RAE Name: Northeast Health Partners (NHP) **Region:** Region 2 **Date Submitted:** July 28, 2017

PEDIATRIC INTERVENTIONS

	INSTRUCTIONS for completing the table below: 1) Identify each Intervention that is part of the Contractor's Population Health Management Plan in the column headers (see example below). 2) Place a checkmark in the cell indicating which interventions will be used for each stratification level.											
Stratification Level	Care Coordination/Case Management	Wellness Technology: Text4Health	Reduce incidence of smoking through texting program and QuitLine	Suicide prevention – Use Zero Suicide Teams	Reduce ED Visits for Ambulatory Sensitive Conditions	Annual Well Child Visit	Improve prenatal care rates for pregnant women					
Low Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity		✓	✓	✓	✓	✓	✓					
High Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓					
Low Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓					
High Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓					

Name of Intervention: Care Coordination/Case Management

Description: Individualized Member and family-centered case management programs with on-site Case Managers and fully engaged providers have demonstrated a net reduction in total cost of care, improved Member and family satisfaction and improved provider satisfaction. We will provide Care Coordination and/or integrated case management/Care Coordination for pediatric Members with complex physical, behavioral, or physical and behavioral issues requiring dedicated support from a dedicated resource. Because of the nature of pediatric care, it is more likely that high-risk pediatric Members will be designated as having either complex physical health or complex behavioral health needs, although there is a subset of children who will present with a combination of complex physical and behavioral health needs. We will make available our full range of Care Coordination and case management support and interventions for these children.

Many of these children will require Care Coordination (defined broadly) for extended periods of time, possibly throughout their lives. The intensity of our engagement may vary over time, but these are children characterized by complex, multiple physical, developmental and/or behavioral needs. We support the children and their families as they need us: we work with these children and their families closely when required and at lesser intervals as their needs stabilize, even if that is temporary. These are cases that may be identified through Business Intelligence and Data Management stratification, other analytics, other agency referrals, hospital, Primary Care Medical Provider (PCMP), or specialist referrals. There is no wrong door.

- We will work with providers and Care Coordinators to identify Members most appropriate for this level of Care Coordination and fully engaging the Member and their families in the process.
- Electronic communication will be provided to Care Coordinators and providers to identify Members and provide information on health status and related agency involvement.
- Program will be staffed by a multidisciplinary care team, which is comprised of PCMPs, RNs, social workers, the Member and family members, and to include all providers working with the individual Member. These are cases that in all likelihood will involve a range of specialists who may be located in Region 2 or in another region where children are accessing tertiary care.
- Care Coordinators/Case Managers will interact with and collaborate with multiple agencies, schools, and community resources in and out of Region 2 to support these children and their families.
- We will engage with schools, school counselors and teachers as necessary.

Please check one of the following three options:

☒ Evidence-Based: (1) Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children and Adolescents. CMS. EPSDT. September 2014. (2) The Care Coordination Conundrum and Children and Youth with Special Health Care Needs: What Is Care Coordination? Who Should Receive It? Who Should Provide It? How Should It Be Financed? Sara S. Bachman, Ph.D., Meg Comeau, MHA and Katharyn M. Jankovsky, MSW. Cahpp.org. November, 2015. (3) Case Management/Care Coordination for high-risk children also addresses a RAE RFP requirement of impacting total cost of care and utilizing Care Coordination to support our Population Health Management Plan.

☐ Promising Practices:

☐ Other:

How the frequency of intervention will be determined: The frequency of intervention will be determined by the care team in collaboration with the Member, family members, caregivers, Care Coordinators, and Case Managers.

Name of Intervention: Care Coordination/Case Management

How the method of delivering the intervention will be determined: A care plan will be developed collaboratively in a team model that includes the Member, family members, all providers serving the Member, the Care Coordinator, other Care Coordinators or Case Managers from sister agencies or health systems and other members of the team. Based on the individualized care plan, a range of interventions will be developed to help that Member meet their goals.

