Characteristics of TP Population

• Individuals eligible for a TP will:
  - Represent a complex population with multiple co-occurring behavioral and physical health conditions made more complex by issues of housing, food insecurity, economic insecurity, isolation, etc. (social determinants of health)
  - Need to access enhanced services, integrated care settings, and community supports
  - Need care management to ensure member doesn’t “fall through the cracks” and during transitions
State Requirements for a Tailored Plan

- Integrated healthcare
- Transportation
- Social determinants of health
- “Risk scoring”
- Care management platform
- Care plan to address all member needs
- Interdisciplinary care teams

Everyone in the plan is eligible for care management
DHHS Goals for Care Management

- Broad Access
- Single Care Manager taking integrated whole person approach
- Person/Family Centered
- Provider-based to extent possible
- Community-based
- Community inclusion
DHHS Goals for Care Management

• Choice of Care Manager
• Consistency Across State
• Harness existing resources
Overview of Tailored Care Management Approach

Department of Health and Human Services

Establishes care management standards for BH I/DD Tailored Plans aligning with federal Health Home requirements

The BH I/DD Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

BH I/DD Tailored Plan

Health Home

Care Management Approaches

BH I/DD Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department’s standards and be provided in the community to the maximum extent possible.

Approach 1:
“AMH+” Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
BH I/DD Tailored Plan-Employed Care Manager

The Department anticipates allowing—but not requiring—CMAs and AMH+ practices to work with a CIN or other partner to assist with the requirements of the Tailored Care Management model, within the Department’s guidelines.
Roles and Responsibilities

• DHHS will certify Care Management Agencies (CMAs) and Advanced Medical Homes (AMH+)

• BH I/DD Tailored Plans will contract with CMAs and AMH+ and assign members

• BH I/DD Tailored Plans will offer training to all care managers

• BH I/DD Tailored Plans will take population health approach and share data with and collect data from CMAs and AMH+ to track beneficiary progress
Care Management Requirements

• Comprehensive Assessment

• Care Team Formation and Person-Centered Care Planning

• Ongoing Care Management
  • Case conference requirements
  • Contact requirements with based on beneficiary acuity
  • Care transition requirements

• Care Manager Qualifications and Training
Multiple Approaches to Care Management

• Allows continuity of care across time and member needs
• Recognizes different levels of support needs over time
• Supports providers to offer high-quality integrated and comprehensive care with data, expertise, and resources
• Allows BH I/DD Tailored Plan to be more actively engaged in care management of high-risk/high-cost members and to offer resources and expertise necessary to improve health outcomes and reduce cost
Risk Stratification Methodology

• “Risk” is determined by evaluating three sets of metrics
  o Physical health, including pharmacy data
  o Behavioral health
  o Social determinants of health
• TP members can be organized utilizing risk stratification and can assist with assignment to AMH+ and CMAs
Alliance TP Care Management Approaches

• All Innovations and TBI waiver enrollees
• TCLI transitions
• Members with high to rising co-occurring PH, BH, SDOH
• Requiring transition team support moving from institutional to community based care AND those transitioning from TP to SP

TP Care Team

Oversight by Alliance Care Management Division

Care Management Agencies

• Adults with SPMI with rising/moderate BH risk
• Adults with SPMI w/o co-occurring chronic physical health
• Children with MHSUD receiving or at risk for non-PRTF residential treatment
• MHSUD moderate/low SDOH

AMH+

• Chronic physical health well managed by primary care
• Complex medication regime with co-occurring enhanced BH supports
• High PH risk

Possible population descriptions to be served with each approach
Supporting Provider-Led Care Management

- Establishing a learning collaborative and provide onsite support for providers interested in becoming a CMA
- Ensure members receive the appropriate care and support providers to offer highest quality of care
- Provide gaps in care/care opportunity reports to providers
- Provide technical assistance and consultation to address care opportunities and quality improvement
Supporting Provider-Led Care Management

• Provide access to MCO resources, i.e. Housing Specialists, pharmacists, clinical consultants

• Ensure timely transmission of claims data to CMA/AMH+

• Provide practice level risk stratification of attributed members for CMAs/AMH+
Levels of Support: High and Rising Risk

• Alliance Care Team model
  o Members with most complex needs/highest risk and those with rising risk benefit from multidisciplinary care team
  o Care Team is led by Care Navigator who serves as point of contact for member
  o Based on risk stratification, expertise is added to the team to address physical health, behavioral health, and community support needs
Roles of Care Team Members

