



# MOM Model Quarterly Design Collaborative

Medicaid Office of Innovation, Research and Development  
Chesapeake Regional Information System for our Patients

March 31, 2020



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# Agenda and Housekeeping

# Agenda

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- Welcome
- MCO Call Trends and Highlights
- Social Determinants of Health Screening Tool and Presentation
- Core Elements of a Care Plan
- Wrap-up and Next Steps

# Housekeeping

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- 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.
- Please be sure to enter your audio PIN in case timing does allow for discussion.

*Tricia Roddy*

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**Welcome**

*Laura Goodman*

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# MCO One-On-One Call Trends

# MCO Call Overview

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- Medicaid organized one-on-one MOM model calls with all nine managed care organizations (MCOs)
- Opportunity to discuss MOM model in-depth and raise initial questions, concerns, and thoughts
- Several common themes arose across the majority of calls

# Participant Barriers

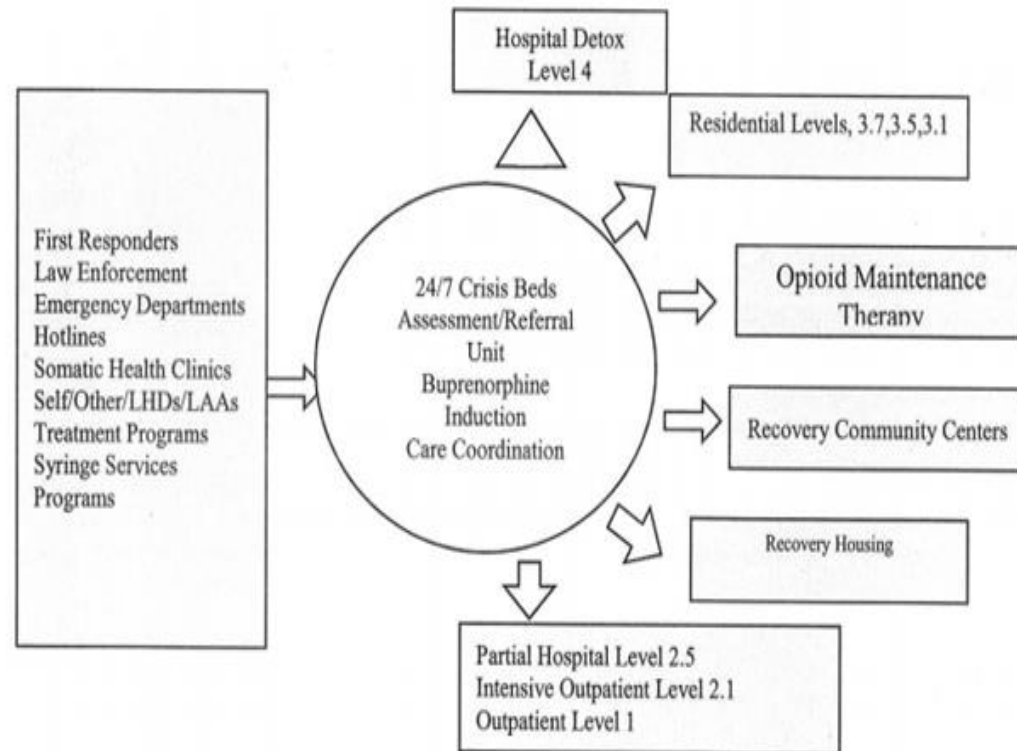
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- The Department is aware that the decision to participate in the MOM Model is sensitive; confidential sharing of data across platforms must be guaranteed as part of the participant consent taken at time of enrollment.
- Historical distrust of the medical system is a barrier to engaging participants.
- Peer Recovery Specialists were cited as an ideal staffing type to build relationships with participants and establish trust.
- The Department will continue to work with CMMI contractors and stakeholders to model potential adverse consequences of MOM model participation for justice-involved and/or social services involved individuals, and develop strategies to mitigate these.