Potential outcomes:

- Reduction in inpatient admissions
- Reduction in Emergency Department (ED) utilization
- Increase in health-related quality of life

Name of Intervention: Wellness Technology: Text4Health

Description: We will offer and use text-based pediatric population health campaigns and tools to support wellness and prevention campaigns for applicable Members across the region. We propose using the Text4Health program that focused on pediatric health care to effectively communicate with and educate parents, grandparents, and caregivers.

- Cellular phone adoption and the use of texting are very high with Medicaid Members, especially those in rural and frontier counties.
- Text messaging is a cost effective and widely accepted method of communicating with Members.
- Over 90% of text messages are viewed within 3 seconds of receipt.
- Text messaging for health has been widely researched and is a well-established population health solution that has proven effective.
- Because of the flexibility of Text4Health, we will be able to add pediatric wellness and prevention campaigns that reach families with children with minimal cost or planning time. PCMPs and Care Coordinators will be engaged in these campaigns so that they can share a consistent message and reinforce the texting information that Members will receive.

Please check one of the following three options:

- ☒ Evidence-Based: (1) Text4Health-FluNet Study. Columbia.edu. (2) Text4Health: Impact of Text Message Reminder-Recalls for Pediatric and Adolescent Immunizations. Stockwell MS, Kharbanda EO, Martinez RA, Lara M, Vawdrey D, Natarajan K, Rickert VI. Am J Public Health. 2012 Feb;102(2): e15-e21, http://www.ncbi.nlm.nih.gov/pubmed/22390457. (3) Mobile Health and Patient Engagement: A Survey of Community Health Centers. Commonwealth Fund. http://www.commonwealthfund.org/publications/issue-briefs/2015
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Through Text4Health, we will be able to communicate with all Members in the region on a regular basis, communicating with them as frequently as daily, depending on the campaign. Our initial pediatric campaign will focus on well child visits and will coordinate with public health and other community efforts.

Name of Intervention: Wellness Technology: Text4Health

The technology enables us to further engage with families concerning children's health—adding campaigns on oral health, how to find a dentist, immunizations, eye exams, nutrition, flu shots, etc.

How the method of delivering the intervention will be determined: This is a text-based solution. The Chief Clinical Officer and the Regional PIAC will develop an implementation schedule as part of finalizing the Population Health Management Plan.

Potential outcomes: The goal of this initial campaign will be to improve awareness of pediatric health issues as well as improve the immunization rate, number of children receiving well child visits, and the number of children accessing dental care.

Name of Intervention: Reduce incidence of smoking through a text solution and QuitLine

Description: We will provide the necessary supports and interventions for Members to quit smoking regardless of age so that we may reduce the incidence of smoking in Region 2 (see Social Determinants of Health):

- QuitLine and Medicaid prescription benefits are already available for Members and will be encouraged.
- Outcome data demonstrate a need for additional Member support to reduce the incidence of smoking in Region 2.
- Evidence demonstrates that integrating technology support with the commitment of the PCMP improves success rates. PCMPs and care teams are integral members of this solution.
- Our goal is that no child begins smoking. However, we recognize that there are teens and young adults who have begun smoking and we will work with PCMPs, Care Coordinators, schools and all other community resources to assist our younger Members quit smoking or using tobacco.
- Support of statewide initiative: Colorado Opportunity Project and Colorado Winnable Battles.
- By purchasing at a multi-region level we will be an aggregator of this common technology. Members moving from one region to another will be able to keep the tools that are working for them.
- Text2quit is a program to help people quit smoking and stay quit. It includes text messages, emails, and access to a personal web portal. Members have to enroll and then the text messages can be used on their own.
- Message frequency varies by account settings. Messages are sent according to quit date. For the 4 weeks before and 4 weeks after the Member's quit date, they receive about 2-5 messages per day. For the remainder of the program, they are sent 1-5 messages per week. The messages are personalized to the quit date and other items in the Member's smoking profile (e.g., smoking triggers, medications used).