• Care Navigator
  o Coordinates all forms of communication among team members and with the person served
  o Primary contact for the member and the rest of the care team

• Behavioral Health Consultant
  o Reviews and recommends EBPs and services, educates the team about latest behavioral health and research findings to promote optimal outcomes for the member
Roles of Care Team Members

• Physical Health Consultant
  o Nurse or pharmacist who reviews medical needs of member and may have consultation with community physical health providers if needed
  o May also suggest equipment or technology that would promote positive health outcomes for the member
Roles of Care Team Members

- Community Health Worker
  - Connects members to non-health reimbursed community resources to meet identified needs
  - Consults with a member of the Community Health and Well-Being team who is most knowledgeable about community specific resources that can address social determinants of health
Roles of Care Team Members

• Provider Network Navigator
  o Maximizes the member’s experience with network providers to achieve identified treatment and recovery goals
  o Monitors the delivery of services to the member, assesses member satisfaction and engagement

• Benefits Consultant
  o Assists with coordination of member payers, resolve Medicaid enrollment issues and to support SOAR activities if applicable
Implementing the Care Team Model

- Community Relations renamed Community Health and Well-Being and reorganized to better support that role

- Four teams
  - Outreach and Education
  - Housing Assistance Program
  - TCLI/Supportive Housing Program
  - Community and Member Engagement
Implementing the Care Team Model

• Community and Member Engagement
  o Transitional Care and Specialty Populations (7-Day Challenge, homeless engagement, crisis readmissions, criminal justice)
  o System of Care (Care Review, Child and Family Teams)
  o Care Teams and Unmet Social Needs (Care Teams, Jiva, Staying Well, Executive Walk Through, Transportation)
  o Health Literacy (Health Literacy initiatives, CARES Campaign)
Implementing the Care Team Model

Provider Network

- Develop strong connections between care teams and network staff with a focus on addressing network adequacy, quality, and competence
- Develop provider profiles and scorecards that better inform care team referrals
- Develop mechanism for routine delivery of service utilization and gaps in care data to providers to enhance their care coordination capacity
Implementing the Care Team Model

Provider Network

• Develop alternative payment arrangements and value-based reimbursement to incent whole person care, provider led care coordination, improve care efficacy and efficiency with a focus on services that support members with complex conditions
• Continue to support network providers to implement EBPs
• Refine scopes of work with a focus on a smaller number of high value outcomes
• Continue to work with state and implement a project plan to support development of provider led care management agencies
Next Steps

• Members and families in IDD Care Coordination received information on transition to care team model in April and had opportunities to attend listening sessions in May

• Notice of Care Coordination changes given to members/families June 17 and implemented July 17

• MH/SUD Care Coordination begins transition to care team model in July for full implementation by January 1, 2020

• Solicit provider interest in becoming a CMA
Next Steps

• Continue to work with state and with providers to develop community care management capacity

• DHHS to release process and application for organizations who wish to serve as an AMH+ or CMA

Traumatic Brain Injury

A traumatic brain injury (TBI) is an injury to the brain that is caused by an external physical force such as hitting your head or other types of blunt force trauma. The most common causes of TBI include slips and falls, motor vehicle accidents and struck by or against events. The injury can cause physical and mental challenges. Every injury to the brain has different effects or consequences.

Federal TBI Grant

The North Carolina TBI Program was awarded a 3-year grant from the federal Administration for Community Living (ACL). The main grant objectives include:

- Educate and train individuals with TBI, caregivers and professionals. Increased understanding and knowledge by those involved in the TBI continuum of care statewide.
- Screening: Increased identification of people who sustain TBI statewide and improved data collection and analysis.
II. Populations Eligible for BH I/DD TPs

- Individuals with a qualifying I/DD diagnosis, including those enrolled in or on the waiting list for the Innovations waiver
- Individuals enrolled in the Traumatic Brain Injury (TBI) waiver who are on the waiting list for the TBI waiver or have used a state-funded TBI service
- Individuals enrolled in the Transition to Community Living Initiative (TCLI)
- Individuals with a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) diagnosis who have used a Medicaid-covered enhanced BH service or a state-funded BH service within the past year
- Individuals with a qualifying substance use disorder (SUD) diagnosis who have used a Medicaid-covered enhanced BH service or state-funded BH service within the past year.
TBI WAIVER: FROM ADVOCACY TO APPROVAL