# Identifying Participants

- MOM model participants will likely be identified through a variety of sources including the Maryland Prenatal Risk Assessment (MPRA), MCO “hot-spotting”, ASO referrals and community-based referrals.
- The state employs a “no wrong door approach” to identify eligible individuals.
- The figure to the right illustrates the referral and service pathways for individual seeking behavioral health care in the State.



# Role of Optum

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- MOM Model Case Managers (CMs) will develop a relationship with the behavioral health administrative services organization (ASO, Optum) case managers.
  - Enhancements to the ASO contract, including additional care coordinators
  - Tentatively envision Optum as a referral source of participants to the MOM model
- MCOs will be able to check to see if participants are engaged with Optum.
- The Department plans to resume the high-utilizer data-sharing meetings between the MCOs and the ASO.

# MOM Model Consent

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- MCOs will need to ensure that participants sign an approved consent form to enroll in the MOM model.
- A signed informed consent will allow consent sharing of both qualitative and quantitative data for MOM model evaluation as well as data-sharing for care coordination purposes.
- There will also be the standard and separate release of information (ROI) form that allows data sharing between the ASO and the participant's MCO.
- Tentative approach: A check box within the CRISP platform that denotes consent has been obtained.
  - MCOs would be responsible for storing signed consent forms.

# Data-Sharing

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- The Department will follow up by early Fall 2020 regarding specifics of data sharing and data elements
- CMMI will soon share a data dictionary which the Department will review and share with MCOs as needed
- Multiple MCOs brought up 42 CFR Part 2 concerns
- CRISP Care Coordination module will allow MCOs to report CMMI required, non-claims data including but not limited to:
  - Informed consent for MOM participation
  - SDOH screening
  - Patient Activation Measure

# Model Uniformity and Alignment

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- MOM Model provides some level of flexibility regarding implementation across MCOs.
- Certain elements will need to be uniform to ensure consistent model implementation and allow for robust evaluation.
- Goal of design collaborative is to develop core standards for implementing the model that every MCO will follow.

# Payments and Incentives

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- All MCOs will receive \$50,000 during the first year of the model for planning and design activities.
- This is separate from the per member, per month (PMPM) payments each MCO will receive for during Year 2.
- The Department cannot provide incentives to participants directly and at this time is not mandating provision of incentives to MOM participants.
- MCOs have continued flexibility, subject to federal and state regulations, to provide incentives to MOM Model enrollees for continued engagement and participation.

# Local Health Departments

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- Relationships between MCOs and local health departments (LHDs) vary by jurisdiction; MCOs identified gaps in communication.
- Envisioned MOM Model providing enhanced opportunities to partner with LHDs, increase collaboration and leverage opportunities to build existing mature programs in selected jurisdictions into MCO workflows
  - *Example of a successful partnership between MCO and a LHD:* Utilizing LHDs as the “boots on the ground” to engage with MOM Model participants and building relationships during advisory committee meetings
- The Department is taking several steps to align with similar initiatives across the state and avoid duplication.

*Marc Rabner, CRISP*

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# **Social Determinants of Health Screening Tool**



