan for infant and mother
- Follow up on needed services and supports

# Health Promotion

- Discussing relapse and creating a relapse safety plan
  - Providing naloxone and educating friends/family on use of naloxone
- Providing literature on Maryland Crisis Connect
  - Available 24/7 to people in need of crisis intervention, risk assessment for suicide, overdose prevention, support, guidance and information or linkage to community behavioral health providers
- Discussing options for family planning
- Nutritional counseling
- Wellness programs
- Education about sexually-transmitted infections and other infectious diseases; *e.g.*, viral hepatitis and HIV/AIDS Preventive healthcare education
- Assisting with medication adherence
- Educating family regarding appropriate infant developmental milestones and healthy attachment behaviors

# Individual and Family Supports

- With participant permission, involving partner and family in care activities
- Training family about the role of relapse and use of naloxone
- Connecting families and children with needed supports such as parenting classes or family counseling

# Linkages to Community and Support Services

- Connecting participants to resources related to the SDOH screening by completing warm handoffs with programs to support the individual participant's needs
- Linking participants with social supports, such as disability benefits, social services, SUD treatment, housing, legal services, life skills training and educational/vocational training
- Key to success: Building relationships between MCOs, LHDs, LBHAs and others to leverage unique local opportunities and programs for MOM model participants

# Monthly Requirement: Health Care Visit

| Behavioral Health Visits | Somatic Health Visits |
|---|---|
| Alcohol and/or drug assessment | Primary Care |
| SBIRT | Specialty Care |
| Individual and/or Group Therapy | Federally qualified health center (FQHC) or other clinic services |
| Family psychotherapy and psychoeducation | Family Planning |
| Medication Management | Dental services for pregnant individuals through date of delivery |
| Ambulatory Detox | Habilitation Services for Expansion Populations:<br>(1) Physical therapy;<br>(2) Occupation therapy; and<br>(3) Speech therapy |
| Intensive Outpatient (ASAM Level 2.1) | OB/GYN Care- Prenatal, perinatal, and postpartum care visits |
| Partial Hospitalization (ASAM Level 2.5) | Labor and Delivery services |
| Opioid maintenance therapy for individuals 18 years or over | Newborn Care and Well Child visits |

Case managers will need to ensure MOM model participants receive at least one behavioral health and/or somatic health visit each month in addition to conducting monthly case management contacts. Examples of behavioral health and somatic health visits are represented in the table to the left.



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# Reassessment

The following assessments and care plan will need to be re-assessed at different times while the participant is engaged with model services:

- SDOH Screening – At least once after the end of pregnancy within 60 days postpartum*
  - Depression – After the end of pregnancy within 60 days postpartum
  - Tobacco – After the end of pregnancy within 60 days postpartum
- SUD – Once within 60 days postpartum**
- PAM – At least 90 days from initial assessment (entered into the Flourish tool and noted in the Care Coordination Module)
- Care Plan – Within 60 days postpartum and as needed during enrollment

*Frequency TBD
**Screening tool TBD



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# Documentation

Document completed tasks into the MOM Care Coordination Module (development and re-assessment of participant goals and indicated barriers, screenings provided, contact information, care team, patient visit and contact type)

Document MOM model core elements provided during monthly visits

Document any contact attempts and type of outreach made when participant misses appointments and case manager visits



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# 60 Days Postpartum through Case Closure

The infant will become the target beneficiary once the participant is past their 60 days postpartum period

The Case Manager will be responsible for reassessing the infant-mother dyad, focusing on a new care plan for the infant

MOM model case management services will focus on parenting, managing stress, and other activities that will contribute to a stable and healthy family environment for the infant

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# 60 Days Postpartum through Case Closure

Case Managers will continue to fulfill the following:

- Monthly case management visits and model requirements (awaiting CMMI guidance on additional somatic and behavioral health services that will count when transitioned to the infant)
- Re-assessments of screenings and infant/dyadic-focused care plan
- Documentation in the Care Coordination Module



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# Substantial Outreach

Substantial outreach is a specific protocol for re-engaging MOM model participants, which case managers will follow in the event that MOM model participants become disengaged from care (*i.e.*, become lost to follow-up).

MCOs will receive a PMPM payment for providing substantial outreach for disengaged beneficiaries for two-month periods.

Participants may be considered in 'substantial outreach,' and MCOs may qualify for PMPM payments multiple times throughout their enrollment period.

There are a variety of loss-to-follow-up activities that the Department will accept to continue the PMPM payment.