Over 20 years of Advocacy: BIAC, BIANC and TBI Community Advocates Join Forces to Advocate for NC's TBI WAIVER

2016 NC GENERAL ASSEMBLY APPROVES FUNDING FOR TBI WAIVER PILOT PROJECT

2016 DHHS Selects Alliance to operate 3 year TBI Waiver Pilot Project in Wake, Cumberland, Durham and Johnston Counties

May 1, 2018 Centers for Medicare and Medicaid Approved NC’s 1st TBI WAIVER

DHB, DHHS, BIANC FORM IMPLEMENTATION PARTNERSHIP
September 2018 WAIVER GOES LIVE
NC TBI Medicaid Waiver Structure:

1915 Medicaid B Waiver

1915 c: NC Innovations Waiver

1915 c: NC TBI Waiver
What is Unique about this 1915C Waiver?

• The TBI Waiver is an ADULT only Waiver
• The TBI waiver was designed for individuals who sustained their injuries at age 22 and Older.
• Several clinical nuances separate TBI Waiver from Innovations 1915 C waiver
WHAT ARE THE GOALS OF NC TBI WAIVER PROGRAM?

1. Value and support individuals to be fully functioning members of their community.

2. Promote rehabilitation; evidence based practices, and promising practices that result in real life outcomes for individuals.

3. Allow individuals to live in homes of their choice, have employment or engage in a day of their choice.
WHAT WILL TBI WAIVER MEMBERS RECEIVE?

- Adult Day Health
- Life Skills Training
- In Home Intensive Support
- Day Supports
- Residential Supports
- Respite
- Crisis Services
- Resource Facilitation
- Community Transition
- Supported Employment
- Community Networking
- Natural Supports Education
- Specialized Consultative Services
- Personal Care
- Cognitive Rehabilitation

*Speech/OT/PT (*payor of last resort)
HOW CAN OUR PROVIDER NETWORK HELP?

HELP TO BRING AWARENESS OF TBI WITHIN YOUR AGENCY
BRAIN INJURY

An injury to the brain that is not hereditary, degenerative or induced by birth trauma.

There are two types of Brain Injury:

- **Non-Traumatic**
- **Traumatic**
Non- Traumatic Brain Injury

• Often referred to as Acquired Brain Injury (ABI)

• Non-Traumatic Brain Injuries cause damage to the brain by internal factors

• Examples: Lack of Oxygen, Overdose, Stroke, Exposure to Toxins, Pressure from a Brain Tumor
An alteration in brain functioning caused by external force.

Traumatic Brain Injury may be caused by direct impact to the head. (Traumatic impact)

Traumatic Brain Injury may also be caused by inertial forces which effect the brain. (Traumatic Inertial)
FALLS ARE LEADING CAUSE OF TBI

BEING STRUCK BY OR HITTING YOUR HEAD AGAINST SOMETHING AND MVC ARE ALSO MAJOR CAUSES OF TBI
WHAT CAN OUR PROVIDER AGENCY DO?

ENCOURAGE YOUR TEAMS TO HELP IDENTIFY THE INDIVIDUALS WITH TBI YOU MAY ALREADY BE SUPPORTING
RECOGNIZE THAT IDENTIFYING INDIVIDUALS WITH TBI CAN BE COMPLEX

PTSD AND DEPRESSION

TBI MAY NOT BE PRIMARY DIAGNOSIS

TBI
Individuals May Be Dually Diagnosed

Examples:

- PTSD – *possibly stemming from their accident*
- Depression- *possibly stemming loss of natural supports*
- Anxiety- *possibly stemming from their frustration with not being able to do what they used to be able to.*
- Substance misuse- *possibly stemming from trying to self medicate or changes in the brain.*
- Drug Addiction- *possibly stemming from trying to self medicate or changes in the brain*
THINK ABOUT WHO YOU ARE ALREADY SUPPORTING

Example: HOMELESS POPULATION

Homelessness – *stemming from lack of employment after accident*

- Food Insecurity
- Their Overall safety may be at risk- *could sustain an additional TBI*
- Lack of natural supports and social networks
- Lack of Transportation

- Lack of access to regular health care
Evidence shows brain injury and substance use are related.
Several studies show decreased drinking after TBI, but other evidence shows individuals returned to preinjury substance use (Walker et al., 2007).
Between 38% and 63% of SUD treatment clients report brain injuries (Corrigan, 2005).
Individuals who drank alcohol are shown to have 4 times the risk of sustaining a brain injury than those who did not drink alcohol (Levy, Maloney, and the Miller, 2004).
SUBSTANCE USE AND TBI

• Traumatic brain injury (TBI) and substance use disorders (SUDs) frequently co-occur.