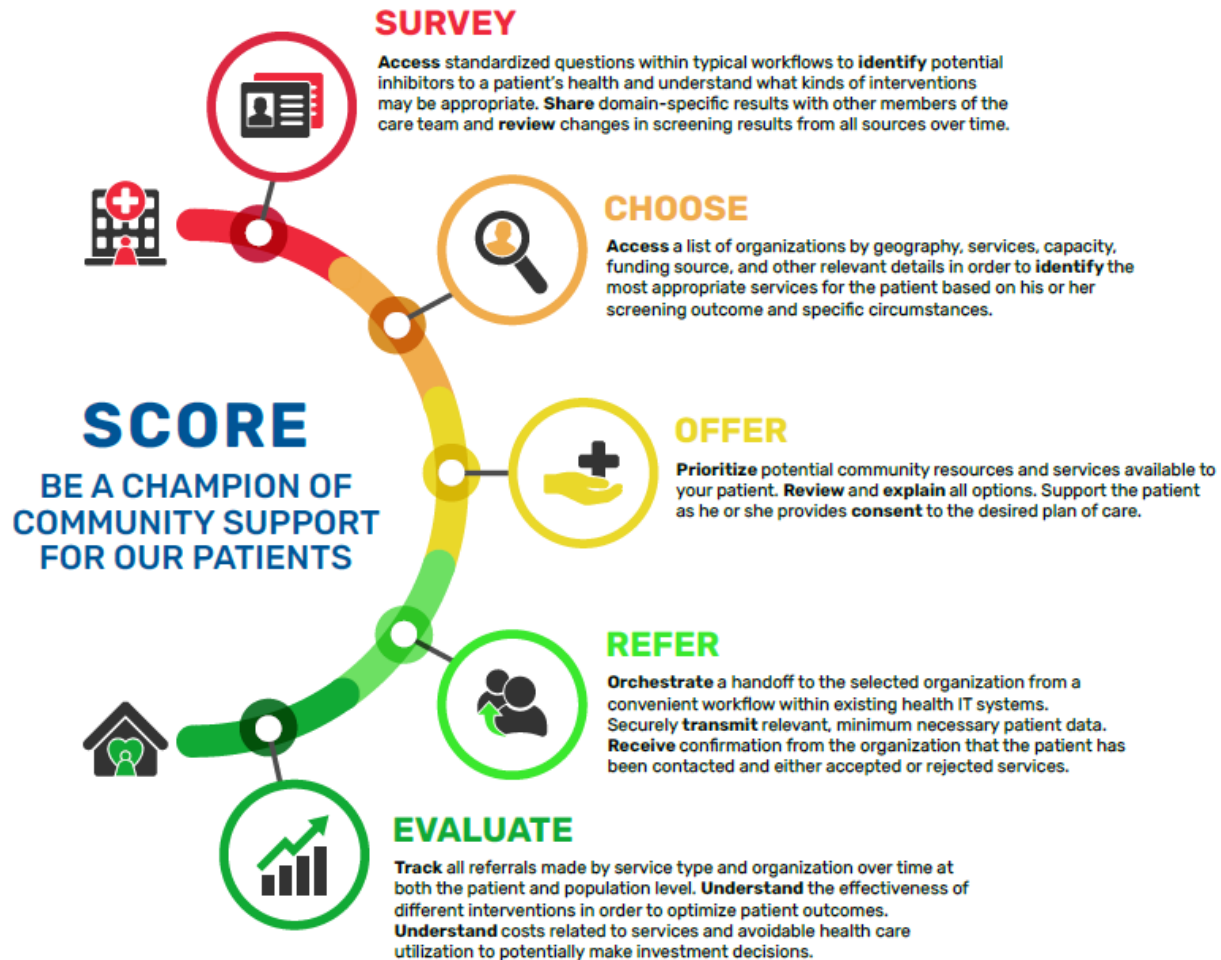


**CRISP**

# CRISP Approach to Social Determinants of Health

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## Survey/Screen

### **Approach:**

- Integrate with EHRs and Care Management platforms where screenings are occurring.
- Consider developing a tool of last resort.
- Present results of screenings within CRISP.

### **Status:**

- Integrating with hospital systems in Baltimore City who are screening for social needs.
- Developing platform for care team to review results within CRISP.



## **Approach**

- Host an up to date resource directory of community-based organizations (CBOs).
  - Accessible to organizations
- Allow organizations to identify resources that are most relevant for their members and their needs.

## **Status**

- Working with Baltimore City and statewide stakeholders to identify resources and establish a statewide solution.



# Offer & Refer

## Approach

- Allow healthcare system to make referrals to CBOs via CRISP.
  - Integrate with existing systems
  - Create a tool of last resort
- “Close the loop” by sending relevant information from the CBO back to the organization making the referral.

## Status

- Piloting a “closed loop system” with a handful of CBOs and MDPCP practices.