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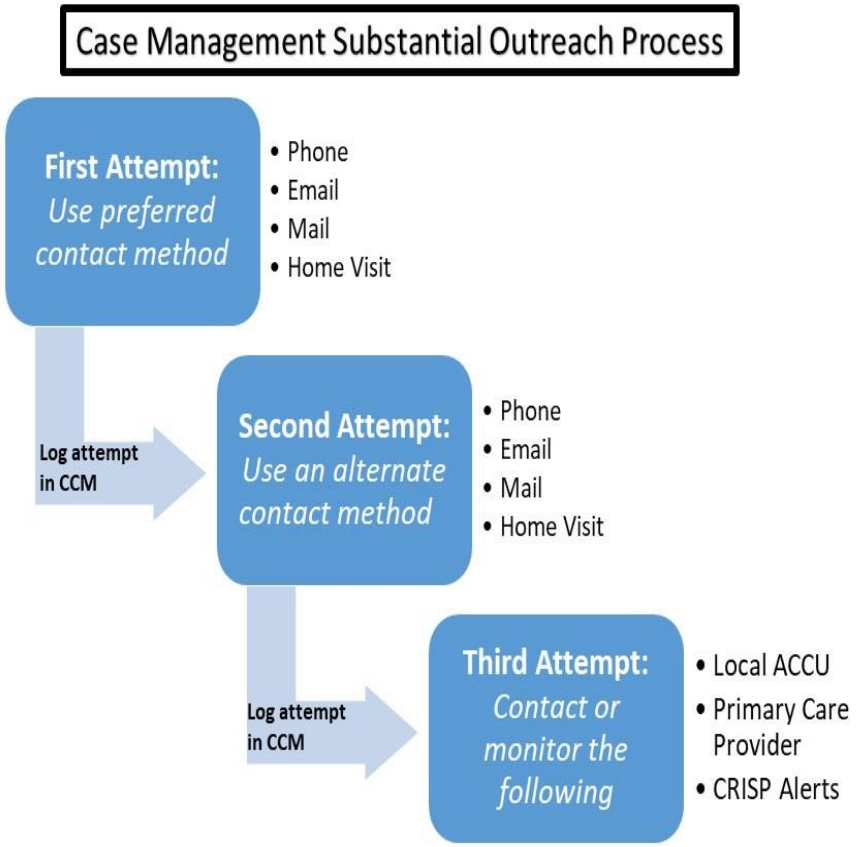
# Substantial Outreach




Case managers will need to follow outreach guidelines for enrolled participants when they first become disengaged from services.

Case managers will need to make three contact attempts per substantial outreach month, to be logged in the Care Coordination Module.



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# Discharge Planning

- Conduct final case management visit, providing at least one core model component:
  - Linkages (wrapping up connecting MOM model participant to social needs)
  - Health promotion (*e.g.,* giving out naloxone; family planning materials)
  - Care coordination and warm handoffs
- Assess outstanding needs:
  - Review care-plan developed goals, determine areas that may need continued support and provide a discharge plan to participant upon the end of services
  - Final SDOH screening and referrals
- Documentation
  - Document all tasks and relevant screenings into the Care Coordination Module
  - Indicate participant is no longer active in services—notating discharge reason—and submit care alert
  - If participant is having their case closed for reasons other than completing services, follow alternative documentation procedure in place of final case management visit

*St. Mary's County Health Department, UnitedHealthcare, Baltimore County Department of Health, Calvert County Health Department*

# ***Perspectives from the Field***

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# St. Mary's County Health Department

Ashley Milcetic

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ST. MARY'S COUNTY HEALTH DEPARTMENT

# Strong Beginnings

Ashley Milcetic, BSN, RN, GC-C
Program Manager

# Overview

2 year CareFirst Maternal Health Program Grant awarded to St. Mary's County Health Department July 2019 – June 2021

Target population:

- Women of childbearing age impacted by Substance Use Disorder (SUD)
- Women of childbearing age with mental health concerns (maternal depression or other)
- Caregivers of Substance Exposed Newborns (SENs)

Goals

- Increase early access to coordinated services
- Ensure access to medical and behavioral health services for Preconception/Prenatal/Postpartum women
- Ensure referral and access to care for Post-Partum reproductive-age women and their children for SUD, positive drug screen at delivery and Substance Exposed Newborns

# Referral Criteria

- St. Mary's County Resident
- Woman of Childbearing Age or Caregiver of Substance Exposed Newborn
- Substance Use Disorder and/or Mental Health Concerns