• Individuals with histories of alcohol or other drug use are at greater risk for sustaining TBI

• Individuals with TBI frequently misuse substances before and after injury.
WHERE ARE YOU POTENTIALLY SERVING INDIVIDUALS WITH TBI?

EXAMPLES:

- Skilled Nursing Facilities
- State Operated Health Care Facilities
- MH Services
- SUD Services
- IDD Services
- County Operated Crisis Centers
- CORRECTIONAL FACILITIES
IDENTIFICATION

What can my agency do to help identify individuals with TBI? Are there specific questions I can ask?
OHIO SCREENING TOOL
1. In your lifetime, have you **ever been hospitalized or treated in an emergency room** following an injury to your head or neck?

2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a **bicycle, motorcycle or ATV**?

3. In your lifetime, have you ever injured your head in a fall or from **being hit by something** (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)?

4. Have you ever injured your head or neck **playing sports** or on the playground?

5. **Was there a LOSS OF CONSCIOUSNESS** during any of these incidents and for how long?
WHAT CAN I DO IF I SUSPECT ONE OF MY CONSUMERS HAS A TBI?

✓ Refer them to their Primary Health Care Doctor for follow up

✓ Refer them to the Brain Injury Association of NC Family Help Line [www.bianc.net](http://www.bianc.net)

✓ Refer them to Alliance Access Center to be screened for possible TBI specific services and supports – *to include being screened for TBI WAIVER services.*
REMEMBER

• The individual you are supporting may shy away from questions regarding their possible TBI

• The member may have difficulty remember the details of the accident – *Natural Supports may be able to provide information*

• Medical Records may be hard to locate

• Accident reports may be difficult to find
ENCOURAGE MEMBERS TO CALL

24-Hour Access and Information Line
call (800) 510-9132
ENCOURAGE FAMILIES TO GATHER THEIR DOCUMENTS TO ASSIST WITH:

- Member Meeting Diagnostic Eligibility Criteria

- Member meets Medicaid Waiver $ financial eligibility requirements
ENSURE FAMILIES KNOW THEY WILL RECEIVE ASSISTANCE ALONG THE WAY!

- Alliance Clinical Team recognizes the need for a more comprehensive outreach plan to members who are on the Registry of Interest.

- Members on the *Registry of Interest* will receive initial outreach from our Alliance’s TBI WAIVER GUIDE.

- TBI Waiver Guide will assist members through the Screening and Eligibility Process. *(Example, document inventory)*
ENCOURAGE STAFF AND FAMILIES TO CONNECT WITH:

BIANC.NET
FREE TBI TRAININGS

BIANC’s Training Modules:

http://www.bianc.net/help/training

BIANC has updated our current NC modules with partnership from Greensboro Area Health Education Center, Michigan Department of Health and Human Services, and Michigan Public Health Institute (MPHI).

- Cognitive & Behavioral Consequences of TBI In Adults
- Crisis De-Escalation & Management for First Responders (New)
- Pediatric Traumatic Brain Injury
- Primary Care & Traumatic Brain Injury
- Public Service and TBI in NC
- Substance Use & TBI
FREE PROVIDER TRAININGS

• What is& What is Now: Brain Injury Basics and Strategies”
• Fitting the Puzzle Together: TBI Legislation, Research & Waiver Service Definitions
• “What’s in a Behavior? TBI &Behavioral De-escalation”
• "Beyond Person-Centered Care: Philosophy to Action”

Contact: cphillips@alliancehealthplan.org
ALLIANCE SERVICE NEEDS WEB PAGE:

https://www.alliancehealthplan.org/providers/current-service-needs/
Traumatic Brain Injury (TBI)

Alliance is hosting a Provider Information Session for providers interested in TBI waiver services. The session will outline the services available through the waiver and Alliance’s procurement plans for the covered services. The session will only be available face-to-face on May 11, 2018 from 10am-noon at The Frontier, 800 Park Offices Drive, RTP.
Engaging Members through Health Literacy
Health Literacy is Critical

• In a 2003 study, only 12 percent of U.S. adults had proficient health literacy skills.