Please check one of the following three options:

☒ Evidence-Based: Evidence: (1) In a randomized controlled trial 11 percent of Text2quit users were abstinent compared to 5 percent of the control group ($p<0.05$). At 6 months, 32 percent of the Text2quit group reported not smoking in the past 7 days compared to 21 percent of the control group (p,0.01). Non-respondents were assumed to have smoked. (2) https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf. (3) Am J Prev Med. 2014 Sep;47(3):242-50. A randomized trial of Text2quit: a text-messaging program for smoking cessation.. Abroms LC1, Boal AL2, Simmens SJ2, Mendel JA2, Windsor RA2. Smoking cessation and reduced use of tobacco products meets many local and state priorities including Region 2 County Health Departments as well as the Colorado Opportunity Project and Colorado's 10 Winnable Battles.

Name of Intervention: Reduce incidence of smoking through a text solution and QuitLine

- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Frequency varies by user participation. Minimum 1 message/week.

How the method of delivering the intervention will be determined: This is a text-based solution. The Chief Clinical Officer and the Regional PIAC will develop an implementation schedule as part of finalizing the PHMP.

Potential outcomes: The goal of this initial campaign will be to reduce the incidence of smoking in the population as measured over time.

Name of Intervention: Suicide prevention—use Zero Suicide Teams

Description: Expand existing suicide prevention programs to provide PCMP training, education, toolkits, referral and follow-up referral mechanisms to aide suicide prevention. Provide educational outreach to PCMPs regarding depression and suicide prevention. We will leverage existing programs in the Region, publicize them and educate PCMPs on their availability. In addition, we will work with the County Public Health Departments and other local community agencies to expand access to programs such as the following across the region**:**

- Applied Suicide Intervention Skills Training (ASIST) teaches skills to confidently intervene with someone at risk of suicide. ASIST is a standardized suicide intervention program developed by Living-Works Education, Inc.
- Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA) has proven to help participants gain confidence in approaching and offering assistance to individuals experiencing a mental health concern such as depression, anxiety, impulse control and misuse of alcohol and other drugs.
- Question Persuade Refer (QPR) Gatekeeper Training is an effective training for adults and provider staffs.
- More than Sad educates high school students about depression, the leading risk factor for suicide in both adults and teens.
- Sources of Strength is used to prevent suicide by increasing help seeking behaviors and promoting connections between peers and caring adults. This upstream model strengthens multiple sources of support (protective factors) around young individuals so that when times get hard they have strengths to rely on.
- Zero Suicide is a commitment to suicide prevention in health and behavioral health systems, and also a specific set of tools and strategies. It is both a concept and a practice. We will collaborate with the Zero Suicide teams from UC Health Sterling, Salud and East Morgan County Hospital and additional resources as they are developed.
- We will participate at the State level in suicide prevention and depression screening initiatives and policy programs.

Please check one of the following three options:

- ☒ Evidence-Based: Evidence: (1) http://zerosuicide.sprc.org/about. Zero Suicide is an evidence based program endorsed by the Colorado Legislature through legislation and embedded in statewide programs through Colorado Department of Public Health and Environment

Name of Intervention: Suicide prevention—use Zero Suicide Teams

☐ Promising Practices:
☐ Other:

How the frequency of intervention will be determined / How the method of delivering the intervention will be determined:

- Provider Relations will educate all Region 2 providers about the availability of these programs annually.
- Care Coordinator and Case Manager trainings will include components on suicide prevention including availability of local resources and programs.
- Our intervention will target PCMPs and Provider groups in areas of the region with the greatest levels of suicide amongst their panel of patients.
- PCMP practices will receive education annually.
- We will develop and deploy practice support tools including Member, family, and provider tip sheets, screening tools, and assistance with billing for screening.
- We will connect PCMPs to Psychiatric Consultation and work with them to ensure they have connection to referral resources and a way to follow up on referrals.
- We will conduct annual quality review of program including performance, provider feedback, and reduction in suicide.
- We will participate at the State level in suicide prevention and depression screening initiatives and policy programs.

Potential outcomes: During Year 1, we will measure the number of PCMPs that have received training and materials, the number of PCMPs that utilize Psychiatric Consultation, and evaluate effectiveness of Care Coordinator and Care Management trainings by assessing their knowledge base on covered materials. We will also work with the Regional PIAC and behavioral health specialists to build additional outcome measures for subsequent years.