# Partners

- SMC Detention Center
- Medstar St. Mary's Hospital
- Outlook Recovery Center (Medicated Assisted Treatment)
- Medstar Medical Group Women's Health (local OB/GYN office)
- Others

# Program Components

## Nurse

-Initial Assessment

-Referral to Services

-Baby Basics Curriculum

-Case Management Services

## Peer Recovery Specialist

-Guidance & Support

-Goal Planning

-Referral to Harm Reduction

-Naloxone Dispensing

# Referral Statistics

- Quarter 1- 4 (soft launch of program)
- Quarter 2- 205
- Quarter 3- 110
- Quarter 4- 7 (COVID-19 restrictions)


substance use
care coordination
reporting
delivery
Trust
Trust
WIC
postnatal
caregivers
screens
resources
increase
pregnancy
MAT
educate
PCP
process
mothers
preconception
reporting
prescribed
techniques
encourage
referral
curriculum
provide
destigmatize
NAS
number
destigmatize
Trust
PCP
calendar
strategies
process
treatment
calendar
pharmacological
caregivers
what to expect foundation
partners
St. Mary's County
postnatal
depression
St. Mary's County
community
self
increase
encourage
substance use
techniques
baby basics
MAT
delivery
substance use
educate
self
provide
PCP
prenatal
strategies
depression
NAS
educate
positive drug screen
Substance Exposed Newborn
resources
preconception
depression
provide
NAS
number
WIC
MAT
Maternal
referral
mothers
prescribed
Maternal
pharmacological
number
referral
prenatal
pregnancy
screens
Maternal
care coordination
destigmatize
increase
Substance Exposed Newborn
curriculum
what to expect foundation
St. Mary's County
baby basics
screens
treatment
partners
community
positive drug screen

# LEARN ABOUT LOCAL PUBLIC HEALTH ACTION AT WWW.SMCHD.ORG

SMCHealthDepartment

SMCHD_gov

HEALTHY ST. MARY'S PARTNERSHIP

**Join our local health improvement coalition or sign up for the e-newsletter:**

www.HealthyStMarys.com

# UnitedHealthcare

Renee Roberts

Lystra Thomas

Tiffany Sparkman

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# Baltimore County Department of Health

Amy Appel

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# Calvert County Health Department

Larry Polsky

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# Healthy Beginnings: Maternal Substance Misuse Program in Rural Maryland

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# Particular Issues in Rural Areas

- Lack of specialty care
  - Inadequate behavioral health capacity (outpt and inpt)
  - No Maternal Fetal Medicine specialists
  - No NICUs
- Minimal public transportation
  - Limited geographic coverage
  - Limited hours
- Everybody knows everybody
  - Increases shaming
  - Limits comfort in group therapy

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# Comprehensive Women's Health Services


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# Healthy Beginnings Outcomes

| | Total US Population | National Data for Opioid Users | Healthy Beginnings |
|---|---|---|---|
| 7 or more prenatal visits | | | 77% (96/125) |
| Low Birth Wt (<2500 grams) | 8.0% | *24% | 14% (18/125) |
| NAS (illicit drug) | | *75% | 9% (11/125) |
| NAS (Rx medication) | | | 15% (19/125)<br>10% (10/101)# |
| LARC or BTL | 29% (CDC 2017) | | 73% (91/125) |

* Quality data is difficult to find.
# Excludes year with new pediatric hospitalists and 38% transfer to NICU for "NAS"

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# Outreach Services 2014-2019

- Reproductive Health and Overdose Reduction Education
  - 4,357 people educated
- Blood-borne infection and STI screening
  - 51 (+) screens for hepatitis
  - 2 (+) screens for syphilis; 1 HIV+

- Long-acting reversible contraception (LARC)
  - **1,466 LARC placed**
- Smoking cessation services

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# Facilitated Discussion

Please submit questions via chat or raise your hand.

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# Wrap-Up and Next Steps

- Presentation slides, updated FAQs and Case Management write-up will be posted to the MOM Model Website (link on following slide).
- MCO Staffing Plans
  - Feedback in the coming weeks
  - Updated MCO Staffing Plan due in December
- Save the date: Q4 webinar tentatively scheduled for December 8, 2020



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# MOM Model Contact Information

**General:** mdh.mommodel@maryland.gov

**For resources and updates, check out our website:** https://mmcp.health.maryland.gov/Pages/MOM-Model.aspx

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