# Evaluate

## Approach

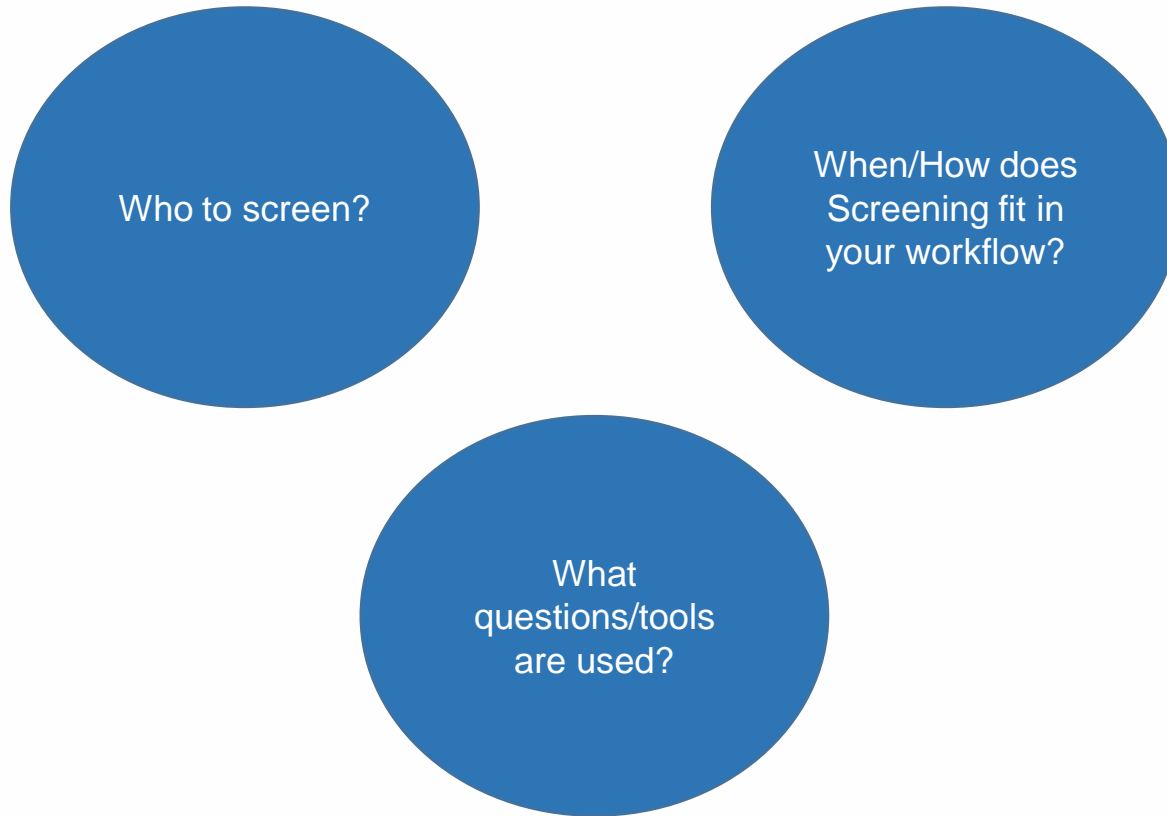
- Record screening and referral data within the HIE to track key quality, utilization, and cost metrics over time.

## Status

- CRISP infrastructure project to link internal data sets to enable new insights and use cases.



# Survey/Screening – A Heterogeneous Approach





# Survey/Screening – A Heterogeneous Approach

## One Domain - 3 Screening Tools - Different Questions/Answers

**Relationships**

**Social Connections**

Patient refused all

In a typical week, how many times do you talk on the phone with family, friends, or neighbors?

Never Once a week Twice a week Three times a week More than three times a week Patient refused

How often do you get together with friends or relatives?

Never Once a week Twice a week Three times a week More than three times a week Patient refused

How often do you attend church or religious services?

Never 1 to 4 times per year More than 4 times per year Patient refused

Do you belong to any clubs or organizations such as church groups, unions, fraternal or

Yes No Patient refused

How often do you attend meetings of the clubs or organizations you belong to?

Never 1 to 4 times per year More than 4 times per year Patient refused

Are you now married, widowed, divorced, separated, never married or living with a partner?