Name of Intervention: Reduce Emergency Department Visits for Ambulatory Sensitive Conditions

Description: We will actively promote The Department of Health Care Policy and Financing's (HCPF) Nurse Advice Line and a local after-hours call center through Member education, Member portal access and wellness materials, Text4Health, and PCMP engagement to educate Members on alternatives to using EDs. Because of the higher incidence of ED visits for ambulatory sensitive conditions, this intervention will focus on parents and caregivers, especially of younger children. Region 2 has already reduced ED utilization significantly through the active involvement of PCMPs, our FQHCs and CMHCs, and the work of both the BHO and RCCO. This is an area we believe can continue to be enhanced.

Please check one of the following three options:

☒ Evidence-Based: (1) Piehl MD, Clemens CJ, Joines JD. "Narrowing the Gap": decreasing ED use by children enrolled in the Medicaid program by improving access to primary care. Arch Pediatr Adolesc Med. 2000;154(8):791–795. (2) Lee TJ, Guzy J, Johnson D, Woo H, Baraff LJ. Caller satisfaction with after-hours telephone advice: nurse advice service versus on-call pediatricians. Pediatrics. 2002;110(5):865–872.
☐ Promising Practices:
☐ Other:

Name of Intervention: Reduce Emergency Department Visits for Ambulatory Sensitive Conditions

How the frequency of intervention will be determined: We recognize that education on appropriate use of an ED and how to access after-hours services is an ongoing process. For many families, this is most relevant when the Member is in need of services.

We will proactively and frequently communicate messages to Members and work with PCMPs and Care Coordinators to reinforce that this is an ongoing effort that needs continuous messaging and especially targeted to parents and caregivers of young children.

Targeted messaging and communications will be made available on the NHP website that focus on how to access the Department's Nurse Advice Line in specific areas such as when a child has a fever, ear infections, vomiting, and other routine childhood illnesses. Related information on when to access an ED such as after an injury, especially a head injury, will also be available on websites. Materials and messages will be provided for PCMP offices, Care Coordinators, on the Member Portal. There will be regular text messages from Text4Health that are distributed to targeted populations. These materials will be developed and the Chief Clinical Officer and his/her staff will manage the frequency of their distribution.

Care Coordinators and providers will have more targeted interventions available and in use for Members that are identified as "high-utilizers" who have a history of ED visits. This is discussed in more detail under Care Coordination.

How the method of delivering the intervention will be determined: Messaging on appropriate use of EDs for ambulatory sensitive conditions and use of alternatives such as HCPF's Nurse Advice Line is an ongoing, multifaceted intervention. We will regularly assess changes in ED utilization by reason, community, age of the population, etc., and revise the intervention to target areas of need. We will engage PCMPs in this process, sharing data on utilization by their Members as well as community-wide data. Through the Regional PIAC, NHP will also explore other options to further improving appropriate use of EDs for ambulatory sensitive conditions.

Potential outcomes: Reduced ED visits for ambulatory sensitive conditions for children.

Name of Intervention: Improve number of children with at least 90 days of continuous program enrollment that have had a well-child visit within a rolling 12-month period

Description: NHP will use three primary methods to further engage Members in their health care to improve the number of Members who obtain well visits:

- PCMPs and Care Coordinators will receive regular alerts identifying attributed Members that have not had a well visit six months into their membership. This is in addition to any Members who, through stratification or other risk categories, have been identified for Care Coordination including access to more immediate health services.
- Text4kids will include regular messages to all Members stressing the benefits of a well visit, especially well child visits to assess screening, routine eye care, and oral health.
- Member Services representatives will discuss the availability of well visits with families with children as well as provide information on how to access PCMPs and how to get assistance in making appointments. This information will also be included on the Health Colorado website, the Member Portal and will be provided to all PCMPs, Federally Qualified Health Centers (FQHC), and Community Mental Health Centers (CMHC)

Name of Intervention: Improve number of children with at least 90 days of continuous program enrollment that have had a well-child visit within a rolling 12-month period

to add to their Member Portals and websites.