• Over a third of U.S. adults—77 million people—would have difficulty with common health tasks, such as following directions on a prescription drug label.

• Compared to privately insured adults, both publicly insured and uninsured adults had lower health literacy skills.

• Even people with strong literacy skills can face health literacy challenges.

• All adults, regardless of their health literacy skills, were more likely to get health information from radio/television, friends/family, and health professionals than from print media.
Health Literacy: What Works

- Multi Media Videos
- Illustrated medication instructions
- Shared Decision Making Aids
- Ask Me Three
- Teach back methods
Health Literacy: Current Activities

- Modifying Alliance’s web content to insure more multi-media and video formats are available.
- Modifying Alliance print content for increasing ‘plain English’.
- Modifying Alliance print content and patient education materials to include health literacy approaches.
- Developed illustrated medication booklets designed to assist individuals in understanding when to take medication.
- Developed Shared Decision Making Aids, in partnership with the Mayo Clinic, Alameda County Behavioral Health, and Cincinnati Children’s Hospital.
My Health and Wellness Record Keeper

General Health Tips:
EAT nutritious food and less sugar.
SLEEP 8 hours and try to go to bed at the same time.
CONNECT with others as often as you can.
HAPPINESS Find three things that make you happy, notice how you feel when you think about them.

Printable versions will also be available on the Alliance website
What You Should Know

Will this medication work for me or my child?
Stimulant medications improved symptoms in 7 out of 10 children who take them. Non-stimulant medications may be a little less helpful for some people.

What will change?
- It is important that a trusted adult give the medication and watch the individual take it. Many parents find it’s easier to give the medication to the child’s school staff to give. Ask your doctor about this option.
- Eating breakfast before taking medications may help reduce side effects related to decreased appetite and weight loss.
- If this medicine causes side effects, it is important to let your doctor know.

Things to Remember

Medication is one of the many tools that can help with behaviors of distraction and hyperactivity. Changing some of your lifestyle habits may improve mental health:
- Regular therapy and/or connection with supportive people
- Going to bed early and waking up at the same time every day
- Scheduling activities: “work before play”
- Being active and participating in activities you enjoy
- Limiting screen time

Other symptoms can look like ADHD such as stress, trauma, and sleep deprivation.

You and your doctor may decide not to start with medications and try other things, such as therapy, first. Therapy and medication used together works best.

Many people with ADHD also experience periods of anxiety, sadness or depression. It is important to communicate often with your doctor or therapist about how you are feeling.
### Duration/Daily Routine

<table>
<thead>
<tr>
<th>Short Acting Stimulants</th>
<th>Duration of Action</th>
<th>When to take?</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ritalin®</td>
<td>4-6</td>
<td>Every 4 hours</td>
<td>1-2</td>
</tr>
<tr>
<td>Focalin®</td>
<td>4-6</td>
<td>Every 4 hours</td>
<td>1-2</td>
</tr>
<tr>
<td>Methylphenidate HCL Cr/WD Tablet</td>
<td>4-6</td>
<td>Every 4 hours</td>
<td>1-2</td>
</tr>
<tr>
<td>Metadate® CD</td>
<td>8-9</td>
<td>45 minutes before activity</td>
<td>1-2</td>
</tr>
<tr>
<td>Adderall® XR</td>
<td>4-6</td>
<td>Every 4 hours</td>
<td>1-2</td>
</tr>
<tr>
<td>Equasym®</td>
<td>4-6</td>
<td>Every 4 hours</td>
<td>1-2</td>
</tr>
<tr>
<td>Provigil®</td>
<td>4-6</td>
<td>Every 4 hours</td>
<td>1-2</td>
</tr>
</tbody>
</table>

### Stopping Approach

When thinking about stopping any medication it is always important to talk with your doctor first about the reason why you want to stop.

<table>
<thead>
<tr>
<th>Short Acting Stimulants</th>
<th>More Side Effects</th>
<th>Sick It You Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ritalin®</td>
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<tr>
<td>Focalin®</td>
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<tr>
<td>Methylphenidate HCL Cr/WD Tablet</td>
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<tr>
<td>Metadate® Solution</td>
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<td>Equasym®</td>
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<tr>
<td>Provigil®</td>
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### Side Effects: Stomach Issues

Stomach issues can include loss of hunger, weight loss and upset stomach. Eating breakfast before taking medicine may help.
For more information please contact:

Davida Jones

djones@alliancehealthplan.org

919-651-8545
References