Married Widowed Divorced Separated Never married Living with partner Patient refused

**Loneliness/Social Isolation:** How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

**Social Connection:**

How often do you see or talk to people that you care about and feel close to? (For example, talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week ☐ 1-2 days a week ☐ 3-4 days a week ☐ 5 or more days a week

**13. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?<sup>11</sup>**

- ☐ I don't need any help
- ☐ I get all the help I need
- ☐ I could use a little more help
- ☐ I need a lot more help

**14. How often do you feel lonely or isolated from those around you?<sup>12</sup>**

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always





# MCO Responses

	SDOH Screening Tool?	What do you use to record the SDOH screenings?
<b>Aetna</b>	Internal Questionnaire	Internal Care Management Platform
<b>Amerigroup</b>	Internal Questionnaire (Case management assessment)	CareCompass
<b>Jai</b>	Internal Questionnaire (OB Case management assessment)	Acuity
<b>Kaiser</b>	YCLS - Your Current Life Situation	EPIC
<b>Maryland Physicians Care</b>	To be determined	Expected 2021
<b>Medstar Family Choice</b>	Accountable Health Communities	Care Coordination Platform
<b>Priority Partners</b>	EPIC's standard SDOH tool	EPIC
<b>United Healthcare</b>	Maternity Risk Assessment Access to Care Assessment	Altruista Health: Community Care
<b>University of Maryland Health Partners</b>	Internal questionnaire	HealthEdge



# Accountable Health Communities - Questionnaire

## **Accountable Health Communities Questionnaire**

26 Questions

- Housing
- Food insecurity
- Transportation
- Utilities
- Safety
- Finances
- Employment
- Language/Immigration
- Education
- Substance Use
- Mental Health
- Social Support
- Physical Activity
- Disabilities



### **Approach:**

- Integrate with EHRs and Care Management platforms where screenings are occurring.
- Consider developing a tool of last resort.
- Present results of screenings within CRISP.

# MCO “Homework” Questions

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- What targeted screening questions specific to the MOM model population are missing from the AHC screening tool?
- What questions from the AHC tool are less relevant to the MOM model population?
- What is the ideal length of a screening tool?
- Please explain the types of changes that would be needed to your workflow in order to conduct standardized SDOH screenings in-person during MOM Model participant enrollment?
- What types of barriers do you foresee in implementing a standardized SDOH screening tool/standard screening questions within your MCO?
- How often should the SDOH screening tool be re-conducted?
- What kinds of technology do you anticipate using to conduct social needs screening and other MOM Model activities?
  - Would you prefer to modify your IT systems to integrate directly with CRISP , where CRISP can pull MOM specific data from your systems automatically or use a screening tool within CRISP?

*Amy Woodrum*

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# **Straw Model: Care Plan Elements**

# Straw Model: Care Plan Elements

## Core Elements of Care Plan

### Social Determinants of Health (SDOH) Screening

**Status** – pending, in progress, complete

**Tasks** – Document completion; Linkages to social needs services; Record outreach efforts

### Patient Activation Measure (PAM)

**Status** – pending, in progress, complete

**Tasks** – To be determined

### Care Team

List of providers that participant is engaged with for MOM model and contact information (where appropriate)

### Consent Forms

**Status** – pending, in progress, complete

**Tasks** – Check box for each consent form needed; Specify level of data sharing

# Straw Model: Care Plan Elements

## Core Elements of Care Plan

### Medications

List of any medications currently prescribed and prescription history

### Patient Visits

**Status** – MOM Model enrollee, loss to follow-up, and discharged  
**Tasks** – visit type, date, future appointments, and discharge planning

### Contact Information

List all contact information for participant (i.e. phone, email, address, contact info for family members and friends)

### Participant Goals

**Status** – pending, in progress, complete  
**Tasks** – 2-3 participant-centered goals, date initiated, and goal status