Please check one of the following three options:

- ☒ Evidence-Based: (1) Pilot evaluation of the text4baby mobile health program, William Douglas Evans, Jasmine L Wallace and, Jeremy Snider, BMC Public Health201212:1031. (2) Improving the Delivery of Adolescent Clinical Preventive Services Through Skills-Based Training, Julie L. Lustig, Elizabeth M. Ozer, Sally H. Adams, Charles J. Wibbelsman, C. Daniel Fuster, Robert W. Bonar, Charles E. Irwin, Jr. Pediatrics May 2001, VOLUME 107 / ISSUE 5
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Education on the need for pediatric well visits, the benefit of well visits and how to access a PCMP or receive assistance is an ongoing effort that needs continuous messaging both for reinforcement with new mothers and as new children are enrolled in Medicaid. Targeted messaging and communications will be made available on the NHP website, available for providers to include on their websites, along with materials and messages for PCMP offices, Care Coordinators, Case Managers and peer counselors, as well as on the Member Portal. There will be specific messages for new mothers as well as communications with new mothers in PCMP offices, at the FQHCs and by Care Coordinators. There will be regular text messages from Text4Health that are distributed to new mothers and families with children. These materials will be developed and the Chief Clinical Officer and his/her staff will manage the frequency of their distribution.

How the method of delivering the intervention will be determined: Our staffs have already developed effective strategies for educating Members on the importance of having a primary care provider and obtaining necessary medical care. We regularly engage with new mothers and families on immunizations, well baby and well child visits. These messages will be further enhanced and targeted messages on the importance of well visits for children including adolescents will be included as part of this intervention. We will seek input on from Members through the Member Advisory Council to enhance the effectiveness of our messaging. Based on analysis of utilization patterns, we will assess gaps and revise the intervention to target areas of need.

Potential outcomes: Increase in number of well-baby and well-child visits.

Name of Intervention: Improve prenatal care rates for pregnant women

Description: Text4baby is a well-established technology solution to improve pregnant care rates for pregnant women. Text4baby is a collaborative program that is implemented with the PCMP or obstetrician. The provider and the Member will voluntary enroll and work together to improve prenatal care for pregnant women. This approach was designed with major national organizations dedicated to improving care for pregnant women and newborns. This approach has been used successfully with teen and young adult women.

Text4baby sends personalized messages directly to the Member with information developed by experts from all over the country. There is also an option to provide additional information about baby's development, pregnancy, childcare tips, and more.

Name of Intervention: Improve prenatal care rates for pregnant women

Text4baby topics include:

- Nutrition for mother and baby
- Baby's milestones
- Doctor visit and personalized appointment reminders for mother and baby
- Car seat safety
- Urgent health alerts
- Safe sleep tips
- Signs and symptoms of labor
- Breastfeeding advice
- Information on health insurance
- Resource hotlines and websites

Text4baby is a free service provided in partnership by the nonprofit organization, ZERO TO THREE, and Wellpass, Inc. The text messages are sent for free. Beacon will be purchasing access to Text4baby on behalf of NHP.

Please check one of the following three options:

- ☒ Evidence-Based: (1) https://www.text4baby.org/about/data-and-evaluation. (2) Improving Adolescent Preventive Care in Community Health Centers. Jonathan D. Klein, Marjorie J. Allan, Arthur B. Elster, David Stevens, Christopher Cox, Viking A. Hedberg, Rita A. Goodman. Pediatrics, February 2001, VOLUME 107 / ISSUE 2.
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Daily/weekly during pregnancy and intermittently for female Members based on age to educate people on the need for prenatal care early in the pregnancy. We will also implement personalized messages and doctor appointment reminders.

How the method of delivering the intervention will be determined: Multimodal approach that emphasizes Member-centric, team-based care. We will work collaboratively with community partners, providers, Care Coordinators, and all components of the Member's team to improve prenatal care. This includes:

- Care Coordination for women identified as high risk
- Interface with Public Health Departments, WIC programs, etc.
- Technology solutions:
  - CONNECTS
  - Electronic medical records systems
  - Text4baby
  - Social media campaigns

Potential outcomes: Increase number of women who are identified during the first term of pregnancy, increase number of women who seek care throughout their pregnancy.