# SDOH Screening

## Social Determinants of Health (SDOH) Screening

**Status** – pending, in progress, complete

**Tasks** – Document completion; Linkages to social needs services; Record outreach efforts

- SDOH screening occurs in-person during initial intake visit
- Record results
- Highlight social needs and provide linkages to appropriate service
  - Examples: housing support; food assistance; vocational services; educational resources; behavioral health treatment; medical care; transportation; childcare; legal assistance; and, peer support.
- Document completion of each task
- Update screening periodically



# Patient Activation Measure

## Patient Activation Measure (PAM)

Status – pending, in progress, complete  
Tasks – TBD

- The Patient Activation Measure® (PAM®) is a 10- or 13-item survey that assesses a person's underlying knowledge, skills and confidence integral to managing their own health and healthcare
- PAM can help predict future health behaviors and outcomes
- Establish baseline PAM score
- Record results
- Categorize MOM participant into one of four activation levels:
  1. Disengaged and overwhelmed
  2. Becoming aware, but still struggling
  3. Taking action
  4. Maintaining behaviors and pushing further
- Update screening periodically

# Care Team

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## Care Team

List of providers that participant is engaged with for MOM model and contact information (where appropriate)

- List of providers MOM Model participant is engaged with such as:
  - MOM model MCO Case Manager
  - OB/GYN
  - Behavioral Health Provider(s)
  - Certified Peer Recovery Specialist
  - Primary Care Physician
  - Community Health Worker
  - Social service agencies
  - Housing authorities and/or landlords

# Consent Forms

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## Consent Forms

**Status** – pending, in progress, complete

**Tasks** – Check box for each consent form needed; Specify level of data-sharing

- Informed consent to participate in MOM model and share data for monitoring and evaluation purposes
- Consent to share data between somatic and behavioral health providers
- Check box to denote if participant has consented to share 42 CFR Part 2 data through Department's standard ROI process

**Note:** Consent forms will be discussed in more thorough detail at future quarterly design collaboratives.

# Medications

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## Medications

List of any medications currently prescribed and prescription history

- History of medications prescribed and active or inactive status
- Prenatal vitamins
- Buprenorphine or other MAT prescriptions
- Notation of any medications prescribed for chronic health conditions
- Notation of any medication allergies and drug interactions

# Patient Visit Considerations

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## Patient Visits

**Status** – MOM Model enrollee, loss to follow-up, and discharged  
**Tasks** – visit type, date, future appointments, and discharge planning

- History of patient interactions with medical system
- Type of visit provided (prenatal, routine care, postpartum, etc.)
- List of future appointments made and visit type
- Discharge planning and summary

# Contact Information Overview

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## Contact Information

List all contact information for participant (i.e. phone, email, address) and approved family members or friends

- Phone: cell and/or landline
- Current living address or P.O. Box
- Email address
- Emergency and secondary contacts
- Care Team contacts
- Other provider or system contact

# Participant Goals

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## Participant Goals

**Status** – pending, in progress, complete

**Tasks** – 2-3 participant-centered goals, date initiated, and goal status

- List of 2-3 goals developed with MOM Model participant within 30 days of enrollment into the Model
- Participant goal status: notation of MOM Model participant progress regarding goal development (pending, in progress, and completed)
- Date goals were developed and any dates of subsequent goal reviews
- Status of participant's progress towards goals (in progress and complete) and notation of active or inactive goals

# MCO “Homework” Questions

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- Using the care plan straw model presentation as a framework, what is your general impression of the core elements displayed?
  - What elements are missing that you would consider to be essential within a care plan for the MOM model population?
  - How well does this align with your MCO’s existing care plan element?
- Of the elements presented during the Design Collaborative, what order should they be in/be conducted?
- MCO case managers will be required to collect and keep on file MOM participant consent forms. How will your MCO store them?



# Wrap Up and Next Steps

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- Homework questions will be sent out to MCO MOM Model contacts and due back ***by April 15<sup>th</sup>***
- Presentation slides will be posted to MDH's [MOM Model Website](#) (link on following slide)
- Look for additional correspondence regarding updates and the next Design Collaborative event in the future

# MOM Model Contact Information

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**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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